

Towards Evidence-Based Practice with Domestic Violence Perpetrators

Kenneth Corvo, PhD
Syracuse University
School of Social Work

Donald Dutton, PhD
University of British Columbia
Department of Psychology

Wan-Yi Chen, PhD
Syracuse University
School of Social Work

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Abstract

This review examines the policy and practice of interventions with male perpetrators of domestic violence in light of the widely accepted principles of evidence-based practice. Thus far these policies and practices have enjoyed a sort of immunity from external, empirical accountability available through implementing the findings from evaluations research and other empirical practice analyses. This immunity is supported by a policy framework where, for example, the state certifying agencies may presumptively forbid methods of intervention that contradict the approved model with no obligation to empirically assess their efficacy or safety. Based on the review of findings from both explanatory research and interventions research, evidence-based recommendations for policy and program change are proposed.

*The preponderance of evidence now accumulated in the field calls into question the efficacy of batterer programs based on the most prevalent national models. Indeed, the main findings from our randomized trial are consistent with other recent trials, of which **none** found that mandating offenders to a batterer program for groups for men produced lower rates of re-abuse. (p. viii)*

Labriola, Rempel, and Davis (2005) Testing the Effectiveness of Batterer Programs and Judicial Monitoring: Final Report Submitted to the National Institute of Justice (<http://www.courtinnovation.org/uploads/documents/battererprogramseffectiveness.pdf>) retrieved 6/29/06

Introduction

Numerous empirical studies, literature reviews, and meta-analyses of standard model interventions with perpetrators of domestic violence have found little or no positive effect on violent behavior (Dutton & Corvo, 2006). In spite of these consistent findings, the standard model of intervention with “batterers” in the United States has not been subjected to the same kind of critical appraisal and reformulation that other behavioral change programs receive. Rather, program content and strategies are shaped and controlled by fixed standards or guidelines developed and disseminated by governmental or quasi-governmental domestic violence “certifying” agencies (usually state-level), thus determining which approaches are permitted for local programs (National Institute of Justice, 1998). The typical program for these offenders is same-sex (most often male), group psychoeducational or cognitive behavioral treatment, of six to thirty-six weeks in length, with content emphasizing “accountability”, rational emotive principles, and feminist gender relations (Corvo & Johnson, 2003; Edleson, 1996; Eisikovits & Edleson, 1989; Feder & Wilson, 2005) .

These programs enjoy a sort of immunity from external, empirical accountability that confounds the dynamic program development strategies available through implementing the findings from evaluations research and other empirical practice analyses. This immunity is supported by a policy framework where, for example, the state certifying agencies may presumptively forbid methods of intervention that contradict the approved model with no obligation to empirically assess their efficacy or safety. (Corvo & Johnson, 2003). For example, the New York Office for the Prevention of Domestic Violence on its website (www.opdv.state.ny.us) under the heading “Best Practices in Domestic Violence Cases” asserts without substantiation or citation: “*Joint counseling in any form – couple counseling, family therapy, mediation – is contraindicated in DV cases, even when the victim insists on it...because it is dangerous...unfair.... ineffective*”. However, Stith, Rosen, McCollum, and Thomsen (2004) found in their review and study that couples treatment was at least as effective as the standard model and more effective in some circumstances.

Much of current policy and practice with respect to domestic violence perpetration emerged Second Wave feminist initiatives formulated in the 1970's and early 80's (see, for example, Dobash & Dobash, 1978; Bograd, 1984). The feminism of the period was responsible for identifying then responding to the domestic abuse of women (Pleck, 1987). However, it can be argued that in setting and maintaining a policy course with respect to domestic violence the more visionary aspects and dimensions of feminist theory, radical or otherwise, have been largely ignored.

Although the roots of the larger policy framework can be traced back to the feminist-inspired Duluth Domestic Abuse Intervention Project, increasingly it has come to resemble the more conservative social control, “law and order” policies which favor the criminalizing of deviance (Dutton & Corvo, 2006). It is this “law and order” custodianship rationalized by a vestigial, rote, feminist ideology that maintains an inflexible, hermetic policy framework.

Although there is abundant scientific information available about the etiology, enactment, and treatment of violence to better inform domestic violence policies, little of it is used for program development or practice. For example, extensive evidence exists describing a variety of individual patterns of intimate abusiveness (e.g. Dutton & Corvo 2006), including: 1) differential patterns of violence (unilateral: male predominant, female predominant and bilateral) and 2) differential profiles of offenders within either gender, including personality disorders and impulse control problems including substance abuse. Yet, most certified perpetrator interventions ignore this variability in favor of a “one-size-fits all” approach.

One of the major custodians of domestic violence policy, the National Institute of Justice (NIJ) has funded a number of “batterer” intervention evaluations (e.g. NIJ, 2003 *Do Batterer Intervention Programs Work?*). However, an ideological and political firewall exists between this kind of information and substantial changes in policy and practice. For example, the links between alcohol abuse and domestic violence, well-established through epidemiological, clinical and laboratory studies, are often minimized in domestic violence policy and practice with the rationale that not all perpetrators abuse alcohol and not all alcohol abusers are violent (Corvo, Halpern, & Ferraro, 2006). Some

states actually prohibit providing counseling for addiction to “batterers” as part of their approved programs. (National Institute of Justice, 1998).

What distinguishes domestic violence policy and interventions from other problem areas is not only a poor showing in effectiveness and outcomes. Babcock, Green, and Robie (2004) found comparably small effect sizes for some interventions in other problems with similar populations. What *does* distinguish domestic violence policy and interventions are the systematic and institutional proscriptions against using evaluation findings and other pertinent data to develop program innovations. The proximal impediments to program development are the domestic violence certifying agencies that oversee interventions with abuse perpetrators involved in the criminal justice system. These agencies formulate and implement policies that regulate what structure, duration and form of intervention is required as a condition of probation for persons found guilty of domestic assault and thereby which form of intervention is deemed acceptable by the courts. Hence, program funding is only available to those programs that conform to these policies (Dutton and Corvo, 2006).

Evidence-based practice (EBP) has emerged as an important treatment model in many fields including medicine, psychiatry, psychology, social work, marriage and family therapy (Thyer, 2004) and criminology (Petrosino, Boruch, , Soydan, Duggan, & Sanchez-Meca, 2001). The core principle of EBP is the commitment to understanding and using the best available scientific research findings to inform practice (Fraser, 2003; APA, online). Some have even suggested that approaching practice without considering the most rigorous research available is unethical and may violate professional norms (Casey Family Services, online).

How does one make progress in a field of practice, interventions with domestic violence perpetrators, where the core principle of EBP may be rejected in favor of maintaining an inordinately political and ideological service delivery system? The task, then, of moving toward evidence-based practice with domestic violence perpetrators must proceed against the inertia of a policy framework that has often suppressed program development efforts and may presumptively exclude important research findings.

Overview of Evidence-Based Practice

An antecedent of EBP in psychology can be traced back to the Boulder Conference in 1949, where clinicians meeting to discuss training and practice in psychology advanced the idea that practice should be founded on research and social science methods – the “scientist-practitioner” model (Fraser, 2003). The roots of EBP in medicine are often attributed to the work of Archibald Cochrane, whose 1971 monograph "Effectiveness and Efficiency. Random Reflections on Health Services" proposed that a medical intervention be considered effective only if it has been demonstrated, preferably by a randomized controlled trial, that it does more good than harm (Hill, 2000). Patterson, Miller, Carnes, and Wilson (2004) identify the further development of the principles of EBP in the 1980's in the work of Gordon Guyatt and colleagues at McMaster University in Canada:

“[they] wanted to create systematic ways of finding, critically appraising, and using available clinical research... Instead of depending on expert opinion, these early leaders wanted to develop systematic principles based on scientific methods that would help individual clinicians make their own research-based clinical decisions.” (p.184)

Howard, McMillen and Pollio (2003) see EBP as a departure from an historical paradigm where theory, supervision, “experience”, common sense, and other authority-based perspectives determined practice methods.

Sackett, Straus, Richardson, Rosenberg, and Haynes (2000) define EBP as the “the integration of best research evidence with clinical expertise and patient values” (p.

1). Further, Sackett, et al. describe EBP as involving five steps:

1. Convert a need for information into an answerable question.
2. Find the best clinical evidence to answer that question.
3. Critically appraise the evidence in terms of its validity, clinical significance, and utility.
4. Integrate the critical appraisal of research evidence with one’s clinical expertise and the client’s characteristics.
5. After implementing the EBP, evaluate one’s effectiveness.

Grounded in science and empiricism, EBP requires the ability and willingness to give up preconceived, untested notions of effective practice. Shlonsky and Gibbs (2004) state, “EBP assumes a predisposition to inquiry as well as the impetus to pose specific questions. It assumes a fair-minded approach that eschews selling a particular position.” (p.151). The general epistemology of EBP, then, can be seen as one of applied scientific research, where certain kinds of systemic inquiry are seen as more valid and more useful. When possible, the preferred methodology is the multi-site randomized controlled clinical trial (Thyer, 2004) with descending value applied to less rigorous forms of experimentation, quasi-experimentation, and non-experimentation. Currently there are several organizations dedicated to designing and conducting systematic reviews of the scientific literature to support practitioners and organizations in identifying best practices. Two of the better known of these organizations are the Cochrane Collaboration

(www.cochrane.org) in the field of medicine and the Campbell Collaboration (www.campbellcollaboration.org) in the fields of education and social and behavioral practice.

Especially pertinent to domestic violence perpetration, not all areas of practice are equally advanced in the amount, accessibility, or methodological sophistication of relevant research findings. Fraser (2003) identifies two types of research-based knowledge as building blocks of EBP: explanatory research and intervention research. Explanatory research seeks to identify causes and describe causal mechanisms; intervention research focuses on the effectiveness and efficacy of interventions.

Explanatory Research and Domestic Violence Perpetration

Three separate, though occasionally overlapping, theoretical perspectives guide explanatory or causal research in domestic violence perpetration. These current major explanatory theoretical views of domestic violence can be broadly categorized as feminist/socio-cultural, social learning theory-based intergenerational transmission, and psychological. (Corvo and Johnson, in press).

Feminist/socio-cultural View

Although the “batterer” treatment standards of most states are premised upon domestic violence being the product of patriarchy, the central causal construct in the feminist/socio-cultural theory, there is little consistent empirical evidence in support of this view. Briefly, the patriarchy-as-cause view asserts that domestic violence is solely a product of the socially sanctioned domination and control of women by men (Corvo & Johnson, 2003). Empirical studies examining the influence of patriarchal gender role socialization or gender-based power inequities on domestic violence behavior have

demonstrated neither strong, nor linear correlations between those factors (Yick, 2000; Sugarman & Frankel, 1996; Dutton, 1994). The effect size of variables generated by feminist/socio-cultural theory is often weak when compared to those generated by other theoretical perspectives (e.g. Corvo & Johnson, in press))

In fact numerous studies contradict this perspective: less than 10% of all couples are male dominant (Coleman & Straus, 1985); women are more likely to use severe violence against non-violent men than the reverse (Stets & Straus, 1992); men in North America do not endorse violence against their wives as acceptable (Dutton, 1994; Simon et al., 2001) and abusiveness is higher in lesbian relationships than in heterosexual relationships (Lie, Schilit, Bush, Montague, & Reyes, 1991). Finally, Archer's (2000) meta-analysis, with a combined n of 60,000, found women to be more domestically violent than men, especially among younger women.

Intergenerational Transmission

The intergenerational transmission of domestic violence has been one of the most commonly reported influences in domestic violence in adulthood. Research conducted on the intergenerational transmission of domestic violence has framed much of its inquiry in social learning theory. The social learning theory-based intergenerational transmission model of domestic violence posits that observing violence in one's family of origin creates ideas and norms about how, when, and towards whom aggression is appropriate. Early studies found a high frequency of violence in the families of origin of domestically violent men (Gayford, 1975; Rosenbaum & O'Leary, 1981; Roy, 1977; Straus, Gelles, & Steinmetz, 1980). Other studies (Gelles, 1974; Carrol, 1980) found associations between child abuse in the family of origin and current domestic violence for both men and

women (as victims). Kalmus (1984), reanalyzing the Straus, et al. (1980) national sample, found that both exposure to child abuse and observation of inter-parental spousal violence contributed to the probability of marital aggression for men and women. Although consistently significant across studies, the effect size of social learning-derived intergenerational transmission variables in predicting domestic violence in adulthood is often small. In their review of the research, Holtzworth-Munroe, Bates, Smutzler, and Sandin (1997) observed, that the correlations found between family of origin violence and current partner violence were not strong and may be mediated by other variables. In spite of its many contributions, the social learning focus has restricted inquiry into a broader range of possibly predictive psychosocial variables. The companion literature on the intergenerational transmission of child abuse and youth violence, for example, has explored a much wider range of family of origin variables (e.g. Sheridan, 1995; Corvo, 1997). Intergenerational transmission studies of domestic violence using broader psychosocial variables are less common (Corvo & Carpenter, 2000).

Psychological Theories

Psychological theories of domestic violence perpetration examine individual psychological, psychiatric, behavioral and neurological factors. Dutton (2006) summarizes these as personality disorders, neurobiological factors, neuroanatomical factors, disordered or insecure attachment, developmental psychopathology, cognitive distortions, and post-traumatic symptoms.

Holtzworth-Munroe, et al. (1997) state, “Violent husbands evidence more psychological distress, more tendencies to personality disorders, more attachment/dependency problems, more anger/hostility, and more alcohol problems than nonviolent men.” (p.94)

Not only do domestically violent men differ from non-violent men on important psychological variables, they differ substantially from each other. With the recognition that domestic violence perpetrators differed greatly on a number of important characteristics, efforts have been made to identify subtypes of perpetrators. Although a number of different instruments, sorting criteria, methods, and samples have been used, there has been substantial consistency in the identification of three sub-types (Lohr, Bonge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005; Holtzworth- Munroe & Stuart 1994). A number of authors have used different labels for these three subtypes typically identified through a variety of analytic strategies, primarily cluster analysis. These subtypes have been shown to differ on measures of personality styles and disorder, psychopathology, hostility, attachment styles, drug and alcohol use, and type and severity of violence (Lohr, et al., 2005).

In addition to the research examining the relationship between psychological factors and domestic violence, there is a much larger body of basic research that looks at the relationship between psychological factors and violence in general. Much of that basic research on causes of violence and aggression is neuropsychological. The consensus statement issued by the Aspen Neurobehavioral Conference (Filley, et al., 2001) summarizes the considerable literature on the neuroscience of violence, identifying genetic, neuroanatomical, neurochemical, developmental, neuropsychological, and psychiatric factors. One area of particular promise is the study of the association between

frontal lobe deficits and violence. Frontal lobe deficits refer, in general, to compromised abilities to inhibit impulsivity or aggression, or to redirect attention from repetitive behavior (Westby & Ferraro, 1999).

Not all research on domestic violence perpetration is conducted with formally identified offender samples. Samples drawn from other treatment populations (e.g. alcohol treatment) or “normal” populations, may exhibit a greater range of variability in factors associated with perpetration. For example, the Dunedin Multidisciplinary Health and Development Study (National Institute of Justice, 1999) found that the factors most closely correlated with partner violence, in a representative birth cohort, were factors often associated with criminal offending in general included mental health problems, academic failure, economic resource deficits, and early anti-social behavior.

Early trauma, borderline personality, and attachment disorders

Particularly useful in understanding psychological issues specific to domestic violence perpetration is the overlapping risk and influence of early trauma, attachment disruption, and borderline personality traits.

There is a strong relationship between borderline traits in male perpetrators and intimate abusiveness (Dutton, 1998, 2002a, 2002b). In a series of studies, Dutton and his colleagues (for a review see: Dutton, 1995a, 1995b, 1998, 2002b) have examined personality profiles of assaultive males. Men’s borderline characteristics were significantly related to chronic anger, jealousy, wives’ reports of clients’ use of violence, and experiences of adult trauma symptoms. In effect, a constellation of personality features (borderline personality organization, high anger, fearful attachment, chronic

trauma symptoms and recollections of paternal rejection) accounted for reports of abusiveness by one's intimate partner.

Bowlby (1969) viewed interpersonal anger as arising from frustrated attachment needs and functioning as a form of "protest behavior" directed at regaining contact with an attachment figure. Thus, attachment theory suggests that an assaultive male's violent outbursts may be a form of protest behavior directed at his attachment figure (in this case, an intimate partner) and precipitated by perceived threats of separation or abandonment. A "fearful" attachment pattern may be most strongly associated with intimacy-anger. Fearful individuals desire social contact and intimacy but experience pervasive interpersonal distrust and fear of rejection. This style manifests itself in hypersensitivity to rejection (rejection-sensitivity), and active avoidance of close relationships where vulnerability to rejection exists. While the fearful share anxiety over abandonment with another insecurely attached group (called "preoccupied"), their avoidance orientation may lead to more chronic frustration of attachment needs.

Dutton and colleagues assessed attachment styles in abusive men. Fearfully attached men experience high degrees of both chronic anxiety and anger (Dutton, Saunders et al., 1994). Fearful attachment alone accounted for significant proportions of variance in both emotional abuse criterion factors completed by female partners. Fearful attachment was also strongly correlated with borderline personality organization. Since anxiety (+.42) and anger (+.48) were both strongly associated with fearful attachment, one could argue that an emotional template of intimacy-anxiety/anger is the central affective feature of the fearful attachment pattern. Babcock et al. also found insecure attachment styles to be related to abusiveness (Babcock, Jacobson, Gottman, &

Yerington, 2000). Mikulincer (1998) found that attachment style related to dysregulation of negative emotions in intimate relationships. Corvo (in press) found that early life separation and loss events were more strongly associated with adult domestic violence perpetration than was exposure to child abuse or parental spousal violence.

In abused boys, a prominent sequela of abuse victimization is hyper-aggression. Carmen, Reiker, and Mills (1984) suggested that abused boys are more likely than abused girls to identify with the original aggressor and to eventually perpetuate the abuse on their spouse and children. In their view, an effect of physical maltreatment by a parent is to exaggerate sex role characteristics, possibly as a means of attempting to strengthen the damaged self. Other studies, however, have suggested that male reactivity to maltreatment may be mediated by genetic variability in some neurotransmitters (Caspi, et. al, 2002). Van der Kolk (1987) noted that traumatized children (including physical abuse) had trouble modulating aggression and included being physically abused as a child as a trauma source. Further, van der Kolk (1987) noted how Posttraumatic Stress Disorder (PTSD) included poor affect tolerance, heightened aggression, irritability, chronic dysphoric mood, emptiness, and recurrent depression and was "described in patients who have been subjected to repeated trauma over a considerable period of time" (p. 114). PTSD may be another link or mediating variable between childhood abuse victimization and adult perpetration of intimate abuse.

In order to test this notion, wife assaulters were compared to two groups of diagnosed PTSD men from independent studies (Dutton, 1995c). In the wife assault sample, 45% of all men met research criteria for PTSD and, assaultive men exhibited elevated levels of chronic trauma symptoms.

The source of trauma, as revealed in this work was physical abuse combined with shaming by the father and with a lack of secure attachment to the mother. Consequently, the latter could not provide buffering against the former (Dutton, 1998, 2002b). Tangney, Wagner, Fletcher, and Gramzow (1992) have presented a more focused analysis of the potential role of shame as a mediator between the early experiences of assaultive men and their adult experience of anger and abusiveness. They describe shame-proneness as a moral affective style that has to do with "global, painful, and devastating experience in which the self, not just behavior, is painfully scrutinized and negatively evaluated" (op. cit., p. 599). In this sense, shame-inducing experiences, which generate a shame-prone style, may be viewed as attacks on the global self and should produce disturbances in self-identity. Shame-prone individuals have been found to demonstrate a limited empathic ability, a high propensity for anger and self-reports of aggression (Wallace & Nosko, 2003). Dutton and colleagues found recollections of shame-inducing experiences by parents of assaultive men to be significantly related to the men's self reports of both anger and physical abuse (Dutton, van Ginkel, & Starzomski, 1995).

Dutton, van Ginkel, and Starzomski (1995) found that the experience of being shamed seemed to interact with exposure to violence to produce assaultiveness.

These features of an abusive personality: insecure attachment, borderline traits, and trauma reactions have not been an explicit focus of treatment for spouse assault.

Drug and alcohol abuse

Of particular importance in understanding risk for domestic violence perpetration is drug and alcohol abuse. With a much longer anecdotal history, empirical studies supporting the concomitance of substance abuse and domestic violence can be traced at

least to the late 1970's (e.g. Hilberman and Munson, 1978). Bennet, Reed, and Williams (1998) reported rates of concomitance of substance abuse and domestic violence ranging from 23% to as high as 100%. The National Institute of Alcohol Abuse and Alcoholism (NIAAA), (1997) summarizes several models describing the relationship between alcohol consumption and violence: disinhibition; overreaction to perceived threat due to impaired information processing; inaccurate assessments of consequences of violence; alcohol-violence expectancies; deviance disavowal; and amplified effects due to neuroendocrinological and hormonal factors. Perry (1997) has proposed that the effects of alcohol on violence can be exaggerated, in part, by compromises in neuroanatomy, with alcohol's disinhibiting properties being multiplied where there are frontal lobe deficits. Westby and Ferraro (1999) using multiple indicators of frontal lobe impairment found that heavier alcohol use, poorer vocabulary, and frontal lobe deficits differentiated domestic violence offenders from non-offenders. A secondary analysis of the Westby and Ferraro data (Corvo, Halpern and Ferraro, 2006) found a cluster of offenders who exhibited higher levels of violence, greater alcohol use and more frontal lobe deficits, suggesting differential effects at higher levels of pathology. Moeller & Dougherty (2001) identify antisocial personality disorder (ASPD) as mediating the effects of alcohol consumption on aggression, with persons diagnosed with ASPD exhibiting increased aggression due to alcohol consumption as compared to controls. They suggest that the association between ASPD and alcohol-related aggression may stem, in part, from ASPD-related impairments in regions of the brain performing executive functions.

Sonkin and Liebert (2003) describe a comprehensive assessment protocol for perpetrators that encompasses many of the behavioral and psychological factors described above with recommendations for individualized treatment plans.

What we see in psychological views of domestic violence perpetration, then, is a number of general risk factors shared with violence and criminality in general as well as a set of more specific risk factors for violence with intimate partners. The latter stemming from particular family of origin influences (e.g. erratic caregiving, parental shaming) and enacted in a particular relational context, cued by real, exaggerated, or feared rejection or threat. The complexity of psychological risk reveals domestic violence perpetration as a disorder primarily of poor impulse control, neuropsychological vulnerability, chemical dependency and intimacy dysfunction.

Interventions Research and Domestic Violence Perpetration

To reiterate, in part, Labriola, Rempel, and Davis (2005): “Indeed, the main findings from our randomized trial are consistent with other recent trials, of which **none** found that mandating offenders to a batterer program for groups for men produced lower rates of re-abuse.” (p. viii). In general, this is the dismal conclusion of evaluators of domestic violence interventions: either little or no positive effects on violent behavior result from standard model interventions. A few evaluations have found slightly larger positive effects, but these are more likely to be quasi-experimental designs, where there maybe a bias toward finding positive treatment effects where none may exist (Babcock, Green, and Robie (2004) – Type I error.

In a treatment outcome study done on the standard Duluth model, Shepard (1987, 1992) found a 40% recidivism rate (arrest, conviction, or protection order) n a six month

follow up of Duluth clients, *higher* than most control recidivism levels. In their meta-analysis, Babcock, Green, and Robie (2004) found that experimentally evaluated programs show only about 1/10th of a standard deviation improvement in recidivism; partner reports put recidivism rates at 35% for a 6-12 month follow up compared to 40% for controls.

In the experimental studies reviewed by Babcock, Green, and Robie (2004) (Dunford, F.W (2000), Feder and Forde (1999), Davis, Taylor, and Maxwell (1998), Ford and Regoli (1993), and Palmer, Brown, and Barrera, (1992)) effect sizes (*d*) for treatment ranged from .00 to .54 with much greater skewing toward the lower end (distribution: .00, .00, .02, .02, .04, .05, .10, .10, .13, .21, .41, .54).

Stith, Rosen, McCollum, and Thomsen (2004) using an eclectic model of group therapy for couples, where the men were violent but mutual violence was the predominant pattern, reduced violence at least as much as the most effective standard model and more in some circumstances. Their rationale for developing a couples treatment modality rested, in part, on known poor outcomes from standard models, perpetrator heterogeneity, and relational dynamics that contribute to violence.

In a meta-analysis, undertaken under the auspices of the Campbell Collaboration, Feder, Wilson, and Austin (2005) reported:

While additional research is needed, results from this meta-analysis leave questions about the effectiveness of court-mandated treatment in reducing recidivism among misdemeanor domestic violence offenders. Unfortunately, additional experimental research testing the effectiveness of these programs is not possible in many jurisdictions in that their statutes require individuals to be mandated into a BIP upon conviction. This has led to a pattern whereby judges, prosecutors and probation officers continue to send batterers to these programs even as they have grave doubts about their effectiveness. The end result is that alternate programs cannot be implemented and tested even as evidence builds indicating that [batterer intervention programs], at least as designed and implemented today, may not be effective. (online)

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In addition to the standard, approved interventions that are directly targeted at perpetrators, there are a number of other interventions and programs that have significance for developing an evidence-based approach to working with domestic violence. For example studies by Stuart, Ramsey, Moore, Kahler, Farrell, Recupero, and Brown (2003) and O'Farrell, Fals-Stewart, Murphy, and Murphy (2003) found that the successful treatment of alcohol dependence, alone, reduced partner violence to a much greater degree than is typically found with domestic violence interventions *per se*.

In the more general fields of offender rehabilitation and forensic psychiatry there is now a broad recognition of the importance of evidence-based treatment. Ward, Day, Howells, and Birgden (2004) report how targeting treatment towards specific areas of need that are functionally related to the offending and adhering to solid principles of program design and delivery has achieved significant reductions in recidivism across offender types. Howells, Day, and Thomas-Peter (2004) suggest that violent behavior can be best changed by integrating evidence-based principles from both offender rehabilitation and forensic mental health.

Restorative justice is another promising approach. In brief, restorative justice views crime primarily as a conflict between individuals that results in harm to victims rather than to the state; its goal is reconciliation and repair rather than retribution (Bevin, Hall, Froyland, Steels, & Goulding, 2005). The process of restorative justice facilitates active participation by all parties involved and supports victims in engaging in dialogue or mediation with offenders.

Bevin, et al. (2005) found that in a sample of community offenders and victims, a restorative justice process, when compared to a conventional court process, produced greater feelings of safety, security and control among victims and a reduction in factors associated with recidivism among offenders.

Currently a randomized comparison study, by Linda Mills and colleagues, between batterer's treatment and a restorative justice intervention, is underway in Arizona (personal communication, Linda Mills, 2005)

Multisystemic Therapy (MST) is one of the “Blueprints Model Programs” identified by the Center for the Study and Prevention of Violence at the University of Colorado (online). It is one of the most effective models of reducing re-offending behavior among violent, substance abusing adolescents. Although not currently tested with domestically violent adults, it’s impressive outcomes with similar problem areas and theoretical orientation of ecological and systemic interventions suggests it may have substantial potential. Of particular promise is MST’s emphasis on the linking of aggressive behavior to individual risk factors and developing specific techniques addressing those risk factors at the individual, familial, and social network levels.

Given the regulatory and legal restrictions on interventions with domestic violence perpetrators, there are fewer variations in treatment models than one might hope and meta-analyses, evaluations, and reviews take on a repetitive note: it is clear that the current standard model has little or no evidence for effectiveness. Looking at more innovative approaches and those from related issues and other populations, some encouraging findings suggest that viewing domestic violence as a complex issue with multiple influences can substantially improve outcomes.

Conclusion

If EBP practice begins with the framing of an answerable question, domestic violence policy has limited the number of questions that are possible to ask. For example, if one wished simply to ask, “What form of domestic violence treatment was most effective in reducing violence?” it would have to be answered within a framework where the range of possible treatments options is overly constrained.

Our review suggests that a thorough, individualized assessment and treatment approach holds promise for more effective program outcomes. Within the existing context of same-sex, group, court-mandated therapy, there are several ways to increase treatment success. Many rely on established CBT techniques used for other problem areas and simply recognize the relevance of these techniques for perpetrator treatment when focused on issues empirically linked to violence perpetration. A rich psychology of intimate violence perpetrators has developed since the first wave of treatment was developed. Essentially this research has unearthed what emotions, cognitions and situational interactions intermingle to generate and support abusive behavior.

The robust findings on perpetrator typologies points toward the need to carefully assess and direct perpetrators into the types of treatment appropriate to their particular constellation of issues.

In addition to promising better outcomes, more individualized treatment may reduce attrition, the *bete noire* of domestic violence programs. Chang and Saunders (2002) suggest, also, that culturally-competent practice with better matching of client types and needs to treatment can improve program retention.

Clearly, the relationship between substance (primarily alcohol) abuse and domestic violence must be directly addressed in treatment in some integrated form, and not relegated to a marginal epiphenomenon.

The success of some forms of couples treatment and the predominance of the mutuality (if not symmetry) of domestic violence suggest that, where appropriate, the interactional and relational issues pertinent to violence be integrated into treatment.

The salience of the emotional and behavioral sequelae of early, disturbed attachment in domestic violence indicates treatment, whether group, couple, or individual, that promotes a sense of secure membership, connection, or bonding.

The current best evidence clearly does not support investing substantial public funds in the continuation, let alone the mandating, of the standard domestic violence program model.

In the face of overwhelming countervailing evidence, why does this model persist? There is no scientific reason why causal explanations of domestic violence and the principles of perpetrator treatment should exist outside the biopsychosocial framework used to understand and address contemporary mental health and social problems. In some sense, then, the political issues in the policy framework “trump” the science to a greater degree than perhaps in most other social problems. Perpetrators are consistently demonized and vilified in such a fashion so as to make them appear unworthy of a broader range of services (e.g. as in comparison to parents who physically assault their children) (Corvo & Johnson, 2003). There are few advocacy groups to put pressure on legislatures for legal or regulatory change. In short, within the existing policy

framework of mandated interventions, there is a lack of political support to reframe the issue so that implementing an evidence-based approach becomes feasible.

Whatever benefits to violent families that may result from improved, evidence-based practice, await a more rational iteration of the policy framework.

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