

Interventions for Intimate Partner Violence: Review and Implications for Evidence-Based Practice

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The objective of this article was to survey available intimate partner violence (IPV) treatment studies with (a) randomized case assignment, and (b) at least 20 participants per group. Studies were classified into 4 categories according to primary treatment focus: perpetrator, victim, couples, or child-witness interventions. The results suggest that extant interventions have limited effect on repeat violence, with most treatments reporting minimal benefit above arrest alone. 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. Rates of recidivism in most perpetrator- and partner-focused treatments are approximately 30% within 6 months, regardless of intervention strategy used. 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. This review shows the benefit of integrating empirically validated substance abuse and trauma treatments into IPV interventions and highlights the need for more work in this area.

Keywords: intimate partner violence, treatment, batterers, child witness to violence

Intimate partner violence (IPV) impacts millions of families worldwide (Watts & Zimmerman, 2002). In the United States alone, lifetime prevalence studies suggest between 20% and 30% of women will be assaulted by an intimate partner and between 5%

and 20% of children will witness a parent being assaulted (McCloskey & Walker, 2000; Tjaden & Thoennes, 2000; Wilt & Olson, 1996). The impact of IPV is well documented in the research literature, with deleterious effects acknowledged for all members of the family (Carter, Weithorn, & Behrman, 1999). For several decades, law enforcement, courts, social service agencies, and mental health providers have attempted to develop interventions to assist victims of IPV and prevent batterers from continuing to use violence in their relationships.

Reducing violence perpetration has proven a challenge, however, as perpetrators of IPV have complicated psychosocial and psychiatric histories. Many have witnessed family violence or were victims of abuse as children (Gortner, Gollan, & Jacobson, 1997). In addition, borderline, narcissistic, and antisocial personality disorders are common among IPV perpetrators (Mauricio, Tein, & Lopez, 2007), and the co-occurrence of substance abuse problems in this population is high, with rates ranging from 40% to 92% across studies (Brookoff, O'Brien, Cook, Thompson, & Williams, 1997; Easton, Swan, & Sinha, 2000; Wilt & Olson, 1996).

Despite the frequent co-occurrence of these problems, incorporation of the perpetrator's own trauma history, personality disorders, and substance abuse are not typically targeted into IPV intervention models. Some of the first studies to evaluate strategies for IPV assessed the impact of mandatory arrest, which required officers to make an arrest or issue a warrant for the perpetrator of violence at the time of the incident in every case of IPV (Sherman & Berk, 1984). This policy eliminated officer discretion in determining the need for an arrest. It was thought that the criminal justice ramifications would deter perpetrators from continuing to use violence.

Aside from mandatory arrest, the standard for batterers' intervention is a group treatment that focuses on feminist psychoedu-

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cation about power and control often referred to as the *Duluth model* (Pence & Paymar, 1993). According to this model, the primary cause of domestic violence is patriarchal ideology and societal sanctioning of men's power and control over women. The fundamental tool of the Duluth model is the *Power and Control Wheel*, which illustrates how men use intimidation, male privilege, isolation, emotional and economic abuse, and violence to control women. The model is implemented in a variety of protocols, lasting 8–36 weeks, and is the unchallenged treatment of choice in most communities. In some states, it is the mandated treatment.

Another common approach to batterer treatment is group cognitive-behavioral treatment (CBT), in which learning nonviolence is the primary focus (Adams, 1988). The CBT therapist works to point out the pros and cons of violence, along with providing skills training (e.g., anger management, communication skills, assertiveness, relaxation techniques) to promote alternatives to violence. Programs have also combined aspects of both the Duluth and CBT models, and distinguishing between the two is becoming increasingly difficult.

In addition to focusing on the needs of perpetrators, numerous IPV interventions aim to address the needs of their partners. Partners of batterers are at risk for a range of negative consequences that go beyond immediate physical injuries to include a variety of stress-related psychiatric disorders (Campbell et al., 2002; Eisenstat & Bancroft, 1999). Associated psychiatric symptoms can be profound and include depression, posttraumatic stress disorder (PTSD), and other anxiety disorders (Dutton et al., 2006; Golding, 1999). Treatments for victims of IPV typically focus on advocacy and counseling to assist the victims in leaving their abusive partners, with the most commonly evaluated services provided by domestic violence shelters.

Child-focused interventions aim to address the most common sequelae experienced by children exposed to domestic violence. Child witnesses are at increased risk for attachment disorders, depression, PTSD, other anxiety disorders, and conduct problems (e.g., Kendall-Tackett, 2004). Standard care for child witnesses involves group treatment while in shelter with their mothers or referral for individual treatment within a community mental health clinic. More recently, several treatment approaches for child witnesses of IPV have been manualized and published (Cohen, Mannarino, & Deblinger, 2006; Lieberman & Van Horn, 2004).

Two recent meta-analytic studies evaluated the efficacy of batterers' treatment programs, but the vast majority of studies included were quasi-experimental (Babcock, Green, & Robie, 2004; Feder & Wilson, 2005). This review focuses on randomized controlled studies and expands the review of empirical research on IPV treatments to include interventions developed for IPV partners and their children. The rationale for focusing on treatments targeting perpetrators, partners, and their children is derived from the frequent co-occurrence of IPV and child abuse and the common practice of protective services workers to mandate treatment for all members of the family when domestic violence is a presenting issue. In addition, as noted earlier, it has been well documented that IPV has deleterious effects on all members of the family, further highlighting the need for efficacious treatments for perpetrators, their partners, and child witnesses of IPV.

Method

MEDLINE and PsycINFO data bases were searched from their respective start dates to June 2007 using specific keywords such as *domestic violence*, *batterers*, *partner abuse*, *intimate partner violence*, *domestic violence intervention*, *children and domestic violence*, *batterer treatment*, and *domestic violence couples treatment*.

Bibliographies of key articles were searched by hand.

Identified IPV interventions were categorized into the relevant client categories (batterer, victim, couple, and child witness). This search yielded 30 batterer, 18 victim, 18 couples, and 19 child-witness intervention evaluations. Studies included in this review met the following criteria: (a) experimental study (randomized treatment and control), (b) sample size of at least 20 participants per group, and (c) recidivism or measures of violence severity as an outcome variable. Application of these selection criteria, however, resulted in identification of only one couple and no child-witness treatment studies. Given that only one couple treatment evaluation utilized a randomized control group, we also included studies that compared couple therapy with another treatment modality for IPV in this review. In addition, relaxing the last criterion of recidivism as an outcome variable resulted in the identification of four evaluation studies that assessed change in symptoms in interventions targeting child witnesses of IPV. In total, seven batterer, six victim, five couple, and four child-witness treatment studies were surveyed in this review. We will describe novel, promising interventions more fully.

Results

Interventions for Batterers

The treatments for perpetrators reviewed in this section are summarized in Table 1. The preponderance of research examined the effect of mandatory arrest or group treatment models. As can be seen in the table, participant dropout was a significant problem for group treatment approaches, with rates approximately 30% across studies. Attrition was also a significant problem in most studies in which recidivism rates relied on victim response, with loss to follow-up rates ranging from 15% to 89%. In addition, when recidivism rates were calculated from police report and victim response, rates were consistently and notably higher when based on victim report. Given the high rate of victim data missing in most studies, the reported recidivism rates should be accepted with caution.

Mandatory arrest. In an initial study of mandatory arrest in Minneapolis, Minnesota, 314 cases of simple (misdemeanor) assault were randomly assigned to receive one of three responses: mandatory arrest of the perpetrator, mediation by the responding officer, or physical separation of the couple for 8 hr. Of suspects randomized to arrest, 99% were arrested, but only approximately three fourths of the subjects in the other conditions received the intervention they were assigned. On the basis of the 12-month follow-up police record data, mandatory arrest resulted in a 13% recidivism rate compared with 26% for those separated from their partners for 8 hr. The recidivism rate for those who received mediation fell midway between and was statistically indistinguishable from the other two groups. Only 49% of the victims were reached for 12-month follow-up, with reported victim recidivism rates of 19% for mandatory arrest and 37% for mediation condi-

tions; recidivism rates for those in the separation condition were midway between and again statistically indistinguishable from the other two groups (Sherman & Berk, 1984).

A large-scale ($N = 4,032$) multisite replication and analysis of mandatory arrest for domestic violence failed to demonstrate a benefit of mandatory arrest on perpetrator violence on the basis of police report data (Spousal Assault Replication Project, or SARP; Maxwell, Garner, & Fagan, 2001). A significantly lower rate of recidivism was reported for arrest on the basis of victim report data, but high rates were still present in both mandatory arrest cases and controls (36% vs. 48%).

Duluth model of group treatment. Two studies evaluated batterers treated with the Duluth model compared with a control group. In the first study, men were randomly assigned either to a 26-week Duluth model group plus probation or to probation only; both interventions were associated with a 24% recidivism rate (Feder & Dugan, 2002). Treatment completers were less likely to be rearrested (13%) compared with noncompleters (30%). In the second study, men were randomly assigned either to 40 hr of Duluth model group treatment (in either 26-week or 8-week format) or to a community service control (40 hr of service completed in a 2-week period). Men randomized in this study agreed to engage in treatment as part of their sentence, biasing the sample to more treatment-motivated men. Recidivism rates were 16% and 26%, respectively, according to police report, and 22% and 21%, respectively, according to victim report (Taylor, Davis, & Maxwell, 2001). Attrition rates were high, with only 30%–50% of victims responding at 12-month follow-up.

Group CBT or combined CBT–psychoeducation interventions. Dunford (2000) conducted the most methodologically rigorous study to date comparing CBT men's groups with conjoint couple therapy groups and no treatment controls. According to police or victim reports, neither treatment had a significant impact on recidivism for this sample of military men at 1-year follow-up. Rates of police-reported recidivism were extremely low in this sample (3%–6%), and consistent with other studies, victim reports yielded considerably higher rates of repeat violence (range: 27%–35%, no difference between groups).

Palmer, Brown, and Barrera (1992) randomly assigned 56 Canadian men to either a 10-week group treatment (combined CBT and psychoeducation) or a no-treatment control group. Based on police records, recidivism rates were significantly higher for controls (31%) than for the intervention group (10%). This study had a small sample size with only 22% of victims responding at 12-month follow-up.

Ford and Regoli (1993) randomly assigned 347 men to pretrial counseling (type of counseling not specified), counseling as probation, or mandatory sentencing. They found that pretrial counseling was more effective than counseling as a condition of probation (recidivism rate: 34% vs. 45%) but no more effective than mandatory sentencing (recidivism rate: 34%). Only 31% of victims were reached for 6-month follow-up assessments.

Summary of batterer treatments. Group treatments for IPV batterers have meager effects on the cycle of violence, with most studies demonstrating no or minimal impact above that of mandatory arrest alone. Most studies, regardless of intervention strategy (mandatory arrest, Duluth model group treatment, CBT), report approximately one in three cases will have a new episode of IPV within 6 months based on victim's reports. This rate must be accepted with caution

given high attrition in victim reports across studies (range: 15%–78%; mean attrition: 46%).

Interventions for Victims of IPV

Interventions that have been evaluated for victims of IPV have been based in (a) shelters, (b) prenatal clinics, or (c) the community, with police–social service outreach and advocacy (see Table 2). These studies had significantly lower follow-up attrition rates than the interventions targeting perpetrators but have reported recidivism rates comparable to, or greater than, those reported in perpetrator-focused studies.

Shelter interventions. In the only methodologically sound set of studies evaluating an intervention for victims exiting shelter, Sullivan and colleagues examined the efficacy of a 10-week advocacy program for women after at least 1 night's stay in a domestic violence shelter. The program included 4–6 hr per week of one-on-one advocacy and counseling. The initial sample of 141 participants did not experience significant differences in repeat violence at 6-month follow-up (Sullivan, Campbell, Angelique, Eby, & Davidson, 1994). Further data collection in a total sample of 278 women interviewed every 6 months for 2 years and in a subset of 124 women reinterviewed at 3 years revealed a modest reduction in revictimization rates between 6 months and 2 year postintervention (31% intervention vs. 37% controls; Sullivan & Bybee, 1999). However, these differences were not sustained for the subsample followed through 3 years (44% intervention vs. 36% controls; Bybee & Sullivan, 2005).

Prenatal clinic interventions. In a study with 329 Hispanic victims of IPV seen in a prenatal clinic, McFarlane, Soeken, and Wiist (2000) compared three interventions: (a) wallet-sized resource cards, (b) unlimited access to supportive, nondirective counseling, or (c) unlimited counseling plus support from a “mentor mother.” Interventions were provided during the prenatal period only, and women were interviewed at 2, 6, 12, and 18 months postdelivery. Although women who received both counseling and mentorship reported less violence at 2 months postdelivery than did the counseling-only group, so did the resource-card group. There were no significant differences among the groups at 12 or 18 months postdelivery. The potency of these intervention strategies cannot be fully evaluated, however, as exact recidivism rates were not reported in the study.

Police–social service outreach programs. Several police–social service outreach programs have been developed in various communities. The Domestic Violence Intervention Education Project (DVIEP) was conducted in the New York City public housing projects. The DVIEP involved follow-up home visits made by police officers and social workers to homes where a domestic dispute was reported to the police to provide victims with information on services available to them. Results of the study indicated that victims who received the DVIEP were more likely to call the police and to call more rapidly to report abuse in the 6 months following the intervention than those assigned to the comparison group (45% vs. 39%, respectively; Davis et al., 2003). However, on the basis of victim report from 72% of the sample at 6-month follow-up, there were no group differences in severity of abuse reported on the Conflict Tactics Scale, with high rates of recidivism reported in both groups

Table 1
Interventions for Batterers

Citation	Sample <i>N</i>	Treatment	Recidivism measure	Posttreatment follow-up	Significance outcome	Recidivism by group	Treatment dropout	Follow-up attrition
Sherman & Berk, 1984	314	Mandatory arrest (136) vs. ordering offender from premises for 8 hr (89) vs. informal mediation (89)	Police and victim report	6 months	Mandatory arrest significantly more effective deterrent than either physical separation or officer mediation	26% separation vs. 13% arrest based on police record; 37% mediation vs. 19% arrest based on victim report; mediation statistically indistinguishable from both groups on both measures	Not applicable	0% for police record; 51% for victim interview
Maxwell, Garner, & Fagan, 2001	4,032	Mandatory arrest (1,748) vs. nonarrest (2,284)	Police and victim report	6 months	No differences between groups on police report; arrest = significantly less violence based on victim report	36% arrest vs. 48% nonarrest based on victim report	Not applicable	0% for police record; 37% for victim report
Feder & Dugan, 2002	404	26-week Duluth model tx group + probation (216) vs. probation only (188)	Partner and self-report CTS, police report	12 months	No significant difference in rates of rearrest, attitudes, or incidence of violence	24% in both groups rearrested in 1 year; 30% tx noncompleters rearrested vs. 13% completers	29%	70% for victim report at 12 months
Taylor, Davis, & Maxwell, 2001	376	40 hr of Duluth model tx group (190) vs. 40 hr of community service control (186)	Partner report CTS, police report	12 months	26 wk lower recidivism at 6 and 12 mo; no difference for victim report of violence	16% Duluth model tx vs. 26% control based on police record; 22% tx vs. 21% control based on victim report	Not reported	50% for victim report
Dunford, 2000	861	Men's CBT group (168) vs. conjoint group (153) vs. rigorously monitored group (173) vs. control group (150)	Partner and self-report MCTS, police and court records	18 months	No differences between groups	4% men's group, 3% couples, 6% monitored, 4% control based on police record; 29% men's group, 30% couples, 27% monitored, 35% control based on victim report	29%	0% for police record; 15% for victim report

(table continues)

Table 1 (continued)

Citation	Sample <i>N</i>	Treatment	Recidivism measure	Posttreatment follow-up	Significance outcome	Recidivism by group	Treatment dropout	Follow-up attrition
Palmer, Brown, & Barrera, 1992	56	10-week psychoeducation group (30) vs. probation only (26)	Partner and police report	12 months	Recidivism significantly higher for control vs. treatment	10% psychoeducation vs. 31% control based on police report; victim data not reported due to high study attrition	30%	70% intervention and 89% control for victim reports
Ford & Regoli, 1993	347	Pretrial counseling (127) vs. counseling as probation (114) vs. mandatory sentence (106)	Partner report	6 months	No difference between groups	34% pretrial vs. 45% probation vs. 34% mandatory sentence	Notreported	37% for victim report at 6 months

Note. Tx = treatment; CTS = Conflict Tactics Scale; CBT = cognitive-behavioral therapy; MCTS = Modified Conflict Tactics Scale.

(45% DVIEP vs. 39% control). These results are consistent with the evaluation of another nonrandomized study that compared a similar police-advocacy intervention that was provided in five police districts with a no-treatment control group of IPV cases in five comparison police districts (Stover, Berkman, Desai, & Marans, 2008).

Summary of victim treatments. Studies of victim interventions reveal higher recidivism rates overall than batterer treatment approaches, regardless of whether victim or official police records are used. Rates ranged from 31% to 44%. It appears that postshelter support and advocacy approaches have short-term impacts that are less effective than mandatory arrest, and none of the other approaches examined to date are effective in reducing subsequent violence.

Couple Treatment for IPV

Couple-focused interventions. Couple treatment studies had the least methodological rigor. Only one study utilized a randomized control condition (see Table 3). The four other studies included in the table compared several types of treatments without a control group. Treatment completion and recidivism rates varied considerably from study to study, with no consistent patterning of findings to explain variability in rates across studies.

As detailed earlier, Dunford (2000) found no group differences for couple treatment, men's CBT, or controls in reducing IPV recidivism for active-duty army personnel. Harris, Savage, Jones, & Brooke (1988) randomly assigned 58 couples to either a multicouple group or individual couple counseling. While only 16% of the 23 couples assigned to the multicouple group condition dropped out, 67% of the 35 couples assigned to individual couple counseling dropped out before completing treatment. For treatment completers, no significant differences in recidivism were found between the two treatments. Overall, a 20% recidivism rate was reported at 6-month follow-up, but given the high dropout rate, between-group comparisons could not be made.

O'Leary, Heyman, and Neidig (1999) assigned 75 volunteer couples to either feminist cognitive-behavioral gender-specific groups or conjoint treatment. Dropout rates were high, limiting the ability of the investigators to compare group outcomes. For treatment completers, violence severity ratings had decreased approximately 50% by posttreatment and were comparably low at 1-year follow up. However, recidivism rates were 74% overall, with no between-group recidivism analyses conducted. A second study examining these two modes of treatment with 49 couples reported notably lower dropout and recidivism rates (Brannen & Rubin, 1996). The sample for this latter study was court referred and limited to men with alcohol use disorders.

Fals-Stewart, Kashdan, O'Farrell, and Birchler (2002) found behavioral couples therapy (BCT) was more effective than individual substance abuse treatment in reducing recidivism for men with comorbid substance abuse and domestic violence, with rates of recidivism at 18% for BCT versus 43% for individual treatment at 12-month follow-up. In BCT, men receive weekly individual and group drug abuse counseling (both of which emphasize cognitive-behavioral anger management and coping skills training). Additionally, males and their female partners meet conjointly for weekly BCT sessions. The BCT sessions, which are described in greater detail by O'Farrell and Fals-Stewart (2006),

are used to (a) help male partners remain abstinent, (b) teach more effective communication skills, and (c) increase positive behavioral exchanges between partners (Fals-Stewart et al., 2002). While not initially developed to target IPV, the CBT portion of BCT includes many of the CBT approaches used in batterer programs. The addition of substance abuse and couples treatment foci appears to have contributed significantly to the lower dropout rate and greater reduction in violence for men participating in this intervention.

Summary of couples treatment. The studies reviewed in this section provide preliminary data to support the efficacy of BCT and multigroup couples interventions for IPV for perpetrators of violence struggling with alcohol and substance use disorders. The efficacy of these approaches when substance use is not identified or addressed has not been consistently supported.

Treatments for Children Exposed to IPV

Child-witness interventions. Studies that measured recidivism as an outcome for child-witness-to-IPV treatments were not found. Instead, four studies were identified that were designed to assess reductions in symptoms of children exposed to violence (see

Table 4). Child-parent psychotherapy (CPP; Lieberman & Van Horn, 2004) was developed to address the needs of preschool children exposed to family violence. It is a 52-week dyadic treatment that integrates modalities derived from psychodynamic, attachment, trauma, cognitive-behavioral, and social learning theories. A randomized controlled trial of CPP for young children exposed to domestic violence resulted in significant reductions in both child and parent symptoms posttreatment and at 6-month follow-up (Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005). In their evaluation, however, Lieberman and Van Horn required the mothers to have ended their relationship with the violent partner, have separate stable housing, and have been clean of substances for 6 months. These exclusion criteria did not allow participation of couples who remained together or those struggling with substance abuse.

Another study of children 6–12 years old who were exposed to IPV compared a 10-week group treatment program for children only (CO) with a 10-week program of combined concurrent group sessions for children and their mothers (CM) and a wait-listed control group. The children's groups provided psy-

Table 2
Interventions for Victims of Intimate Partner Violence

Citation	Sample and N	Treatment (n)	Recidivism measure	Posttreatment follow-up	Significance outcome	Recidivism by group	Treatment dropout	Follow-up attrition
Sullivan et al., 1994	DV shelter; 141	10 weeks ^a of postshelter advocacy (71) or shelter only (70)	Victim report CTS	6 months	No difference between groups; quality of life and social supports improved in both groups	43% experienced further abuse	Not reported	Not reported
Sullivan & Bybee, 1999	DV shelter; 278	10 weeks ^a of postshelter advocacy counseling (135) vs. shelter alone (130)	Victim report CTS	2 years	Intervention group = less violence and less risk for reabuse, but overall significant decrease for both groups	31% intervention vs. 37% control at 2-year follow-up	Not reported	5% at 2 years
Bybee & Sullivan, 2005	DV shelter; 124	10 weeks ^a of postshelter advocacy counseling (71) vs. shelter only (70)	Victim report CTS	3 years	No differences between groups	44% intervention vs. 36% control between 2 and 3 years	Not reported	12% at 3 years
McFarlane, Soeken, & Wiist, 2000	Prenatal clinic; 329	Brief ^b (94) vs. counseling ^c (73) vs. lay outreach ^d (92)	Victim report CTS	2, 6, 12, and 18 months	Outreach decreased violence scores at 2 months postdelivery more than counseling alone, but not sustained at 6-, 12-, or 18-month follow-up	No effect of intervention on elimination of abuse; percentage not reported.	Not reported	21% at 18 months
Davis, Maxwell, & Taylor, 2006	IPV cases in NYC housing projects; 434	DVIEP (police-social worker home visit) vs. control	Police and victim report CTS2	6 months	Significantly more police calls in DVIEP group, but no difference in CTS2 severity	45% DVIEP vs. 39% control based on police report; no victim report provided	All intervention cases received at least one DVIEP home visit	28%

Note. DV = domestic violence; CTS = Conflict Tactics Scale; IPV = intimate partner violence; NYC = New York City; DVIEP = Domestic Violence Intervention Education Project.

^a 4–6 hr/week. ^b Wallet card with resource information. ^c Unlimited access to DV counselor. ^d Unlimited professional counseling plus “mentor mother.”

Table 3
Interventions for Couples in Violent Relationships

Citation	Sample N	Treatment (n)	Outcome measure	Posttreatment follow-up	Significance outcome	Recidivism by group	Treatment dropout	Follow-up attrition
Dunford, 2000	620 IPV couples who were active army	Men's CBT group (168) vs. conjoint group (153) vs. rigorously monitored group (173) vs. control group (150)	Partner and self report MCTS, police and court records	18 months	No differences among groups	29% men's, 30% couples, 27% monitored, 35% control	29%	0% police report; 15% victim report
Harris et al., 1988	58 IPV couples in community	Couples group (23) vs. individual tx (35) vs. wait-listed controls (10) ^a	Partner report CTS	12 months	No significant difference at 6–12 mo follow-up	18% overall	47% total dropout: 16% couples group, 67% individual tx	59%
O'Leary et al., 1999	74 IPV couples	14 sessions of gender-specific group (30 couples) vs. conjoint tx group (44 couples)	Partner report MCTS	12 months	Improvement in marital adjustment, husbands' taking responsibility for aggression in both tx conditions, with no difference between groups in recidivism	74% overall	50% gender specific, 45% conjoint, 47% overall	16%
Brannen & Rubin, 1996	49 IPV couples	Gender-specific group (26) vs. conjoint group (22) ^b	Partner report MCTS	6 months	In couples with EtOH, conjoint treatment was superior, but gains were not sustained in either at 6-month follow-up	8.3% gender-specific vs. 7.1% conjoint	24%	57%
Fals-Stewart et al., 2002	86 IPV couples with alcoholic husband	BCT (43 couples) vs. individual tx (43 individuals)	Partner report of violence	12 months	Lower violence scores in couples tx for pts with comorbid substance abuse	18% BCT vs. 43% individual tx	14%	Not reported

Note. CBT = cognitive-behavioral therapy; MCTS = Modified Conflict Tactics Scale; CTS = Conflict Tactics Scale; BCT = behavioral couples therapy; tx = treatment; EtOH = alcoholism.
^a Couples group was 10 sessions (3 hr each) with same-sex peer group and teaching sessions with both genders; individual treatment was family systems based with an open-ended time frame. Wait-listed controls received treatment after 10 weeks. ^b Gender-specific group was 12 weeks (1.5-hr session twice a week) of Domestic Abuse Project model treatment. Conjoint group received CBT with change, anger, and problem-solving skills.

Table 4
Interventions for Child Witnesses of Intimate Partner Violence

Citation	Sample and N	Treatment (n)	Outcome measures	Posttreatment follow-up	Outcome	Treatment dropout	Follow-up attrition
Lieberman, Van Horn, Ippen, & Ghosh Ippen, 2005	75 preschool child–mother dyads exposed to IPV	Child–parent psychotherapy (42) vs. community treatment–case management (33)	CBCL, SCL–90, CAPS	Posttreatment only	Significant Group \times Time interactions with children's behavior problems, PTSD symptoms, diagnostic status, and mother's avoidance; trend toward decreasing mother's PTSD and general distress at end of 1 year of intervention	Not reported	14% tx vs. 12% comparison
Lieberman, Ghosh Ippen, & Van Horn, 2006	75 preschool child–mother dyads exposed to IPV	Child–parent psychotherapy (42) vs. community treatment–case management (33)	CBCL, SCL–90, CAPS	6 months	Improvement in children's behavior problems and maternal symptoms	Not reported	33% not available for follow-up
Graham-Berman et al., 2007	181 children 6–12 years old exposed to IPV	CO (62) vs. CM (61) vs. wait-listed comparison (58)	CBCL, Attitudes About Family Violence Scale	8 months	CM condition had greatest improvement in externalizing scores, but CO improved compared with wait-listed group at posttest	18%, not randomized	6% intervention vs. 18% comparison
Cohen et al., 2004	237 sexually abused children: 90% PTSD, 58% IPV witnesses	TF-CBT (114) vs. CCT (115)	K-SADS-PL–PTSD, CBCL, CDI, CAPS, CSBI	Posttreatment only	TF-CBT associated with decrease in PTSD symptoms (19% posttest); CCT (46% posttest)	11% of those enrolled attended <2 sessions	12% TF-CBT vs. 10% CCT

Note. IPV = interpersonal violence; PTSD = posttraumatic stress; tx = treatment; CBCL = Child Behavior Checklist; SCL–90 = Symptom Checklist; CAPS = Clinician-Administered PTSD Scale; TF-CBT = trauma-focused cognitive-behavioral therapy; CCT = child-centered therapy; CO = child-only treatment; CM = child-and-mother treatment; K-SADS-PL-PTSD = Kiddie Schedule for Affective Disorders and Schizophrenia—Present and Lifetime Version, PTSD section; CDI = Child Depression Inventory; CSBI = Child Sexual Behavior Inventory.

choeducation about family violence, surveyed children's attitudes about families, and addressed their social emotional adjustment. Mothers' groups focused on parenting competence and understanding the impact of violence on children. This was a community sample, with 17% of the mothers and children still living with the abusive partner. Children whose mothers were seen concurrently showed the greatest reduction in externalizing symptoms (Graham-Bermann, Lynch, Banyard, Devoe, & Halabu, 2007).

A third treatment, trauma-focused cognitive-behavioral therapy (TF-CBT), has been the most vigorously studied and widely disseminated. In a randomized controlled trial with sexually abused children, 58% of whom also had a history of witnessing domestic violence, TF-CBT was associated with significantly better outcomes than supportive child-centered therapy (Cohen, Deblinger, Mannarino, & Steer, 2004). TF-CBT comprises specific modules including psychoeducation; expressing feelings; recognizing the relationship among thoughts, feelings, and behaviors; learning relaxation skills; gradual exposure; cognitive processing of the abuse experience; joint parent-child sessions; and parent management training to address behavioral problems (Cohen et al., 2004). TF-CBT is designed to be provided in 12–18 sessions, and caregiver involvement is important for treatment success.

Summary of child-witness to IPV treatments. Several treatments have shown promising effectiveness data, with conjoint treatment of mother and child being the most effective. These treatments primarily have been implemented with families in which the mother and child were no longer living with the perpetrator, with maternal substance abuse also an exclusion criterion, limiting the generalizability of these treatments in “real-world” settings.

Discussion

Overall, results of this treatment review indicate a lack of research evidence for the broad, long-term effectiveness of many of the most common treatments provided for victims and perpetrators of IPV, including the Duluth model for perpetrators and shelter-advocacy approaches for working with victims of domestic violence. According to partner reports, rates of recidivism in most perpetrator- and partner-focused treatments are approximately 20%–30% within 6 months, regardless of intervention strategy used. This rate is comparable to the rate reported in studies examining the efficacy of mandatory arrest in deterring subsequent family violence.

Much more attention needs to be paid to the question of, “Which treatment for whom?” Blanket policies requiring specific treatment approaches for all male batterers are not effective. Assessment of individual treatment needs would allow for a better fit between individual batterers and their court-mandated treatment. While not initially developed to target IPV, behavioral couples therapy (BCT)—which integrates substance abuse treatment approaches, couples therapy, and CBT coping skills—appears to be an effective strategy for IPV cases in which one or both partners have a comorbid substance use disorder. BCT had the lowest rates of recidivism (18%) and treatment dropout (14%) compared with the other treatments reviewed for batterers. Given the high comorbidity between IPV and substance abuse problems, further systematic evaluation of this sort of integrated treatment approach appears warranted.

Advocacy interventions for victims of IPV result in increased feelings of safety and support and some short-term reductions in violence. Manualized dyadic or concurrent child-parent trauma-focused interventions (e.g. CPP and TF-CBT) have been shown to reduce symptoms in both children and their caregivers. Thus, incorporation or coordination of advocacy for victims and dyadic parent-child trauma-focused treatment, along with batterer intervention, may yield the best overall outcomes for families impacted by IPV. Instead, families are often referred to a variety of providers in multiple settings. The courts may mandate attendance at a batterers' group, substance abuse treatment, and a parenting class for a perpetrator of IPV. Additionally, child protective services may request that the victim-mother attend her own individual treatment and a parenting class, as well as bring her children for their own individual treatments. Often, these services are provided by a variety of agencies in different locations and are not well coordinated. Better integration of treatment approaches in one location (e.g. substance abuse, batterer, and parenting treatment for perpetrators) is needed.

Dropout is a significant problem in most treatment studies for batterers. In substance abuse treatment studies, intervention completion has been increased by incorporating motivational enhancement therapy (MET) techniques (Carroll & Onken, 2005). The goal of MET is to resolve ambivalence concerning whether or not the client has a problem and to increase motivation to change. There are five main strategies to motivational interviewing (Irons, 2006): (a) express empathy, (b) develop discrepancies, (c) avoid argumentation, (d) roll with resistance, and (e) support self-efficacy. Examination of these approaches in IPV treatments is warranted, with the parenting role a potentially valuable focus of MET interventions, as research suggests most batterers report an attachment to their children and an awareness of the negative impact of their violence on them (Baker, Perrilla, & Norris, 2001; Israel & Stover, in press).

Most IPV victims stay with or return to the batterer (Lerner & Kennedy, 2000). If partners separate, visitation is an ongoing issue, with one study finding that preschool-aged children who had limited contact with their previously violent fathers had higher levels of internalizing symptoms than children who had frequent (at least weekly) contact, even after controlling for the severity of violence exposure (Stover, Van Horn, Turner, Cooper, & Lieberman, 2003). Focusing on the perpetrators' role as parents in therapy, in addition to enhancing motivation for treatment, may also help to improve child outcomes. This proposition is supported by the promising results of dyadic treatment approaches in working with mothers and children exposed to IPV (Lieberman et al., 2006), and the efficacy of parent-child interaction therapy when used with physically abusive parents and their children (Chaffin et al., 2004; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002).

Study Limitations

Although every attempt was made to do a thorough review of all available studies, it is possible that computerized literature searches missed relevant research. Given the well-documented “file drawer phenomenon”—the failure to publish negative studies—it can be assumed that the published literature captures only a subset of all research conducted in this area. In addition, implementation of treatment with batterers requires the use of

forensic tools to determine risk, coordination of treatment with the legal system or the child protective services system, and careful incorporation of safety planning to assure the well-being of victims and children. Unfortunately, the breadth of material covered in this review did not permit discussion of these additional important topics relevant in implementing and investigating IPV interventions.

Summary and Closing Remarks

Extant interventions have limited effect on repeat violence, with most treatments reporting minimal benefit above arrest alone. The results of this treatment review indicate a lack of research evidence for the effectiveness of many of the most common treatments provided for victims and perpetrators of IPV, including the Duluth model for perpetrators and shelter-advocacy approaches for victims. According to partner reports, rates of recidivism in most perpetrator- and partner-focused treatments are approximately 30% within 6 months, regardless of intervention strategy used. Emerging data supports the integration of empirically validated substance abuse, couples, and trauma-focused interventions into IPV treatments. However, considerably more work is needed in this area.

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Clarification Notice

We wish to clarify the relationship between “Racial Microaggressions in the Life Experience of Black Americans” by Derald W. Sue, Christina M. Capodilupo, and Aisha M. B. Holder (*Professional Psychology: Research and Practice*, 2008, Vol. 39, No. 3, pp. 329–336) and “Racial Microaggressions Against Black Americans: Implications for Counseling” by Derald W. Sue, Kevin L. Nadal, et al. (*Journal of Counseling and Development*, 2008, Vol. 86, No. 3 pp. 330–338). These two articles are based on the same sample of subjects and set of interviews; however, separate qualitative analyses by different teams of researchers were performed on the transcripts of the interviews. The first study investigated racial microaggressive dynamics, processes, and their detrimental consequences for African Americans, whereas the second study explored the universe of hidden demeaning racial microaggressive themes. In the second article, which did not mention the sample overlap, a few descriptive sentences from the first article, primarily in the Method-section, were repeated verbatim and without citation from the earlier study. We apologize for these oversights.

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