Intervention Programs for Perpetrators of Intimate Partner Violence: Conclusions from a Clinical Research Perspective

Christopher I. Eckhardt, PhD[a]
Christopher Murphy, PhD[b]
Danielle Black, BA[b]
Laura Suhr, BA[a]

SYNOPSIS

In this article, the authors consider the empirical status of batterer intervention programs (BIPs) for male perpetrators of intimate partner violence (IPV). Recent reviews have reported only small average effect sizes for BIPs, with the small number of randomized trials showing little benefit of BIP attendance in preventing future abuse. The most widely adopted BIP intervention model has little empirical justification to support this dominance, yet states with standards governing the content of BIPs often mandate this approach as a contingency for state funding. Little data exist concerning the moderators and mediators of BIP effects on IPV recidivism, and a variety of factors threaten to impede future design advancements, including "turf" battles regarding the causes of IPV and limited funding outlets. Given this discouraging summary, the authors argue that research efforts concerning BIP effectiveness should borrow the design strategies and programmatic research efforts that have proven successful in psychotherapy research, in which significant advances have been made with regard to the evaluation and validation of empirically supported treatments for a wide variety of mental health problems. They conclude by calling for a new generation of IPV researchers to work across professional boundaries in a multidisciplinary manner to design the sophisticated evaluation studies that funding agencies would readily support, and that would provide the substantive answers to the many IPV-related public health questions that remain.

[a]Department of Psychological Sciences, Purdue University, West Lafayette, IN

[b]Department of Psychology, University of Maryland, Baltimore County, Baltimore, MD

Address correspondence to: Christopher I. Eckhardt, Department of Psychological Sciences, 703 3rd St., Purdue University, West Lafayette, IN 47907; tel. 765-494-6983; e-mail <eckhardt@purdue.edu>.

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Battered women are at higher risk for depression, suicide, post-traumatic stress disorder, alcohol/drug abuse or dependence, and poor physical health relative to women in non-abusive relationships.[1,2] The financial costs associated with intimate partner violence in the U.S. exceed $5.8 billion each year.[3] Given the staggering individual, interpersonal, and societal costs of intimate partner violence (IPV), it is critical to examine how this problem is being addressed in terms of intervention programs that target the abusive individuals who are responsible for these negative outcomes. In this article, we discuss recent empirical findings regarding the efficacy and effectiveness of batterer intervention programs (BIPs). During the course of this review, we will also attempt to answer several critically important questions: Do such programs actually reduce the likelihood of subsequent acts of IPV? Are particular methods of BIP intervention more effective than others? If these programs are indeed effective, how do they accomplish their effects? In addition, we will contrast what we know about these programs with what we've learned from a parallel area of research and inquiry: the effectiveness and efficacy of psychotherapy for mental health problems. We'll compare and contrast the design and analysis strategies common to both approaches and outline possible strategies for improving research on BIP effectiveness.

CONCLUSIONS FROM PREVIOUS REVIEWS OF BIP EFFECTIVENESS

Research over the previous 20 years concerning the effectiveness of batterer intervention programs suggests that batterer intervention programs result in a small average reduction in intimate partner violence. An early review of 25 studies conducted by Rosenfeld to investigate the effectiveness of BIPs did not find promising results for the effect of treatment.[4] Rosenfeld examined studies that reported recidivism rates and found that men who were arrested but not referred for treatment had a recidivism rate (39%) that was not significantly higher than the recidivism rate for men who were arrested and received treatment (36%). Davis and Taylor calculated the average effect size for five studies using quasi- or true experimental designs and obtained a small-to-moderate treatment effect size (h=0.41).[5] A larger review of 17 studies conducted by Levesque and Gelles (1998) also reported small effect sizes for BIP (range: h=0.18–0.27).[6]

Two recent meta-analytic reviews of BIP effectiveness confirm that BIP attendance is associated with small effects on abuse recidivism. Babcock, Green, and Robie reviewed 22 studies that used quasi- or true experimental designs and police or partner reports of violence recidivism and found that the effects of BIP on violence cessation were small, with effect sizes ranging from d=0.09 to d=0.34.[7] Using the more conservative effect size estimate, Babcock et al. concluded that men mandated to attend batterer intervention programs are only *5% less likely to commit an act of violence* against partners than men who do not attend/receive BIP.[7] In addition, there appears to be an inverse relationship between research design complexity and effect size. Specifically, using partner reports of violence recidivism, the effect sizes associated with the influence of BIP on violence cessation based on studies using randomized experimental designs (d=0.09) were significantly lower than effect sizes from studies using non-randomized (quasi-experimental) designs (d=0.34). Using police reports of violence, randomized experiments resulted in smaller effects (d=0.12) than quasi-experiments (d=0.23), although these effects sizes were not significantly different from one another.[7]

Feder and Wilson also reviewed BIP effectiveness studies in a meta-analysis, including the experimental studies quantitatively reviewed by Babcock et al., but including only those quasi-experimental studies that established initial equivalence between groups via matching or use of statistical controls.[8] Feder and Wilson's analysis of the 10 studies that qualified for inclusion indicated that among experimental studies, BIP had no overall effect on victim reports of physical violence (d=0.01) and small/moderate effects on official reports of spousal assault (d=0.26). Among quasi-experimental studies, BIP had a small iatrogenic effect according to victim reports of violence (d=−0.11) and official reports relative to no treatment comparison groups (d=−0.14). Interestingly, when BIP dropouts were used as a comparison condition in quasi-experiments using official reports of spousal assault, BIP had a very strong effect on violence reduction (d=0.97). While these meta-analytic reviews may be criticized for the relatively small number of studies reviewed, the general pattern of findings suggest that *(1)* BIP may be associated only with small positive effects in reducing the likelihood of male-to-female IPV, and (*2*) effect sizes attributable to BIP completion appear to decrease as a function of the methodological and evaluative rigor used in BIP effectiveness research.

Given these findings, it may be instructive to examine findings from randomized controlled trials (RCTs) of BIP effectiveness more closely. Taylor, Davis, and Maxwell randomly assigned 376 men convicted of a domestic violence offense in Brooklyn, NY, to an eight-week traditional gender-role focused group BIP (the "Duluth Model"), a 26-week traditional group BIP, or

a control (community service) group.[9] Follow-ups at six-months and 12-months post-sentencing showed a significant impact of treatment on violence cessation according to police reports of violence recidivism. On partner reports of violence, however, there was no significant impact of treatment. In addition, when the treatment groups were separated by length of treatment, only men assigned to the 26-week treatment group had significantly fewer incidents of violence than those in the control group.[9] Feder and Dugan randomly assigned 404 men in Broward County, FL to a Duluth Model BIP group plus probation monitoring, or to a probation monitoring-only control group.[10] At a six-month and 12-month follow-up, the men assigned to receive BIP had levels of violence similar to the control group, according to police and partner reports. Dunford randomly assigned 861 men in the U.S. Navy stationed in San Diego to either a 26-week cognitive-behavioral group BIP, a 26-week couples therapy group, a rigorous monitoring group, or to a no-treatment control group.[11] Follow-up reports from female partners of male participants gathered six and 12 months post-treatment indicated no differences in male-to-female physical aggression across the four groups. Similarly, in a study of over 300 IPV perpetrators randomly assigned to treatment as a pretrial diversion, treatment as a condition of probation, or a purely legal intervention (i.e., fine or jail time), Ford and Regoli found no significant difference in partner reports of violence across the three groups at six-month follow-up.[12] In contrast, Palmer, Brown, and Barrera found a positive effect of treatment with an abusive sample.[13] Palmer et al. used a block random procedure to assign 59 Canadian IPV perpetrators to a 10-week psychoeducational treatment group versus a no-treatment control group. Police reports at a follow-up one year later indicated that men assigned to the treatment group showed lower rates of IPV recidivism than men in the control group.[13] Overall, the results of these experimental investigations, which incorporate the highest degree of control over confounding factors, suggest that the BIP interventions produce, at best, quite modest benefits relative to non-BIP comparison conditions.

It is also important to examine whether there is evidence concerning differential treatment effectiveness: Does one type or format of BIP outperform other formats? At the risk of overgeneralizing this issue, there are two major models of treatment upon which most BIPs are based. The most popular intervention is a psychoeducational model that attempts,[14] in a group format, to educate men about their attitudes concerning their perceived right to use power and violent coercion to control or subjugate women (the "Duluth Model").[15] A second approach, the cognitive-behavioral treatment (CBT) model, considers IPV as a learned behavior and focuses on the therapeutic modification of faulty cognitions and intense emotions and in teaching communication skills and emotion control techniques to prevent future violent behavior.[16] The Babcock et al. meta-analysis found no significant difference between effect sizes of different BIP approaches.[7] However, as noted by Babcock et al. and Healey et al., it has become increasingly difficult to discern between BIP groups that label themselves a Duluth Model program versus those that are self-described Cognitive-Behavioral Programs, a situation that artificially increases the likelihood of null results when comparing differences between intervention types.[7,14] As both interventions purport to target faulty attitudes and beliefs and to address the behavioral consequences of holding those beliefs, it is common for both types of BIP formats to label themselves with the more generic CBT label. However, as noted by Murphy and colleagues, the primary differences between these formats lie in the methods used to enact cognitive and behavioral change.[16,17] Duluth Model-based programs are typically didactic and education/consciousness-raising groups that consistently focus on issues relating to gender egalitarianism and patriarchal ideology. While there is a focus on attitudes and behaviors that is within the general scope of CBT practice, these programs typically have limited, if any, focus on coping with intense emotions, relationship skill building, trauma recovery, or other interventions to address various individual psychological problems. CBT interventions, in contrast, are more likely to address these latter topics, and also focus on the modification of faulty cognitive processes from a perspective based on the specific set of therapeutic principles and practices derived from generic cognitive behavioral treatments for mental health problems,[18] rather than a strict focus on gender-themed factors (See Murphy and Eckhardt,[19] for additional discussion of these approaches).

Aside from Duluth Model and CBT approaches, there are precious few alternative BIP formats. Despite the consistent link between disturbances in anger experience and expression among IPV perpetrators (for a review, see Norlander and Eckhardt[20]), interventions that focus on anger control are not standard approaches and are often discouraged in states with guidelines governing BIP content.[14,21] Interventions that focus on relationship systems are also forbidden according to the majority of state batterer intervention standards, despite extensive data demonstrating the bidirectional and often mutual nature of physical

aggression in close relationships.[22–27] More research is needed using a treatment comparison design strategy that attempts to uncover whether there are meaningful differences in IPV-related outcomes across different BIP programming formats. The available studies have provided valuable insights in need of further empirical study.[28–30] As an example, consider the empirical status of couples' treatment for partner abuse. In Dunford's randomized study of BIP (described above), there was no difference in IPV recidivism between men assigned to couples treatment versus a CBT group.[11] Using couples volunteering for treatment at a university marital distress clinic, O'Leary et al. found no difference between men assigned to either couples treatment versus a group Duluth Model intervention.[22] Brannen and Rubin reported similar results using a court-referred sample.[31] Thus, one can either conclude that couples treatment is unwarranted since it does no better than more traditional group treatments, or one can perhaps see couples treatment as a useful alternative for some violent couples (especially those who are clearly planning on staying together), since it appears to work just as well as traditional interventions.

A final complicating factor concerns the outcome variables measured in previous studies of BIP effectiveness, which have traditionally focused on dichotomous outcomes such as the cessation of physical violence. While partner-directed physical abuse has about a 20%–30% prevalence rate,[2,32] it has a relatively low frequency of occurrence within violent couples.[2] As such, additional abuse indicators are necessary in order to capture more frequent but similarly damaging forms of IPV. One such indicator that has unfortunately received only infrequent attention in BIP evaluation research is psychological abuse. As indicated by a variety of studies, psychological abuse has a higher base rate of occurrence than physical abuse and is strongly associated with a variety of negative outcomes among victims.[33,34] While a number of recent studies examining BIP effectiveness have used multiple measures of partner abuse (including psychological aggression) and relatively long follow-up assessment period of 1–2 years,[11,29] these advances are relatively recent design developments; the majority of studies to date have utilized limited measures of IPV-related outcomes and relatively short follow-up assessment periods (i.e., six months post-intervention). Among these latter studies, it is possible that one reason for the lack of significant differences between treatment conditions is the low base rate of partner physical abuse and the lack of attention to other forms of IPV. This is not to say that psychological abuse should replace physical abuse as an outcome variable, but regular inclusion of emotional abuse measures may add more useful information about higher base rate forms of IPV in addition to more difficult to predict and lower base rate physical forms of IPV that may go undetected in BIP evaluations with limited follow-up assessments.

BIPs were designed to go beyond mere incarceration or legal punishment in cases of IPV and provide an intervention that might actually change perpetrators' behavior for the long term and prevent future abuse from occurring. The available data concerning the effectiveness of such programs in actually accomplishing this goal are rather discouraging: a large percentage of men (around 40%–60%) either do not attend or drop out of BIP, and there is only a negligible relationship between attending BIP and IPV cessation.[35] It is our position that while data regarding BIP effectiveness have improved in many significant ways in recent years, much is simply unknown about how such programs should be designed, how they should be applied in the field, and how they should be studied empirically. This state of affairs is very similar to the status of psychotherapy for mental health problems approximately 40 years ago. At that time, there were a small number of treatments, with each claiming success and theoretical dominance. There were remarkably few carefully designed studies of treatment packages that used random assignment to treatment, construct valid assessment instruments, and long-term follow-up practices. Since that time, however, a tremendous amount has been learned concerning the effectiveness of psychotherapy, in large measure due to the development of rich and complex methodologies for evaluating the causal effects and generalizability of therapeutic interventions. The literature on psychotherapy and behavior change has much to offer the nascent area of IPV intervention and prevention programs in terms of theory, research design, and application.

DETERMINING BIP EFFECTIVENESS: THE VIEW FROM PSYCHOTHERAPY RESEARCH

Clinical research on psychotherapy and behavior change can be divided into two general categories: outcome research and process research. Outcome research focuses on the ability of an intervention to produce a targeted change in behavior, emotion, or symptoms. Process research focuses on the mechanisms of change or the ingredients of treatment that are associated with positive outcomes. Outcome studies have been further subdivided into efficacy research, which focuses on intervention effects in highly controlled experiments, versus effectiveness research, which focuses on outcomes in naturalistic, real-world

practice, and often has fewer controls in place to rule out alternative explanations of findings.[36]

The last quarter-century has witnessed a steady stream of methodological advances in psychotherapy research, such that the modern clinical trial has become a very ambitious and expensive undertaking.[37] Long gone are the days when a small number of loosely diagnosed cases could be subjected to a novel intervention with clinician ratings of change from baseline as the primary outcome. To be considered state-of-the-art, the modern randomized controlled trial (RCT) requires, at minimum, the following features:

1. A sufficient number of cases to detect modest intervention effects (high statistical power).
2. Careful screening and diagnosis to ensure that study participants have the clinical problem under investigation and do not have other problems or complicating factors likely to compromise treatment efficacy (which, together with #1, implies access to a large potential subject population).
3. One or more well-specified experimental treatments with a manual (typically book-length), containing detailed conceptual and procedural information on competent treatment delivery.
4. Methods for demonstrating the integrity of treatment, at a minimum containing measures of adherence to treatment protocols and often also containing measures of competence (e.g., ratings of therapist skill in delivering the specified treatment) and discriminability (e.g., demonstration that specific elements of treatment are delivered exclusively or primarily within specific experimental conditions or that specific elements are not delivered within certain conditions).
5. Methods for training therapists and certifying their competent delivery of experimental treatments (often involving detailed training protocols and close supervision of training cases).
6. Specification of one or more control conditions that will promote causal conclusions regarding treatment efficacy, such as waiting list or no-treatment controls, placebo controls that receive a "theoretically inert" form of clinical attention, or treatment-as-usual controls.
7. Random assignment to experimental versus control conditions (often including additional procedures to promote balancing of key subject features across conditions).
8. Multiple reliable and valid measures of key outcome and process variables, preferably from more than one reporter (e.g., self-report, partner report, criminal justice data, clinician ratings) and generated from multiple methods (e.g., behavioral observation of treatment, self-monitoring) and gathered at pre-intervention baseline and multiple time points during follow-up in order to detect initial change, change trajectories, and maintenance of gains.
9. Data gatherers (assessors) who are not involved in the delivery of treatments and ideally are blind to treatment condition (to reduce the likelihood that participants will respond to please treatment providers or that assessors will bias data gathering to confirm hypotheses).
10. Detailed tracking strategies and incentives to reduce subject attrition in order to avoid erroneous experimental findings as a result of differential drop-out from conditions.
11. Sophisticated data processing and analytic techniques to handle missing data, identify individual growth/change functions, and assess the statistical significance, magnitude, and clinical significance of experimental effects.

Needless to say, such an undertaking is not for the faint-hearted, (and probably not for the untenured). To be considered "empirically supported," a treatment must have solid evidence of efficacy from at least one randomized controlled trial meeting most of the features listed above.[38] One can also set a higher standard, considering a treatment to be "empirically valid," which implies replicated success in RCTs conducted by more than one investigator at multiple sites, thus supporting strong claims regarding both efficacy and generalization of treatment effects.

To date, *there are no interventions for partner violence perpetrators that approach the standard of "empirically valid," and it is debatable whether any intervention can be labeled "empirically supported."* The majority of existing studies lack random assignment to treatment versus control conditions, and therefore cannot rule out alternative explanations such as spontaneous (naturally occurring) change in behavior over time (e.g., in pre-post-intervention designs with no control or comparison group) or selection artifacts (i.e., preexisting differences between treatment and controls that explain results).[39] Selection effects are prominent alternative explanations for findings that use drop-outs or treatment refusers as the control group, as these individuals are likely to differ from treatment completers in a number of important ways (e.g., lower stake in conformity, more disorganized life styles, greater antisocial features) that may account

for poorer outcomes. As noted above, the meta-analytic review by Babcock et al. indicated that the vast majority of studies used some type of non-randomized research design, mostly involving treatment drop-out controls.[7] Among the five studies that used randomized experimental designs, very small average intervention effects were observed.

In response to the outcomes of experimental investigations of BIP effectiveness, various authors have highlighted limitations present among these studies, with some researchers suggesting that these flaws may be responsible for the otherwise negligible effects reported. Criticisms have been discussed either in terms of specific design flaws within a particular study or in terms of supposed limitations of RCTs in general,[40–42] and the interested reader may wish to consult these sources for a more complete accounting of the issues involved. For example, while the research by Dunford applied most of the ideals of the RCT listed above, one may question the exclusive use of military personnel and the high rate of duty-reassignment among men in the study as it relates to the ability of the interventions to produce differential outcomes and the generalizability of findings to civilian populations.[11] More generally, Gondolf has questioned whether RCTs should indeed be the "gold standard" for determining research design quality, noting the practical limitations to implementing such designs in criminal justice settings and conceptual issues concerning how best to analyze differences among experimental and comparison groups (e.g., intent to treat versus completer analyses).[42] Thus, acknowledging and addressing limitations to available research is a critically important step toward improving the quality of future BIP effectiveness research. However, it would be mistaken logic to imply that since experiments are imperfect and difficult to implement, less rigorous research designs are somehow more desirable. In addition, most of the research design elements offered as alternatives to randomized experiments (e.g., statistical modeling of treatment exposure in instrumental variables analysis) were developed to better approximate experimental designs with non-experimental data, and can be applied to strengthen the findings from experiments with problems such as subject attrition. Thus, it is a far stretch of reasoning to argue that these strategies are somehow superior to the RCT when it comes to generalized causal inference.[39]

That said, it is worth highlighting the strong points present in the small number of BIP effectiveness studies that have approximated the ideals of the RCT, or that have at least used strong quasi-experimental controls. Researchers have randomly assigned very large samples (e.g., 300–800) of men to competing intervention conditions,[5,11,43] used multiple measures and reports from multiple informants (for a review see Gondolf[42]), implemented assessments of treatment integrity and adherence,[11,30] incorporated important analytical innovations from the public health arena including instrumental variable and propensity score analyses,[41,44] and utilized long-term follow-ups of one to three years.[11,41,30] Thus, in the previous decade, high quality experimental and quasi-experimental studies of BIP effectiveness have successfully informed the field about what may work in the context of programs designed to stop men's abuse of their female partners. However, recent research syntheses cast some doubt on the overall degree of effectiveness among BIPs compared to relevant comparison conditions. Even if one were to accept the most optimistic appraisal of the effectiveness of partner violence interventions,[42,45] serious questions remain regarding alternative explanations of intervention effects as a function of research methodology, and there is no clear way to attribute any potential effects to specific aspects of intervention. In a nutshell, both non-randomized studies and experimental studies with high attrition rates and inadequate treatment specification, which together account for the vast majority of research on BIP interventions, require that a number of plausible alternative explanations be ruled out before any causal conclusions of treatment efficacy can be drawn.

THE PROCESSES OF CHANGE IN BIP: THE VIEW FROM PSYCHOTHERAPY RESEARCH

A number of factors have emerged quite consistently as successful predictors of treatment outcome in the general research literature on psychotherapy and behavior change. Perhaps most notable is the working alliance—the collaborative relationship between therapist and client.[46] The alliance is typically thought to have three components: a warm bond between therapist and client, agreement on the goals of treatment, and agreement on the tasks or strategies needed to attain those goals. The collaborative alliance is a controversial concept in partner violence intervention, as supportive and empathic therapist behaviors thought to promote a strong alliance have been seen by some in the field as promoting collusion with the abuser's negative outlook. It is also important to note that the alliance, as currently conceived, is not a therapist-delivered entity, but rather a relationship level, two-person construct. Thus, it is expected that both the client and therapist

contribute to the establishment of the working alliance, and that client personal characteristics may impede alliance formation.

To date, the available empirical evidence consistently supports the predictive value of a strong working alliance in partner violence intervention. In both a study of couples and gender-specific group treatments for voluntary (self-referred) abusive men as well as a study of cognitive-behavioral group treatment for primarily court-referred abusive men,[47,48] ratings of the working alliance predicted lower levels of self-reported and partner-reported abusive behavior post-treatment. Interestingly, in the study by Taft and colleagues,[48] therapist ratings of the alliance late in group treatment (at sessions 11 and 13 of a 16-session program) were the most strongly associated with outcome (as compared to client ratings and early session ratings of both client and therapist). With this often interpersonally challenged and treatment-resistant population, it may take a while for the alliance to develop or for the therapist to have a clear picture of the quality of the alliance.

Additional factors that have been found to predict successful change in other areas of psychosocial treatment research have also enjoyed some predictive success in partner violence treatment. Compliance with homework assignments in CBT (i.e., participation in active change strategies) was associated with lower levels of psychological abuse after treatment. In addition, client ratings of positive group cohesion were associated with lower levels of both physical and psychological abuse at follow-up.[48]

Client motivational readiness to change may play an important part in these process results. Researchers investigating the transtheoretical ("stages of change") model of behavior change have reported that approximately one-third of abusive men mandated to attend BIP present with characteristics suggestive of the earliest stage of the behavior change process, i.e., men who do not recognize the existence of a problem and who have no plans to make active attempts at behavior change (the "precontemplative" stage).[49–52] Precontemplative men reported using fewer behavior change processes than men in other stages,[50] reported fewer benefits relative to costs of making a commitment to nonviolence,[51] demonstrated minimal therapeutic change over the course of BIP,[52] and were more likely to be arrested for any criminal offense one year post-adjudication.[53] Not surprisingly, therefore, motivation to change is a strong predictor of the working alliance.[54] Abusive clients who reported higher motivational readiness to change at program intake established a stronger working alliance, which in turn is associated with higher compliance with the structured change elements of treatment and with lower levels of post-treatment abusive behavior.[19]

Consistent with the process findings, the use of motivational interviewing (MI) strategies during the intake process at a community agency for partner violence treatment appears to promote client engagement into treatment and improvement on process factors related to outcome. Motivational interviewing was designed for working with substance abusing clients who are often ambivalent about change.[55,56] It uses a high level of reflective listening, affirmation of client autonomy and control over the change process, techniques for "rolling with resistance," and interventions tailored to the client's stage of change.[51,52] A study comparing a standard structured intake to an intake process involving two 45-minute motivational interviews found that abusive clients who received the motivational intake articulated more positive statements about treatment and took more personal responsibility for their abusive actions during early sessions of their subsequent domestic violence group (as measured by observational coding of group treatment sessions), had much higher levels of CBT homework compliance, and higher therapist ratings of the working alliance in subsequent group treatment.[57]

In brief, the available research to date, although limited, indicates that partner-violent clients are quite similar to other psychosocial treatment populations in responding to therapist support and reflective empathy. Factors that predict successful outcomes in other areas of psychotherapy and behavior change likewise appear to predict cessation of physical assault and reduction of emotionally abusive behavior in this treatment population. Although we do not as yet have sound empirical support for this speculation, careful reading of many existing treatment manuals in this area indicate that high levels of therapist confrontation and critical or punitive attitudes toward abusive clients by service providers may impede the development of the working collaborative alliance and other active elements of the helping relationship.[58–60]

DESIGN STRATEGIES AND ASSUMPTIONS IN IPV RESEARCH

Research on the effectiveness of interventions for IPV perpetrators has generally followed the logic of social policy analysis (trying to investigate the effectiveness of existing programs in the field) rather than the logic of clinical trials (trying to develop interventions and test their efficacy in carefully controlled settings before

attempting to generalize them to field work). While the social policy approach may offer important answers to short-term needs existing within the criminal justice and advocacy communities to develop useful violence rehabilitation and desistance practices, it offers relatively little for our long-term understanding of how violence cessation programs ought to be designed and implemented, and how these practices actually work to affect behavior change. Thus, state-of-the-art technology from clinical behavior change research has not been sufficiently brought to bear on counseling/treatment interventions for partner-violent men.

But why not? Is it any more difficult to successfully study what interventions promote nonviolent change than to investigate what treatments alleviate episodes of depression or reduce the likelihood of self-injurious behavior? While there are indeed a variety of practical obstacles that make randomized designs more difficult to implement in criminal justice settings (see below), such obstacles are not insurmountable; public health researchers have clearly demonstrated that close links between basic and applied research can result in successful prevention programs for a wide variety of health perils. Thus, there are other forces at work besides task difficulty that likely explain why research on BIP effectiveness is lagging behind. We offer several possibilities:

1. The research/practice rift

There has been, and continues to be, a deep and often contentious controversy surrounding how to conceptualize the causes of, and intervention approaches for, IPV. A perspective held by many practitioners and grass roots activists suggests that the root causes of IPV lay in our fundamentally patriarchal societal and institutional structures that tacitly or overtly reward the continued domination of males over females, and that justify any means (including physical aggression), enabling men to occupy positions of power.[61] Males absorb these messages of male privilege during socialization by community and family members, and apply them in intimate relationships in the form of behaviors that exert power, control, and domination over their female partners. Given this heuristic, which represents a starting point in the development of structured intervention programs for IPV perpetrators, it follows that intervention strategies should be centered around psychoeducational reprogramming, whereby the patriarchal ideologies and philosophy of male privilege among perpetrators are exposed, power and control tactics discouraged, and more gender-egalitarian strategies encouraged. Most existing intervention programs and state coalitions against domestic violence espouse both this specific conceptual framework and singular intervention approach. In some states, approaches that run counter to these perspectives are discouraged or prohibited by existing standards.[14,24]

A somewhat different perspective often espoused by IPV researchers and empirically-oriented practitioners from a wide array of professional backgrounds is that power, control, and misogynistic attitudes are indeed important factors in understanding IPV and intervening with perpetrators. However, additional factors are added to the equation that may also be important in understanding the causes of IPV and in designing intervention strategies. Thus, this perspective provides allowances for such perpetrator-focused factors as psychopathology, anger arousal disturbances, cognitive distortions, and the long-term effects of childhood traumas, and considers alternative intervention strategies for abusive men that focus on additional risk factors or treatment modalities (e.g., conjoint treatment) other than those specified by the patriarchal ideology model. These intervention targets are usually supported by available empirical studies, but are often criticized by practitioners for running too far afield from the feminist analyses of IPV causation.[24]

While it seems obvious that the perspectives of practitioners and researchers are intertwined and largely complementary, the more proximal consequences of this rift have unfortunately been twofold: (*1*) a pervasive lack of trust between BIP practitioners/administrators and IPV researchers, and (as a consequence), (*2*) an infrequent collaboration between IPV researchers and BIP practitioners. It would seem logical for BIP practitioners/administrators to adopt the most efficacious intervention for batterers available, since doing so is directly related to the one goal that unifies all parties involved: promoting the future safety and welfare of abused partners. Researchers ought to be in a prime position to aid BIP programs in this regard, as the question of what works best for whom is the kind of question that researchers, who are more likely to have a specific background in research design and methodology, are ideally suited to answer. And since researchers have more direct access to external funding sources, they could financially aid BIP programs such that those agencies could perhaps serve more perpetrators more effectively. But researchers are unlikely to progress with research questions relating to improvements in BIP effectiveness without the aid of BIP practitioners/administrators, who typically have the greatest access to IPV perpetrators and thus serve as quasi-gatekeepers in the path of BIP research efforts. While reports have suggested the potential benefits of researcher-practitioner collaborations in BIP design

and evaluation,[29] cooperation between researchers and practitioners at present needs strengthening.[42]

2. Difficulties with definition and design

As noted above, most BIP research follows the logic of social policy analysis: evaluating the criminal justice policies currently in practice in response to IPV and the effects that these policies have on future acts of violence. While such an approach is warranted given the emerging nature of this research area, we would posit that a critical question still unaddressed by the social policy approach is a question of definition: Is a BIP punishment, a therapeutic intervention, an educational experience, or some amalgam of all three? Clearly, IPV offenses are violations of the law and the criminal justice system reacts to that offense by mandating that most offenders attend a batterers intervention group or face a jail penalty, so in that sense BIP is obviously a punishment in response to a specific criminal offense. But we expect individuals in these groups to learn something, to gain important information that helps them understand their prior decisions to act violently and contributes to a new understanding and personal responsibility to eliminate IPV from their lives. So, in that sense, BIP is psychoeducational. Yet, it's also clear that a variety of psychological and lifestyle factors are among the more robust risk factors for acts of IPV, and many BIP programs will address these risk factors in a therapeutic manner (e.g., cognitive behavioral interventions that change faulty beliefs or improve emotional coping). BIP is therefore a difficult to define amalgam of punishment, education, and therapy.

This amalgamation creates problems from a design and evaluation standpoint. It is difficult to disentangle which of these three operations are contributing to any changes that occur as a result of BIP in designing and evaluating a particular intervention. While any therapeutic intervention involves an amalgam of ingredients that promote change including client education, the presumed active components of the intervention, and other nonspecific factors stemming from the therapeutic relationship, BIP presents a most unique case given the coercive nature of the referral source, the often restricted nature of what events are allowed to serve as the causes of IPV as well as the focus of BIP interventions,[24] and the ever-present threat of legal retribution for treatment noncompliance. To disentangle these components, one must design the evaluation in such a way that educational, therapeutic, and punishment factors that may be mediating the relationship between BIP attendance and IPV outcomes can be reliably assessed. To date, there have been relatively few efforts to measure the mediators of BIP outcomes, and doing so would add extremely valuable information about the processes of change involved in IPV cessation. Recent articles have provided a detailed description of how researchers can assess mediating and moderating factors in RCTs, and BIP effectiveness research must rise to this design challenge to address three pressing and unanswered research questions regarding BIP effectiveness: (*1*) How can particular interventions be tailored to address the most critical treatment targets for IPV perpetrators? (*2*) Under what conditions and for whom does a given intervention work? (*3*) Do the presumed active components of a particular BIP modality uniquely contribute to behavior change? [62] We would argue that the research design strategies and lessons learned from decades of research on psychotherapy and behavior change hold substantial promise for answering these questions, but have received only minimal attention to date.

Since there is little agreement about how best to define BIP, it follows that there are diverse viewpoints regarding how best to study its effects. Most would agree that the RCT is the ideal method of determining the efficacy of a clinical intervention, but as noted above, there have only been a handful of such studies in the history of BIP research and evaluation, and they are the studies with some of the lowest effect sizes for reducing violent recidivism. There are several reasons for the dearth of RCTs evaluating BIPs. Given the long list of RCT-defining aspects listed above, one can readily infer that the complexity inherent to such designs involves numerous practical obstacles within any research context. In the criminal justice context, a variety of 'real world' demands and problems can interfere with implementation of an RCT. A variety of community, legal, and criminal justice agencies are typically involved or implicated with the design and implementation of the research, and each will likely have a broad array of concerns, differing perspectives, and other interests that must be addressed before the study can proceed. For example, will BIP program administrators and/or domestic violence court judges allow random assignment of batterers to treatment and control groups? Will there be an opportunity to present informed consent information to potential participants at the beginning of a BIP session, or must this occur at another time or location? Will there be sufficient cooperation between the researchers and the agencies that control access to important information (e.g., police, probation officers, BIP counselors) to allow the research design to be fully implemented? In addition, the dynamic changes of personnel, policies, and procedures that typically occur in criminal justice settings over the course of an evaluation period can significantly

affect how design details are implemented.[43] Such practical demands and organizational constraints require a close degree of cooperation between researchers and nonresearchers well in advance of data collection or even submission of a grant application. Without clear communication and detailed cooperative agreements between the parties involved, there will be a limited degree of trust between the research and nonresearch personnel, which in turn may lead to difficulties related to how the research is conducted and ultimately lead to the presence of factors that may confound the results of the evaluation.

3. Funding sources

Even with a strong working relationship between a BIP agency and one or more clinical researchers, an RCT comparing, for example, just two variations of BIP to a suitable control group requires considerable resources.[37] Costs include intervention staff, assessment staff, money for participant and partner follow-up, and funds to support scientific administration and project oversight. Assuming the design is well constructed and the overall proposal is conceptually clear, it *should* be the case that such a strong research coalition investigating a critically important public health problem will have little difficulty locating a funding source. However, this is far from true. In fact, the limited funding available for BIP-related research threatens to attenuate the already limited progress of this area of research. Since IPV perpetration is not an official diagnosis in the latest revision of the Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM IV-TR),[63] it may fall outside the realm of traditional behavior change funding sources (e.g., the National Institute of Mental Health). While various branches of the National Institutes of Health (NIH) have funded research on IPV, a recent electronic search of IPV-related grants funded by NIH since 2000 indicate that less than 20% of funded projects actually investigated specific intervention programs to reduce IPV. In addition, it has become increasingly the case that new research proposals need to substantively address factors relating to mental health (i.e., using DSM-IV diagnostic categories) in addition to violent behavior to be favorably reviewed. Other branches of the U.S. Health and Human Services, most notably the Centers for Disease Control and Prevention, have recently become more regular and visible funding outlets for IPV research and BIP investigations in particular.

The creation of the Violence Against Women Office (VAWO) within the United States Department of Justice in 1995 was designed to provide a central coordinating agency that would enact and enforce the monitoring and criminal justice policies relating to the 1993 Violence Against Women Act. In addition, in collaboration with the research arm of the Department of Justice, the National Institute of Justice (NIJ), it has also served as a specialized funding source for research on IPV, with the number of discretionary grants awarded to IPV-related research project increased from 92 funded proposals in 1995 to more than 400 in 2000.[64] NIJ/VAWO has funded numerous important research projects regarding BIP, published a series of useful monographs concerning the present and future status of BIP,[14,40,65] and convened several noteworthy national conferences devoted solely to discussing the state of BIP research and practice. However, there has been limited interest expressed in recent requests for proposals in investigating specific intervention strategies for IPV perpetrators. While NIJ/VAWO has been interested in the effectiveness of BIPs and has funded two of the five published studies using random assignment of perpetrators to treatment, the focus of such studies has been on the criminal justice or social policy implications of BIP rather than on the specific content of the interventions involved. In addition, the amount and duration of NIJ grants are often well below that required to conduct a high quality RCT investigation.

Thus, in order to secure funding, a research coalition may need to go beyond the rudimentary questions of whether BIP works and differential effectiveness of multiple BIP interventions, and instead make their BIP evaluation proposal relevant to issues relating to mental health/substance abuse or directly relevant to criminal justice policy and practice. The problem, of course, is that accumulated research on BIP effectiveness and our knowledge of the potential moderators and mediators of its effects are at such an elementary stage that these very basic questions are precisely what need to be answered at the present time. Thus, as researchers gather more evidence about the processes of change underlying IPV cessation and put this information to use in RCTs investigating BIP process and outcome, there is also the coexisting dimension that such research needs to be designed in the context of additional content areas deemed important by relevant funding agencies.

CONCLUSIONS

In conclusion, the limited research on BIP effectiveness and the lack of suitable application of sophisticated research design strategies that have so clearly benefited research on psychotherapy and behavior change are not because of a lack of awareness that these issues exist; rather, any careful examination of the general

BIP literature suggests that it is an area where theoretical/ideological concerns have largely outstripped the importance of empirical evidence. For example, some have argued that state standards governing BIP content appear to have been formulated largely on the basis of loyalty to a particular explanatory model rather than on a careful examination of the research evidence on abuse perpetrators or evidence for a particular intervention model's empirical support.[25,66] While there is likely to be more flexibility in program design at the local level,[42] additional empirically informed insights are needed to guide the optimal development of BIP interventions.

As a result of these problems, research on interventions for IPV perpetrators is at a critical juncture. The accumulation of largely unremarkable outcomes regarding BIPs could potentially signal to those in the criminal justice community that such programs are simply not worth the effort: Why mandate an intervention that men have little motivation to attend, that at best has a small impact on criminal recidivism, and that doesn't really qualify as a punishment, an educational experience, or a therapeutic intervention? Should the criminal justice community decide to eliminate BIPs, funding sources would shrink even further and research would stagnate. Thus, we hope that the relatively discouraging findings from controlled studies to date do not completely undermine our efforts to develop effective interventions for abusers.

Perhaps a more optimistic implication is that the field needs an infusion of new researchers, with parallel increases in support from relevant funding agencies. Thus, if a concerted effort could be made to cast aside issues of professional boundaries and theoretical ownership of the area, and to apply the most sophisticated methods for the study of intervention and behavior change with support from multiple funding agencies, the field might be in a position to do something that it cannot do today: to answer the questions posed at the outset of this paper—do such programs actually reduce the likelihood of subsequent acts of IPV? Are particular methods of BIP intervention more effective than others? What are the moderators and mediators of BIP success and failure; how do BIPs accomplish their effects? Perhaps a new generation of clinical researchers can bring us to a point where we can actually possess empirically informed answers to these questions from theoretically supported and methodologically sophisticated research designs. These are the kinds of answers that ought to inform matters of criminal justice policy, rather than the very limited and much debated conclusions that are currently in play. To get there, funding agencies will have to increase their funding of this kind of high level research in order to generate not only a new generation of researchers but a new generation of more complex research questions.

For example, one promising avenue is to examine the effects of batterer interventions for co-occurring conditions that often accompany partner violence. While some elements of the BIP community continue to reject the notion that individual mental health problems can ever influence IPV, it is reasonable to assume that at least a small percentage of perpetrators will also have co-occurring psychiatric and substance-related problems. While these problems may or may not directly cause IPV, they certainly make the intervention process much more complicated. Indeed, researchers are just starting to progress on elucidating the prevalence and role of comorbid mental health problems and partner violence,[67] and this should presumably involve examination of effects that interventions for those particular disorders have on partner violence. In fact, Gondolf and colleagues at Indiana University of Pennsylvania are currently conducting an NIJ-funded randomized trial of adjunctive mental health interventions for IPV perpetrators, the results of which are eagerly anticipated.

In conclusion, it is clear at this point that researchers investigating intervention programs for men who abuse intimate partners can no longer "go it alone"—the multifaceted nature of IPV and the complex issues surrounding the treatment goals of BIPs mandate nothing less than a multidisciplinary approach to addressing this problem. While this is hardly a novel suggestion, putting this ideal into practice has proven challenging. In our view, the noteworthy methods and lessons learned from the area of psychotherapy research has much to offer the emerging area of BIP effectiveness research. Individuals who have been charged with the responsibility of counseling men mandated to BIP, be they at treatment delivery or administrative levels, must move beyond the traditional and well accepted perspectives on how such programs should be designed. While this is always a difficult goal to achieve, the evidence reviewed in this article suggests that current BIP programs adopted by most jurisdictions are in need of improvement. Thus, it is time for researchers and practitioners to move beyond the traditional boundaries that have separated various professional areas involved in IPV research and treatment in hopes that future generations of individuals can experience love and intimacy without abuse.

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