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viewpoint and theory

One Size Does Not Fit All in Treatment of Intimate Partner Violence

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A critical examination is needed of the often mandated one-size-fits-all Duluth intervention for male perpetrators of intimate partner violence (IPV). The underlying philosophy of Duluth-based interventions is evaluated as well as the treatment outcome literature for this intervention. There is very little evidence to justify the current legal system practice of mandating all perpetrators to psychological interventions addressing power and control issues. A literature review of scientific findings with IPV perpetrators and the issues that need to be taken into consideration in developing alternative evidence-based interventions are presented. The evidence seems to favor heterogeneity and not homogeneity with respect to both type of perpetrator and type of violence. Assessment and treatment suggestions are made to address this evidence-based heterogeneity and a call is made to those responsible to stop perpetuating the practice of mandating all perpetrators to attend a single intervention for which there is very limited evidence of effectiveness. About two-thirds of male perpetrators of IPV cease being physically aggressive against their partners if they are assigned to a probation officer, but there is minimal evidence that the addition of a Duluth-based intervention makes perpetration less likely.

KEYWORDS: intimate partner violence; evidence-based interventions; Duluth heterogeneity versus homogeneity

Domestic violence (DV) is a critical problem in the United States. Between 600,000 and 6 million women are victims of DV each year and between 100,000 and 6 million

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men, depending on the type of survey used to obtain the data (Straus & Gelles, 1990; Tjaden & Thoennes, 2000). On average, three women and one man are murder victims by their intimate partners in the United States every day (Rennison, 2003). More specifically, in 2000, 1,247 women were killed by an intimate partner, and in that same year, 440 men were killed by an intimate partner. The disparity across genders was also seen in the partner homicide data of the last decade. That is, in 2010, 241 males and 1,095 females were murdered by an intimate partner (U.S. Department of Justice, 2011). Intimate partner homicides account for 30% of the murders of women and 5% of the murders of men (Bureau of Justice Statistics, 2003, 2006). Recent estimates by the Centers for Disease Control and Prevention (CDC) suggest that the health-related costs of intimate partner violence (IPV) exceed $5.8 billion each year. Of that amount, nearly $4.1 billion are for direct medical and mental health care services, and nearly $1.8 billion reflect indirect costs of lost productivity or wages (CDC, 2003).

Men arrested for DV are typically mandated to attend a treatment program for DV as part of a coordinated community response. However, at best, these intervention programs help between 5% and 20% of the perpetrators and, in some instances, such programs have been found to increase recidivism rates (Babcock, Green, & Robie, 2004; Klein & Crowe, 2008). Most of these treatments, hereafter referred to as Duluth-type interventions, are based on a power and control theory of DV. Standards have been created which determine the type of treatment allowed in various states. These standards are typically based on the power and control theory. In fact, as of 2008, there were 48 states in the United States with such standards (Maiuro & Eberle, 2008). These standards have generally failed to incorporate research and scientific evidence on the characteristics of male perpetrators and the multifactorial nature of IPV. They are based on a one-size-fits-all ideological conceptualization of male perpetrators of IPV. They fail to acknowledge the many studies that have identified the heterogeneity of male perpetrators of IPV. It is possible that the outcomes for these interventions might improve if state policy makers abandon the "one-size-fits-all" approach and instead begin to take into consideration the evidence base regarding the heterogeneity of perpetrators and the possibility that different types of perpetrators may need different types of interventions. It is important that the problem of IPV be approached from a scientific perspective rather than simply from an ideological perspective. More specifically, we need to develop treatment approaches to the problem that take into consideration the substantial scientific findings regarding the heterogeneity of IPV that have been accumulated over the past three decades.

In that light, this article is designed to review the characteristics of male perpetrators and accumulated scientific knowledge about IPV that need to be taken into consideration in the assessment and treatment of male perpetrators of IPV. It is hoped that attention to the heterogeneity of perpetrators as well as the acknowledgment of the multifactorial nature of the problem of IPV will lead to improved outcomes of these programs.

Of particular importance is the issue of whether outcomes are different for different types of perpetrators of partner violence. Studies have shown that treatment is more successful for men who have a "stake in conformity." Legal sanctions were found to be most effective in deterring domestic abuse when batterers faced potential personal loss such as termination of employment and social connections, in other words loss of their "stakes in conformity" (Sherman & Smith, 1992). More specifically, offender programs are more effective in reducing the prevalence and incidence of rearrest among offenders with higher individual levels of stake in conformity (Hanson & Wallace-Capretta, 2000; Woodward & Bechtel, 2008; Wooldredge & Thistlethwaite, 2001). That is, men who are older, are married and living with their partner and children, and are employed are more likely to complete treatment programs and less likely to be rearrested for future intimate violence. These characteristics seem to be important for predicting adjustment regardless of exposure to treatment. Despite substantial evidence for the validity of different subtypes of batterers (Boyle, O'Leary, Rosenbaum, & Hassett-Walker, 2008; Holtzworth-Munroe & Meehan, 2004), there is a scarcity of treatment studies which have systematically assessed the importance of offender subtype. One recent study provides preliminary evidence that attention to offender heterogeneity improves our ability to predict treatment outcome (Stoops, Bennett, & Vincent, 2010). They demonstrated that a behavior-based typology distinguishing low-level criminality, dysphoric volatile behavior, and dysphoric general violence was able to predict both program completion and rearrest in an urban criminal justice system in Cook County, Illinois. Men classified as dysphoric volatile men had significantly lower DV rearrests than the low-level criminality men and the dysphoric general violence (DGV) men, and the DGV men were significantly less likely to complete the program than the other two groups.

In this article, we will first review current approaches to working with male perpetrators of IPV, including treatment interventions and their limitations. We will then discuss the different variables that need to be considered in the assessment and treatment of male perpetrators of IPV from an evidence-based point of view. We will finally make suggestions regarding how current treatment strategies need to be modified taking these issues into consideration.

Throughout the article, it is important to keep in mind the differences between ideology and science. According to Turner (1986), ideologies seek knowledge to confirm how the world ought to be, not how the world is. Information that does not conform to adherents' views of how the world ought to be is excluded from consideration. Criticism or contradiction of scientific findings is an inherent component of knowledge building. Ideology prohibits contradiction and criticism and views them as betrayal (Dutton & Corvo, 2006).

CURRENT TREATMENT OF MALE PERPETRATORS

Most states in the United States have passed laws mandating treatment for male perpetrators of violence against their partners. DV laws frequently also explicitly

spell out the type and length of treatment that perpetrators must complete. County probation departments are given the responsibility to certify local treatment providers and are responsible for assuring that the providers are complying with the legal mandates. As stated earlier, as of 2008, 45 states had standards for batterer intervention programs (Maiuro & Eberle, 2008). Ninety percent of these standards specify that power and control issues are to be included as the major focus in program content. Other topics generally included in the curriculum are the sociocultural basis for men's violence toward women, types of abuse, and methods men use to maintain power and control over women. This treatment approach is part of a more extensive community response to the abuse which holds men accountable for the violence and monitors their behavior for a specified term, including placement on probation. Thus, not only is treatment mandated but the type of treatment to be received is also mandated. When other treatment interventions are proposed, they are not usually sanctioned in many states. Some interventions, such as individual and couples treatment, and practices that could be construed as psychological treatment have actually been prohibited in many states (Dutton & Corvo, 2006; Healey, Smith, & O'Sullivan, 1998). According to Dutton and Corvo (2006), by 2001, 43 states had set up DV certification agencies to oversee the "intervention" with abuse perpetrators. Dutton and Corvo (2006) further state that

> These agencies, often staffed by political appointees and activists, have formulated and applied policies that regulate not only the conditions of probation for persons found guilty of domestic assault but also which form of intervention is deemed acceptable by the courts. Hence, program funding is only available to those programs that conform to these policies, called interventions (using "batterer accountability" strategies) instead of "treatment" because the Duluth model deems assault to be a willful exercise of male privilege, a choice made by men acting in concert with the norms of a sexist society. (p. 459)

Given the aforementioned mandates, one would assume that the efficacy of both participation in treatment and the type of treatment mandated by the standards would have been amply documented empirically.

However, documentation for the efficacy of such treatments is lacking. Recent reviews of studies assessing the outcome of these interventions reveal there is very little support for the efficacy of these interventions. Although proponents of Duluth-based treatments have argued that there is evidence supporting this intervention approach (Gondolf, 2007), meta-analytic reviews suggest that these treatments add very little to simply placing the men on probation without any intervention or treatment (Babcock et al., 2004; Feder & Wilson, 2005; Feder, Wilson, & Austin, 2008). These meta-analyses reveal that most studies use a quasi-experimental design in which they compare treatment completers to noncompleters, including treatment dropouts. However, the participants who drop out of treatment typically differ from

those who complete treatment on several dimensions. Thus, it is likely that these pretreatment individual differences account for some of the differences in outcomes between completers and noncompleters. In other words, the meta-analyses reveal that the relationships between individual differences in variables such as education, severity of problems, and so forth and treatment completion make it difficult to attribute differences in outcome (e.g., posttreatment violence) to the effectiveness of the treatment. In fact, such studies have provided some evidence for the "stake in conformity hypothesis," which states that it is the men with more to lose who are more likely both to complete treatment and to refrain from further episodes of violence (Sherman & Smith, 1992). Thus, we would expect men who are employed, have higher income, own a home, and are married to be more likely to complete treatment and less likely to recidivate than those who are not. Alternatively stated, the men who have some stake in remaining in their jobs and marriages are more likely to complete the programs. In addition, with particular reference to undocumented aliens, one would expect those who are undocumented and likely to get deported if arrested to be more likely to complete treatment and less likely to recidivate. In line with the stake in conformity hypothesis, we would expect men with a lengthier criminal record to be less likely to complete treatment and more likely to recidivate. The latter is of particular relevance when we take into consideration that DV treatment dropout rates are as high as 42%–60% on average (Brown, O'Leary, & Feldbau, 1997), sometimes as high as 73% and 86% (Davis, Taylor, & Maxwell, 2000; DeMaris & Jackson, 1987; Jewell & Wormith, 2010).

Notwithstanding the aforementioned methodological problems in attributing treatment differences to the intervention, with the studies included in the meta-analyses, the results reveal that when only studies employing experimental designs were reviewed, the effect sizes for the efficacy of DV treatment were reduced to $d = 0.09$, using victim reports as the outcome measure and $d = 0.12$ based on police reports, very small effects, leading the authors to conclude that "a woman is 5% less likely to be re-assaulted by a man who was arrested, sanctioned and went to a batterer's program than by a man who was simply arrested and sanctioned" (Babcock et al., 2004, p. 1004). In a subsequent meta-analysis including a reanalysis of the four experimental studies and including an additional study, Feder, Wilson, and Austin (2008) conclude that there is some support for the modest benefits of batterer programs from official reports in the experimental studies but that this effect is smaller (and nonsignificant) if we look only at studies using a general batterer population. They additionally state that the effect is absent when victim-reported measures are examined. With respect to the quasi-experimental studies using a no-treatment comparison, they failed to find a positive treatment effect in terms of a reduction in violence when measured with official reports. They further reported that the quasi-experimental studies, using men who were rejected from treatment or who rejected treatment as a comparison group to the treatment group, were the only studies to consistently show a large, positive, and significant effect on reducing reoffending. The authors conclude

that the meta-analysis does not offer strong support that court-mandating treatment to misdemeanor DV offenders reduces the likelihood of further reassault.

A recent study evaluating the efficacy of a coordinated community-based approach to dealing with DV provides further evidence in support of the stake in conformity hypothesis in that there are differences in the types of offenders who appear to be compliant with various aspects of the court-mandated order for supervised community-based assessment and treatment for DV (Bouffard & Muftić, 2007). The study also documents that participation in increasing numbers of these intervention components was not found to significantly impact either general or DV recidivism rates among this sample of male offenders. A recent review of the research evaluating the effectiveness of batterers' intervention programs further concludes that there is very little support regarding the long-term effectiveness of batterers' intervention programs (Woodward & Bechtel, 2008). In a study completed in Cook County, Illinois, Bennett, Stoops, Call, and Flett (2007) examined recidivism among 413 men who completed a DV treatment program versus 136 noncompleters. Recidivism as measured by official reports was 14.3% for completers and 34.6% for noncompleters, with an effect size of $d = .10$. Rearrest was predicted by younger age, use of illegal drugs, failure to complete a program, and alcohol use. In this study, program completion was associated with having injured a victim, not using illegal drugs, marriage, employment, ethnicity (i.e., being Latino), and being assessed as an active changer, defined as being at the active or maintenance stage of change as rated by probation officers. The most important predictors of program completion included being Latino and being an "active changer." Lower social class, unemployment, and being single reduced the odds of program completion. In contrast, having fewer prior arrests and reporting lower levels of trauma symptoms also predicted program completion. Those who are employed, have a higher social standing, and are in a relationship would likely risk losing their job, their social status, and their relationship if they continued to get in trouble with the law for not completing the program. Again, those who have less to lose are less likely to complete treatment. As stated previously, the men who have some stake in remaining in their jobs and marriages are more likely to complete the programs.

The situation may be no better when we look outside the United States. A recent study carried out in Spain reporting the outcome of 10 years of treatment research with perpetrators of IPV highlights the previously mentioned problems in documenting treatment efficacy with this population. Echeburúa, Sarasua, Zubizarreta, and de Corral (2009) report findings for a cognitive-behavioral treatment program carried out over a 10-year period in Spain and show that only 46% of treatment-eligible men chose to participate and that of those who did participate, only 55% completed treatment. At the end of treatment, 88% of these men who finished are deemed to be successes based on their not having recidivated as per their partner and this figure dwindles down to 52 at the end of the first-year posttreatment when a further 44 men were lost. Of interest is the fact that treatment dropouts are not taken into consideration at any point in the study, that there is no control group, and that only

6% of the sample were court mandated into treatment. If we consider the initial number of people referred to the program ($N = 451$), 52 men represent 12% of the population referred for this treatment. If we look at the final 196 men accepted into treatment, 52 men represent 27% of the men accepted into treatment. If we consider the 108 men who completed treatment, 52 men represent 48%. There is positive outcome data for 1-year posttreatment for 52 men. Thus, treatment success rates are inflated depending on who is omitted from the treatment group. We have no information as to what happens to the men who do not participate or complete treatment. This suggests that the situation is no better in Spain than in the United States.

A multisite treatment study completed in Canada reaches similar conclusions. Hanson and Wallace-Capretta (2000) report that this study examined the relative effectiveness of four treatment programs for abusive men ($n = 230$), where outcome was assessed by new arrests for violence after an average 58-month follow-up period and that there was little difference in recidivism rates across programs despite substantial differences in the four treatment philosophies (cognitive-behavioral, humanistic, profeminist, eclectic). Of the 320 men with follow-up information, 55 (17.2%) recidivated with a violent offense and 82 (25.6%) recidivated with any offense. The follow-up period ranged from 39 to 73 months (average of 58, $SD = 7.7$). Men who were court-ordered to treatment were more likely to recidivate ($r = .22$ for violence, $r = .18$ for any, $p < .01$) than treatment volunteers. The men who were married at posttreatment were less likely to recidivate ($r = -.28$, $p < .01$) than the men who were single or who had separated/divorced. They conclude that in general, the batterer recidivists tended to have the same lifestyle problems associated with recidivism among general offenders (substance abuse, frequent moves, prior convictions) and that batterers who failed to complete treatment were at increased risk to recidivate ($r = .18$ for violence, $r = .14$ for any, $p < .05$), but most of the effect could be attributed to high-risk offenders being the most likely to drop out.

Summarizing, it is quite evident that these treatment programs or partner education programs, as they are more frequently referred to, have minimal impact on postintervention recidivism rates and that the small effects observed in some interventions can be attributed to characteristics of the men that choose to attend treatment.

This state of affairs has led to widespread calls for a need to abandon the "one-size-fits-all" strategy and to begin to pay more attention to the heterogeneity of males who perpetrate violence against their partners (Bell & Naugle, 2008; Cantos, 2005; Capaldi & Kim, 2007; Graham-Kevan, 2007). The need to identify men who have substance abuse or mental health issues prior to participation in these programs has been frequently pointed out (Cerulli, Conner, & Weisman, 2004; Foran & O'Leary, 2008; Golinelli, Longshore, & Wenzel, 2009; Moore et al., 2008). Indeed, this strategy was used in one study which appears to report better outcomes using the Duluth model and in which men with substance abuse problems were not included in the treatment program (Gondolf, 2003). Other variables that have been deemed relevant to both treatment completion and outcome have included personality pathology,

the type of abuser (Boyle et al., 2008; Holtzworth-Munroe & Meehan, 2004; Huss & Langheinrichsen-Rohling, 2006; Stalans, Yarnold, Seng, Olson, & Repp, 2004), frequency and severity of the aggression, the developmental stage of the relationship in which the aggression occurs, and stage of motivation for change of the perpetrator (Eckhardt, Babcock, & Homack, 2004). An additional variable to be taken into consideration is the directionality of the violence whether it is a one directional pattern in which one member of the dyad is the aggressor and the other is a victim or whether the violence is bidirectional and both members of the dyad aggress against each other. If only one member of the dyad is aggressing, treatment would focus on this individual. However, if both members are aggressing and reciprocating the violence against each other, it would be important to include both members of the dyad in therapy. Attention to these kinds of individual difference variables in treatment may improve on the dismal outcome rates commonly reported.

Couples treatment may be more relevant for those men involved in relationships in which there is low-level and bidirectional violence (O'Leary, 2008). Including the spouses of these men in treatment might have a greater impact in terms of reducing the recidivism rates. Moreover, the likelihood of obtaining men and women who would seek such treatment may be higher than if they are mandated by the courts for an intervention. Further, one could have a sequence of interventions for such men and women with an initial intervention addressing the need for reduction and/or cessation of psychological abuse and preparation for a couple intervention (Stith, McCollum, Rosen, Locke, & Goldberg, 2005).

EVIDENCE FOR DISTINCT TYPES OF BATTERERS

Several researchers have independently documented the existence of different types of male perpetrators of IPV with seemingly overlapping categories (Dutton, 1995; Hamberger, Lohr, Bonge, & Tolin, 1996; Holtzworth-Munroe & Stuart, 1994). Of particular interest are the Holtzworth-Munroe and Meehan (2004) categories of family-only aggressive, antisocial, generally violent, and borderline dysphoric perpetrators of DV. Although there has been widespread interest in this classification system, efforts to replicate this proposed typology have met with mixed success (Hamberger et al., 1996; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000, 2003; Waltz, Babcock, Jacobson, & Gottman, 2000). Boyle et al. (2008) suggested that a more easily applied method of distinguishing between subgroups of partner-violent men, based on a theoretically important behavioral distinction (i.e., the generality of the violence committed—as seen in one of the three subtypes of Holtzworth-Munroe & Stuart), provides a better focus for research in this area. They found that generally violent and partner-only violent men differed on several characteristics including lifetime history of conduct disorder and delinquent behavior, behavioral disinhibition, lifetime psychological abuse of intimate partners, and family of origin violence. However, studies have rarely examined whether there are also treatment outcome differences between these two groups. Attention to these differences in treatment may improve on the unfortunate outcomes noted

earlier. Huss and Ralston (2008) found that men classified as generally violent had lower rates of treatment completion than those classified as family-only violent men and were much more likely to recidivate than both men classified as family-only violent and those classified as borderline. More recently, Stoops et al. (2010) provided the first direct evidence that a behavior-based typology can predict both treatment program completion and rearrest in an urban criminal justice system in Cook County, Illinois. In this study, the authors compared treatment success for three types of DV perpetrators: (a) those characterized by low-level criminality, (b) by dysphoria and volatile behavior, and (c) by dysphoria and general violence. However, although the authors claim that their behavior-based approach to classifying these men would make it easier for criminal justice and community staff with less training in psychological assessment to classify the men along the trifold typology, their use of complicated statistical procedures to develop their classification limits its application to the real world. Nonetheless, they found, as mentioned previously, that men classified as dysphoric volatile men had significantly lower DV rearrests than the low-level criminality men and the DGV men, and the DGV men were significantly less likely to complete the program. Brenner, Cantos, and Narvaez (2010), in turn, used a simple reliable behavioral rating scale to classify men placed on probation following arrest for IPV. They found that using this rating scale, they were able to classify this group of men on the dimensions of generally aggressive (37%), family-only aggressive (63%), substantial alcohol use requiring prior treatment (75%), other substance use (60%), and mental illness (35%).

It thus appears that there is substantial evidence to suggest that men who engage in IPV represent a heterogeneous group who can be reliably classified into different typologies, and there is also preliminary evidence to suggest that these typologies influence treatment outcome (Stoops et al., 2010). Stalans et al. (2004) found that the strongest predictor of violent recidivism while on probation was whether the offender was a generalized aggressor or not, with generalized aggressors more likely to be arrested for new violent crimes and also that prior arrests for violent crimes predicted violent recidivism of generalized aggressors.

The evidence for the existence of different types of male perpetrators is particularly strong for the existence of a distinction between generally violent and family-only violent men. This typology has been replicated by independent investigators using different methodologies, and it has been shown to be both reliable and valid. The typology has been found useful in predicting both treatment completion and recidivism rates. That is, family-only violent men are more likely to complete treatment and less likely to be rearrested.

DEVELOPMENTAL STAGE OF THE VIOLENCE

Longitudinal studies with community or national samples have studied the course of the violence, that is, what happens following a first violent episode. Quigley and Leonard (1996) followed young couples who had just married into their second and third years of marriage, and they found that 76% of the men who were physically aggressive against

their partners in the first year of marriage were physically aggressive at either the second or third year into marriage. Those most likely to desist were those who had no severe aggression in the first year of marriage and only one act of minor aggression. Similarly, in another sample of newlywed couples, 72% of the men who were physically aggressive initially were physically aggressive at one or more of the next three assessments across 30 months (Lorber & O'Leary, 2012). In sum, at least for young couples, partner aggression seems quite stable if there are repeated assessments across a multiple-year period and if one can be counted as physically aggressive at any one of the assessments after the initial assessments. However, in older couples, physical aggression may be less stable as evidenced in a sample of married men who were 41 years old on average from a community sample of couples. In this case, physical aggression significantly decreased over time, but 54% of the men who were physically aggressive at Time 1 were physically aggressive at either Time 2 or Time 3 (Vickerman & Margolin, 2008).

In the 1985 National Family Violence Survey, with men who were much older than those in the young married samples, 40% did not aggress either in the second or third year (Aldarondo, 1996). In one of the longest follow-ups of partner aggression in marriage, a very significant decrease in men's aggression was reported by women. Women who had been followed across the first 30 months of their marriage were assessed again 10 years later. According to the women, 35% of their husbands engaged in some aggression against them during the year of their engagement. However, 10 years later, only 10% of the men were reported to have engaged in physical aggression against their wives (Timmons-Fritz & O'Leary, 2004).

It is thus clear that there are also differences in the type of men's IPV that have to be taken into consideration. The previously mentioned research suggests that some men will only aggress on one occasion and never aggress again. There are others who will repeat their aggression within the first 3 years following the first act, but their aggression will cease at some point thereafter and then there are some men who exhibit a more chronic pattern of IPV continuing to aggress beyond the third year.

It has also become known recently that partner aggression is highest in the late teens but appears to steadily decline thereafter (Fernández-González, O'Leary, & Muñoz-Rivas, 2013; O'Leary & Slep, 2012). In short, partner aggression increases in adolescence, peaks at about 16–17 years, and decreases thereafter until age 70 years (O'Leary & Woodin, 2002). If it occurs several times, it becomes stable. Thus, it is not the same for a 20-year-old man to slap his partner once as it is for a 40-year-old man who has been physically abusing his partner over the years, and the treatment should not be the same. There appear to be differences in the developmental stage of the violence. Different issues have to be addressed with each type of aggression.

Severity of the Behavior

There are also differences with respect to the severity of the violence engaged in by perpetrators. There is great variability ranging from a push and a shove to severely beating the partner. Moreover, it is possible that there may be qualitative differences

when the extremes are taken into consideration. It is not the same for a man to push or shove his partner as it is for another man to choke, kick, and punch his partner. This is another dimension that needs to be taken into consideration when assessing the perpetrator and developing a treatment plan. Lorber and O'Leary (2004) reported that researchers have found that the frequency and severity of physical aggression are robust predictors of violence continuation.

There is some preliminary evidence that severity of aggression at intake may be related to increased recidivism; however, the evidence is mixed with some studies finding a relationship and others not. These differences could be because of sample and methodological differences, however. Hilton, Harris, and Rice (2007) found that severity of the index event was significantly related to official records of IPV measured 5 years later. Harrell and Smith (1996) failed to find a relationship between severity of violence described in the complaint and subsequent abusive incidents or specific types of abuse as reported by both victims and official records. Miller and Krull (1997) reported a significant relationship between victim injury or medical treatment received because of the partner violence and levels of recidivistic violence. In a longitudinal study with newlywed couples, Lorber and O'Leary (2012) found that high levels of wives' premarital aggression predicted increases in husbands' aggression between engagement and 6 months postmarriage. In a 5-year follow-up study, Caetano, Field, Ramisetty-Mikler, and Mcgrath (2005) showed that couples reporting severe IPV in 1995 were more likely than others to report severe IPV at follow-up. Thus, it appears that severity of aggression may not only be related to the perpetrator's continued aggression at treatment follow-up but also to partner increases in aggression in a nonintervention community sample. There are several other longitudinal studies that find a relationship between initial severity and subsequent continued perpetration. In a longitudinal study examining whether subtypes of maritally violent men continue to differ from one another, over time, in levels of relationship violence and in individual characteristics assumed to be related to their use of violence, the researchers found that not all men escalate their marital violence, but the men who are the most severely violent initially are the most likely to continue their violence over time (Holtzworth-Munroe et al., 2003). This is supported by findings from other studies (Aldarondo, 1996; Feld & Straus, 1989; Jacobson, Gottman, Gartner, Berns, & Shortt, 1996; Lawrence & Bradbury, 2001; O'Leary et al., 1989; Quigley & Leonard, 1996).

As has been stated elsewhere, the continuum of partner aggressive behaviors ranges from psychological aggression to mild physical aggression to severe physical aggression. In consideration of the continuum of partner aggression, it is very important to understand that there are different correlates and causes of the different aggressive behaviors (O'Leary, 1993). Both the criminal justice response and treatment interventions should acknowledge and address the differences in type and severity of aggression and their respective correlates in their development and determination of appropriate interventions. Somebody presenting with only psychological aggression requires a different intervention and response from the criminal justice system than

somebody who is an intimate terrorist and has consistently and repeatedly terrorized his or her partner both psychologically and physically. There is some evidence from both existing criminal justice and psychological studies to support such differential intervention (Buzawa, Hotaling, Klein, & Byrne, 1999; Cantos, Brenner, Goldstein, Lee, & Fowler, 2012; Puffett & Gavin, 2004).

Alcohol and Drug Abuse

Recent meta-analytic reviews (Foran & O'Leary, 2008; Stith, Smith, Penn, Ward, & Tritt, 2004) clearly indicate that alcohol abuse and IPV are associated for both males and females (Foran & O'Leary, 2008). In an alcoholic and batterer sample, the odds of aggression were found to be 8–11 times greater on days when drinking than on days of no drinking (Fals-Stewart, 2003). Moreover, this association remained after controlling for antisocial personality and relationship distress (Fals-Stewart, Golden, & Schumacher, 2003). Alcohol abuse is hypothesized to impact individuals differently and lead to varying likelihoods of severity of aggressive behaviors depending on an individual's particular personality, relationship characteristics, or situational factors (Fals-Stewart & Stappenbeck, 2003). Studies have further shown that successful reduction in alcohol abuse during treatment results in reductions in IPV (O'Farrell & Choquette, 1991; O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003; Stuart, Moore, Ramsey, & Kahler, 2003) and that these effects are maintained for a 2-year follow-up period (O'Farrell, Van Hutton, & Murphy, 1999). In addition, a meta-analytic review has documented that increases in drug use and drug-related problems were significantly associated with increases in aggression between intimate partners (Moore et al., 2008).

Accordingly, it becomes clear that perpetrators of IPV would benefit from a comprehensive drug and alcohol assessment at intake and a referral to drug and/or alcohol treatment programs prior to participation in any IPV intervention.

VIOLENCE IN THE FAMILY OF ORIGIN AND CHILDHOOD VICTIMIZATION

A modest association has also been shown between growing up in a violent home and engaging in IPV (Delsol & Margolin, 2004). In a longitudinal study, White and Widom (2003) demonstrated a link between early childhood victimization and later perpetration of violence against a partner for both men and women. Dutton and Corvo (2006) incorporated variables from attachment theory and reported that separation and loss variables were found to exert effects on respondents' violent behavior greater than or comparable to those from exposure to family of origin violence. Wareham, Paquette Boots, and Chavez (2009) reported that in a sample of DV offenders, experiencing frequent corporal punishment in childhood was associated with reports of engaging in minor forms of partner violence in adulthood but that witnessing interparental violence during childhood was not, although combining both measures of

intergenerational transmission significantly improved the percentage of variance explained. Franklin (2010) analyzed data derived from the Fourth Annual Texas Crime Victimization Study and reported that neither witnessing interparental violence nor experiencing violence as a child were related to physical violence perpetration as an adult, although both variables were related to both psychological victimization perpetration as well as intimate partner psychological victimization. In a 20-year follow-up study, Ehrensaft, Cohen, Smailes, Chen, and Johnson (2003) found that conduct disorder in childhood was the strongest risk for perpetrating partner violence for both sexes, followed by exposure to DV in childhood and power assertive punishment. They further report that the exposure to DV conferred the greatest risk of receiving partner violence and that child physical abuse and conduct disorder in adolescence were strong independent risks for injury to a partner. Ehrensaft et al. (2003) found that the presence of conduct disorder in children during adolescence mediated the relationship between early witnessing of IPV and being the victim of child abuse, and later perpetrating IPV as an adult.

Murrell, Christoff, and Henning (2007) examined differences in generality, frequency, and severity of violent offenses, nonviolent criminal behavior, and psychopathology within a battering population of 1,099 adult males with varying levels of exposure to violence as children. They found that generality, frequency, and severity of violence and psychopathology all increased as level of childhood exposure to violence increased and that men who witnessed DV as children committed the most frequent DV. Delsol and Margolin (2004) reviewed studies looking at exposure to violence in the family of origin and concluded that modest associations between experiencing violence in the family of origin and marital violence are found in community samples and in studies with prospective and longitudinal designs. Smith, Ireland, Park, Elwyn, and Thornberry (2011), using data from a longitudinal study of the development of antisocial behavior in a community sample of 1,000 urban youth followed from age 14 years to adulthood, found that adolescent exposure to caregiver's severe IPV resulted in significantly increased risk of relationship violence in early adulthood (age 21–23 years) and that there was an indirect effect of adolescent exposure to severe IPV on later adult involvement in IPV (age 29–31 years) mediated by involvement in a violent relationship in early adulthood. Stith et al. (200) completed a meta-analysis on studies looking at the intergenerational transmission hypothesis and showed a small effect size of witnessing IPV with an effect size of 0.22. More specifically, they found a stronger relationship between family of origin violence and perpetrating marital violence for males than for females.

In summary, there appears to be an association between experiencing and witnessing interparental violence in childhood and subsequent perpetration and victimization, but the results may be different by observation of violence versus being the direct target of violence. The relationship is complex and varies with the population studied but nevertheless needs to be taken into consideration. Whether or not someone has been physically abused or has witnessed interparental violence in childhood appears to matter at some level in perpetrators and victims of IPV and needs to be

taken into consideration in treatment planning. Many will argue that children who are abused or witness interparental violence in childhood are victims and that these events have consequences on their emotional and behavioral well-being. However, the fact that they were victimized in childhood seems to be disregarded and glossed over when one is considering adult perpetrators of IPV.

Attachment

There have also been some attempts to view DV from an attachment theory perspective (Buttell, Muldoon, & Carney, 2005; Fonagy, 1999; Gormley, 2005; Lafontaine & Lussier, 2005). According to Bowlby (1977), attachment expectations developed in infancy, childhood, and adolescence persist throughout the lifetime. Interpersonal anger arises from frustrated attachment needs and functions as a form of protest behavior aimed at recovering contact with the attachment figure. According to Dutton, Saunders, Starzomski, and Bartholomew (1994), men's violent behavior is a form of protest directed at his attachment figure (sexual partner) and precipitated by threats of separation or abandonment. An emotional model of anger and anxiety in intimate relations is the central affective feature of the fearful attachment style.

Some men who engage in IPV exhibit a personality profile which generates conflict and abuse in relationships: attachment anger, tendency to blame and project anger on to the partner, and inability to verbalize dysphoric states. There is some empirical evidence providing support for the notion that the excessive levels of dependency observed in abusive men are associated with insecure attachment in childhood (Dutton, 1995, Holtzworth-Munroe, Bates, Smutzler, & Sandin, 1997). In a recent paper examining the degree to which attachment dimensions and interpersonal problems predicted IPV posttreatment variables, it was reported that (a) pretreatment attachment anxiety and vindictive interpersonal problems predicted posttreatment mild physical abuse and psychological abuse, (b) pretreatment intrusive interpersonal problems predicted posttreatment psychological abuse, and (c) pretreatment attachment avoidance and vindictive interpersonal problems predicted posttreatment total violence severity (Lawson & Brossart, 2009).

It is therefore important to begin to take attachment difficulties into consideration when determining the treatment needs of male perpetrators of IPV because, as is evident earlier, attachment needs appear to be related to posttreatment variables. It is reasonable to assume that the type of treatment required by a perpetrator with attachment problems is quite different to that required by a perpetrator who is generally violent or one who has power and control issues.

Head Injury

Researchers have also shown an association with head injury and perpetration of IPV (Rosenbaum & Hoge, 1989; Rosenbaum et al., 1994). A study looking at the neuropsychological correlates of IPV found that current cognitive status, prior brain injury,

childhood academic problems, and psychosocial influences contributed to a propensity for DV and coexisting emotional distress (Cohen, Rosenbaum, Kane, Warnken, & Benjamin, 1999). A recent meta-analysis concluded that the prevalence of traumatic brain injury (TBI) among perpetrators of IPV appears to be significantly higher than the prevalence of TBI in the general population (Farrer, Frost, & Hedges, 2012). These studies suggest that for a group of men, there may be some biological determinants involved in their perpetration of IPV and it is possible that associated levels of impulsivity and executive dysfunction may mediate their violent behavior. It is obvious that treatment for these men should focus on remediating these deficits and not simply on power and control issues. It is questionable whether mandating men with impulse control issues because of head injury to partner abuse education programs will result in any positive outcome if such men are assigned to an intervention based solely on a power and control model.

Consistent with the latter, Howard (2012) has recently discussed the role of executive functioning, verbal deficits, impulsivity, and an integrative biopsychosocial model including the roles of quantitative electroencephalography, the hypothalamus-pituitary-adrenal axis, sympathetic nervous system, and serotonergic system to enrich current conceptualization and treatment of partner-abusive men.

MOTIVATION FOR TREATMENT

It is also important to take the men's motivation for treatment/readiness for change into consideration at the time of determining the type of treatment required. Treating somebody who takes responsibility for his or her violence requires a different approach to treating someone who denies having engaged in the violence or even having a problem to address. In a meta-analysis assessing the ability of stages of change and related readiness measures to predict psychotherapy outcomes, clinically significant effect sizes were found for the association between stage of change and psychotherapy outcomes ($d = .46$) leading the authors to conclude that the amount of progress clients make during treatment tends to be a function of their pretreatment stage of change (Norcross, Krebs, & Prochaska, 2011). Application of the transtheoretical model of change to the treatment of male perpetrators of IPV suggests that men in treatment for partner assault are not uniform in their readiness to change their abusive behavior (Echardt, 2004) and that there is a relationship between the stage of change of the perpetrator and treatment participation and dropout (Scott, 2004). Evidence of different stages of motivation for change was also provided by Levesque, Gelles, and Velicer (2000) who found that in a sample of 292 men involved in a DV counseling group, 24% were in the precontemplative stage, 63% were in the contemplation/preparation stage, and only 13% were in the action stage. Awareness of the importance of readiness for change has led to the development of motivational interventions for partner-abusive men (Musser, Semiatin, Taft, & Murphy, 2008). In an investigation of the effects of a motivation-enhancing intervention for batterers highly resistant to intervention, resistant batterers who attended specialized

intervention were reported to complete an intervention at a significantly higher rate (84.2%) than both resistant clients in standard intervention (46.5%) and nonresistant clients (61.1%; Scott, King, McGinn, & Hosseini, 2011). Motivational readiness to change has been found to be particularly important for establishing a positive working alliance among a sample of men participating in a cognitive-behavioral group treatment program for partner violence and a positive working alliance has in turn been associated with reductions in abusive behavior in treatment for partner violence (Brown & O'Leary, 2000; Taft, Murphy, King, Musser, & DeDyn, 2003). The findings from a cross-sectional correlational study examining characteristics affecting self-reported readiness to change abusive behavior among a sample of men in a 52-week batterer treatment program led the authors to suggest that interventions aimed at moving clients into contemplation, and reducing physical aggression and manipulative parenting styles, may increase the likelihood that batterers will take action to stop violence (Hellman, Johnson, & Dobson, 2010).

The earlier studies suggest there are differences with respect to the stage of motivation for change in male perpetrators mandated to attend intervention programs, that these differences may be related to both treatment completion and outcome, and that it might be beneficial to take these differences into consideration with respect to treatment planning. At the very least, it appears that it might be important to continue to study whether pretreatment motivational interventions have a positive impact on treatment completion and recidivism. Alternatively, it might prove beneficial to provide different group treatment for people at different stages of change.

CONCLUSION

In summary, there is substantial empirical support for the notion that there is significant variability among perpetrators of intimate partner aggression and the evidence suggests that the one-size-fits-all approach to treatment is not very effective, is simplistic, and fails to take this variability and heterogeneity into consideration. The frequency and severity of DV varies dramatically. IPV also varies with respect to its developmental stage, that is, in the beginning stages or in a more chronic stage. There are different types of perpetrators along several dimensions, including childhood traumas, generalized versus family-only aggression, and personality type. The important impact and association with alcohol and substance abuse has been amply documented. Stage of motivation for change and level of moral development of the perpetrator are also important variables to be taken into consideration. There are also biological variables resulting from head injury that may also need to be taken into consideration which point to the importance of applying a biopsychosocial model to the understanding and treatment of IPV.

Ideally, it would be important to develop treatments that take all the previously mentioned variables into consideration. It is clear from the previously mentioned that there is substantial individual variability and that appropriate matching of treatment would require a comprehensive individualized assessment akin to a functional

analysis to determine each individual perpetrator's needs and that an individualized treatment plan would be subsequently developed to address these needs. It is important to tailor the treatment to the individual rather than make the individual fit into existing predetermined treatment based on ideological conceptualizations. It is possible that different subgroups of male perpetrators of IPV that share similar characteristics could be identified and that specialized group interventions to meet their needs could be developed. We have already pointed out the family-only versus generally aggressive distinction. It is possible that these two groups respond differently to treatment. It is also possible there may be further subgroups within the family-only group based on presence or absence of personality disorder or attachment difficulties, for example. These are empirical questions to be determined through a scientific approach to the problem.

Treatment of the family-only perpetrators could focus on the traditional social learning approach emphasizing a combination of discussions on the deleterious consequences of the use of violence in intimate relationships, anger control skills, effective communication skills, use of egalitarian conflict resolution skills, effective assertion skills, and appropriate expression of feelings. This group is possibly the one that also benefits the most of court supervision. Within this group, we earlier pointed to the existence of two other groups with similar deficits: a borderline dysphoric group and a group of men with attachment problems. The borderline dysphoric group might benefit from participating in a dialectical behavior therapy group with a focus on IPV. The group with attachment difficulties would benefit from a therapeutic group which would target these attachment problems. There could also be a Duluth type group for perpetrators of IPV with assessed power and control issues in their relationship. Finally, the question of what to do with the large group of perpetrators who present with generalized violence. It is evident that this group presents with additional lower class variable problems that predispose them to and underlie their general violence and history of crime. In addition to placement on probation and interventions to curtail their use of aggression toward others to get their needs met, it would be important to address the lower class variables such as unemployment, low income, education, and so forth if any improvement is to be seen with this population. In addition to the previously mentioned, problems with substance use should be assessed at the outset for all perpetrators and treatment for substance abuse problems should precede any subsequent intervention. Finally, in those cases where there is conjoint partner violence and a careful assessment showed the woman would not be placed in danger, a couples' treatment approach to the problem might be more effective.

Given the previously mentioned, there are certain recommendations that can be made with respect to assessment questions that every mental health professional counselor for perpetrators of IPV and probation officers involved with these cases should be asking when evaluating perpetrators of IPV.

In addition to obtaining the typical demographic information frequently required by most programs as to age, education, ethnicity, employment, and marital

status, first and foremost, a determination of whether the perpetrator is a family-only or generally violent perpetrator needs to be made because there are clear differences with respect to the way these two types respond to both court-mandated sanctions and treatment (Bennett, Stoops, Call, & Fleet, 2007; Cantos, Goldstein, Brenner, & O'Leary, 2013). A combination of questions regarding their violence history, arrest record, violence toward others outside the family, behavior during the school years, were they suspended, expelled from school, any history of getting into frequent fights at school, and so forth would be important to ask to make this determination. Those men that are generally violent will be less likely to benefit from or even attend a partner education program of the Duluth type. It would be important for these men to receive some preintervention services with the goal of increasing their level of motivation to attend to and complete treatment. Given that most of the generally violent men frequently also score positive on what have been referred to as underclass variables such as unemployment and low income (Bennett, Hsieh, Huss, & Ralston, 2008; Cantos et al., 2013), it would be important to address these underclass variables prior to the intervention proper. Maslow's work would suggest that it would prove difficult to have these men attend to therapeutic intervention when other more basic needs are left unattended (Maslow, 1954). Interventions directed at increasing stake in conformity variables for this group of men would appear to be common sense preconditions for these perpetrators to be able to benefit from these groups. For example, assistance in job training and/or job placement could assist a man to feel better about himself and his ability to care for others, including his children. Once some attention has been given to these variables and the perpetrator's motivation to remain free of court sanctions has been increased, it would then be possible to provide these men with anger control and impulse control skills training as well as conflict resolution skills. It would also be important to have the perpetrators complete the Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) or a brief version of such to assess frequency and severity of violence.

Other assessment procedures to be used at the initial stage would be measures targeting the individual's preparedness to engage in treatment such as the University of Rhode Island Change Assessment-Domestic Violence Scale (URICA-DV), a stage of change measure (Levesque et al., 2000). This measure would allow for a determination of how ready the perpetrator is to begin the change process and alert us to the need for more motivational interventions to address their unpreparedness. It would also be important to provide these men with a brief anger control inventory to assess their level of difficulties with anger control. It would also be helpful to ask the men to complete the Millon Multiaxial Inventory (Millon, Davis, & Millon, 1997) which will provide a determination of the presence of Axis I or Axis II disorders that may require attention. This will also help toward determining the presence or absence of affect regulation/borderline personality problems. Perpetrators scoring high on either of these could be referred to a group emphasizing dialectical behavior therapy. Those perpetrators presenting with substantial mental illness problems

will be referred to a specialized program addressing these issues. Although Gondolf (2009) concludes that mandatory court referral to mental health treatment produced no significant improvement in batterer program completion, reassault, and other abuse indicators, a careful reading of the reported study reveals that only 48 out of 148 men complied with the assessment referral and that out of these, only 28 received treatment. Gondolf (2009) reports that the small number of men who did receive mental health treatment did better than those who did not. An additional issue to be assessed is that of the presence or absence of attachment disorder. Perpetrators could be asked to complete the Adult Attachment Scale (AAS; Collins & Read, 1990) to determine if there are any attachment issues to be addressed in treatment. Dutton and Corvo (2006) has noted that if some aspects of DV may be attributable to the emotional aftermath of disrupted attachment in childhood, not to learned models of behavior, standard psychoeducational interventions may not be adequate. Clinical approaches addressing these issues may include a more thorough assessment of associated emotional problems; more individualized treatment plans; and longer term, supportive, behavioral change strategies. Finally, it is important to make a determination of the type of violence relationship the perpetrator is involved in and more specifically whether the violence is unidirectional and bidirectional, and this bidirectionality does not simply represent the victim's attempt at self-defense. This can be ascertained by asking the victim to complete the Conflict Tactics Scales during a comprehensive interview focused on assessing the type of violence and other variables which might deter from referral to a couple's program, such as the level of individually reported fear of the other person involved in the violent relationship.

If the female partner of the male offender is interested and willing to participate in any aspect of the assessment process, as is suggested in some states (Stith, McCollum, & Rosen, 2011), it would be helpful to have the female partner complete the Fear of Partner Scale (O'Leary, Foran, & Cohen, 2013) along with the Conflict Tactics Scales and a measure of relationship satisfaction. Finally, if possible, obtain the partner's perception of substance abuse problems of either or both partners with a screening measure like the Alcohol Use Disorders Identification Test (AUDIT; Allen, Litten, Fertig, & Babor, 1997).

In spite of the fact that most states mandate a one-size-fits-all approach to the treatment of IPV (Maiuro & Eberle, 2008), there have been a few attempts to develop and test the efficacy of alternative interventions which do take into account the aforementioned findings attesting to the heterogeneity of this population and provide support for several aforementioned conclusions. These have nevertheless been isolated and few because of the difficulties inherent in providing treatment which is not officially sanctioned to a court-mandated population. As a result, methodologically sophisticated studies with internal and external validity and random assignment have been almost impossible to implement. However, the few studies that have been completed do attest to the possibility and feasibility of alternative interventions with positive outcomes.

In a recent study, Scott et al. (2011) showed that resistant batterers who attended a specialized intervention consisting of a 6-week motivation-enhancing intervention completed intervention at a significantly higher rate (84.2%) than both resistant clients in standard intervention (46.5%) and nonresistant clients (61.1%) and that these differences were maintained even after controlling for demographic and lifestyle-related predictors of attrition. When men recruited for a multisite batterer intervention study were asked how they avoided violence over a 15-month postintervention follow-up period, more than half of the men (53%) said that they relied on interruption methods, 19% on discussion, and 5% on respect for women (Gondolf, 2000). These results suggest that anger control skills and problem solving were largely responsible for the positive outcomes and that teaching anger control skills to those men who have deficits in this area might be an important avenue to explore, especially with those men that are generally violent. This is corroborated by Eckhardt, Samper, and Murphy's (2008) findings in a sample of 190 perpetrators of IPV mandated to attend group counseling. They documented that although most partner-abusive men do not present with anger-related disturbances, the presence of anger problems may be a marker for an array of traits that may complicate the treatment process. Further, they reported that high anger expressive men perpetrated more IPV, reported experiencing and witnessing more abuse during childhood, scored higher on psychopathology measures, and reported more substance problems. High anger expressive and moderate anger inexpressive males had higher program attrition and rearrest rates. Moderate anger inexpressive males were more likely to be arrested for assault-related offenses. Such results again suggest that anger control treatment may be an important intervention component for some perpetrators of IPV. More generally, a recent meta-analysis on the psychological treatment of anger concludes that psychological treatments are generally effective for treating anger (Saini, 2009) which supports the validity of anger-based interventions for at least those intimate partner violent males with substantial anger problems. There is substantial evidence that a significant percentage of male perpetrators of IPV have borderline personality tendencies with accompanying affect regulation difficulties as noted earlier on in this article. As a result, interventions such as dialectical behavior therapy, which have demonstrated effectiveness with people with borderline personality disorder (Kliem, Kröger, & Kosfelder, 2010), has been proposed as a treatment strategy for those male perpetrators of IPV with the aforementioned characteristics (Cavanaugh, Solomon, & Gelles, 2011; Fruzzetti & Levensky, 2000; Tollefson, Webb, Shumway, Block, & Nakamura, 2009). Cavanaugh et al. (2011) presented the findings of a randomized controlled trial (RCT) of an experimental intervention (Dialectical Psychoeducational Workshop [DPEW]) and a control condition, an 8-week anger management program (AMW) providing preliminary support for the DPEW's effectiveness in lowering a participant's desire to express anger physically while decreasing the potential risk for physical violence. The authors conclude that this pilot study demonstrated promising initial support for the DPEW as an alternative, preventative intervention for males at risk for IPV.

Tollefson et al. (2009) describe how a rural state–sponsored DV offender program uses a treatment approach known as Mind–Body Bridging to help its clients overcome their abusive behaviors. They present preliminary findings from an ongoing outcome study documenting that the program has a high completion rate coupled with a low recidivism rate. Ninety-three percent (82 of 88) of the clients who participated in this program completed the program, and just 7% (6 of 82) of those who completed the program reoffended during the follow-up period, which ranged from 9 to 27 months. Siegel (2013) reviews neuroscience research in DV and concludes that neuroscience research suggests that emotional regulation may be an important link in the heritability of family violence and promotes awareness of the importance of internalizing as well as externalizing responses to stress, neglect, and abuse. This suggests that interventions with perpetrators of IPV who were exposed to IPV or child abuse while they were in their maturational years may benefit from therapeutic approaches designed to develop emotional regulation skills. McGuire et al. (2008) provide evidence for the use of structured cognitive-behavioral treatment programs in reducing criminal recidivism in a 17-month follow-up study of structured, community-based, offense-focused intervention programs designed to reduce rates of reconviction among adjudicated offenders under probation supervision and conclude that results suggested a possible treatment effect for moderate and higher risk cases. These results would support the development of similar interventions for the generally violent males placed on probation for IPV. Saunders (1996) provided evidence suggesting that men with dependent personalities had better outcomes in the process-psychodynamic groups and those with antisocial traits had better outcomes in the cognitive-behavioral groups and concluded that the results suggest that more effective treatment may occur if it is tailored to specific characteristics of offenders. Finally, Stover, Meadows, and Kaufman (2009) in a review of existing interventions for IPV conclude that there is a lack of research evidence for the effectiveness of the most common treatments provided for victims and perpetrators of IPV, including the Duluth model for perpetrators and shelter–advocacy approaches for victims, that the rates of recidivism following completion of these programs are high, but that couples treatment approaches that simultaneously address problems with substance abuse and aggression yield the lowest recidivism rates, and manualized child trauma treatments are effective in reducing child symptoms secondary to IPV. In fact, McCollum and Stith (2008) reviewed the outcome literature for couples treatment of IPV and conclude that a "one-size-fits-all" treatment approach to IPV is not appropriate and conjoint treatment may have a place in the treatment of at least some couples. Based on their review, they recommend that best practices include couples treatment as part of a larger community response to IPV, careful screening of couples for inclusion in couples treatment, modification of typical conjoint approaches to promote safety, and ongoing assessment of safety with contingency plans for increased risk. Simpson, Atkins, Gattis, and Christensen (2008) have also provided evidence for the efficacy of non-

aggression-focused behavioral couples therapy for couples with a history of mild physical aggression and report there was no exacerbation of violence contrary to common belief and the presence of low levels of physical aggression did not prevent increases in marital satisfaction.

There is thus some evidence which is strongly suggestive of the feasibility and effectiveness of intervention approaches that acknowledge the heterogeneity of male perpetrators of IPV and target particular needs of the perpetrators rather than assume a one-size-fits-all approach based on a political analysis of the problem.

Empirical identification of the predictors of treatment outcome for male perpetrators of IPV would be in line with remarks made by President Obama at the Academy of Science:

> That is why I have charged the White House Office of Science and Technology Policy with leading a new effort to ensure that federal policies are based on the best and most unbiased scientific information. I want to be sure that facts are driving scientific decisions—and not the other way around.

At stake is not only the cost to the states in terms of dollars and cents but also the cost to the individuals and families involved. Of great concern is the counterintuitive possibility that female victims may be placed at greater risk by the very existence of these programs and the male perpetrators' participation in these programs. In particular, DV perpetrators' participation in treatment may motivate their victims to stay with them in the hope that treatment will make them change, when this may not be the case. DV caseworkers in the Department of Probation in Lake County, Illinois estimate that about 50% of the women remain with the perpetrators. That abused women stay with the perpetrator of violence has been amply documented (Strube, 1988). The men are being forced to attend a treatment program that may not work for many of the participants, and the participants have to pay for the program. Because many of these men come from lower socioeconomic status (SES) backgrounds, treatment costs are not only an economic hardship for the perpetrators but may contribute to financial burdens on the victims who remain with perpetrators and further contribute to the cycle of violence by increasing stress levels within the family.

Given these potential costs, it is important to continue to assess the outcome of these treatment programs as they are being carried out and to identify variables that predict when these programs are likely to be effective. One especially likely possibility is that the weak average effects of treatment reflect the existence of heterogeneity among offenders. To the extent that we can identify variables that predict treatment effectiveness, we will be able to demonstrate better prediction of treatment outcome. In addition, the identification of these variables will ultimately contribute to the development of alternative interventions to help those for whom current treatments are

ineffective and eventually lead to better treatment outcome, increased protection to victims, and a reduction in human suffering.

A recent article in the *European Journal on Criminal Policy and Research* cautions against the shaping of policy and practice guidelines for dealing with DV offenders by political lobbyists rather than academic literature and evidence-based practice (Graham-Kevan, 2007). Pointing to the lack of academic support for the patriarchal theory of IPV, the author emphasizes that DV is not a unitary phenomenon and that perpetrators are a heterogeneous group whose treatment should match their criminogenic needs and risks.

Finally, it is worth pointing out that treating all individuals as if they are the same has the following problems, especially if the individual is court-mandated to treatment: First, it does not take into account that the ethics standards of the American Psychological Association (APA) require that treatment providers describe the known outcome of treatment 10.01 (b): When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their client/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of the participation (American Psychological Association [APA], 2010, p. 13). Secondly, it does not take into account that an individual is forced to be in a treatment that may well not be designed for such a person. The one size is in part related to treatment dropout, dropout rates which as pointed out earlier are as high as 50%–80%. Single pushers do not see themselves as others. And last but not the least, because we have a mandate to do no harm—following the Hippocratic tradition—we may be doing harm when we refer clients to or provide them with a therapy that has been repeatedly shown to have limited effectiveness if any. Ethics standard 3.04 states, "Psychologists take reasonable steps to avoid harming their clients/patients.. . . and to minimize harm where it is foreseeable and unavoidable" (APA, 2010, p. 6). Given the previously mentioned, it becomes quite clear for us, and we hope the readers of this article, that it is time to take a stance. It is time to publicly question the use of mandating perpetrators of IPV to a one-size-fits-all treatment which is at best ineffective and might possibly harm clients when they are exposed to a treatment that does not address their needs. These clients are frequently mandated to attend these programs for as long as 52 weeks, and they have to pay for these sessions. A high percentage of these perpetrators come from low-income families and the cost of the program has a substantial economical impact on the family. Most importantly, the victim might feel a sense of hope and safety because their partners are attending a program which will help reduce their partner's violence toward them when this is not the case. It is also time for APA to publicly recognize the multifactorial nature of IPV by modifying its "resolution on male violence against women policy" and making the public aware of the limitations of treatment strategies based on a one-size-fits-all power and control model. The resolution states, "The APA Task Force on Male Violence Against Women noted that violence has multiple causes,

but it remains fundamentally a learned behavior that is shaped by sociocultural norms and role expectations that support female subordination and perpetuate male violence" (APA Council Policy Manual, 1999). The evidence does not seem to support this policy statement.

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