



Respect response to criticisms about our approach to accreditation of domestic violence perpetrator programmes

Thangam Debbonaire, Respect Research Manager, January 2012

There have been several articles, emails and conference presentations recently which have various significant inaccuracies or misleading statements about Respect and Respect member programmes. Members and others have contacted us to discuss these. This article summarises the criticisms or inaccurate statements and our considered responses. We have already published one response to one such article (Farrall and Wellaway, 2011) in *Therapy Today* (Debbonaire, 2011) and will be doing the same to another recently published article (Dixon, Archer and Graham-Kevan, 2011) in the journal *Legal and Criminological Psychology* in the next edition. We are fully aware of emails written by Dave Eggins, of Temper in Northampton, which he has circulated widely over several years. Some of the criticisms he regularly makes are dealt with in this paper.

We believe that it would be unprofessional and potentially dangerous for us to ignore inaccurate, ill-informed and downright misleading statements about Respect and Respect members and we will continue to respond vigorously when appropriate, based on evidence from practice and research. We always welcome debate and discussion and invite responses to this article.

Respect and its members and accreditation standard deny the existence of male victims and female perpetrators. There is nothing in the Respect accreditation standard or position statements, including the Respect position statement on gender, which says or implies that there are no male victims and no female perpetrators. Respect runs a national helpline for male victims, taking thousands of calls each year. The Respect Phoneline responds to women as well as men using violence in intimate relationships. Many of our members work with women using force and/or male victims.

If Respect recognises the existence of male victims and female perpetrators, why is the accreditation Standard only concerned with work with male perpetrators and female victims? This is because that is the model for which there is the greatest provision, greatest need and the only model for which there is any substantial body of research on which to call. As practice and research develop, we will develop new standards for other types of work. We will consult widely on these, as we did with the current standard.

Respect promotes only one model of work with perpetrators. The Accreditation standard states quite clearly that we accredit any organisation using any model of work or method of working, providing it fulfils the qualifications of promoting victim safety, challenging use of violence, working with other agencies, working with diversity, recognising the needs and experiences of children and working accountably as part of a coordinated community response (Respect, 2008). There is a wide range of models and methods in use in Respect accredited organisations.



Respect position statements and standard are based on feminist ideology, not research. The Respect position statement on gender (Respect, 2009) makes clear that in line with the vast majority of researchers world-wide, we recognise that the majority of perpetrators of Intimate Partner Violence (IPV) are male and the majority of their victims are female (for reviews of this research topic, see, for example, Kimmel, 2003; Worcester, 2002). Further research has investigated further the specifics of different categories of Intimate Partner Violence, showing that the majority of perpetrators of intimate terrorism (against partners) are male (e.g. Johnson, 2008; Hines and Douglas, 2010; Walsh et al, 2010). When developing our standard and our positions papers we always consult a wide range of researchers, who all offered valuable comments and insight. We also base our practice guidance and accreditation on actual experience in practice.

Respect treats gender as the only risk factor for domestic violence. Our skilled specialist risk assessment work carried out by members and by the practitioners on our risk assessor register recognise, work with and assess against a wide range of evidence based risk factors, including childhood experiences, attachment disorder, mental health, alcohol and drug misuse, unemployment, psychopathy and many others. We recommend clearly in our Standard that for court and child protection risk assessment an evidence based approach and skilled specialist risk assessors should be used. However, gender is one of the significant risk factors for the onset of intimate partner violence (Walby and Allen, 2004), for violence causing injury (Stark and Flitcraft, 1996; Archer, 2000) fear (numerous British Crime Surveys) and for homicide (Smith et al, 2011).

Respect members make men feel ashamed of being men. From the many hundreds of hours of viewing of programme group work following a wide range of models of work, Respect assessors have yet to witness any practices where facilitators make men feel bad about being men. Indeed in order to support men to change we believe it is essential that facilitators establish respectful, enabling relationships with group members; that they help men explore their own feelings of shame; that they model positive and respectful ways of being and relating to others and that through this they help group members to develop empathy. Facilitators in a range of accredited programmes focus on many aspects of domestic violence and the justifications for it, not only gender. Respect has accredited programmes of a wide range of models, approaches, settings and philosophical understanding of domestic violence.

There is no evidence to show that programmes with a feminist understanding of domestic violence are effective. Dobash et al, 2000 found that perpetrator interventions, which were using a pro-feminist understanding of domestic violence, significantly reduced the rate of re-offending. Gondolf (2002) further demonstrated that the majority of men didn't just stop being violent in the short term, they were still non violent four years post-programme and that most women felt safer as a result. The male and female clients our members and our helplines work with discuss their own expectations of how men and women should behave in relationships. Even if we set out to run a group for perpetrators without looking at gender, we would not succeed as the clients themselves refer to this routinely and regularly.



Respect programmes are too long. The research strongly suggests that 3 months or 13 weeks' work is the bare minimum even to begin to assess and address men's violence adequately (Gondolf, 2002). Most men who will re-offend do so in these initial thirteen weeks, but many of these will go on to cease abusive behaviour during the course of the following weeks of the programme. The critical factor in keeping them on programmes to completion is often the impact of the coordinated community response. No one element of this response can work at its best in isolation. Shorter programmes may be easier to run and easier to get clients through, but this is pointless if they don't make victims safer.

Most men don't complete programmes. Statutory services such as child protection and family courts increasingly rely on domestic violence perpetrator programmes for specialist risk assessment and interventions to prevent men from using further violence or abuse. Many men are referred to programmes who are not suitable, or who are not motivated sufficiently to participate. This does affect the proportions of men who complete programmes. Critics of the Respect Standard who put forward this criticism (often with no evidence or by misquoting or ignoring research evidence) often support or run an extremely short programme with little or no substantial or rigorous research carried out on the outcomes. However, success does not only mean programme completion – some of the men referred to Respect member programmes may not start or complete programmes but their partners and children are significantly safer as a result of the improved risk assessment and safety planning which happens as a result of the interventions with the men.

Without research which meets the so-called "gold standard" of medical model research with randomised control trials the evidence is useless. Medical model "gold standard" research, briefly summarised, is the practice of carrying out research on an intervention as if it were a new medicine or medical treatment. Gold standard or Randomised Control Trial (RCT) research usually means randomly allocating a large group of clients to receive the "dose" (or intervention) and comparing them with a matching control group of clients who are randomly assigned to receive no "dose". For social interventions such as drug or domestic violence treatment, it can be nearly impossible to maintain the necessary conditions to be comparing the two groups. In the case of domestic violence, some have also suggested it may also be unethical and unsafe, as it risks leaving known victims unprotected or offered a lower level of protection. In other cases, the clients themselves disrupt the "gold standard" by refusing to attend programmes. Even if the programmes are identical, individual practitioners will have their own style, engage with clients in different ways, so the "dose" is never identical. There are other rigorous methods of evaluating outcomes which are possible, ethical and safe. Demonstrating our commitment to rigorous research, we initiated research, now being carried out independently of Respect. This is the Mirabel project, led by Professor Liz Kelly of London Met University, alongside Professor Charlotte Watts of the London School of Hygiene and Tropical Medicine and Doctors Nicole Westmarland and Simon Hackett of Durham University. This research is using a comparison group and modelling to ensure they are comparing the outcomes for similar women with similar experiences.

"The research shows that programmes don't work. Researchers quoting research carried out apparently using the "gold standard" Randomised Control Trial model usually don't mention that this



research is frequently on a very small scale (for example, Dunford, 2000), has poor follow up rates (Labriola et al, 2007) and is often using very narrow measurements or doesn't even ask the victim about her experiences pre or post programme. **Finally, it is worth noting that medicines are licensed with only modest rates of successful outcomes – a new drug which improves particular symptoms in as little as 20% of test cases can be licensed. Programmes appear to be asked to fulfil higher standards than medicines.**

There are as many female perpetrators as male. There are female perpetrators as well as male perpetrators. However, gender is one of the most significant indicators for perpetration of intimate partner violence (numerous British Crime Surveys) for serious IPV causing injury (Archer, 2000) and death, for post-separation IPV and for sexual assault (See, for example, numerous British Crime Surveys). Numerous rigorous, well informed and academically peer-reviewed articles in scholarly journals and other publications have examined this in depth and come to this conclusion (see, for example, Kimmel, 2003 and Worcester, 2010). Some research does appear initially to show that nearly equal numbers of men and women have experienced violence against a partner “one or more times” in their adult lives (see Smith et al, 2011). However, on closer inspection, the evidence from the British Crime Survey consistently shows that the majority (around 75%) of victims of four or more incidents of domestic violence are female. Research going back as far as the 1970s has consistently failed to take this into account and has often excluded sexual assault as domestic violence. Most also fails to differentiate between offence and self defence or resistance (see Johnson, 2008, for further exploration of this). As a result, a woman who pushes her abusive partner away after he has raped her would be counted as the aggressor in most of such research, whilst he would be counted as the victim. Many researchers have criticised these practices (see, for example, Dobash et al, 2000 and others listed elsewhere in this paper).

The question of whether there are equal numbers of male and female perpetrators is not just an academic one. It is important to be clear about who is doing what and to whom in order to develop, provide, review and improve interventions which meet need and achieve successful outcomes.

Some researchers assert that attachment disorder is the main cause of domestic violence (see, for example, Dutton, 2006) and go on to conclude that therefore treating attachment disorder should be the main (or even only) form of intervention with perpetrators (Dutton, Corvo and Chen, 2008). However, these same practitioners and researchers have no evidence to offer for the effectiveness of attachment disorder treatment for ending domestic violence. They also recommend that therapeutic responses are more appropriate to domestic violence than criminal ones. Furthermore, this assertion is mixing up cause and treatment, which is often misleading. For example, there are a range of reasons why people choose to break the speed limit – but we know that speed cameras and fines significantly reduce speeding. Having a law against allows us to take action. The evidence for the alternatives to domestic violence intervention programmes remains weak (Gondolf, 2011).



Conclusion

There is now over two decades of UK and USA practice experience in work with intimate partner abusers. There is also a substantial and developing body of research about the range of ways domestic violence perpetrator programmes help to make victims, perpetrators and their children safe. These include, but are not confined to, the perpetrator ending his or her abusiveness, as part of a coordinated community response. Gender is well established as a significant factor in domestic violence experience and treatment but risk assessment of course looks at others. Respect is committed to open debate about effectiveness of different interventions. For this reason we have invested substantial time, resources and energy into research across domestic violence topics. We remain committed to increasing the safety and well-being of victims by promoting, supporting, delivering and developing effective interventions with perpetrators.



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