

# **Treatment for Perpetrators of Domestic Violence: A Review of the Literature**

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*Utah Criminal Justice Center*

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## **Executive Summary**

### **Background**

The earliest public response to the issue of domestic violence was in the form of shelters for battered women and their children. Due to the large number of women returning to their partners and/or multiple victims from a single perpetrator, shelter workers recognized the need to develop programs to address the behavior of the abuser (Davis & Taylor, 1999; Feder & Wilson, 2005). Feder and Wilson (2005) describe early batterer groups as, “unstructured educational groups focused on consciousness-raising and peer self-help within a context of feminist theory” that focus on the role of patriarchy in perpetuating domestic violence (p. 240). Over time, Batterer Intervention Programs (BIPs) became more structured and blended with psychoeducational models and cognitive-behavioral therapeutic techniques and skill building exercises. The 1980s saw significant growth in the number of BIPs nationwide, due to mandatory arrest and mandatory prosecution policies. Davis and Taylor (1999) describe the policies as requiring that “cases be pursued to conviction regardless of victim desires or willingness to cooperate” (p. 70). Because of these policies, the courts experienced an increase in the number of IPV cases and turned to BIPs as an alternative to incarceration (Davis & Taylor, 1999; Feder & Wilson, 2005). In 1984, the Attorney General’s Task Force on Family Violence recommended mandated treatment for batterers in an attempt to increase treatment compliance (Feder & Wilson, 2005). The Violence Against Women Act (VAWA) of 1994 (most recently reauthorized in 2013) promotes a continued coordinated criminal justice response to domestic violence, which includes mandatory arrest and prosecution of batterers. VAWA provides guidelines and technical assistance, incentivized through grant funding, but the responsibility for developing, implementing, and enforcing laws and policies remains in state control (U.S. Department of Justice, 2011).

### **BIP Standards**

According to Messing and colleagues (2015), all states have strengthened the criminal justice response to domestic violence since the inception of VAWA. In that time, many jurisdictions have developed standards of care for BIPs; however, those standards remain fragmented across states (Gondolf, 1995; Babcock et al., 2004). Nationally there are wide variations in whether states have standards, and when those standards were last updated. Standards also vary according to the governmental units involved and the means of regulation, which might be a local judicial board, another criminal justice body, or a state code agency such as public health, child protection, or human services (Maiuro & Eberle, 2008). For the majority of states with standards, the role of research in formulating or revising state standards is unknown and less than a quarter of states with standards have documented methods for assuring the quality of treatment programming.

State standards often dictate the type, modality, and duration of treatment used to treat IPV perpetrators. Many states ban certain treatment modalities, including interventions for couples and those that primarily target anger management or substance use disorder. This has resulted in a significant tension due to the difficulties these bans create with respect to developing and implementing new treatment modalities (Bennett & Vincent, 2001). Seven states allowed clinical research testing of new modalities of treatment, but definitively banned couples counseling (Miller et al., 2013). In a current review of Utah standards, there were no banned approaches; however, couples therapy cannot be utilized until the IPV perpetrator has completed twelve weeks of

treatment and is reassessed. The assessment must determine that “the victim is at low risk for endangerment of further abuse due to counseling” (UDCFS DV Practice Guidelines, 2010, p.11).

Nationally, as well as in Utah, a variety of types of organizations facilitate BIP treatment, including victim service organizations, family service organizations, and mental health clinics (Davis & Taylor, 1999). As a result, there is significant variety in the facilitation of these groups such as fidelity to a modality, number/duration of sessions, or training and supervision for group facilitators. As such, the efficacy of BIPs in both the state of Utah and nationally are not easily known.

## **Efficacy of IPV Perpetrator Treatment**

This review examined extant research on the impact of treatment in reducing criminal recidivism among adult male Interpersonal Violence (IPV) perpetrators (see Appendix A for details on search methodology). Findings are presented for the most commonly used treatment modalities (Duluth and CBT – referred to as the *primary modalities* throughout this report) as well as a number of promising approaches. According to Eisikovits & Edelson (1989), the Duluth Model was designed to confront male perpetrators’ attitudes about women, particularly the normalization of violent and controlling behaviors toward women that are conceptualized to result in victimization. Cognitive-behavioral therapy (CBT) is a therapeutic intervention developed by psychologists that seeks to change specific thoughts and behaviors and improve skills (Dutton, 2007; Murphy & Eckhardt, 2005; Babcock & Taillade, 2000) and the application of CBT for IPV was developed as an alternative to the Duluth model (Murphy & Eckhardt, 2005). Although developed separately, in practice many BIPs utilize a mixed intervention approach that includes components of both the Duluth model and CBT (Eckhardt et al., 2013; Smedslund et al., 2012; Babcock et al., 2004; Davis & Taylor, 1999).

Overall, the findings with respect to effectiveness of the primary modalities (i.e., Duluth and CBT) are modest at best. Of the four higher-quality experimental studies conducted on the primary modalities, only one showed support for the effectiveness of BIPs. Criticisms of research on IPV treatments are vast and include limitations of both study design (e.g., varying definitions, accuracy of outcome measures, and a lack of comparison/control group) and intervention (e.g., lack of uniformity amongst treatment groups, lack of fidelity, exclusion of higher-risk or co-morbid IPV perpetrators).

In light of such findings on the efficacy of the primary modalities in reducing recidivism in IPV perpetrators, there are many new treatments being proposed as replacements; however, there is insufficient research to confidently identify new modalities that would be more effective than Duluth or CBT. Nevertheless, emerging research does suggest important considerations in the treatment of these offenders. For instance, reductions in attrition seen with individualized treatment (e.g., motivational interviewing, substance use disorder treatment, and separation by risk and/or perpetrator typology) suggest that it should be a component in IPV perpetrator treatment; similar to best practice recommendations for general offender treatment (Andrews & Bonta, 2010). Perpetrators of IPV in treatment are most often involved with the criminal justice system. As such, it is vital to have a coordinated response among criminal justice stakeholders, treatment providers, and victim advocates as consequences of a punitive response, namely its impact on victims are still being determined. Best practices for general offenders and other violent perpetrators (e.g., RNR) are promising and should be tested and evaluated with IPV perpetrators specifically. Examples of well-designed evaluations are offered throughout the report.

Compared to national trends, Utah standards allow for more flexibility with regard to innovation and implementation of modalities outside of the Duluth model and CBT. Specifically, recent revisions to legislation acknowledge the absence of an evidence-based practice in IPV perpetrator treatment, and promote continued research on what works in IPV perpetrator treatment in light of the continued prevalence of IPV in Utah. In addition to piloting promising approaches, program evaluations of individual BIPs, including measures of recidivism and/or the successful acquisition of skills targeted by the BIPs, are recommended to ensure accountability amongst treatment providers across the state.



## Introduction

This review serves as a tool to understand effective treatments for reducing the recidivism of Interpersonal Violence (IPV) perpetrators commonly called batterer intervention programs (BIPs). Results are presented in two parts: 1) a review of state and federal laws in relation to research on BIPs and 2) a synthesis of research on the effectiveness of BIP interventions, including primary modalities and promising approaches.

The review considers studies published in peer-reviewed journals in the fields of medical and social science. Studies must have been published in English in the United States after 1990. The review only includes studies that examined adult males (over 18 years of age) who have been charged or convicted of at least one domestic violence offense against a female adult (over 18 years of age) partner or former partner (whether or not they are/were married or cohabiting at the time) and subsequently mandated to treatment.

The review prioritizes treatment methods and modalities that have the most research completed to date. This includes group treatment in the form of a feminist-psychoeducational (e.g., Duluth model) or cognitive-behavioral approach. The review is also focused on recidivism as an outcome, defined as new criminal justice contact (i.e., arrest, conviction, incarceration) for any crime including domestic violence. In order to situate the discussion within the complexities of both treating batterers and subsequently studying those impacts, variations in outcome reporting will be explored and discussed. For example, there are three primary methods for tracking offender recidivism: self-report, official report, and victim report. Due to the likelihood that batterers underreport, studies that used self-reported recidivism as an outcome are not included (Palmer, 1991). Studies that used official records are included, with the caveat that underreporting is still likely. Dutton et al. (1997) reported that the proportion of arrest to victim-reported abuse was one in 35; that is, for every reported arrest, there were 35 assaultive actions. Victim report is complicated by the difficulty in maintaining contact with victims as well as the possibility that the perpetrator has a new partner after treatment (Bennett & Williams, 2001). This review includes studies that defined recidivism by victim report and/or official record. A thorough review yield a total of 95 articles, including: 28 studies on the efficacy of the primary modalities; five studies on coordinated criminal justice responses; 40 studies on promising practices; 14 meta-analyses, systematic reviews, literature reviews and book chapters; and eight references that inform the discussion of state and federal legislation and standards for the treatment of IPV perpetrators.

For complete detail, including search terms and databases searched, see Appendix A.

## **Background**

The earliest public response to the issue of domestic violence was in the form of shelters for battered women and their children. Due to the large number of women returning to their partners and/or multiple victims from a single perpetrator, shelter workers recognized the need to develop programs to address the behavior of the abuser (Davis & Taylor, 1999; Feder & Wilson, 2005). Feder and Wilson (2005) describe early batterer groups as, “unstructured educational groups focused on consciousness-raising and peer self-help within a context of feminist theory” that focus on the role of patriarchy in perpetuating domestic violence (p. 240). Over time, BIPs became more structured and blended with psychoeducational models and cognitive-behavioral therapeutic techniques and skill building exercises. The first structured BIPs were EMERGE, in Boston, and the Domestic Abuse Intervention Project, or the Duluth Model, in Duluth, Minnesota (Messing et al., 2015).

The 1980s saw significant growth in the number of BIPs nationwide, due to mandatory arrest and mandatory prosecution policies. Davis and Taylor (1999) describe the policies as requiring that “cases be pursued to conviction regardless of victim desires or willingness to cooperate” (p. 70). Because of these policies, the courts experienced an increase in the number of IPV cases and turned to BIPs as an alternative to incarceration (Davis & Taylor, 1999; Feder & Wilson, 2005).

In 1984, the Attorney General’s Task Force on Family Violence recommended mandated treatment for batterers (Feder & Wilson, 2005). Mandating treatment was an early attempt to increase compliance within this offender population with high rates of attrition from treatment. Currently, a majority of BIP participants are court-mandated to complete treatment (Messing, 2015). At the state level, batterers may be mandated to treatment through a variety of approaches: pre-trial diversion, as a condition of their sentence, a requirement of probation, or by entering a plea in abeyance (Davis & Taylor, 1999).

The Violence Against Women Act (VAWA) of 1994 (most recently reauthorized in 2013) promotes a continued coordinated criminal justice response to domestic violence, which includes mandatory arrest and prosecution of batterers. VAWA provides guidelines and technical assistance, incentivized through grant funding, but the responsibility for developing, implementing, and enforcing laws and policies remains in state control (U.S. Department of Justice, 2011). According to Messing and colleagues (2015), all states have strengthened the criminal justice response to domestic violence since the inception of VAWA. In that time, many jurisdictions have developed standards of care for BIPs; however, those standards remain fragmented across states (Gondolf, 1995; Babcock et al., 2004).

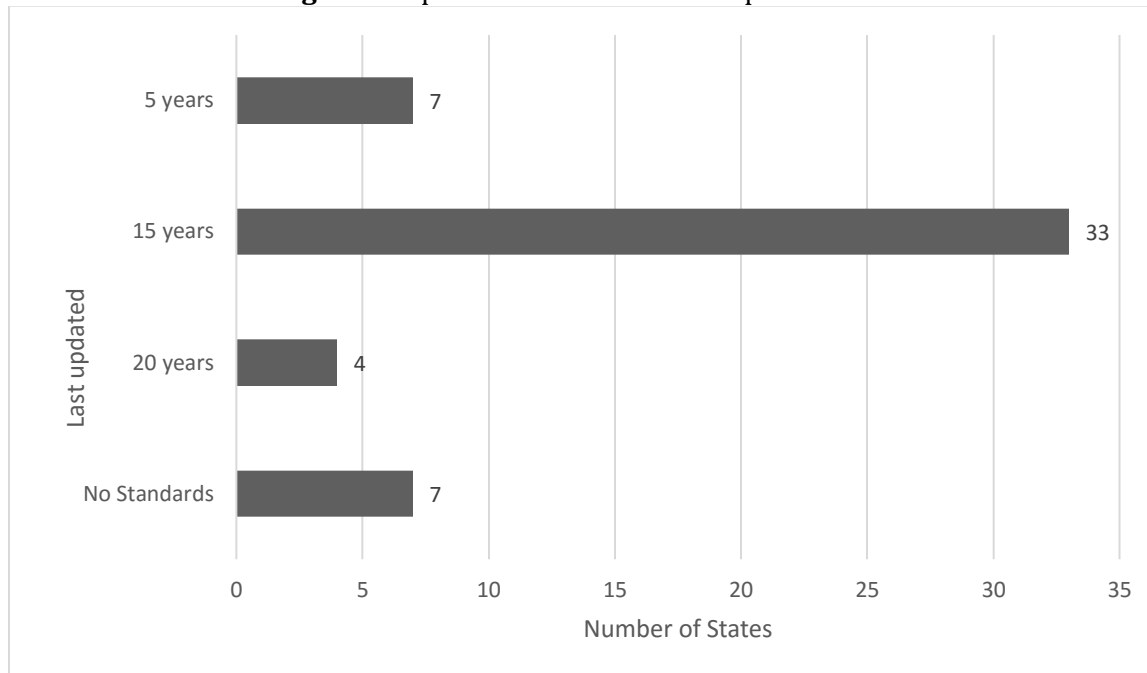
## **BIP Standards**

### **National Standards**

Primary mechanisms for states to implement required standards include certification requirements for providers and tying funding to compliance (Stover & Lent, 2014; Saunders, 2008). While states are continuously updating standards, this review will utilize the compiled state standards from a review conducted by Miller and colleagues (2013) to characterize the range of standards across the United States. Nationally there are wide variations in whether states have standards, and when those standards were last updated. As shown in Figure 1, as of 2013, seven states had not

developed standards and seven states, including Utah, had updated standards within the last five years.

**Figure 1: Updated Standards-IPV Perpetrator Treatment**

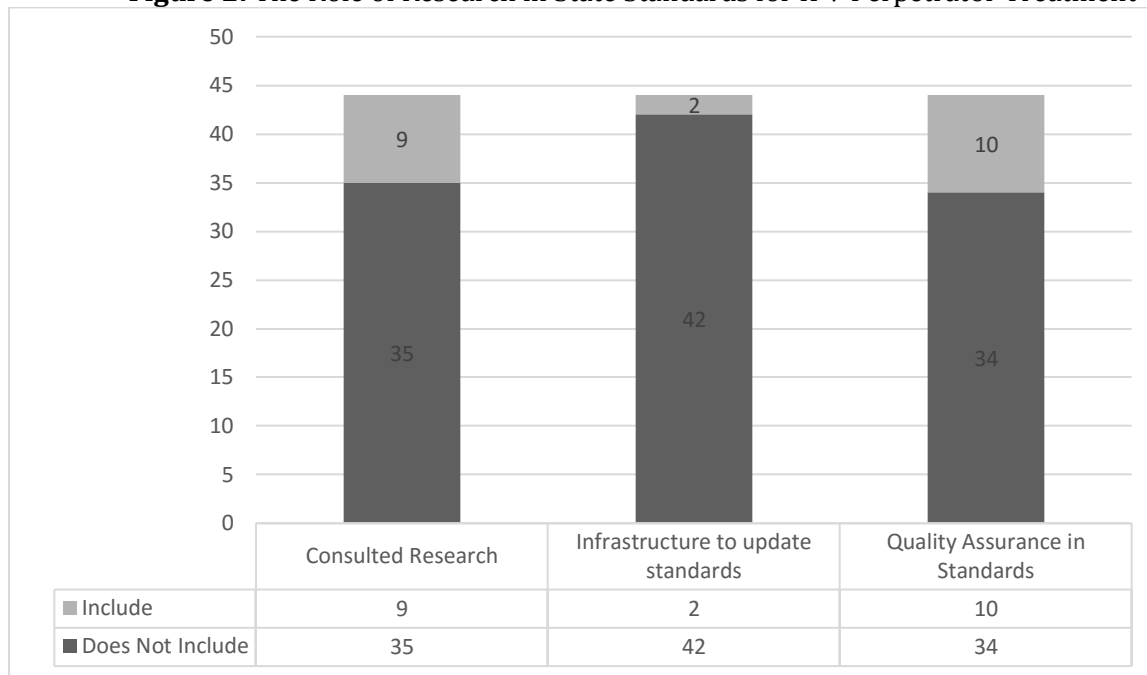


According to Maiuro and Eberle (2008), standards vary according to the governmental units involved and the means of regulation, which might be a local judicial board (CO), another criminal justice body (IA), or a state code agency such as public health (MA), child protection (WA), or human services (IL). Twenty-seven states, including Utah, had required standards<sup>1</sup>. An example of a required standard is one that requires programs to adhere to standards for licensing or funding. Sixteen states (not including Utah) had mandated BIPs. An example of a mandated BIP is when a state requires that all IPV perpetrators attend a BIP for treatment.

For the majority of states with standards, the role of research in formulating or revising state standards is unknown. There are even fewer states that have documented where the responsibility of updating standards resides and less than a quarter of states with standards that document methods for assuring the quality of treatment programming. Figure 2 shows the role of research in state standards for IPV perpetrator treatment. Of the 44 states with documented standards, nine (IA, IL, CO, ID, PA, VT, NH, HI, AZ) explicitly referenced some body of research that was consulted in drafting the standards. Only two states (IA, NH) described an infrastructure for determining and updating standards such as a steering committee that monitors research findings and conducts pilot projects to make appropriate decisions. Ten states described efforts at quality assurance in the development of BIP treatment standards (ID, IL, MA, MN, ND, NH, OH, VA, VT, WV). Quality assurance refers to an explicit mechanism that encourages governing bodies to use research and/or evaluation to develop standards, including: pilot projects, collection of data recommended, mandated implementation studies, program evaluation or outcomes studies.

<sup>1</sup> In 2015, Williston noted that 45 states had mandated batterer intervention standards.

**Figure 2: The Role of Research in State Standards for IPV Perpetrator Treatment**



State standards dictate a variety of aspects including the type of treatment used to treat IPV perpetrators. The preferred modality of treatment is often dictated by state standards. The majority of states with standards promote the use of the Duluth Model. A Cognitive-Behavioral approach is the second most preferred modality. Utah allows programs to choose the modality utilized in treatment. However, in reviewing materials utilized for training Utah healthcare providers and a separate training from the Utah Domestic Violence Coalition, both utilized standard Duluth resources and CBT techniques (UDVC Training Presentation, 2013; DHS Provider Manual, 2014). This highlights the prevalence of a mixed Duluth and CBT approach in the state of Utah. As the primary modalities covered in the available research on treatment for IPV perpetrators, these modalities are discussed in depth below.

Many states ban certain treatment modalities, including interventions for couples and those that primarily target anger management or substance use disorder. This has resulted in a significant tension due to the difficulties these bans create with respect to developing and implementing new treatment modalities (Bennett & Vincent, 2001). Seven states (CO, HI, ID, MI, OR, RI, TX) allowed clinical research testing of new modalities of treatment, but definitively banned couples counseling (Miller et al., 2013). One state (IA) encouraged standards that safely test innovative interventions and did not ban couples therapy. In a current review of Utah standards, there were no banned approaches; however, couples therapy cannot be utilized until the IPV perpetrator has completed twelve weeks of treatment and is reassessed. The assessment must determine that “the victim is at low risk for endangerment of further abuse due to counseling” (UDCFS DV Practice Guidelines, 2010, p.11).

State standards also often dictate length of treatment and how the treatment should be delivered. The shortest length required is four hours (MT) and the longest is a minimum of 52 weeks (OK, MA, NM, CA, ID, WA, NH) (Miller et al., 2013). The national average for mandated treatment length is 16-26 weeks and Utah minimum treatment length standards are in-line with the national average (i.e.,

16-24 weeks). Thirty-eight states specifically recommend group treatment, 26 recommend gender-specific treatment and 25 promote a gender-specific group treatment (i.e., men's group treatment).

For additional tables of the state standards adapted from Miller et al., 2013 see Appendix B.

## **Utah Standards**

Utah adopted standards in 1996 and most recently updated legislation that impacted state IPV standards in 2016. Updated legislation included the removal of the treatment mandate, which was changed to a provision that the court should order treatment as determined necessary. Utah legislation promotes coordination between the criminal justice system and treatment providers, in the form of pro-arrest policies and court-based monitoring of treatment compliance.

The Utah Division of Children and Family Services (DCFS) is responsible for administering domestic violence services, including IPV perpetrator treatment services. The division's goal is "to ensure the availability of treatment programs for court-ordered and voluntarily participating perpetrators to teach them non-violent behavior patterns" (Utah's Division of Child and Family Services Domestic Violence Practice Guidelines, 2010). The guidelines require that programs:

- Hold perpetrators of domestic violence, not their victims, responsible and accountable for their abusive behavior
- Increase the safety of the adult victim as a strategy for increasing the safety and well-being of the children
- Respect the rights of adult victims to direct their own lives
- Facilitate community collaboration
- Be offered to all persons meeting the definition of co-habitant who either voluntarily or through a court order seek domestic violence services regardless of whether they have children

Funding for treatment is a point of tension both locally and nationally. Victim services organizations are concerned that funding to batterer treatment reduces the amount of funding available to support victims. In a 2014 General Session issue brief, DCFS defended public funding of batterer treatment to the Social Services Appropriation Subcommittee:

DCFS uses some of its funding to provide intervention for perpetrators which some have questioned. DCFS defends the practice stating, among other reasons that it 'pays for treatment of perpetrators because it is essential to keep children safe, strengthen families, and provide quality domestic violence services. Research tells us that preventing domestic violence requires a multi-systemic approach that includes supporting the needs of all family members with a coordinated community response' (Office of Legislative Fiscal Analyst, 2014).

For all outpatient treatment providers, the Department of Human Services Office of Licensing has requirements for treatment, which include compliance measure with Utah State Core Rules, (R501), the Outpatient Treatment Program Rules (R501-21), and the Direct Service portion (R501-21-6-D) (UDVC presentation). Additionally, there are specialized training requirements for providers. There are approximately 20 providers that are listed as contract providers with DCFS. A contract provider has "prior authorization from the regional DCFS DV specialist and further allows DCFS to subsidize

the cost of the offender evaluation and intervention services” (Department of Human Services-Licensing Division, 2014).

Due to county size, and subsequent shortage of providers, 12 counties (i.e., Beaver, Box Elder, Emery, Garfield, Grand, Juab, Kane, Morgan, Piute, Rich, San Juan, and Wayne) must refer IPV perpetrators directly to their regional office Division of Child & Family Services (DCFS) in order to determine a BIP provider. There are providers outside of DCFS in 15 counties in Utah (i.e., Cache, Carbon, Davis, Duchesne, Iron, Salt Lake, San Pete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Weber). Within these counties, there are approximately 65 unique domestic violence abuse providers (UDVC, 2013; DHS, 2014) with at least 11 of those providers having multiple sites available for treatment.

Nationally, as well as in Utah, a variety of types of organizations facilitate BIP treatment, including victim service organizations, family service organizations, and mental health clinics (Davis & Taylor, 1999). As a result, there is significant variety in the facilitation of these groups such as fidelity to a modality, number/duration of sessions, or training and supervision for group facilitators. As such, the efficacy of BIPs in both the state of Utah and nationally are not easily known.

While treatment standards across the nation are in flux, Utah standards allow for more flexibility when compared with other states with regard to innovation and implementation of modalities outside of the Duluth model and CBT groups for men. Specifically, recent revisions to legislation acknowledge the absence of an evidence-based practice in IPV perpetrator treatment, and promote continued research on what works in IPV perpetrator treatment in light of the continued prevalence of IPV in Utah.

### **Efficacy of IPV Perpetrator Treatment**

Referral of an IPV perpetrator to a BIP is one of the strongest predictors that a woman will leave shelter and return to the perpetrator (Bennett & Williams, 2001). As such, the prevalence of IPV perpetration in Utah underscores the importance of understanding BIP efficacy. According to the Utah Department of Health’s Violence and Injury Prevention Program (VIPP, 2010a), women in Utah experience approximately 170,000 partner-related physical assaults and rapes each year. Further, when asked if they had ever been physically assaulted, 14.2% of women (18 years and older) reported being assaulted. There is approximately one DV-related homicide each month in Utah, with the majority of those homicides committed by male offenders against a female victim (VIPP, 2010b).

Clearly, the consequences of ineffective treatment are high. There were approximately 2,500 BIPs in the United States as of 2007 (Saunders, 2008) and courts continue to mandate treatment to hundreds of thousands of convicted offenders (Mills et al., 2013), suggesting a public confidence in the effectiveness of treatment (Bennett & Williams, 2001, p.14). Overall, the available research is not clear with respect to the efficacy of BIPs, which means some questions remain regarding the allocation of resources and whether or not they result in a positive and significant impact on individuals, families, and communities.

Historically, there has been much published on treatment of IPV perpetrators. In 1989, more than fifty published works that described or evaluated treatment groups for men who batter; however, no experimental evaluations had been completed (Eisikovits & Edelson, p. 392). More recently,

Saunders described more than 35 program effectiveness studies, but noted that few had rigorous designs that allowed for firm conclusions (2008). Since the first review on the efficacy of BIPs, there have been many critiques of the quality of studies including:

- Lack of uniformity amongst treatment groups (curriculum, length & frequency of treatment, structure of intervention)
- Collection and uniformity of follow-up data
- Lack of information on comparison or control group
- Reliance on IPV perpetrator self-report or measures that underreport occurrences
- Varied measures of success
- Variation in statistical sophistication
- Variation in populations which impact generalizability
- Exclusion of difficult or higher-risk IPV perpetrators
- Exclusion of higher risk IPV perpetrators or those with co-occurring problems (substance abuse, mental disorders, unemployment)

(For more detail, see Eisikovits & Edelson, 1989; Palmer, 1991; Davis & Taylor, 1999; Bennett & Williams, 2001; Feder & Wilson, 2005).

With those challenges considered, this review will organize studies by quality in the following way:

A higher-quality study, commonly referred to as experimental, where a randomly assigned treatment group receiving an intervention and/or multiple treatment groups receiving separate interventions are compared to a randomly assigned control group who is not receiving therapeutic treatment. For court-mandated IPV perpetrators, the control condition included probation or community service. There must be a report of recidivism, either from the official criminal record or victim report, that is collected at least six-months after treatment and researchers must discuss the generalizability and limitations in their findings.

A mid-quality study, commonly referred to as quasi-experimental, where treatment participants are compared to a matched comparison group that receives no treatment or received treatment as usual (TAU); alternatively, multivariate statistical methods were used to reduce selection effects, such as instrumental variables analysis or propensity score matching. Studies that compare treatments but do not include a control group receiving no treatment are included here.

A lower-quality study may be quasi-experimental where treatment participants are compared to another group without controlling for selection effects. An example is comparing treatment completers to treatment dropouts. Additionally, non-experimental, single-sample, with pre- and post-test only designs are summarized in this section if they made significant contributions to the field.

## **Primary Modalities**

When considering the criteria described above, only a few modalities of treatment have been empirically tested with scientific rigor (Babcock & Taillade, 2000). These are the feminist-psychoeducational men's group (e.g., the Duluth Model) and cognitive-behavioral men's groups.

Mixed variations of these models also exist. These models will be referred to as the *primary modalities* for this review.

Higher-quality studies evaluating the primary modalities are prioritized. Substantial contributions will be summarized for mid- to lower-quality studies and studies that have been completed on populations outside of the United States. Couples treatment, as a modality, has a number of efficacy studies that have been completed to date; however, this form of intervention has been and continues to be largely discouraged or prohibited by most states (Feder & Wilson, 2005; Babcock et al., 2004; Miller et al., 2013). Such bans have been implemented with the assumption that couples therapy poses a threat to victim safety and have reduced opportunities for continued research on the approach. A discussion of couples treatment is provided within the Promising Approaches section of this report as it has not been proven an ineffective alternative to gender-specific group interventions.

**The Duluth Model.** The Duluth Model, so named because it was developed in Duluth, Minnesota, was originally called the Domestic Abuse Intervention Project. As one of the earliest modalities, feminist psychoeducational groups originated from the belief that intimate partner violence (IPV) is a product of patriarchy or male socialization. Treatment is typically 16-50 weeks. Facilitators are not required to have a graduate or professional degree to facilitate groups nor to follow a particular theoretical orientation (Pender, 2012), but are required to follow the laws of the state in which the group is being held. Facilitators assume the following six roles (Pence & Paymar, 1993, p. 67):

- participate in an interagency effort to hold participants in a group accountable
- keep the group focused on the issues of violence, abuse, control, and change
- to facilitate reflective and critical thinking
- to maintain an atmosphere that is compassionate and challenging and not colluding
- to provide new information and teach noncontrolling relationship skills
- to facilitate a healthy group process

In treatment, the Duluth Model is designed to confront male perpetrators' attitudes about women, particularly the normalization of violent and controlling behaviors toward women that are conceptualized to result in victimization (Eisikovits & Edelson, 1989). The eight themes of the Duluth Model, which guide the agenda of the group, are as follows (Pence & Paymar, 1993, p. 25):

- Theme One: Nonviolence
- Theme Two: Nonthreatening Behavior
- Theme Three: Respect
- Theme Four: Support and Trust
- Theme Five: Accountability and Honesty
- Theme Six: Sexual Respect
- Theme Seven: Partnership
- Theme Eight: Negotiation and Fairness

Reeducation is accomplished with techniques such as an individualized action plan, role-plays, worksheets and logs including the control log and figures such as the Equality Wheel and the Power and Control Wheel (Pence & Paymar, 1993).



This model contrasts to others that rely on individual treatment through therapeutic intervention (Eckhardt et al., 2013). In this way, Duluth is represented as neither a therapy nor as therapeutic. As Pender (2012) describes, to Pence and Paymar, “psychoeducational groups are not intended to be reparative or have a treatment orientation” (p.222). Further Pender (2012) describes how, facilitators are guided with the Duluth Model curriculum manual to screen out “potential participants including: men with chronic or severe alcohol or drug abuse problems or psychological problems.

All BIPs intersect with the criminal justice community due to the large number of mandated IPV perpetrators, but the Duluth Model is one of the few modalities to situate treatment or intervention within the broader community response to domestic violence. As one of the earlier models, this communicated an expectation about where treatment is situated in the larger response to IPV perpetrators.

**Cognitive-Behavioral Therapy.** Cognitive-behavioral therapy (CBT) is a therapeutic intervention developed by psychologists that seeks to change specific thoughts and behaviors and improve skills (Dutton, 2007; Murphy & Eckhardt, 2005; Babcock & Taillade, 2000). Whereas the Duluth Model requires a criminal justice response, proponents of an independent psychosocial counseling response seek to offer an alternative to incarceration, prosecution, and the associated costs (Murphy & Eckhardt, 2005).

CBT facilitators promote individualized treatment, case formulation, a strong working alliance between participants and clinicians, and a progression through the following treatment phases:

- Phase 1: Stimulating and consolidating motivation to change
- Phase 2: Promoting safety and stabilization
- Phase 3: Enhancing relationship functioning
- Phase 4: Promoting trauma recovery and preventing relapse

The phases are accomplished with a variety of techniques that may include motivational interviewing, functional analysis of abusive behaviors, cognitive restructuring, cognitive processing, identification of relapse pattern and relapse cues, anger management, stress management, and relationship skills training, among others (Murphy & Eckhardt, 2005).

The application of CBT for IPV was developed as an alternative to the Duluth model (Murphy & Eckhardt, 2005). CBT interventions emphasizes the individual, which has been criticized by Duluth-model practitioners (Babcock & Taillade, 2000) for its dismissal of the gender and societal context that is presumed, by Duluth, to be a primary factor in the occurrence of IPV. Duluth-model practitioners also criticize CBT for the potential for collusion to occur between therapist and offender because there is no direct confrontation. Others, outside of a Duluth-type approach, have also criticized CBT for focusing on skill building and changing cognition and not engaging with the offenders’ emotional experience and history.

Despite these critiques, the Duluth-model has adopted much from a CBT approach to treatment. Rosenbaum and Kunkel (2009) describe modern models of Duluth as having more of a CBT-orientation. Many of the studies referenced in this section document a mixed-method intervention. In some cases formally, but often informally, seen in the descriptions of the intervention used.

**Mixed Interventions.** Although the modalities were developed separately, in practice a large number of BIPs utilize a mixed intervention approach that includes components of both the Duluth model and CBT (Eckhardt et al., 2013; Smedslund et al., 2012; Babcock et al., 2004; Davis & Taylor, 1999).

The similarities shared between the two interventions include changing perceptions of personal responsibility, beliefs, and teaching different behaviors (Saunders, 2008). Babcock & Taillade (2000) describe mixed modality BIPs as often having different phases including a feminist educational format, cognitive-behavioral components to teach skill building, and an attempt to resolve psychological issues. The five primary components of current iterations of a mixed model are: (1) recognizing abusive behaviors using the Duluth Power and Control Wheel, (2) identifying positive relationship behaviors using the Duluth Equality Wheel, (3) identifying relationship thinking errors, (4) learning anger management and problem-solving skills, and (5) developing positive communication skills (Tollefson and Gross, 2006, p. 49). However, the drawback to a mixed modality is that it has complicated the ability to replicate an intervention across studies and has contributed to the lack of uniformity seen across the studies reviewed in this section.

**Review of Research on Primary Modalities.** While there are few higher-quality experimental studies, there are multiple reviews characterizing the impact of the primary modalities used in IPV perpetrator treatment. Two recent reviews are highlighted in Table 1. A list of additional reviews is available in Appendix A as part of the extended search strategy.

**Table 1:** Meta-analyses of IPV perpetrator treatment efficacy

<b>Institution</b>					<b>Overall Efficacy of BIPs</b>
<i>Author</i>	<i>Date</i>	<i>Modalities Reviewed</i>	<i>Study Design</i>	<i># of studies</i>	
<b>Washington State Institute for Public Policy</b>					No
<i>Miller, Drake &amp; Nafziger</i>	<i>2013</i>	<i>Duluth-like</i>	<i>Meta-analysis</i>	<i>5</i>	
<b>Campbell Systematic Reviews</b>					No
<i>Feder, Wilson &amp; Austin</i>	<i>2008</i>	<i>Duluth-like, Cognitive- Behavioral, and Mixed</i>	<i>Systematic Review</i>	<i>10</i>	

The Washington State Institute for Public Policy reviewed five studies using a Duluth-like model (Davis et al., 2000; Feder & Forde, 2000; Gordon & Moriarty, 2003; Harrell, 1991; Labriola et al., 2008) and found no effect on reducing IPV recidivism (Miller et al., 2013). The review focused on criminal DV offenders where the studies had a reported measure of criminal recidivism.

In a Campbell Systematic Review, Feder and colleagues (2008) found a modest benefit from four experimental studies (Davis et al., 2000; Dunford, 2000; Feder & Forde, 2000; Feder & Dugan, 2002;

Palmer et al., 1992) using official reports of IPV recidivism<sup>2</sup>; no effect was found when using victim report of IPV recidivism. For the six quasi-experimental studies (Chen et al., 1989; Dutton, 1986; Gordon & Moriarty, 2003; Jones & Gondolf, 2002; Palmer et al., 1992; Syers & Edelson, 1992), there was an overall small harmful effect reported for studies that used a no-treatment comparison. The quasi-experimental studies that used a treatment dropout design showed a large, positive effect on outcomes. The authors explain the disparity between results as a selection bias in the latter group of studies. The review focused on the effects of post-arrest court-mandated interventions (including pre-trial diversion programs) for male domestic violence offenders in reducing likelihood of re-assault. The interventions used by the included studies included a psychoeducational or cognitive behavioral approach or a mix of the two.

**Higher-Quality Research-Primary Modalities.** Palmer, Brown and Barrera (1992) published the first higher-quality experimental study of IPV treatment in 1992; since it was completed in Canada, results will be included in the section on non-U.S. studies. Three experimental studies followed, and were conducted simultaneously in Brooklyn, San Diego and Broward County, Florida. The most recent experimental study of BIPs, to date, was conducted in the Bronx, NY in 2005.

**Findings.** Three of the four experiments did not show that BIPs were more effective than the control condition (see Table 2). Only one of the studies, the Brooklyn Experiment, showed support for the effectiveness of BIPs.

**Table 2.** Higher-Quality Studies-Primary Modalities

<b>Experiment</b>	<i>State</i>	<i>Modality Used</i>	<i>Study Design</i>	<i>N</i>	<i>BIPs effective</i>
<i>Author</i>	<i>Date</i>				
<b>The Bronx Misdemeanor Domestic Violence Court</b>	NY	Duluth	RCT	420	No
Labriola et al.	2008				
Labriola et al.	2005				
<b>The Brooklyn Domestic Violence Treatment Experiment</b>	NY	Duluth	RCT	376	Yes
Maxwell et al.	2004				
Davis et al.	2003				
Taylor et al.	2001				
Davis et al.	2000				
Davis et al.	1998				
<b>The Family Advocacy Center: The San Diego Navy Experiment</b>	CA	Mixed Duluth/CBT	RCT	861	No
Dunford	2000				
<b>The Broward Experiment</b>	FL	Duluth	RCT	404	No
Feder & Dugan	2002				
Feder & Forde	2000				

<sup>2</sup> The Broward Experiment (Feder & Dugan, 2002; Feder & Forde, 2000) included a measure of any recidivism in addition to IPV-specific recidivism.

All four experiments were conducted in North America and evaluated programs using primary modalities (a psychoeducational Duluth-type model, cognitive-behavioral, or mixed approach) to reduce IPV perpetrator recidivism. In the most recent experiment—the Bronx Experiment—the researchers concluded that none of the experimental conditions showed any reduction of recidivism above the control condition; rates of rearrest between the groups were “nearly identical” in both official and victim reports. In the Broward Experiment, Feder and Dugan (2004) propose that men who completed treatment versus dropping out were a subgroup of men who were unlikely to reoffend<sup>3</sup>. A limitation of the Broward Experiment was generalizability; the study only included one jurisdiction. The Navy Experiment (Dunford, 2000) was also not generalizable due to the population targeted; however, it was a well-executed experiment with rigorous randomization, a large sample size, and a high rate of completed interviews. Statistical significance was not found between any of the conditions. The Brooklyn study (Maxwell et al., 2000) did find that the 26-week treatment option showed support for the effectiveness of the Duluth model when compared to the control group. However, there were limitations to the findings including that only 376 of 11,000 sentenced IPV perpetrators were included in the study, 53 cases were erroneously assigned to the treatment group by the judge, and the low response rate of victims.

**Demographics.** All four studies had interventions that were delivered in single-gender (male) group settings. Three studies used a general civilian population of IPV perpetrators who had faced court prosecution for domestic violence.

The Broward Experiment included men with misdemeanor domestic violence charges (from two courts in the county) who were court-mandated to treatment and 1-year probation. The researchers describe forty-three exclusions due to the defendant or victim characteristics (i.e., not speaking English or Spanish, under 18 years of age, severely mentally ill) or because the judge allowed the defendant to move to another jurisdiction.

The Brooklyn and the Bronx studies targeted male, criminal court defendants charged with assaulting their female partners. In Brooklyn, the defendants, in addition to the judge and attorneys, had to agree to participate in the treatment option. In the Bronx, the sentencing judge retained the discretion to exclude eligible offenders from the randomization, and did so 14% of the time (Davis et al.); the researchers referred to these as individuals as “higher-risk offenders”.

The Navy Experiment included active-duty, U.S. Navy males where physical assault against their wives was substantiated. Further, the researchers noted that participants could not have divorce-proceedings officially in process, must have had more than 6 months left to serve in the area, were not alcoholically impaired, and were devoid of significant pathology (including active psychosis, antisocial personality disorder, pathological jealousy, or suicidal ideation). The Navy Experiment would refer any men who had substance abuse issues to be assessed prior to being considered for the experiment. The Navy Experiment was conducted with such quality that it is included in this section, but is limited due to the limitations in generalizability to the broader population of court-mandated IPV perpetrators. The Navy Experiment included a couples treatment as one of four experimental conditions. This portion of the experiment will be discussed in the section that describes research on couples interventions.

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<sup>3</sup> This confirmed the *stake in conformity* theory that had originated with Berk et al. (1992) and Sherman (1992) proposing that men who were invested in their community through factors such as employment or reputation were more motivated to change. See the section on individual characteristics and background for more information.

**Intervention.** The Broward Experiment intervention included 26 weeks of Duluth-model treatment at one of five local BIPs (referred to as SAAPs or Spouse abuse abatement programs) and one year of probation. The control group had one year of probation. The Brooklyn Experiment included 40 hours (26-week model at 1.5 hours per week or 16-week model at 2.5 hours per week) in a Duluth-Model program. The control group was sentenced to 26 weeks of community service. The Bronx Experiment included; 26 weeks (75 minutes) of a mixed Duluth/CBT model at one of two programs in the area (Domestic Violence Accountability Program, DVAP or Fordham Tremont) with either monthly judicial monitoring or graduated monitoring. The control group included either monthly monitoring or the graduated monitoring without treatment. The Navy Experiment also included multiple experimental conditions for 52 weeks; a mixed Duluth/CBT group, couples mixed Duluth/CBT group, rigorous monitoring or no treatment (which included stabilization and safety planning for the victim).

The Navy Experiment was the most rigorous regarding fidelity to a treatment approach. Researchers audio taped and evaluated the adherence to treatment protocols monthly with group facilitators throughout the experiment. The weekly meetings included both didactic and process activities using a cognitive-behavioral model that was developed by Daniel Saunders and David Wexler (Dunford, 2000). All of the group leaders facilitated both groups in an attempt to control for the effect of therapist characteristics. The Broward Experiment and the Brooklyn Experiment described the specific use of a Duluth-model of treatment, but specific details about the curriculum or adherence by facilitators through the experiment was not available. The Bronx Experiment describe two different programs that participants could be assigned to. The programs, DVAP and Fordham-Tremont, had a similar length and amount of time required for the weekly meeting. The DVAP program considered its approach educational with six modules. The Fordham-Tremont program reported a psycho-educational approach including the use of a mixed Duluth and CBT approach. However, researchers observed the use of CBT techniques at DVAP. Adherence to curriculum was not available for either location.

**Recidivism Defined.** All four experiments operationalized recidivism as new violence by the IPV perpetrator against the victim. The Bronx experiment included threats and other non-physical re-abuse. The Broward experiment and the Navy Experiment were also specifically looking for arrest. All four experiments attempted to utilize multiple sources to document recidivism, including official records from police or court, victim report; three of the experiments (not the Bronx) included IPV perpetrator report as well.

**Follow-up.** A longer follow-up period is important in order to determine if the effects are maintained after treatment; however, studies that rely on victim-report often suffer from low response rates (Feder & Dugan, 2004; Palmer et al., 1992). The Navy Experiment followed up at six-month intervals over an 18-month period and successfully reached a substantial percentage of victims for interviews (86% at the first interview, 82% at the second interview, 78% for the third and 75% for the fourth). The Bronx Experiment reviewed official records at one-year and 18-months for most of the sample (n=360); however, the study had a low victim interview response rate (25%). The Broward Experiment reviewed official records one-year after adjudication. Additionally, researchers sought victim interviews at six and 12 months after adjudication, but had a low response rate (49% for the first, 30% for the second, and 22% for the third). The Brooklyn Experiment had a small number of victim reports 6-months after sentencing and 12-months after sentencing, but their findings were not significant (48% at first, 50% at second, or 35% of the total sample). At one year, official records were reviewed for new incidents within the prior two months.

**Mid- to Lower-Quality Research-Primary Modalities.** There were a number of quasi-experimental and non-experimental studies; as noted earlier, findings should be interpreted with caution due to methodological limitations. Harrell (1991) conducted a quasi-experimental study that compared men court-mandated to treatment to those who were not court-mandated to treatment but were sentenced to probation. Multivariate analysis was used to control for the effects of group differences in marital status, past criminal history and unemployment. The analysis used treatment completers whom had higher recidivism compared to the control group. This is considered an outlier amongst the studies and is often excluded from meta-analyses and systematic reviews.

A number of studies did not show effectiveness of BIPs but proposed that completers have lower recidivism than noncompleters; these studies took large groups of IPV perpetrators and compared completers to noncompleters based on either official record or victim report (Bennett et al., 2007; Chen et al., 1989; Coulter & VandeWeerd, 2009; Gondolf, 1997; Gondolf, 1999; Gondolf, 2000; Gondolf & Jones, 2001; Gordon & Moriarty, 2003; Jones & Gondolf, 2002; Jones, Gondolf & Heckert, 2004; Hamberger & Hastings, 1988; Rosenbaum, Gearan, & Ondovic, 2001). Rosenbaum and colleagues (2001) found that court-mandated participants of BIPs were more likely to complete treatment than voluntary participants of BIPs. In contrast, Herman and colleagues (2014) found that program completion was not associated with decreased levels of recidivism; the study examined 156 offenders from one program and used a 9-year post-treatment follow-up period. A few of these studies evaluated multiple programs at one time across a county (Bennett et al., 2007; Coulter & VandeWeerd, 2009; Gordon & Moriarty, 2003), or across multiple states (Gondolf, 1997; Gondolf, 1999, Gondolf, 2000; Gondolf & Jones, 2001; Jones & Gondolf, 2002); the studies completed by Gondolf and Jones were all from the same dataset of four cities.

All findings should be viewed cautiously as there are no comparison groups in most of these studies (except Chen et al., 1989), and often there are no measures to ensure that program delivery was consistent across multiple locations. In order to control for such limitations, some studies utilized more advanced statistical designs such as instrumental variable estimation and logistic regression or propensity score analysis (Bennett et al., 2007; Gondolf, 1999; Gondolf & Jones, 2001; Jones & Gondolf, 2002; Jones, Gondolf, & Heckert, 2004).

***Comparative Research.*** A group of studies compared one modality to a different modality. The quality of these comparative studies is limited by the lack of a control condition and the lack of generalizability of the findings due to the variety amongst populations, treatment types, and methodological design.

Two studies included volunteer, intact couples in a quasi-randomized study design (O'Leary et al., 1999; Brannen & Rubin, 1996). O'Leary and colleagues compared a CBT-type couples therapy to a CBT-type gender-specific treatment (male perpetrators and female victims). The couple's group intervention was conceptualized on the premise that men and women share responsibility for reducing marital discord<sup>4</sup>. The researchers reported that among victims in the couples group intervention, none reported an episode of victimization during treatment. Both approaches showed equivalent improvements post-treatment and at the 1 year follow-up when using perpetrator and

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<sup>4</sup> This is of unique, due to this treatment conceptualization being one of the primary concerns victim advocates have about couples therapy as a BIP modality.

victim self-report pre- and post-treatment and at one-year follow-up<sup>5</sup>. However, the study as a whole suffered from high attrition (47%) and a low cessation rate (26%).

Brannen and Rubin (1996) utilized a Duluth-model group for the men's group treatment compared to the CBT-type couples group treatment with a small sample of perpetrators (n=48). Follow-up was completed at 6-months using self-report measures and official record, and no difference was identified between the recidivism rates of men in either group. This was measured using self-report from the male perpetrator and female victims and confirmed by a review of the official record<sup>6</sup>. The largest reduction of violence was seen with substance abusing perpetrators in the couples group intervention. Brannen & Rubin contribute this reduction to group confrontation. The study did not have a control group that received no treatment and the participants were limited to intact low-risk couples.

Three studies (Morrel et al., 2003; Saunders, 1996; Edelson & Syers, 1990) compare a more structured intervention (CBT, Duluth-type with CBT, Education model) to an unstructured model (supportive group therapy, process-psychodynamic, self-help model). Edelson and Syers (1990) included a third intervention that was a combination between an education and self-help model and included two intensities (12 or 32 sessions). All three studies had non-significant findings, and all were limited by the lack of a control group. However, all three influenced the field with specific findings. Morrel et al. (2003) found that therapeutic environment and group cohesion were correlated to a reduction in recidivism. Saunders (1996) determined that offenders with dependent personalities had significantly lower rates of recidivism in process-psychodynamic groups while antisocial personalities had lower recidivism rates in the structured, feminist-cognitive-behavioral group. Edelson and Syers (1990) influenced later higher-quality studies by attempting a rigorous design including random assignment to treatment groups and using partner reports of recidivism.

**International Research-Primary Modalities.** Internationally, studies conducted on the efficacy of BIPs parallel the interventions and methodology of those conducted in the United States. Of note, the generalizability to US-based studies is impacted by the standards and legislation of the country where the study was conducted.

Early studies in Canada influenced research on IPV perpetrator treatments in the United States. Palmer and colleagues (1992) completed the earliest experimental study using a block random procedure on a small group of IPV perpetrators (59 men convicted of wife abuse, placed on probation, and court mandated to treatment). The treatment targeted: 1) understanding of violence and its consequences, 2) responsibility for violent behavior, 3) coping with conflict and anger, 4) self-esteem, and 5) relationships with women (Palmer et al., 1992, p. 279). Treatment included a combination of information giving, modeling values, teaching skills for dealing with anger, reinforcing self-esteem, and building empathy for women partners. Police records were utilized 12-24 months after treatment and results show modest support for a short, unstructured treatment program having long-term benefits. Findings are limited by high attrition rates, small sample, and a policy that screened out offenders with alcohol abuse problems.

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<sup>5</sup> Outcomes were measured with the following assessment tools: Modified Conflict Tactics Scale (MCTS), the Dominance/Isolation Scale, Beck Depression Inventory (BDI), Dyadic Adjustment Scale (DAS), the Spouse Verbal Problems Checklist, the SCID with the supplementary PTSD module, the Fear of Spouse scale and pre-session reporting on fear and/or aggression due to treatment sessions.

<sup>6</sup> Outcomes were measured with the following assessment tools: Modified Conflict Tactics Scale (MCTS), the McMaster Family Assessment Device (FAD) and the Marital Satisfaction Inventory (MSI), and the Long-Term Evaluation Form

Dutton and colleagues (1997) followed 156 treatment completers for 11 years and reported recidivism for any crime committed in Canada. The 156 completers were compared to 167 noncompleters, 32 ineligible offenders, and 92 no-shows. While the outcome findings are of limited use because of the methodology, the researchers did identify other important findings, including the importance of assessment. The authors also identified an important discrepancy between official report and victim-reported recidivism, with the finding of 35 victim reports for every 1 official report. These findings have laid the groundwork for methodological updates including the use of victim report as the preferred measure of recidivism.

In 2002, Bowen, Brown, and Gilchrist describe how it was not until 1997 that “penal policy has started to acknowledge its (IPV) prevalence” in Britain (p. 232). One likely contribution to this change was a study by Dobash et al., (1996) that suggested that cognitive-behavioral based treatment might contribute to a reduction in domestic violence. According to Bowen and colleagues (2005), a pro-feminist approach was the most prevalent approach, and as such recommends that “if we are to entrust the rehabilitation of offenders to the pro-feminist treatment model, further evaluations are required to ensure that this approach fulfills its aim to stop the physical and psychological abuse of women” (p. 232); a sentiment echoed by U.S. researchers. Bowen completed a study in 2005 that compared completers and dropouts for one program in Britain. Alleged reoffending was used in this study and means, “in some cases the data used did not represent either an admission or finding of guilt” (Bowen et al., 2005, p. 195). Using police data, it was found that completing the program was not significantly associated with either alleged reoffending or time to first alleged incident; there was a small effect size reported for the small sample. This finding challenges U.S. studies (Gondolf, 1999; Gondolf, 2001; Hanson et al., 2000) who associate a completion of treatment with reduced recidivism. A strength of this study was the focus on program fidelity. The authors describe monitoring “content covered, issues of concern arising, perceived level of offender risk at the end of the session, attendance, and participation for each offender referred to the programme” (Bowen et al., 2005, p. 195).

In 2016, Blatch and colleagues evaluated an Australian domestic abuse program for offending males. Male IPV perpetrators (n=253) were enrolled in the BIP and compared to a propensity-score matched control group. The control group was matched on the following risk factors that have been associated with reoffending: LSI-R score, type of supervision order; most serious offense committed, custodial sentence and conviction counts in the previous five years, and Aboriginal and Torres Strait Islander (ATSI) status. The group targeted “medium” to “high” risk perpetrators as measured by the LSI-R<sup>7</sup>.

The BIP utilized a mixed-modality intervention theoretically grounded in risk, need, and responsibility and CBT principles. Perpetrators attended 20 sessions (40-50 hours total). The five modules targeted:

- Identifying abuse (includes psycho-educational and CBT techniques)
- Managing and challenging emotions, beliefs and attitudes that support violent behaviors
- Offense mapping (utilizing a behavior chain analysis)
- Victim Impact (includes psycho-educational and CBT techniques)
- Sexual respect, relationship skills and safety strategies modeled

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<sup>7</sup> The LSI-R was validated for use for DV risk assessment in this study



An unstructured final session with each module allows participants to process group issues and increase therapeutic engagement. Facilitation was highly structured with supervision and training for the group facilitators.

The reduction to recidivism shown was promising. Program completion was determined necessary for significant treatment effect with rates of reconviction being significantly lower for the 62% of enrollees who completed the program. One limitation was that partner violent reconvictions could not be separated from violent reconvictions due to the official data that was available when the study was completed. Another limitation was the lack of a victim report. The strength of this study was inclusion being based on an assessed level of risk, targeting higher-risk perpetrators, and the intensive training and supervision of group facilitators to maintain fidelity.

## Promising Approaches

In addition to the aforementioned interventions, the following approaches were considered promising, but not well studied, at the time of this review. Promising approaches are presented to highlight emerging trends and directions in IPV perpetrator treatment. Initially, we reviewed interventions that are complementary or collaborative with the primary modalities. These primarily include criminal justice-related mechanisms, such as coordinated responses, and applicable approaches for general offenders that show promise with domestic violence offenders. *Adjunct interventions*, such as motivational interviewing (MI), treatment for substance use disorder, mental health and individual therapy are presented to illustrate movement in the field toward individualized treatment for IPV perpetrators. Lastly, approaches that depart from the primary modalities are presented. These alternative approaches include couples therapy, restorative justice and theoretically unique modalities such as Solutions-Focused, Strength-Based, Mind Body Bridging (MBB), Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT). Throughout these sections, higher and mid-quality studies are given priority over lower quality studies.

**Criminal Justice Techniques.** Due to the prevalence of pro-arrest and mandatory arrest policies, the majority of IPV perpetrators are court-mandated to treatment; as such, the efficacy of treatment interventions is difficult to separate from the criminal justice system.

**Coordinated responses.** Bennett and Williams (2001) suggest that asking whether IPV perpetrator programs are more effective than probation alone is asking the wrong question, because IPV perpetrator programs were never designed to be used instead of probation. A review of DV-specific courts and the utilization and efficacy of assessments is outside the scope of this project; however, their impact cannot be dismissed when pursuing the question of BIP efficacy. Coordinated community responses (CCRs) will be reviewed, because the study of CCRs intersects with the literature on BIP effectiveness.

Coordinated community response (CCR) councils are an interdisciplinary system-based strategy that brings together law enforcement, courts, social service agencies, community activists, and victim advocates to address the problem of domestic violence (Salazar, 2007). According to Salazar (2007), the key goals of the CCR are to provide victim protection, offender accountability, evaluation of existing services, development of new services, and cultural change of the social climate tolerant of domestic violence (p. 632). Duluth, Minnesota was one of the first communities to develop a coordinated community response through the work of the Domestic Abuse Intervention Project (DAIP), which was initiated in 1980 (Shepard et al., 2002). Murphy, Musser

and Matton (1998) also note that Duluth-type programs situate domestic violence as a societal problem and therefore are more likely to be part of a community intervention program and consequently more likely to benefit from the additive effects of arrest and prosecution, assertive sanctions for non-compliance, victim advocacy, and counseling.

Throughout the literature on BIP efficacy, many researchers recommended coordinated community responses as a promising approach for reducing recidivism IPV perpetrators (Aldarondo, 2010; Babcock et al., 2004; Babcock & Steiner, 1999; Broidy et al., 2016; Messing et al., 2015; Murphy, Musser, & Matton, 1998; Saunders, 2008; Syers & Edelson, 1992). However, CCRs have very little research support (Barber & Wright, 2010; Ford & Regoli, 1993; Pitts et al., 2009; Salazar, 2007; Shepard, 2002), and the studies that exist show very modest benefits (Peterson, 2008) and face methodological limitations. This is in part because it is hard to study the effects of system-wide changes. Salazar (2007) describes how CCRs emerge in a variety of ways, employ a variety of stakeholders, and are without standardized protocols. Slaght and Hamilton (2008) note in their qualitative review of Illinois' Family Violence Coordinating Councils that "coordination is not necessarily a product of the existence of a coordinating body but rather results from a unified philosophy that integrates law enforcement and treatment responses" (p. 58). Further, as the impacts are intended to be community-wide, there is a question of whether recidivism should be situated as one measure amidst others. Salazar (2007) suggests, "an examination of how CCRs affect the behavior of the service systems or the attitudes of the community in which the CCR was implemented" (p. 632). Specific measures could include reviewing the following: number of arrests made by law enforcement agencies, sentencing by judges, the percentage of cases that were prosecuted before and after the implementation of the CCR, or surveying the community in which the CCR operates. Barber et al. (2010) recommended that courts and other referring agencies keep attendance records, mandate monthly check-ins with case managers, require defendants to appear in court for follow-up hearing, and dedicate staff to monitor domestic violence cases to increase completion rates among IPV perpetrators in treatment. However, this is a difficult request to meet without financial support.

In 2007, Salazar and colleagues conducted a study evaluating implementation of a CCR in two counties in Georgia and found an increase in arrests of male offenders; there was also an increase in females arrested, many of whom were victims. This example shows the potential of increased risk to the victims with a coordinated response. Additionally, a coordinated response including law enforcement and the judicial system may negatively affect victim preference and empowerment (Ford & Regoli, 1993; Pitts et al., 2009).

In light of the dismal findings across the field of IPV perpetrator treatment, Peterson (2008) called for a reinvestment in victim services and prevention efforts but concluded, "criminal justice interventions are, and will continue to be, important. They may provide small amounts of specific deterrence, and they help to reinforce community standards against IPV" (p. 542).

***Domestic violence perpetrator typology.*** Several researchers have attempted to provide and validate a typology for IPV perpetrators (Gottman et al., 1995; Stare & Fernando, 2014; Hall, et al., 2012). Graña and colleagues (2014) note, "initial efforts [to identify characteristics of men who perpetrate IPV] were focused on finding the common elements that would differentiate perpetrators from non-perpetrators" (p. 1). However, when it became apparent that perpetrators "form a heterogeneous group, most recent efforts have been directed towards identifying meaningful perpetrator subtypes" (p. 1).

The most cited typology of IPV perpetrators, proposed by Holtzworth-Munroe and Stuart (1994), appears to have empirical support (Hamberger et al., 1996; Holtzworth-Munroe et al., 2000; Huss & Ralston, 2008) and presents three subtypes of IPV perpetrators: family-only, borderline/dysphoric, and generally violent/antisocial. According to Huss and Ralston (2008), family-only perpetrators exhibit relatively low intimate partner violence and show lower rates of alcohol abuse, depression, and personality disorders than the other groups. Borderline/dysphoric perpetrators have high levels of anger and depression, moderate levels of substance use disorder, and more personality disorders. They exhibit higher levels of intimate partner violence but low generalized violence. Generally violent/antisocial perpetrators present with high levels of both marital and generalized violence and show criminal tendencies overall. Holtzworth-Munroe and colleagues (2000) later added a fourth subtype, low-level antisocial, which falls between family-only and generally violent/antisocial perpetrators on many indicators. Utilizing this typology, researchers have explored whether there are differences across perpetrator subtypes. Family-only IPV perpetrators appear to fare best in terms of treatment completion and recidivism, while generally violent/antisocial perpetrators appear, on the whole, to have the worst outcomes (Eckhardt et al., 2008; Huss & Ralston, 2008).

There are models proposed as a treatment for antisocial and psychopathic perpetrators of IPV (Juodis et al., 2014 and Huss et al., 2006). In an examination of the correctional files of 37 male perpetrators of domestic homicide compared to 78 non-domestic homicide perpetrators, the authors identified 20% of the domestic homicide perpetrators as being psychopaths. As a subset of the IPV perpetrator population that is extremely difficult to treat, routine assessments are recommended to identify perpetrators, for whom some treatments were contraindicated, including couples therapy, emotion-based, talk therapy, insight-oriented or psychodynamic, geared toward self-esteem, empathy, conscience, or interpersonal skills (Huss et al., 2006; Juodis et al., 2014). The authors also caution treatment providers from allowing groups to have a high proportion of IPV perpetrators with these traits or allowing these individuals to “run” the group. For institutionalized perpetrators, Juodis and colleagues (2014) recommend following a treatment based on risk-need-responsivity (RNR) with high dosage, combining cognitive-behavioral treatment for the criminal population with relapse-prevention techniques in the absence of a “properly designed and empirically-supported treatment” (p. 386).

To understand the connection that IPV perpetrators have with other violent offenders, researchers have compared IPV perpetrators who had committed family-only violence to IPV perpetrators who had also committed violence outside of the home (i.e., generalized aggressors). Cantos and colleagues (2015) found generalized aggressors had more extensive substance use disorder and criminal histories; they were also less likely to complete treatment and were deemed higher risk for recidivism by probation officers. Similarly, Stalans and colleagues (2004) compared family-only (i.e., IPV) perpetrators, non-family-only (non-IPV) perpetrators, and generalized aggressors on risk of recidivism. They concluded that generalized aggressors of violence had the highest risk for recidivism. More generally, Kiss and colleagues (2015) noted that women whose partners had been violent toward other men (i.e., male-to-male violence) were at an increased risk of IPV themselves.

Other researchers have compared IPV perpetrators with perpetrators of other types of violent crime. Some studies suggest there is a dearth of support for categorizing IPV perpetrators as distinct from perpetrators of other types of violent crime (Date & Ronan, 2000). In contrast, Olson and Stalans (2001) compared domestic violence offenders with other violent offenders on several variables. They found domestic violence offenders tended to be older compared to other violent

offenders<sup>8</sup>. However, they noted no differences between types of offenders in income, gender<sup>9</sup>, history of illegal drug use, or prior criminal convictions for violent crime. More importantly, they noted no significant differences between offender groups in number of arrests or probation revocations. Likewise, Gunnin (1997) conducted a study comparing IPV perpetrators with other violent offenders and found no significant differences between groups on the majority of risk factors.

Debate about whether criminal offenders specialize in one type of criminal behavior or commit an array of crimes has existed for decades (see review by Richards, Jennings, Tomsich, & Gover, 2013). IPV perpetrators, on the aggregate, are not qualitatively different—in terms of background or risk—from other violent offenders. However, IPV perpetrators who perpetrate violence both inside and outside the home may present a greater risk for recidivism than IPV perpetrators whose actions are limited to the domestic sphere alone. No studies were found that discussed how IPV perpetrators fare in interventions designed for other violent offenders. At the time of this review, it is unclear if treatment targeting general violence would decrease recidivism among IPV perpetrators. Nevertheless, Herman and colleagues (2014) called for new ways to increase the effectiveness of interventions with violent men (p. 14). Fleming, Gruskin, Rojo, and Dworkin (2015) argue that treatment for all types of violent crime should be integrated, rather than isolated by type, because there are etiological commonalities across violent behaviors.

***Risk-Need-Responsivity (RNR).*** Assessing individual perpetrators and assigning treatment based on risk and need is a promising direction. There were not any available experimental evaluations of RNR in IPV perpetrator treatment at the time of this review, but there are promising models emerging.

The state of Colorado revised their IPV treatment standards in 2010, and now utilizes a model based on the Risk-Need-Responsivity principles. Research has shown the efficacy of RNR in reducing general offender recidivism. In 2015, Gover and colleagues studied IPV perpetrators who were placed into different treatment intensity levels based on assessed risk/need. This offers valuable insight into a differentiated, non-time-driven or one size fits all approach. Other examples include Coulter and VandeWeerd's (2009) proposed model of treatment through the Thirteenth Judicial Circuit Domestic Violence Division that assigned perpetrators to one of three levels of treatment based on the results of a screening tool.

In 2016, Radatz and Wright proposed adoption of the principles of effective intervention (PEI) that include RNR with additional tenets on treatment and fidelity. In order to improve BIPs, the authors offer detailed comparisons of PEI use to serve as a guide for researchers to evaluate BIPs. Radatz and Wright (2016) acknowledge that there are other intended goals for BIPs, outside of recidivism, such as “participation in a coordinated community response to IPV, offender accountability, and victim safety” (p. 83). However, the primary target, and potential limitation, of a RNR approach is to focus on a reduction in recidivism.

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<sup>8</sup> This finding did not reach the required significance level (Olson & Stalans, 2001, p. 1172)

<sup>9</sup> This finding reiterates that the majority of both domestic violence offenders and other violent offenders are male (Olson & Stalans, 2001, p.1173)

**Individualized Treatment.** Despite the entrenchment of the group format evidenced in the state standards, some researchers argue for the potential of individual treatment for reducing IPV recidivism (Arias et al., 2013; Bennett & Williams, 2001; Eckhardt, 2011; MacLeod et al., 2009; Murphy & Meis, 2008; Tollefson, 2002). While there is very little research on individual treatment for IPV perpetrators, there is research evaluating the impact of individual characteristics on IPV treatment. Murphy and Meis (2008) describe limitations to group interventions, and suggest that the group format is unable to meet individual perpetrators' needs, which may include improving readiness to change, treating trauma, personality disturbances or emotional dysregulation, and ongoing use of substances, all of which can result in poorer responsiveness to the intervention (p.177). Further, the group format risks a negative peer influence and reinforcement of problematic thinking, attitudes or behaviors from other group members (Murphy & Meis, 2008).

**Individual characteristics and background.** Many researchers emphasize the need to base treatment on individual needs and profiles of IPV perpetrators, rather than relying on blanket approaches as has been done in the past. Murphy and Meis (2008) describe how IPV perpetrators are heterogeneous with respect to other presenting concerns. Eckhardt (2011) argues the ideologies that have historically undergirded IPV advocacy and treatment have stymied implementation of research on the role of individual and relational risk factors in IPV, which has, paradoxically, hurt those victims they were intended to help. "Programs that are tailored to the specific needs of each IPV perpetrator enhance treatment efficacy, whereas standard programs with similar content across the board for all IPV perpetrators not only lack efficacy but may even prove counterproductive due to the failure to adapt the intervention to the needs of each IPV perpetrator" (Arias et al., 2013, p.154).

According to Bennett & Williams (2001), BIPs are more effective for some men than others; "whether the effect is analyzed by a man's stake in conformity (education, employment, relationship commitment, community bonding), mental status (the effects of personality disorder, mental disorder, substance abuse disorder), or cultural congruity (the more group facilitators share culture and language with the participants, the greater the stake in the group), one in four men referred to a BIP will account for most of the repeat violence and most of the serious injury within a IPV perpetrator program" (p. 8). In an evaluation of five jurisdictions in California, consisting of 1400 men enrolled in treatment programs, MacLeod and colleagues (2009) found that individual characteristics were the strongest predictor of rearrest; men who were more educated, older, had shorter criminal histories, and did not display signs of drug or alcohol dependence had a lower likelihood of rearrest independent of the kind of treatment they received. Bennett and colleagues (2010) found that higher socioeconomic status (i.e., combined measure of marital status, level of education, full-time employment, and income) was a significant predictor of program completion. Tollefson (2002) also found that psychopathology and low socioeconomic status were important determinants of recidivism and treatment dropout. Likewise, Catlett and colleagues (2010) report that low income, high levels of hostility, and no longer being a relationship with the victim were all predictive of treatment attrition. Although some research suggests that individual characteristics of perpetrators may influence program completion and/or recidivism, the research is not always consistent. In fact, some studies have found no significant relationship between demographic, background, and intrapersonal variables and program completion (Carney et al., 2006; Cuevas & Bui, 2016).

**Substance use.** Substance use disorder (SUD) and domestic violence are significantly correlated. In a large meta-analysis, Cafferky and colleagues (2016) note that SUD (including alcohol and drug use) significantly relates to both IPV victimization and perpetration (with effect sizes ranging from  $r = .18$  to  $.23$ ). Approximately half of men participating in IPV perpetrator

intervention programs (BIPs) report having alcohol-related issues, while about one-third endorse features congruent with a drug-related diagnosis (Gondolf, 1999; Stuart et al., 2003). Not only is SUD a risk factor for IPV, it is predictive of lower treatment engagement and attrition in BIPs (Daly & Pelowski, 2000; Ting et al., 2009). Thomas and colleagues (2013) compared IPV perpetrators with and without SUD problems and found the former were more violent and more likely to perpetuate severe violent acts. For these reasons, Thomas and Bennett (2009) note that screening for these co-occurring issues should be universal in both BIPs and SUD programs, and they advocate for partnership across fields.

Likewise, Easton and Crane (2016) argue the etiology of IPV is complex, so multiple treatments are needed (as opposed to one modality targeting all IPV perpetrators, exclusive of individual characteristics), including incorporation of SUD treatment into standard IPV perpetrator treatment models. IPV perpetrators with comorbid SUD issues are less likely to engage in acts of IPV *following* SUD treatment; furthermore, those who stay sober are two to three times less likely to perpetrate IPV than those who relapse (Murphy & Ting, 2010). This suggests that all IPV perpetrators should be screened for addiction and referral to an evidence-based SUD treatment program in addition to IPV treatment. According to Wilson, Graham, and Taft (2014), because of the strong correlation between the two, interventions that decrease SUD may also decrease IPV.

Several studies have examined the efficacy of conjoint treatment approaches. Conjoint referring to a treatment for domestic violence and a co-occurring disorder such as SUD. For example, Easton and colleagues (2007) found that alcohol-dependent IPV perpetrators randomly assigned to an integrated SUD-DV cognitive behavioral treatment approach showed decreased alcohol use and violence compared to IPV perpetrators assigned to a twelve-step group. Other results regarding conjoint approaches have been more nuanced. For instance, Stuart and colleagues (2013) found that IPV perpetrators who participated in standard BIP plus a brief intervention for alcoholism showed initial improvements in alcohol use and episodes of violence compared to men participating in standard BIP alone, but these improvements faded over time. In a similar study, men assigned to a standard BIP plus a brief alcohol intervention exhibited significantly less physical violence and a greater percentage of days sober than those assigned to a standard BIP alone (Stuart et al., 2016). Other researchers have found no significant benefits of conjoint DV-SUD approaches over standard BIP (e.g., Puffett & Gavin, 2004). In sum, some of the recent literature pertaining to these conjoint approaches is promising, but more research is needed to draw any firm, causal conclusions (Wilson et al., 2014).

***Motivational Interviewing (MI).*** MI is a non-confrontational, person-centered interviewing approach that emphasizes client autonomy in decision-making and change (Miller & Rollnick, 2002). Rather than taking an authoritarian role, the therapist reflectively listens, provides support, and develops a collaborative relationship. Two primary goals are to elicit “change talk” and explore ambivalence about change. In contrast to more confrontational approaches, like the Duluth model, MI emphasizes that the therapist express empathy, “roll with resistance” to change, and emphasize client self-efficacy (Miller & Rollnick, 2002).

Guided by the transtheoretical model of change (TTM), motivational-based approaches are particularly suited for court-mandated and other involuntary client populations who are oftentimes at earlier stages of change (i.e., precontemplation or contemplation) as indicated by the fact that they are not seeking treatment of their own accord. Murphy and Baxter (1997) argue that interventions that are confrontational may paradoxically increase defensiveness and resistance to treatment in IPV perpetrators.

Several authors emphasize the importance of assessing perpetrators' individual readiness for change (based on TTM), rather than assigning them to a one-size-fits-all group (Alexander & Morris, 2008; Levesque, et al., 2008; Murphy & Meis, 2008). MI's effectiveness may rest on matching IPV perpetrators appropriately. For instance, Alexander (2007) conducted a randomized controlled trial (RCT) comparing an adapted stages-of-change MI intervention to standard cognitive behavioral therapy (CBT) gender reeducation treatment. The MI condition was found to be more effective in reducing female victims' reports of physical aggression at follow-up for male first-time offenders who were court-ordered to treatment or in earlier stages of change. The MI condition was no more effective than the CBT condition, however, for perpetrators with multiple admissions. Men who were at a later stage of change actually benefitted more from the CBT treatment (see also Alexander et al., 2010).

Many of the studies incorporating motivation-based approaches did not look at MI as a primary treatment but as a brief adjunct to improve attendance, adherence, and outcomes in other interventions. For example, Crane and Eckhardt (2013) conducted an RCT comparing IPV perpetrators who were assigned to a standard BIP versus a BIP plus a single-session MI-type intervention. The latter significantly increased attendance and treatment compliance compared to those in the standard BIP alone. The authors again note that this effect was moderated by the perpetrators' readiness to change, meaning participants in earlier stages of change were more likely to benefit, while the differences between groups disappeared for those in later stages of change. Notably, however, even though the intervention increased attendance, there were no differences between groups in terms of recidivism.

Congruent with this study, other research suggests adding an adjunct MI component prior to treatment significantly increases attendance and completion (Scott et al., 2011; Taft et al., 2001), promotes treatment compliance and working alliances (Murphy et al., 2012; Musser et al., 2008), and helps perpetrators progress in readiness for change (Kistenmacher & Weiss, 2008; Murphy et al., 2012). Across these studies, perpetrators in earlier stages of change benefit most from MI-type interventions, reinforcing the importance of individual assessment. The exception to this trend was an RCT conducted by Kennerley (2000) who found no significant differences between IPV perpetrators assigned to pre-intervention MI versus control on measures of attendance, participation, or likelihood of program completion; this study, however, appears to be an anomaly compared to the broader developing literature base.

As noted earlier, IPV and SUD frequently coexist. Given that MI was developed to treat SUD and is an evidence-based approach in this regard, MI may be particularly suited to IPV perpetrators who struggle with comorbid SUD. That it appears to increase attendance is an added benefit in that, as stated above, SUD is predictive of attrition and decreased treatment engagement in BIPs (Daly & Pelowski, 2000; Ting et al., 2009). Crane, Eckhardt, and Schlauch (2015), for example, conducted a study wherein a pre-BIP MI intervention predicted significantly better treatment compliance amongst binge drinkers than those in the control group.

Few studies have been conducted utilizing MI (or similar approaches) as a primary intervention for IPV perpetrators, though the research that has been done offers promise. More research has been done exploring the effect of MI as a brief adjunct to other types of BIPs. Those studies suggest MI may increase participation in and completion of treatment, especially amongst perpetrators who have comorbid SUD problems or who are in earlier stages of change. The effect MI has on recidivism is unclear, however, with a few studies showing decreases in recidivism and others showing no significant effect. Further research is needed to draw any conclusions.

**Mental Health.** Many evaluations have excluded IPV perpetrators who need mental health treatment. However, men in IPV perpetrator programs have a high prevalence of co-occurring mental disorders, personality disorders, and substance use (e.g., Dutton & Starzomski, 1993; Gondolf, 1999; Hamberger & Hastings, 1988; Holtzworth-Munroe & Stuart, 1994). Bennet and Williams (2001) describe a consensus among professionals that battering, if not a symptom of SUD or mental disorders, is at least a confounding factor that inhibits IPV perpetrators from learning alternative non-violent behaviors.

A study by Watkins and colleagues (2016) found that emotion dysregulation and partner violence perpetration were associated; the study suggests that emotion regulation might be a key factor in predicting IPV in individuals with mental disorders (p. 311). From a neuroscience perspective, Siegel (2013) promotes the use of strategies in treatment that address emotional regulation. However, there is not enough evidence at this time to support treatment for mental health as requisite beyond screening and referral (Bennet & Williams, 2001).

**Anger Management.** Historically, the role that anger plays in IPV has especially been controversial (from the standpoint of feminist approaches). Currently, many state standards do not allow anger management to be the primary intervention for IPV perpetrator treatment. Rather, the roles of patriarchy and power and control have been emphasized. Regardless, anger does appear to be an important individual variable in IPV perpetration. Norlander and Eckhardt (2005) conclude in their meta-analysis that IPV perpetrators exhibit higher levels of anger and hostility (than comparable nonviolent males) and that levels of anger differentiate perpetrators who commit mild versus more severe acts of violence, signifying a possible linear relationship between anger and severity of IPV. Perpetrators with moderate to high levels of anger may also be at greater risk for program attrition and rearrest (Eckhardt, Samper, & Murphy, 2008). There is insufficient evidence to conclude that anger *causes* IPV (Norlander & Eckhardt, 2005); however, given the significant relationship between IPV and anger, it should be assessed and should not be dismissed within the context of research or treatment.

**Other Modalities.** There are a number of new modalities that are being proposed as alternatives to the primary modalities discussed earlier. Those that have available research were included.

**Couples Therapy.** As presented earlier, couples therapy as a court-ordered response to IPV is widely disputed amongst researchers. Melton and Sillito (2012) discuss the issue of couples counseling in a study of the role of gender in officially reported intimate partner abuse:

The issue of couples counseling is just one example of the many possible policy implications of the gender debate. The conflict and debate between feminist and family violence can be summarized by their opposing stand on whether or not gender is the central contributing factor to IPA. If the problem is nongendered violence, then nongendered solutions (such as couples counseling) could be proper interventions. On the other hand, if gender is at the heart of IPA, then nongendered solutions magnify the problem, place undue blame on the victim, and shift blame from the perpetrator to the “couple” (p. 1097).

Stemming from this dispute is a wide ban on the use of couples counseling as a treatment intervention for IPV perpetrators across the United States. An outcome of this exclusion is a barrier to studying the efficacy and subsequently a lack of studies available on its effectiveness. The studies that do exist are limited in similar ways to the studies of primary modalities with respect to



heterogeneity in the treatment intervention, outcomes measures, and eligibility criteria (Stith et al., 2003). Further, the studies available have been largely conducted with low-risk IPV perpetrators where safety of the victim can be ensured (Dunford, 2000; O'Leary et al., 1999). The result is a lack of generalizability to the majority of IPV perpetrators mandated to treatment. Where studies of efficacy do exist, couples therapy has been compared to the primary modalities and showed minimal effectiveness, similar to the primary modalities (Brannen & Rubin, 1996; Dunford, 2000). However, these studies also included very specific populations of IPV perpetrators that are not representative. An example being the Navy Experiment (Dunford, 2000) which included couples interventions for its active duty participants. For more information on couples therapy as a treatment for IPV perpetrators and studies that have been completed to date see the recent systematic review completed by Armenti and Babcock (2016).

***Restorative Justice.*** A restorative justice approach to IPV offender treatment seeks to reintegrate the perpetrator in the community. This approach has faced opposition since it challenges the conceptualization of justice and the role that community members play in treatment. Challenging current criminal justice approaches to the treatment of IPV offenders, Ferguson (2009) suggests that by protecting the victim from all blame, an assumption is made which results in aggressive arrest and prosecution, even if the victim does not seek it (2009, p. 17).

The guidelines for restorative justice practice in family violence cases are as follows (Friend, 2009, p. 149):

- Involvement of family violence experts in the design and planning of the restorative process,
- Involvement of larger community in the design and oversight of the process,
- Involvement of the formal justice system in the design and oversight of the process to assure that harm is addressed,
- Presence of persons knowledgeable about family violence,
- Involvement of persons outside the nuclear family who have close ties to the family, can speak the truth, and disapprove of the violence,
- Establish a continual feedback loop for updates from the victims about the impact of the restorative justice process,
- Regular self-reflection on the use of restorative justice values and principles in one's own life,
- Regular self-reflection by the larger community on the causes of and remedies for family violence locally

Friend (2009) also confronts concerns raised in the literature about Circles of Peace as a BIP such as the use of intake screeners and reassessment for victim safety and training of facilitators to ensure that the circle keeper stays attuned to IPV issues and related safety dynamics (p. 152).

In 2013, Mills and colleagues reported results from a RCT where IPV perpetrators were sentenced to Circles of Peace (CP) or a BIP group using a mixed Duluth-type model. No difference was found between the interventions and there was not a significant reduction in domestic violence recidivism. Mills and colleagues (2013), suggested that the non-significant findings indicate that restorative justice and couples treatment were no worse than predominant treatment models used and proposed that CP be viewed as a viable treatment alternative. A follow-up study comparing the effectiveness of a standard BIP to CP is currently being conducted in Salt Lake City, Utah. A few studies have lent support to other restorative justice alternatives to BIP, including: Healing Circles

(Zakheim in 2011) and Shame Transformation Treatment (Loeffler et al., 2010). Although these studies lay the groundwork of support for these approaches, significantly more research is needed to determine if they provide a better option than existing approaches in the reduction of recidivism.

***Mind-Body Bridging.*** The Mind-Body Bridging (MBB) approach focuses on increasing emotional regulation, reducing aggression and hostility, and improving intimate relationships (Tollefson & Phillips, 2015). The proposed treatment includes sixteen hour-long group sessions that focus on teaching the perpetrator how to prevent triggering the “Explosive State.” There is not a manual for treatment, but a workbook was employed in the experiment to facilitate exercises. A summary of the sessions includes:

- Session 1 and 2: Establish group rules, introductions and creating a “problem” map
- Session 3: *Bridging Scale* (a mindfulness exercise) and additional mapping
- Session 4: recognizing negative self-talk and negative perception of self
- Session 5: recognizing coping mechanisms that are neglecting the well-being of others
- Session 6: identifying triggers and requirements through a *Relationship Requirements Map*
- Session 7: complete *Fear Map* and an *Incident Map*
- Session 9-16: continued work with the *Bridging Scale*, completion of workbook, presentation of *Incident Map*

Sessions are working toward mindfulness where perpetrators are demonstrating a control of self, regulating emotions, and minimizing their need for their partner to behave certain ways (Tollefson & Phillips, 2015, p. 788).

A randomized design comparing MBB to an “eclectic mix of interventions commonly used in domestic violence offender programs” found a non-statistically significant difference favoring MBB (Tollefson & Phillips, 2015, p. 788). Post-treatment follow-up was an average of 18 months. The limitations to this experiment were the reliance on official report as the sole measurement for recidivism as well as some potential for cross-contamination due to the facilitator being the same for both groups and some MBB being present in the comparison treatment curriculum. Additional studies are needed to understand the effects of a MBB approach.

***Acceptance and Commitment Therapy.*** A model of Acceptance and Commitment Therapy (ACT) for IPV perpetrators was developed in Iowa through a partnership with the University of Iowa and the Iowa Department of Corrections. It is called ACTV: ACT for Domestic Violence in Iowa. The premise is that violent offenders negatively evaluate the experience and expression of emotions, have poor empathic accuracy with others’ thoughts and feelings, show an inability to tolerate one’s own and others’ negative emotions and aggression provides short-term distraction from emotion (Prell, 2016). The processes are as follows:

- Acceptance as an exploration of the futility of emotional control & avoidance, which can increase distress & deter from engaging in purposeful & vital value driven behavior
- Defusion as a radical shift in context, where thoughts are observed events, rather than literal truths that must dictate behavior
- Mindfulness to build awareness of what is being experienced in the present moment. Thoughts come & go – they don’t have to control behavior
- Self-as context builds awareness of the observing self, wherein people come to realize they can let go of unhelpful self-evaluations & retain a sense of self

- Values as shown by participants choosing willingness to experience difficult thoughts & feelings in order to engage in valued behavior
- Committed action where ACT helps people see they must choose the valued direction again and again, for example, after failure.

ACT is comprised of 24 sessions that are an hour and a half to two hours in length and focused on identifying barriers to change and developing emotion regulation, cognitive, and behavior skills in a collaborative, non-judgmental, and experiential learning atmosphere (Prell, 2016). At the time of this review, there were no studies available evaluating the effectiveness of Acceptance and Commitment Therapy (ACT); however, preliminary results of a study on an ACT-based curriculum (ACTV), are promising and show significantly improved general recidivism and domestic assault recidivism. Unfortunately, details of the study design were not provided and a final report has not yet been published.

***Dialectical Behavior Therapy (DBT).*** Dialectical Behavior Therapy (DBT) “is a treatment for emotion dysregulation and the various behavioral difficulties associated with severe and chronic emotion dysregulation” (Fruzzetti & Levensky, 2000, p. 436). Based on the findings of Saunders (1996), borderline/dysphoric batterers did better in process-oriented psychodynamic groups that address childhood trauma history. DBT has been recommended as a promising treatment for borderline/dysphoric participants (Banks, Kini, & Babcock, 2013). Further, DBT has been proven effective for the concomitant problems that batterers often face such as substance use disorder, affective disorders and other quality-of-life problems (Fruzzetti & Levensky, 2000). Additionally, DBT has had success in treating clients with high dropout rates.

In 2000, Fruzzetti and Levensky proposed a DBT BIP model; the targets of treatment include:

- Decrease:
  - Life-threatening behavior: suicidal and parasuicidal behaviors, thoughts, urges, actions; aggressive and violent thoughts, urges, and actions; child neglect
  - Therapy-interfering behaviors
  - Quality-of-life interfering behaviors (that threaten stability, individually or in the family) such as:
    - Criminal behaviors that may lead to jail
    - Problematic sexual behavior (outside relationship, high risk/unprotected)
    - Seriously dysfunctional interpersonal behaviors
    - Significant employment or school-related dysfunctional behaviors
    - Illness-related dysfunctional behaviors
    - Housing-related dysfunctional behaviors
    - Mental health-related dysfunctional behaviors (e.g., severe DSM Axis I- IV disorders )
- Increase:
  - Individual Behavioral Skills and Self-Management
  - Mindfulness
  - Distress tolerance
  - Emotion regulation
  - Interpersonal effectiveness
  - Validation and empathy

The treatment model includes five modules including: mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and validation. The model may also include behavior

assessment and behavior interventions that include active skill building, psychoeducational components, and mindfulness. No studies have been conducted on effectiveness of the DBT BIP model.

***Strengths-Based Approaches.*** In 2016, a systematic analysis by Waller sought to propose a more effective approach to treatment for black males, and classified the primary modalities as modernism. According to Waller (2016), Modernism being a “paradigm that is directive, disempowers, participants, provides punitive mechanisms of reinforcement for noncompletion, and models victimization for the perpetrators” (p. 46). This is contrasted by the author against a postmodern paradigm that is, “supportive, position the therapist as a collaborative partner, and empowers clients to construct their own identities...assist clients with acknowledging their contextualized histories and perspectives concerning their problems” (p.46). The author suggests that a strengths-based approach is promising in light of the lack of support for the primary modalities. Lebmman and Simmons (2009) also promote a strengths-based approach, cautioning against “assuming heterogeneity among and between perpetrators, manualizing BIPs, relying too heavily on specified protocol and group confrontation, and presuming the safety of the victims/survivors will be jeopardized by adopting a new perspective” (p. 130). One article by Curwood and colleagues (2011) presented qualitative findings from the narratives of a small sample of men in a BIP. The study recommended, “recognizing their [batterers] strengths rather than weaknesses, identifying and encouraging the change processes that begin prior to treatment programming, and fostering self-determined goals” (Curwood et al., 2011, p.2710).

***Solution-Focused Therapy.*** Solution-Focused Therapy “evolved out of using a strategic approach in family therapy (Lee et al.,1999, p. 40). The focus is on accountability for “solutions and strengths” as opposed to “deficits and blames” (Lee et al., 1999, p. 53). Utilizing the typologies of IPV offenders, Lee (1999) suggests that the primary treatment modalities where confrontation is utilized (e.g., Duluth-type) are not appropriate for IPV offender treatment and suggest Solution-Focused Therapy as a promising approach.

Solution-Focused Therapy is positioned as part of a coordinated community response and relies on the sanctions provided by the legal system (Lee et al., 2004; Lipchick et al., 1997). Lee and colleagues describe how Solution-Focused Therapy to date had been used in low-risk couples interventions where domestic violence is the problem. Lipchick and colleagues (1997) and Lee and colleagues (1999) present models for using Solution-Focused Therapy with IPV offenders. Lipchik and colleagues present a couples intervention for couples who choose to stay together. The model presented promotes safety of the victim, but also reduction of confrontation by the therapist and client-defined goals.

Lee and Colleagues (2004) present a brief group treatment model for male IPV offenders; eight one-hour group sessions over a 3-month period with both male and female IPV offenders (p. 465). The brief intervention is in part an attempt to confront attrition by IPV offenders. The only exclusionary factor for this type of treatment is when IPV offenders are actively psychotic (Lee et al., 1999, p. 47).

The principles that guide treatment are as follows (Lee et al., 2004, p. 467):

- a focus on solutions and strengths
- utilizing language of strengths and successes
- accountability for solutions
- participants define their goals and construct their solutions
- present and future orientation
- a collaborative therapeutic relationship
- utilization: a noninstructional/educational approach

At the time of this review, only a single pre/post comparison study had been conducted on the use of Solution-Focused Therapy for IPV (Lee & Colleagues, 2004) and additional research is needed before statements can be made regarding the effectiveness of this approach.

## **Conclusion**

This review examined extant research on the impact of treatment in reducing criminal recidivism among male IPV perpetrators. Overall, the findings with respect to effectiveness of the most commonly used treatment modalities (Duluth and CBT) are modest at best. In light of such findings on the efficacy of the primary modalities in reducing recidivism in IPV perpetrators, there are many new treatments being proposed as a replacement; however, there is insufficient research, at the moment, to confidently identify new modalities that would be more effective than Duluth or CBT. Emerging research does suggest important considerations in the treatment of these offenders.

Early studies established that there are differences amongst perpetrators and Saunders (1996) found that different therapy modalities are more effective when treating different perpetrator types (e.g., antisocial, dependent). Research has shown that a group of perpetrators with a stake in conformity would do well in treatment regardless of the intervention. However, attrition is high for this population of offenders. The reductions in attrition seen with individualized treatment (e.g., motivational interviewing, substance use disorder treatment, and separation by risk and/or perpetrator typology) suggest that it should be a component in IPV perpetrator treatment; similar to best practice recommendations for general offender treatment (Andrews & Bonta, 2010).

Perpetrators of IPV in treatment are most often involved with the criminal justice system. As such, it is vital to have a coordinated response among criminal justice stakeholders, treatment providers, and victim advocates as consequences of a punitive response, namely its impact on victims are still being determined. Best practices for general offenders and other violent perpetrators (e.g., RNR) are promising and should be tested and evaluated with IPV perpetrators specifically. Examples of well-designed evaluations are offered throughout the report.

Considering the necessity for more research on the efficacy of IPV perpetrator treatment, it is important to note how more explicit state standards seen across the nation, which may require compliance in order to be licensed or funded, impact new research and often stifle innovation. For example, modalities that target individuals or couples are often limited or banned in state standards for IPV perpetrator treatment. The risk is that many state standards do not utilize the body of research on efficacy to inform standards. Namely, that the current research does not show one modality that is reliably more effective than others. Compared to national trends, current state standards in Utah offer a potential to preserve innovation while prioritizing victim safety. Examples

are the Utah-based, higher-quality experiments for Mind-Body-Bridging and Circles of Peace included in this report.

In light of the lack of consensus about which treatment is best for IPV perpetrators, what is known as best practice for offenders, in general, should influence the coordinated response. Specifically, program evaluations of individual BIPs, including measures of recidivism and/or the successful acquisition of skills targeted by the BIPs, are recommended to ensure accountability amongst treatment providers across the state.

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*\*an asterisk denotes studies reviewed for the primary modalities*

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## Appendix A: Extended Search Strategy

The primary goal of the search was to identify published research on the effectiveness of domestic violence batterer interventions. The search unfolded in several stages. First, a preliminary web-based search for domestic violence batterer interventions was conducted using Google. Out of this, several government reports and open access articles were identified as pertinent. Second, a preliminary search of academic databases was conducted, focusing specifically on systematic reviews and meta-analyses.

The following databases were searched: PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection, Academic Search Premier, CINAHL, Criminal Justice Abstracts, and MEDLINE. The following search term clusters were used, separated by the Boolean *AND*:

- “domestic violence” or DV or “intimate partner violence” or IPV
- “systematic review” or meta-analy\*
- “batterer intervention” or “batterer treatment” or “perpetrator intervention” or “perpetrator treatment”

This returned 13 results. Of these, six were identified as proper meta-analyses or systematic reviews addressing the effectiveness of batterer interventions specifically.

Third, the citation lists for these six articles were reviewed for article titles pertinent to domestic violence batterer interventions. When relevant-looking titles were identified, they were incorporated into the larger article database. When new meta-analyses, systematic reviews, and literature reviews were identified, their citations lists were likewise reviewed for relevant articles (in a sort of snowball sampling strategy). In all, twelve citation lists were reviewed, and this review concluded when only repeat articles were turning up. In total, 242 references were gleaned from the preliminary searches and review of citation lists.

Fourth, the main database search was conducted. The following databases from EBSCO were searched: Academic Search Premier, CINAHL, Criminal Justice Abstracts, ERIC, Health Source: Nursing/Academic Edition, MEDLINE, PsycARTICLES, and PsycINFO. Additionally, Scopus, Web of Science, Social Work Abstracts, Social Service Abstracts, Sociological Abstracts, and LexisNexis Academic were also searched. Parameters for the search were from year 1990 forward.

The following four search clusters were used, again separated by the Boolean *AND*:

- “domestic assault” or “domestic violence” or “family violence” or “spous\* abuse” or “partner abuse” or “domestic abuse” or duluth or “intimate partner violence” or DV or IPV
- program\* or treatment\* or intervention\*
- effective\* or outcome\* or evaluat\* or experiment\* or quasi\* or randomize\* or reoffen\* or “random assign\*” or recidiv\* or efficacy
- batter\* or offender or perpetr\*

This returned 7,400 results, which when added to the aforementioned 242 references, totaled 7,642 articles. The vast majority of these references were peer-reviewed journal articles but also included government documents, books, book chapters, and dissertations.

Duplicate references were identified and deleted, resulting in 4,911 references. Article titles were then reviewed. Clearly irrelevant titles were deleted, resulting in 1,035 results. All abstracts were subsequently reviewed. Again, clearly irrelevant articles were deleted, resulting in 923 remaining

articles. During this winnowing of the database, special care was made to organize study by quality (higher-, mid-, lower-quality) and intervention type (primary including Duluth, CBT and Mixed-Intervention and promising approaches) and to track meta-analyses, systematic reviews, and literature reviews. In all, 12 meta-analyses, systematic reviews and literature reviews, and 34 higher-, mid-and lower-quality studies were identified. Additionally, 9 recent (and potentially promising) approaches pertaining to batterer treatment were identified and categorized by intervention type. This does not include models of treatment modalities where there was no experiment of efficacy.

Lastly, a web-based search for state and federal domestic violence batterer intervention laws or standards was conducted using Google. Utah state specific articles or reports were identified. Out of this, several government reports and open access articles were identified as pertinent. Additionally, the citation lists of articles that discussed state and/or federal standards were reviewed for sections pertinent to laws or standards for domestic violence batterer interventions. When relevant sections were identified, the articles were incorporated into the larger article database.

#### Review Article Citation Lists Searched:

- Akoensi, T. D., Koehler, J. A., Losel, F., & Humphreys, D. K. (2013). Domestic violence perpetrator programs in Europe, Part II: A systematic review of the state of evidence. *International Journal of Offender Therapy and Comparative Criminology*, 57, 1206-1225. <http://dx.doi.org/10.1177/0306624X12468110>
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Miller, M., Drake, E., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy. Retrieved from [http://www.wsipp.wa.gov/ReportFile/1119/Wsipp\\_What-Works-to-Reduce-Recidivism-by-Domestic-Violence-Offenders\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1119/Wsipp_What-Works-to-Reduce-Recidivism-by-Domestic-Violence-Offenders_Full-Report.pdf)

Smedslund, G., Dalsbo, T. K., Steiro, A., Winsvold, A., & Clench-Aas, J. (2011). Cognitive behavioural therapy for men who physically abuse their female partner. *The Cochrane Database of Systematic Reviews*, 4, 1-33.

Waller, B. (2016). Broken fixes: A systematic analysis of the effectiveness of modern and postmodern interventions utilized to decrease IPV perpetration among Black males remanded to treatment. *Aggression & Violent Behavior*, 27, 42-49. doi:10.1016/j.avb.2016.02.003

## Appendix B: State/Federal Trends/Comparisons

State	Updated (Year)	Research Used	Standards Exist	Standards Required	Treatment Required	Minimum Length (Wks)	Modality Preferred	Banned Approaches
<p><i>Research: INF=Infrastructure for review and revision of standards (incl. formal committees and annual practices; QA=Quality Assurance (incl. Encourages use of research and/or evaluation, Pilot Projects, Collection of data recommended and/or mandated Implementation Studies, Program Evaluation, Outcome Studies); IN=innovation, new research promoted.</i></p> <p><i>Approaches preferred: D=Duluth; CBT=Cognitive Behavioral Therapy; GR=Group; Ind=Individual Therapy; GE=Gender-specific</i></p> <p><i>Banned Approaches: AC=Addiction Counseling and/or Violence as an Addiction; AD=Alternative Dispute Resolution; AM= Anger Management (as primary); CE=Communication Enhancement; CR=Conflict Resolution (as primary); C=Containment; Co=Couples Therapy and/or conjoint therapy; Edu=Education about DV (as primary); FF=Fair Fighting (as primary); FB=Faith-Based Ideology and/or Pastoral Counseling; FS=Family Systems or Systems Theory; FT=Family Therapy (as primary); GC=Gradual Containment; IC=Impulse Control (as primary); Ind=Individual Therapy; InsM=Insight Model=InsM; IntM=Interaction Model; Medication Management=MM; PsyTest=Psychological Tests; PT=Psychodynamic Therapy; Psy=Psychopathology (as primary); SM=Stress Management; SA=Substance Abuse treatment only; VT=Ventilation Techniques; VB=Victim Blaming; VC=Victim Coercion; VM=Victim Mandating; VP=Victim Participation; VMP=Violence as a Mutual Process</i></p>								
AK	2004		Y	Y	N	24	D; Gr	Co (first six months); VP
AL	2008		Y	N	N	16	CBT; D	AC; C; CO; FF; FS; IC; Psy; VB; VM
AR	-	-	-	-	-	-	-	-
AZ	2003	Y	Y	Y	N	26	Gr; Ind	AM; CR; Edu; FT
CA	2010		Y	Y	Y	52	Gr; Ge	CO
CO	2012	Y; IN	Y	Y	Y	Varies, offender level	CBT; Gr; Ge	CO
CT	-	-	-	-	-	-	-	-
DE	2006		Y	Y	N	24 hours/15 weeks/12 sessions	D; Gr; Ge	AC; AM; CO; FS; IC; Psy; PT; VB; VC
FL	2012		Y	N	Y	24 sessions within 29 weeks	D; Gr; Ge	AM; CO; FB; FF; IC
GA	2010		Y	Y	Y	24 sessions within 27 weeks	Gr; Ge	AM; CO; Ind; SM; VB:
HI	2010	Y; IN	Y	N	N	24	Gr; Ge	AC; AM; CO; FS; GC PT; Psy; VT
IA	2005	Y; INF; IN	Y	Y	Y	24	Varies depending on offender type	AM
ID	2011	Y; QA, IN	Y	Y	Y	52	Gr	CO
IL	2005	Y; QA	Y	N	N	24 weeks/36 hours	Gr; Ge	AC; AM; FB; FT; IC; SA; VB
IN	2007		Y	N	N	26	Gr; Ge	CO
KS	2012		Y	Y	Y	24	Gr	AC; C; CO; FS; IC; Psy; VB; VC
KY	2009		Y	Y	N	28	Gr; Ind; Ge	
State	Updated (Year)	Research Used	Standards Exist	Standards Required	Treatment Required	Minimum Length (Wks)	Modality Preferred	Banned Approaches

Research: INF=Infrastructure for review and revision of standards (incl. formal committees and annual practices; QA=Quality Assurance (incl. Encourages use of research and/or evaluation, Pilot Projects, Collection of data recommended and/or mandated Implementation Studies, Program Evaluation, Outcome Studies); IN=innovation, new research promoted.

Approaches preferred: D=Duluth; CBT=Cognitive Behavioral Therapy; GR=Group; Ind=Individual Therapy; GE=Gender-specific

Banned Approaches: AC=Addiction Counseling and/or Violence as an Addiction; AD=Alternative Dispute Resolution; AM= Anger Management (as primary); CE=Communication Enhancement; CR=Conflict Resolution (as primary); C=Containment; Co=Couples Therapy and/or conjoint therapy; Edu=Education about DV (as primary); FF=Fair Fighting (as primary); FB=Faith-Based Ideology and/or Pastoral Counseling; FS=Family Systems or Systems Theory; FT=Family Therapy (as primary); GC=Gradual Containment; IC=Impulse Control (as primary); Ind=Individual Therapy; InsM=Insight Model=InsM; IntM=Interaction Model; Medication Management=MM; PsyTest=Psychological Tests; PT=Psychodynamic Therapy; Psy=Psychopathology (as primary); SM=Stress Management; SA=Substance Abuse treatment only; VT=Ventilation Techniques; VB=Victim Blaming; VC=Victim Coercion; VM=Victim Mandating; VP=Victim Participation; VMP=Violence as a Mutual Process

LA	2012		N	N	Y			
MA	1995	Y; QA	Y	Y	Y	8 hours	Gr; Ge	AC; AM; CO; FF; FS; GC; IC; Psy; PT
MD	2006		Y	Y	N	32 hours over at least 20 weeks	Gr; Ge	
ME	2008		Y	Y	N	48	CBT; Gr; Ge	AC; AM; CO; FS; FT; Ind; MM
MI	1998	Y; IN	Y	N	N	26	Gr; Ge	AD; CO; Psy; VB
MN	2001	Y; QA	Y	Y	Y	24 sessions or 36 hours	Gr; Ge	CO
MO	2006		Y	N	N	26	D; Gr; Ge	AC; AM; CO; IC; VB; VT
MS			N		N			
MT	2003		Y	N	Y	4 hours	Gr	
NC	2004		Y	Y	N	39 hours/26 weeks	Gr; Ge	AC; AM; CO; VMP
ND	2008	Y; QA	Y	N	N	24	D; Gr	AM; CO; SA; VB
NE	2008		Y	N	N	24	D; Gr; Ge	AC; AM; C; CE; CO; FF; FS; IC; Psy; PT
NH	2002	Y; QA; INF	Y	Y	N	52	D; Gr; Ge	AC; AM; C; FF; FS; IC; Psy; VP; V
NJ	2004		Y	N	N	26	D; Gr	
NM	2009		Y	Y	Y	52	Gr; Ge	CO
NV	2010		Y	Y	Y	36	D; Gr; Ge	AC; SA; VP
NY	-	-	-	-	-	-	-	-
OH	2010	Y; QA	Y	N	N	24	D; Gr	AM; CO; FB; Psy; SA
OK	2012		Y	Y	Y	52	Gr; Ge	AC; CO; VB; VMP; VT
State	Updated (Year)	Research Used	Standards Exist	Standards Required	Treatment Required	Minimum Length (Wks)	Modality Preferred	Banned Approaches

Research: INF=Infrastructure for review and revision of standards (incl. formal committees and annual practices; QA=Quality Assurance (incl. Encourages use of research and/or evaluation, Pilot Projects, Collection of data recommended and/or mandated Implementation Studies,



Program Evaluation, Outcome Studies); IN=innovation, new research promoted.

Approaches preferred: D=Duluth; CBT=Cognitive Behavioral Therapy; GR=Group; Ind=Individual Therapy; GE=Gender-specific

Banned Approaches: AC=Addiction Counseling and/or Violence as an Addiction; AD=Alternative Dispute Resolution; AM= Anger Management (as primary); CE=Communication Enhancement; CR=Conflict Resolution (as primary); C=Containment; Co=Couples Therapy and/or conjoint therapy; Edu=Education about DV (as primary); FF=Fair Fighting (as primary); FB=Faith-Based Ideology and/or Pastoral Counseling; FS=Family Systems or Systems Theory; FT=Family Therapy (as primary); GC=Gradual Containment; IC=Impulse Control (as primary); Ind=Individual Therapy; InsM=Insight Model=InsM; IntM=Interaction Model; Medication Management=MM; PsyTest=Psychological Tests; PT=Psychodynamic Therapy; Psy=Psychopathology (as primary); SM=Stress Management; SUD=Substance Use Disorder treatment only; VT=Ventilation Techniques; VB=Victim Blaming; VC=Victim Coercion; VM=Victim Mandating; VP=Victim Participation; VMP=Violence as a Mutual Process

<b>OR</b>	2006	Y; IN	Y	N	N	48	Gr; Ge	AC; CO; VB; VMP; VT
<b>PA</b>	1992	Y	Y	N	N	29	D; Gr; Ind	CO: InsM; IntM; VT;
<b>RI</b>	2007	Y; IN	Y	Y	Y	2 weeks or 4 hours	Gr; Ge	CO; VB
<b>SC</b>	2005		Y	Y	N	26	Gr	
<b>SD</b>	-	-	-	-	-	-	-	-
<b>TN</b>	1999		Y	Y	N	24		AM; CO; SA; VP
<b>TX</b>	2009	Y; IN	Y	Y	Y	36 hours or 18 weeks	Ge	AM; CO; IC; Psy
<b>UT</b>	2012		Y	Y	N	16		CO (before 12 weeks of treatment)
<b>VA</b>	2010	Y; QA	Y	N	N	36 hours or 18 weeks	Gr	AM; CO; VP
<b>VT</b>	2010	Y; QA	Y	Y	N	26	Gr	AM; CO; VP
<b>WA</b>	2001		Y	Y	N	52	D; Gr; Ge	AM; CO; FT; Ind; SUD (evaluations)
<b>WI</b>	2007		Y	N	N		D; Gr; Ge	AM; CO; FT; PsyTest; SA
<b>WV</b>	2003	Y; QA	Y	Y	Y	32	Gr	AM
<b>WY</b>	-	-	-	-	-	-	-	-

Source: Miller, M., Drake, E., & Nafziger, M. (2013). What Works to Reduce Recidivism by Domestic Violence Offenders? *Washington State Institute for Public Policy*, 1-19.