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STATUS: IN PROCESS 20081009

OCLC #: 36347672

REQUEST DATE: 20081009 NEED BEFORE: 20081106

SOURCE: ILLiad

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RECEIVE DATE:

DUE DATE:

RENEWAL REQ:

NEW DUE DATE:

SPCL MES:

LENDERS: \*NJM, NYP, MIA

LHR SUMMARY: v.14-(2007-)

TITLE: Journal of aggression, maltreatment & trauma.

ISSN: 1092-6771

IMPRINT: Binghamton, NY : Haworth Maltreatment & Trauma Press, [1997-

ARTICLE: Corvo , Dutton, Chen: Toward Evidence-Based Practice with Domestic Violence Perpetrators

VOLUME: 16

ISSUE NUMBER: 2

ISSUE DATE: 2008

PAGES: 111 to 130

VERIFIED: <TN:69932> OCLC

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# Toward Evidence-Based Practice with Domestic Violence Perpetrators

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

**KEYWORDS.** Domestic violence, treatment effectiveness, forensic mental health, program evaluation

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The authors would like to thank the Board and staff of the FHL Foundation for their generous support in the research and writing of this article.

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Journal of Aggression, Maltreatment & Trauma, Vol. 16(2) #48, 2008

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doi:10.1080/10926770801921246

The preponderance of evidence now accumulated in the field calls into question the efficacy of "batterer" programs based on the most prevalent national models. Indeed, the main findings from our randomized trial are consistent with other recent trials, of which none found that mandating offenders to a batterer program for groups for men produced lower rates of re-abuse. (Labriola, Rempel, & Davis, 2005, p. viii)

Numerous empirical studies, literature reviews, and meta-analyses of standard model interventions with perpetrators of domestic violence (DV) have found little or no positive effect on violent behavior (Dutton & Corvo, 2006). In spite of these findings, the standard model of intervention with batterers in the United States has not been subjected to the same kind of critical appraisal that other behavioral change programs receive. Rather, program content and strategies are shaped and controlled by fixed standards or guidelines developed and disseminated by governmental or quasi-governmental DV "certifying" agencies (usually state-level), thus determining which approaches are permitted for local programs (National Institute of Justice [NIJ], 1998). The typical program for these offenders is same-sex (most often male), group psychoeducational or cognitive behavioral treatment of 6 to 36 weeks in length with content emphasizing "accountability," rational emotive principles, and feminist gender relations (Corvo & Johnson, 2003; Edleson, 1996; Eisikovits & Edleson, 1989; Feder & Wilson, 2005).

These programs enjoy immunity from external, empirical accountability, confounding the program development strategies that are available via implementation of findings from evaluation research and other empirical practice analyses. This immunity is supported by a policy framework where, for example, the state certifying agencies may presumptively forbid methods of intervention, with no obligation to empirically assess their efficacy and safety, that contradict the approved model (Corvo & Johnson, 2003). For example, on its website the New York Office for the Prevention of Domestic Violence (n.d.) asserts without substantiation or citation, "joint counseling in any form—couple counseling, family therapy, mediation—is *contraindicated* in DV cases, even when the victim insists on it . . . because it is dangerous . . . unfair . . . . Ineffective." However, Stith, Rosen, McCollum, and Thomsen (2004) found that the couple treatment was as, and in some cases more, effective than the standard model.

Much of current policy and practice related to DV perpetration emerged from Second Wave feminist initiatives formulated in the 1970s and early 1980s (e.g., Bograd, 1984; Dobash & Dobash, 1978). The

feminists of the period were responsible for identifying and then responding to the domestic abuse of women (Pleck, 1987). However, it can be argued that in setting and maintaining a policy course with respect to DV the more visionary aspects and dimensions of feminist theory, radical or otherwise, have been largely ignored.

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

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

One of the major custodians of DV policy, the National Institute of Justice (NIJ), has funded a number of batterer intervention program evaluations (e.g., NIJ, 2003), but an ideological and political firewall exists between the kind of information the NIJ gathered and substantial changes in policy and practice. For example, the links between alcohol and DV, well established through epidemiological, clinical, and laboratory studies, are often minimized in DV policy and practice with the rationale that not all perpetrators abuse alcohol and not all alcohol abusers are violent (Corvo, Halpern, & Ferraro, 2006). Some states actually prohibit providing counseling for addiction to batterers as part of their approved programs (NIJ, 1998).

What distinguishes DV policy and interventions from other problem areas is not only a poor showing in effectiveness and outcomes. What does distinguish DV policy and interventions are the systematic and institutional proscriptions against using evaluation findings and other pertinent data to develop program innovations. The proximal impediments to program development are the DV certifying agencies that oversee interventions with abuse perpetrators involved in the criminal justice system.

These agencies formulate and implement policies that regulate what structure, duration, and form of intervention is required as a condition of probation for persons found guilty of domestic assault and thereby which form of intervention is deemed acceptable by the courts. Hence, program funding is only available to those programs that conform to these policies (Dutton & Corvo, 2006).

Evidence-based practice (EBP) has emerged as an important treatment model in many fields, including medicine, psychiatry, psychology, social work, marriage and family therapy (Thyer, 2004), and criminology (Petrosino, Boruch, Soydan, Duggan, & Sanchez-Meca, 2001). The core principle is the commitment to understanding and using the best available scientific research findings to inform practice (American Psychological Association, 2002; Fraser, 2003). Some have even suggested that approaching practice without considering the most rigorous research available is unethical and may violate professional norms (Casey Family Services, n.d.).

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

### OVERVIEW OF EVIDENCE-BASED PRACTICE

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

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

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

Sackett, Straus, Richardson, Rosenberg, and Haynes (2000) defined EBP as “the integration of best research evidence with clinical expertise and patient values” (p. 1). Further, they described it as involving five steps: (a) Convert a clinical need into an answerable question; (b) search for and find the best evidence to answer that question; (c) critically appraise the evidence in terms of its validity and utility; (d) apply the results; and (e) evaluate effectiveness.

Shlonsky and Gibbs (2004) stated, “EBP assumes a predisposition to inquiry as well as the impetus to pose specific questions. It assumes a fair-minded approach that eschews selling a particular position” (p. 151). The general epistemology of EBP, therefore, can be seen as one of applied scientific research, where certain kinds of systemic inquiry are seen as more valid and more useful. When possible, the preferred methodology is the multi-site randomized controlled clinical trial (Thyer, 2004), with descending value applied to less rigorous forms of experimentation, quasi-experimentation, and nonexperimental. Currently several organizations are dedicated to designing and conducting systematic reviews of the scientific literature to support practitioners and organizations in identifying best practices. Two of the better known organizations are the Cochrane Collaboration ([www.cochrane.org](http://www.cochrane.org)) in the field of medicine and the Campbell Collaboration ([www.campbellcollaboration.org](http://www.campbellcollaboration.org)) in the fields of education and social and behavioral practice.

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

## EXPLANATORY RESEARCH AND DOMESTIC VIOLENCE PERPETRATION

Three separate general theoretical perspectives guide explanatory or causal research in DV perpetration. These current major explanatory theoretical views of DV can be broadly categorized as feminist/sociocultural, social learning theory-based intergenerational transmission, and psychological (Corvo & Johnson, 2007).

### Feminist/Sociocultural View

Although the batterer treatment standards of most states are premised upon DV being the product of patriarchy, the central causal construct in the feminist/sociocultural theory, there is little consistent empirical evidence in support of this view. Briefly, the patriarchy-as-cause view asserts that DV is solely a product of the socially sanctioned domination and control of women by men (Corvo & Johnson, 2003). Empirical studies examining the influence of patriarchal gender role socialization or gender-based power inequities on DV behavior have demonstrated neither strong nor linear correlations (Dutton, 1994; Sugarman & Frankel, 1996; Yick, 2000). The effect size of variables generated by this theory is often weak when compared to those generated by other theoretical perspectives (e.g., Corvo & Johnson, 2007). In fact, numerous studies contradict this perspective: Less than 10% of all couples are male dominant (Coleman & Straus, 1985); women are more likely to use severe violence against nonviolent men (Stets & Straus, 1992); men in North America do not endorse violence against their wives as acceptable (Dutton, 1994; Simon, Anderson, Crosby, Shelley, & Sacks, 2001); and abusiveness is higher in lesbian relationships than in heterosexual relationships (Lie, Schilt, Bush, Montague, & Reyes, 1991). Finally, Archer's (2000) meta-analysis, with a combined *N* of 60,000, found women, especially younger women, to be more domestically violent than men.

### Intergenerational Transmission

The intergenerational transmission of DV has been one of the most commonly reported influences in DV in adulthood. Research conducted on the intergenerational transmission of DV has framed much of its inquiry in social learning theory. The social learning, theory-based, intergenerational transmission model of DV posits that observing violence in

one's family of origin creates ideas and norms about how, when, and toward whom aggression is appropriate. Early studies found a high frequency of violence in the families of origin of domestically violent men (Gayford, 1975; Rosenbaum & O'Leary, 1981; Roy, 1977; Straus, Gelles, & Steinmetz, 1980). Other studies (Carrol, 1980; Gelles, 1974) found associations between child abuse in the family of origin and current DV for both men and women (as victims). Kalmus (1984), reanalyzing the Straus et al. (1980) national sample, found that both exposure to child abuse and observation of interparental spousal violence contributed to the probability of marital aggression for men and women. Although consistently significant, the effect size of social-learning-derived intergenerational transmission variables in predicting DV in adulthood is often small. In their review of the research, Holtzworth-Munroe, Bates, Smutzler, and Sandin (1997) observed that the correlations found between family of origin violence and current partner violence may be mediated by other variables. In spite of its many contributions, the social learning focus has restricted inquiry into a broader range of possibly predictive psychosocial variables. The companion literature on the intergenerational transmission of child abuse and youth violence, for example, has long explored a much wider range of psychosocial variables (e.g., Corvo, 1997; Sheridan, 1995). Intergenerational transmission studies of DV using broader psychosocial variables are less common (Corvo & Carpenter, 2000).

### Psychological Theories

Psychological theories of DV perpetration examine individual factors. Dutton (2006) summarized these as personality disorders, neurobiological factors, neuroanatomical factors, disordered or insecure attachment, developmental psychopathology, cognitive distortions, and posttraumatic symptoms. Holtzworth-Munroe et al. (1997) stated, "Violent husbands evidence more psychological distress, more tendencies to personality disorders, more attachment/dependency problems, more anger/hostility, and more alcohol problems than nonviolent men" (p. 94). Not only do domestically violent men differ from nonviolent men on important psychological variables, they differ substantially from each other. With the recognition that DV perpetrators differed greatly on a number of important characteristics, subtypes of perpetrators have been identified. Although a number of different instruments, sorting criteria, methods, and samples have been used, there has been substantial consistency in the identification of three subtypes (Holtzworth-Munroe & Stuart, 1994;

Lohr, Borge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005). These subtypes have been shown to differ on measures of personality styles and disorder, psychopathology, hostility, attachment styles, drug and alcohol use, and type and severity of violence (Lohr et al., 2005).

In addition to the research examining the relationship between psychological factors and DV, there is a much larger body of basic research that looks at the relationship between psychological factors and violence in general. Much of that basic research on causes of violence and aggression is neuropsychological. The Aspen Neurobehavioral Conference consensus statement (Filly et al., 2001) summarized the considerable literature on the neuroscience of violence, identifying genetic, neuroanatomical, neurochemical, developmental, neuropsychological, and psychiatric factors. One area of particular importance is the association between frontal lobe deficits and violence. Frontal lobe deficits refer, in general, to compromised abilities to inhibit impulsivity or aggression or to redirect attention from repetitive behavior (Westby & Ferraro, 1999).

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

### *Early Trauma, Borderline Personality, and Attachment Disorders*

Particularly useful in understanding psychological issues specific to DV perpetration is the overlapping risk and influence of early trauma, attachment disruption, and borderline personality traits. There is a strong relationship between borderline traits in male perpetrators and intimate abusiveness (Dutton, 1998, 2002a, 2002b). In a series of studies, Dutton (for a review, see Dutton 1995a, 1995b, 1998, 2002b) examined personality profiles of assaultive males. Men's borderline characteristics were significantly related to chronic anger, jealousy, wives' reports of clients' use of violence, and experiences of adult trauma symptoms. In sum, a constellation of personality features (borderline personality organization, high anger, fearful attachment, chronic trauma symptoms, and recollections of paternal rejection) accounted for partner's reports of abusiveness.

Bowlby (1969) viewed much interpersonal anger as arising from frustrated attachment needs. Thus, attachment theory suggests that an assaultive male's violent outbursts may be a form of protest behavior directed at his attachment figure and precipitated by perceived threats of separation or abandonment. A *fearful* attachment pattern may be most strongly associated with intimacy-anger. This pattern manifests itself in hypersensitivity to rejection and active avoidance of close relationships where vulnerability to rejection exists. Although the fearful share anxiety over abandonment with another insecurely attached group (called *preoccupied*), their avoidance orientation may lead to more chronic frustration of attachment needs.

Dutton, Saunders, Starzomski, and Bartholomew (1994) found that fearfully attached men experience high degrees of chronic anxiety and anger. Fearful attachment accounted for significant proportions of variance in both emotional abuse criterion factors completed by female partners. It was also strongly correlated with borderline personality organization. Since anxiety and anger were both strongly associated with fearful attachment, an emotional template of intimacy/anxiety/anger may be the central affective feature of a fearful attachment pattern. Babcock, Jacobson, Gottman, and Yerington (2000) found insecure attachment styles to be related to abusiveness. Mikulincer (1998) found that attachment style was related to dysregulation of negative emotions in intimate relationships. Corvo (2006) found that early life separation and loss were more strongly associated with adult DV perpetration than was exposure to child abuse or parental violence.

In boys, a prominent sequela of abuse victimization is hyperaggression. Carmen, Reiker, and Mills (1984) suggested that abused boys are more likely than abused girls to identify with the aggressor and to eventually perpetuate abuse on their spouse and children. Other studies, however, have suggested that male reactivity to maltreatment may be mediated by genetic variability in some neurotransmitters (Caspi et al., 2002). It was noted by van der Kolk (1987) that traumatized (including physically abused) children had trouble modulating aggression. Further, van der Kolk noted how posttraumatic stress disorder (PTSD), including poor affect tolerance, heightened aggression, irritability, chronic dysphoric mood, emptiness, and depression, may be another link or mediating variable between childhood abuse victimization and adult perpetration.

Dutton (1995c) found that 45% of wife assaulters met research criteria for PTSD and exhibited elevated levels of chronic trauma symptoms. The source of trauma was physical abuse combined with shaming by the

father and a lack of secure attachment to the mother. Consequently, the latter could not provide buffering against the former (Dutton, 1998, 2002b). Tangney, Wagner, Fletcher, and Gramzow (1992) analyzed the potential role of shame as a mediator between the early experiences of assaultive men and their adult experience of anger and abusiveness. They describe shame-proneness as a moral affective style involving a "global, painful, and devastating experience in which the self, not just behavior, is painfully scrutinized and negatively evaluated" (op. cit., p. 599). Shame-inducing experiences, which generate a shame-prone style, may be viewed as attacks on the global self and can produce disturbances in self-identity. Shame-prone individuals have been found to demonstrate limited empathic ability, a high propensity for anger, and self-reports of aggression (Wallace & Nosko, 2003). Dutton and colleagues found recollections of shame-inducing experiences by parents of assaultive men to be significantly related to the men's self-reports of anger and physical abuse (Dutton, van Ginkel, & Starzomski, 1995). These features of an abusive personality (insecure attachment, borderline traits, and trauma reactions) have not been an explicit focus of treatment for spouse assault.

### *Drug and Alcohol Abuse*

Of particular importance in understanding risk for DV perpetration is drug and alcohol abuse. Empirical studies supporting the concomitance of substance abuse and DV can be traced to as early as the late 1970s (e.g., Hilberman & Munson, 1978). Bennett, Reed, and Williams (1998) reported rates of concomitance of substance abuse and DV ranging from 23% to as high as 100%. The National Institute of Alcohol Abuse and Alcoholism (1997) summarized several models describing the relationship between alcohol consumption and violence: disinhibition; overreaction to perceived threat due to impaired information processing; inaccurate assessments of consequences of violence; alcohol-violence expectancies; deviance disavowal; and amplified effects due to neuroendocrinological and hormonal factors. Perry (1997) proposed that the effects of alcohol on violent behavior can be exaggerated, in part by com-promises in neuroanatomy, with alcohol's disinhibiting properties being multiplied where there are frontal lobe deficits. Using multiple indicators of frontal lobe impairment, Westby and Ferraro (1999) found that heavier alcohol use, poorer vocabulary, and frontal lobe deficits differentiated DV offenders from nonoffenders. In a secondary analysis of this data, Corvo et al. (2006) found a cluster of offenders who exhibited higher levels of

violence, greater alcohol use, and more frontal lobe deficits, suggesting differential effects at higher levels of pathology. Moeller and Dougherty (2001) identified antisocial personality disorder (ASPD) as mediating the effects of alcohol consumption on aggression; persons diagnosed with ASPD exhibited increased aggression due to alcohol consumption compared to controls. These findings suggest that the association between ASPD and alcohol-related aggression may stem, in part, from ASPD-related impairments in regions of the brain performing executive functions. Sonkin and Liebert (2003) described a comprehensive assessment protocol for perpetrators that encompasses many of the behavioral and psychological factors described above with recommendations for individualized treatment plans.

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

### *INTERVENTIONS RESEARCH AND DOMESTIC VIOLENCE PERPETRATION*

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

In a treatment outcome study done on the standard Duluth model, Shepard (1987, 1992) found a 40% recidivism rate (arrest, conviction, or protection order) in a six-month follow-up of Duluth clients, a rate higher than most control recidivism levels. In their meta-analysis, Babcock et al.

(2004) found that experimentally evaluated programs show only about one tenth of a standard deviation improvement in recidivism; partner reports put recidivism rates at 35% for a 6- to 12-month follow-up compared to 40% for controls.

In the experimental studies reviewed by Babcock et al. (2004), including Davis, Taylor, & Maxwell, 1998; Dunford, 2000; Feder & Forde, 1999; Ford & Regoli, 1993; and Palmer, Brown, & Barrera, 1992), effect sizes (*d*) for treatment ranged from 0.00 to 0.54 with much greater skewing toward the lower end (distribution: 0.00, 0.00, 0.02, 0.02, 0.04, 0.05, 0.10, 0.10, 0.13, 0.21, 0.41, 0.54). Conducting an experiment in which judicial discretion is sacrificed and criminals are randomly assigned to treatment or no treatment can be problematic on ethical as well as practical grounds.

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

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

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

In addition to the standard, approved interventions that are directly targeted at perpetrators, there are a number of other interventions and

programs that have significance for developing an evidence-based approach to working with DV. For example, studies by Stuart et al. (2003) and O'Farrell, Falls-Stewart, Murphy, and Murphy (2003) found that the successful treatment of alcohol dependence alone reduced partner violence to a much greater degree than is typically found with DV interventions per se.

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

Restorative justice is another promising approach. In brief, restorative justice views crime primarily as a conflict between individuals that results in harm to victims rather than to the state; its goal is reconciliation and repair rather than retribution (Bevin, Hall, Froyland, Steels, & Goulding, 2005). The process of restorative justice facilitates active participation by all parties involved and supports victims in engaging in dialogue or mediation with offenders. Bevin et al. found that in a sample of community offenders and victims, a restorative justice process produced greater feelings of safety, security, and control among victims and a reduction in factors associated with recidivism among offenders when compared to a conventional court process. A randomized comparison study by Linda Mills and colleagues between batterer's treatment and a restorative justice intervention is currently underway in Arizona (L. Mills, personal communication, 2005).

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

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

### CONCLUSION

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

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

The robust findings on perpetrator typologies points toward the need to carefully assess and direct perpetrators into the types of treatment appropriate to their particular constellation of issues. In addition to promising better outcomes, more individualized treatment may reduce attrition, the bete noire of DV programs. Chang and Saunders (2002) also suggested that culturally competent practice with better matching of client types and needs to treatment can improve program retention. Clearly, the relationship between substance (primarily alcohol) abuse and DV must be directly addressed in treatment in some integrated form and not relegated to a marginal epiphenomenon. The success of some forms of couples treatment and the predominance of the mutuality (if not symmetry) of DV

suggest that, where appropriate, the interactional and relational issues pertinent to violence should be integrated into treatment. The salience of the emotional and behavioral sequelae of early, disturbed attachment in DV indicates the need for treatment, whether group, couple, or individual, that promotes a sense of secure membership, connection, or bonding.

The current best evidence clearly does not support investing substantial public funds in the continuation, let alone the mandating, of the standard DV program model. In the face of overwhelming countervailing evidence, why does this model persist? There is no scientific reason why causal explanations of DV and the principles of perpetrator treatment should exist outside the biopsychosocial framework used to understand and address contemporary mental health and social problems. In some sense, then, the political issues in the policy framework "trump" the science to a greater degree perhaps than in most other social problems. Perpetrators are vilified in such a fashion so as to make them appear unworthy of a broader range of services (e.g., as in comparison to parents who physically assault their children; Corvo & Johnson, 2003). There are few advocacy groups to put pressure on legislatures for legal or regulatory change. In short, within the existing policy framework of mandated interventions, there is a lack of political support to reframe the issue so that implementing an evidence-based approach becomes feasible. Whatever benefits to violent families that may result from improved, evidence-based practice await a more rational iteration of the policy framework.

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SUBMITTED: May 31, 2007

REVISED: July 17, 2007

ACCEPTED: July 21, 2007

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