



*A key mission of the Center for Research on Violence Against Women is to ensure that the findings of quality research make it into the hands of advocates. This translation of research to practice ensures that science has an impact on the lives of women and children.*

*In 2010 the Center for Research on Violence Against Women conducted a survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. Advocates identified ten top issues. A series of ten briefs were prepared by the Center to answer the Top Ten Things Advocates Need to Know.*

## TOP TEN THINGS ADVOCATES NEED TO KNOW

1. What services do survivors of rape find most helpful, and what help do they say they need?
2. What type of sex offender is most likely to recommit their crimes? Incest offenders, rapists, or pedophiles?
3. What mental health issues are caused by experiencing intimate partner violence or sexual assault?
4. Do protective orders work? Who violates protective orders the most?
5. What is the impact of mandatory arrest laws on intimate partner violence victims and offenders?
6. What are the most significant long-term health consequences of chronic sexual or physical violence?
7. What percentage of rape cases gets prosecuted? What are the rates of conviction?
- 8. DOES TREATMENT WITH INTIMATE PARTNER VIOLENCE OFFENDERS WORK?**
9. Does a report of intimate partner violence or sexual assault by a partner put a woman at risk of losing custody of her children?
10. How do women from different racial/ethnic backgrounds experience intimate partner violence (IPV) or sexual assault? Does race and ethnicity matter?

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**DOES TREATMENT WITH INTIMATE PARTNER  
VIOLENCE OFFENDERS WORK?**

**REPORT AT A GLANCE**

- Batterer treatment and intervention programs are often used as a way for the criminal justice system to respond to domestic violence offenders.
- In 2008, 45 states had legislative statues mandating the use of batterer interventions with specific standards.
- Most programs follow either the Duluth power and control model or utilize elements of unstructured group psychotherapy.
- Research finds a minimal benefit from attending batterer interventions, estimating treatment prevents future violence only about 5% more than arrest alone.
- Dropout rates vary by program, but research has found that about half of all men assigned to attend interventions do not finish the program.
- Researchers are exploring factors which affect drop-out rates and have investigated ways to improve participation and success rates for racial minorities, individuals with substance abuse problems, and batterers with differing psychological problems and needs.
- Some researchers suggest re-examination of what "success" in intervention means, suggesting that preventing some violence or reducing the severity of violence should be viewed as a positive effect of intervention, even if treatments do not accomplish the ideal outcome of ending violence completely.

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*Introduction*

Clinical treatments and batterer intervention programs for intimate partner violence offenders have been in existence since the 1970's. Many of these programs started locally and grew over time, eventually resulting in partnerships between the mental health system and the legal system, frequently with help from state legislatures who mandated treatment for domestic violence offenders. As of 2008, only five states did not have legislative standards in place mandating batterer treatment (1). Since their inception, two major treatment approaches to intervening with men who abuse their partners have emerged: the feminist "Duluth" power and control model developed by advocates (2), and the unstructured group psychotherapy model based on cognitive-behavioral therapy (CBT) techniques developed by clinical psychologists (3). Research finds that both of these men's group therapy approaches have strengths and weaknesses, and limited research has also been conducted on a limited range of other interventions.

Over the past several decades, the prevailing question in the area of batterer treatment programs has been deceptively simple: "do they work?" Interventions for men who batter are a part of a larger system dealing with domestic violence which includes police, criminal courts, civil courts, victim's advocates, children's advocates, and mental health professionals. Because these organizations have different goals and perspectives, the "success" of intervention programs for men has been contested and difficult to measure (4). To date, researchers have conducted, compared, and reviewed numerous studies which can give us a more informed picture of the strengths, weaknesses, shortcomings, and opportunities these batterer intervention programs offer as one small part of addressing the common problem of ending domestic violence.

## *Types of Batterer Treatment Programs*

Treatment programs for men who batter have been broadly categorized into two types depending on the philosophical orientation of the people responsible for developing the interventions.

1. Feminist approaches following the "Duluth model" (named for the city in which it was first developed) see domestic violence as a consequence of men using their power in society to exert control over their female partners (2). These approaches seek to educate men about connections between patriarchy and violence using tools like the well-known *Power and Control Wheel*.
2. Clinical psychology techniques are grouped together as the "unstructured group psychotherapy" approach using cognitive-behavioral therapy (CBT) techniques, which view violence as a learned behavior of individual men. Group psychotherapy approaches examine the pros and cons of violence and teach abusive men to utilize communication skills, anger management techniques, and alternatives to violence (3, 5).

Research has extensively debated the strengths and weaknesses of each of these two major approaches to batterer intervention. The Duluth approach confronts men with the idea that violence is a voluntary control strategy made possible by patriarchy and gender-based power in society, yet critics argue that "focusing on the political context and ignoring the individual context seems dehumanizing and dismissive of men's experience, which often includes histories of abuse and or neglect" (6, p. 179). On the other hand, psychotherapy approaches are criticized by feminists as dismissive of women's experience, by ignoring how patriarchy permits men to get away with abusing women within the home. Employing techniques like anger management "downplays the fact that most batterers selectively confine their violence to their partners, rarely striking friends or coworkers" which feminists claim demonstrates that men can, in fact, control their behavior in the parts of society where they are more likely to be held accountable (6, p. 171). Through 2008, 43 states had mandated that a

power and control perspective be included in batterer treatment programs (1). In all, 12 states require treatment programs to exclusively use a power and control model, and 31 require programs to discuss both power and control, and social psychology principles (1).

About half of batterer treatment programs nationwide identified their primary approach as "Duluth" (53%) and half as cognitive-behavioral (49%, according to Price & Rosenbaum, 2007, as cited by Saunders. (7, p. 157).

Despite the basic philosophical differences between the two major approaches and legislative mandates, in practice most intervention strategies for batterers utilize elements of both strategies: men's group cognitive-behavioral therapy, and confrontation of oppressive social attitudes towards women (5, 6, 7, 8). Some researchers have raised concerns which might apply to any batterer intervention program, regardless of the basic approach. For example when the criminal justice system forces men to attend treatment programs, or when group facilitators use their position of authority to confront men, these actions may inadvertently reinforce the effectiveness of using power and control to get your way, which the programs are trying to teach men to avoid using in their own homes (4, 6). Others point out that court-ordered interventions are "one size fits all" (1, 4, 9, 10) and that criminal justice driven programs detrimentally blur the lines between legal punishments and mental health treatments (6, 11).

Some researchers argue that if intervention programs are not clearly shown to be effective, they will give a false sense of security to the partners of abusers (12).

## *Do Batterer Treatments Stop Recidivism?*

Over the past several decades, dozens of studies have documented the outcomes of batterer intervention programs, attempting to address the question of whether or not batterer treatment can prevent repeat acts of violence. Each of these outcome studies is limited to specific treatment programs, study populations, and research methodologies. In order to draw conclusions across decades of similar studies of varying quality and

## A COMPARISON OF THE TWO MAJOR MODELS FOR BATTERERS INTERVENTION (6)

	<u>Unstructured Group Psychotherapy</u>	<u>Feminist Power &amp; Control Model</u>
Practitioners	<ul style="list-style-type: none"> <li>Developed and supported mainly by mental health practitioners</li> </ul>	<ul style="list-style-type: none"> <li>Developed and supported mainly by feminists, victim's advocates</li> </ul>
Program Length & Conditions of Completion	<ul style="list-style-type: none"> <li>Groups typically last between 3 months and 18 months, depending on the program and conditions of court mandate</li> </ul>	<ul style="list-style-type: none"> <li>Groups typically last 6 months, but can vary depending on state standards and conditions of court mandate</li> </ul>
Group Structure	<ul style="list-style-type: none"> <li>Men in the groups are at different stages in the program—modeling is expected</li> </ul>	<ul style="list-style-type: none"> <li>Men in the groups are at different stages in the program—modeling is expected</li> </ul>
Group Content	<ul style="list-style-type: none"> <li>Themes emerge, but the topics and activities of each week are not extensively preplanned</li> <li>Men are encouraged to share experiences of victimization and vulnerability</li> </ul>	<ul style="list-style-type: none"> <li>Focus on eight preplanned themes, each presented in a similar fashion with similar activities over a 3-week period</li> <li>Men typically discouraged from sharing experiences of victimization, but instead are required to take responsibility and be accountable</li> </ul>
Group Facilitation	<ul style="list-style-type: none"> <li>Meetings are facilitated by a trained leader, often a clinician</li> <li>Facilitator encourages the group to be self-directed, often taking a back seat in discussions</li> </ul>	<ul style="list-style-type: none"> <li>Meetings are co-facilitated by trained male and female activists</li> <li>Facilitators are vigilant for and routinely confront the men's sexist and controlling attitudes</li> </ul>
Additional Program Components	<ul style="list-style-type: none"> <li>Men often expected to continue emotional work related to program outside the group</li> </ul>	<ul style="list-style-type: none"> <li>Men have homework assignments that include journals and reading</li> </ul>

design, researchers have utilized two common research techniques: traditional review articles (i.e., grouping many previous studies by key characteristics and looking for noteworthy similarities) and a technique called *meta-analysis* (i.e., gathering all known quantitative studies of a certain methodological quality which measure the same variables, then using advanced statistical techniques to combine the results for a measurable "overall" effect). While individual study results vary, both of these research techniques find that batterer treatment programs generally have only a small overall effect on stopping repeat domestic violence.

Stover, Meadows & Kaufman (8) reviewed the research on batterer treatment programs and conclude that "group treatment for batterers have meager effects on the cycle of violence, with most studies demonstrating no or minimal impact above that of mandatory arrest alone" and that recidivism rates are similar "regardless of intervention strategy" (p.225).

Comparing studies on the effectiveness of mandatory arrest, batterer interventions, and victim advocacy

interventions, Stover, Meadows & Kaufman (8) conclude that repeat offending occurs at a rate of "20-30% within 6 months, regardless of the intervention strategy" (p.231).

A meta-analysis by Babcock, Green, and Robie (5) combined data from 22 research studies that measured recidivism using either police records or victim reports, were based on experimental (i.e., a treatment group compared to a control group with no treatment) or quasi-experimental design (i.e., no true control group, but instead comparing program drop-outs to completers), and recorded whether the intervention was based on the Duluth model, CBT, or another approach. There was no significant difference between the Duluth and CBT approaches in their analysis.

Regardless of intervention program, they found that "based on a partner report, treated batterers have a 40% chance of being successfully nonviolent, and without treatment, men have a 35% chance of maintaining nonviolence. Thus, there is a 5% increase in success rate attributable to treatment" (p.1044).

Based on this 5% success rate, they calculate that if batterer interventions for every reported domestic violence case in the U.S. might protect as many as 42,000 women per year, but they also caution that "whether this success rate is cause for celebration or despair depends on a cost-benefit analysis" taking into account both costs and potential "side effect" dangers to some families for whom mandatory interventions might do more harm than good (p.1044).

Using different inclusion criteria than Babock, et al. (5), Feder and Wilson (11) conducted a more limited meta-analysis of 10 studies from 1986-2003 which had stricter rules about experimental design, post-arrest court-mandated programs designed to reduce battering, and followed offenders for at least 6 months post-treatment using third-party recidivism data. Like the previous meta-analysis, this analysis across multiple studies found only a small, if any, positive effect of treatment on recidivism.

Another approach to measuring the effectiveness of a batterer's treatment program is by gathering the input from the partners of men in treatment. In fact, Carol Gregory and Edna Erez (13) criticize studies that measure the success of batterer intervention programs by simply whether or not there is any future violence, claiming that this narrow definition of "success" ignores the input of the women these programs are designed to help. Interviews with 33 women whose partners entered a batterer intervention program in Ohio found that even though most of the women continued to experience abuse, about half of the women felt the program had improved their relationship, 81% reported a decrease in violence and threats, and 70% said the program reduced the severity of the violence and threats they did experience (pp. 214-215). While the interventions may not have ended the violence, the majority of women felt they had benefitted from their partner's treatment. Still, about one-fifth of the women in their sample reported that the program made their partner angry or taught the men new strategies for abuse. Most women in the study, even those reporting benefits, reported an increase or no

About one-fifth of the women in Gregory and Erez's sample reported that the program made their partner angry or taught the men new strategies for abuse (13).

change in verbal abusive tactics after batterer interventions (13).

### *Batterer Program Limitations*

After examining the above review of existing research, one may be tempted to conclude that batterer treatment programs have limited, if any, effect on preventing future abuse. However, a number of critical limitations to the reviewed studies exist. First and foremost, batterer treatment programs have very high drop-out rates of around 46% on average, and in individual studies have attrition rates as high as 78% (8).

Researchers have investigated the reasons that men drop out of batterer treatment programs, and find that stable demographic characteristics (e.g., employment, older age, higher income, stable housing, married, higher education) predict which individuals complete the treatment (14, 15). On the other hand, abusers with previous domestic violence, other criminal histories, and with substance abuse problems are more likely to drop out of treatment (14).

Research also finds that white participants are more likely than minorities to remain in treatment (14), however culturally-specific batterer programs, all-minority groups, or groups with minority counselors have been shown to improve treatment completion rates (1, 10). At least one study improved batterer participation significantly by employing motivational enhancement techniques like phone call reminders and follow-ups for missed session (16).

The second limitation of existing studies is the "one size fits all" approach to batterer treatment. While attrition rates and recidivism rates are high in most studies, there are studies which show promise by acknowledging differences between offenders. Jewell and Wormith (14) found that "men who were more educated and court mandated were more likely to complete feminist psychoeducational programs than were men who were not as educated or court mandated, whereas

batterers who were older completed cognitive-behavioral programs more readily than younger men" (p.1107).

Mankowski and colleagues (6) remind us that patriarchy might not explain all abuse, since "not all men become batterers and not all batterers are violent for the same reasons" (p.177). In fact, other domestic violence research has discovered strong evidence supporting different "types" of batterers based on clusters of psychological characteristics (17, 18, 19). Matching batterers to certain types of treatments based on their psychological traits, abilities, and motivations has been shown to improve program completion and success rates (7, 14, 20, 21).

A third limitation of the current knowledge is that most research on batterer treatment outcomes focuses on the court-mandated Duluth power and control group programs which predominate the treatment landscape, arguably to the detriment of other treatment alternatives. The Duluth model is favored by feminist political activists, who have accomplished the widespread acceptance of this model through state law in 95% of states with laws regarding batterer treatment (1). However, as reviewed above, research has repeatedly shown only minor improvements from these treatments. Some scholars now argue that while these laws have raised awareness of domestic violence as a serious political and social issue, the restrictions within the framework of the legal and criminal justice system which allow only one treatment model may inhibit the testing of new, potentially more effective intervention strategies (1, 4, 11, 9). Feder and Wilson (11) argue that "alternative 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" (p.258). Evidence from state statutes highlights these types of restrictions; 68% of states with batterer treatment laws forbid couples therapy for batterers, 2 states forbid individual therapy, and 35% of states with batterer treatment laws explicitly forbid any treatments based on mental health disorder models or approaches such as anger management, based on the reasoning that these approaches might allow the abuser to deny responsibility or blame the victim in some way (1,

pp. 136-137). A separate, but related issue, may also be the lack of qualified personnel to serve as group facilitators for these state-mandated programs, either due to limited resources in smaller rural communities (9), or tension between professionally licensed psychologists and experienced advocate facilitators over minimum qualifications to lead groups (6).

### *Treatment Possibilities and Controversies*

Despite legal restrictions in many states on the types of interventions the court can mandate for abusers, there is growing evidence that incorporating a more holistic approach to batterer treatment may produce more favorable results for some batterers. One of the most promising areas of research for improving batterer treatment addresses the second limitation described above; that is, improving treatment by assessing the batterer's other needs and thereby avoiding the "one size fits all" approach. Research indicates that many abusers also have substance abuse and addictions problems, which can lead to program attrition (14) as well as lead to increases in domestic violence perpetration (22). A few research studies exist which find that alcohol treatment on its own (23), or in combination with batterer treatment may help to prevent partner violence (9, 24, 25).

Currently, only 40% of states (up from 20% in 2001) require a bachelor's degree for treatment facilitators, and 15% (including Kentucky) require professional licensure at a master's level or better (1, p. 145).

Along with substance abuse, researchers suggest that treatments for men who batterer might also be improved by addressing issues of racial prejudice, economic stress, detrimental community or family culture, mental illness, and the men's own histories of childhood abuse (4, 6). Saunders (7) describes this multi-faceted approach as a "coordinated community response" such that no single intervention is expected to solve the complex problem of domestic violence (p.165). Such a response may, for example, involve prosecution, probation, counseling, drug courts, and danger assessments in coordination with victim services.



Finally, some controversial research challenges many traditional assumptions about batterer intervention groups and

has discovered some noteworthy results when examining outcomes from couples' therapy or individual counseling involving abusive men. Most state laws now expressly forbid mandatory couples counseling for batterers (since this is equivalent to forcing abuse victims to attend treatment or to stay with their abusers, and could also endanger victims as a direct result of their disclosures in couples' therapy), and a few prohibit individual counseling (1, 26). Unfortunately, research also shows that many battered women initially choose to stay with their abuser after one or more incidents of violence (27), so some researchers argue that working with couples could still be a last-resort alternative in some cases, since a few research studies suggest that batterers may be less likely to drop out of couples' treatment than from men's groups (8). Critics have argued that couples therapy or individual therapy unfairly diffuses responsibility for the abuse, and may even prevent reporting of repeat violence by victims (4, 6). Nevertheless, abusers may already be in couples' therapy since many couples who voluntarily seek counseling report a history of domestic violence. Also, some women may seek a more active role in their abusive partner's treatment, evidence by one qualitative study in which some battered women suggested that there "should be an option to include both partners" in order to improve interventions (13). Emerging new research within couples' therapy that includes working on intimate partner violence issues suggests that, under certain restrictive qualifications and circumstances, these approaches might reduce violence and improve therapy outcomes (28, 29). One study found that couples therapy in combination with substance abuse treatment significantly reduced reported male violence better than substance abuse treatment alone (30), and several research reviews cited couples' therapy studies which had lower drop-out rates and slightly better success rates among batterers (5, 11, 8). Still, these results should be viewed with caution since couples therapy is certainly not

appropriate in most cases, and the participants in these handful of studies "differ substantially from the prevailing court-referred population" (9). Individual treatment has largely been ignored or outright banned as a possible batterer intervention, but research on case-tailored therapy suggests that it may be beneficial for men with underlying psychological issues either by itself, or alongside traditional group therapy (31).

Researching controversial alternatives to Duluth model such as individual or couples' therapy seems to violate the feminist principles on which much of the domestic violence movement is based, however other feminists argue that scholars and advocates should listen to battered women's voices in order to best understand needs of women living with abusive men. The study cited above (13) that reviewed the experiences of women whose partners were in batterer's treatment is a good example of this approach. Their qualitative results, like the results of other research, reinforces the fact that each domestic violence case is a unique, multifaceted, and ongoing problem that cannot be solved with a one-time, "one size fits all" intervention.

### *Conclusion*

Batterer treatment and intervention programs have been in existence in the United States for decades, and have become a widely used option for the criminal justice system to respond to domestic violence offenders. In the most recent national review of states' batterer intervention laws in 2008, 45 states had legislative statutes in place mandating the use of batterer interventions with specific standards (1). Most batterer intervention programs are men's groups which focus on the Duluth power and control model, a feminist educational approach aimed at confronting men with the knowledge that patriarchal social attitudes are a misguided justification for sexism and abuse. In practice, many intervention groups also utilize elements of unstructured group psychotherapy, also known as cognitive-behavioral therapy (CBT) which attempts to help men learn non-abusive behavioral responses to stress and conflict in their lives. Research that compiles and analyzes outcome studies from dozens of

these mandated batterer intervention programs, however, finds at best a very minimal benefit from attending batterer treatment, estimating treatment to prevent future violence only about 5% more than arrest alone (5, 8, 11).

Despite these somewhat discouraging findings, the results of these research reviews should be viewed with caution. Treatment or education can only work if batterers actually attend and complete the programs, and research finds that almost half of all men who are assigned to attend batterers interventions do not finish the program (8). Some researchers are now exploring factors which affect drop-out rates (14), and others have investigated ways to improve participation and success rates for racial minorities (10), individuals with substance abuse problems (24, 25), and batterers with differing psychological problems and needs (6, 7, 20). An emerging area of research is examining controversial alternatives to the traditional batterer intervention models, including the use of individual counseling (31), couple's therapy approaches (29), or a combination of treatment strategies (25, 30). Some researchers even go as far as to suggest re-examination of what "success" in intervention means, suggesting that preventing some violence or reducing the severity of violence should be viewed as a positive effect of intervention, even if treatments do not accomplish the ideal outcome of ending violence completely (4, 13).

Ultimately, research on batterer interventions demonstrates that current intervention approaches, sometimes criticized as a "one size fits all" approach, are not as successful as victims, advocates, researchers, or criminal justice personnel would like them to be. Despite political and legislative successes, there are still many tensions, controversies, and opportunities to improve the way both the criminal justice system and the broader community intervene and attempt to address domestic violence through the treatment of men who abuse their intimate partners.

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