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State Standards for Domestic Violence Perpetrator Treatment: Current Status, Trends, and Recommendations

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We empirically surveyed and analyzed existing standards for the treatment of perpetrators of domestic violence across the United States. Specific areas examined included: presence and scope; administrative entity for certifying; screening and risk assessment protocols; minimum length of treatment; theoretical or conceptual orientation; treatment content; preferred or allowable modalities of treatment; whether research findings are mentioned; methods for revising standards; and minimum education and training required for providers. We examined trends using several methods including comparisons between present and previous survey data (Maiuro et al., 2001). Positive trends were evident including increased use of multivariate models of treatment content, use of an intake assessment prior to treatment, use of a danger/lethality assessment to manage risk, recognition of the need for program evaluation and supportive research, and the requirement of a minimum level of formal education as a prerequisite for providers. We identify specific areas for further research and development and make recommendations for improving existing practice and standards of care.

Keywords: perpetrator treatment standards; state standards for domestic violence; batterer intervention; trends in domestic violence perpetrator treatment

Available research suggests that treatment of perpetrators of domestic violence is an important component of a coordinated community response to domestic violence and abuse (Jackson et al., 2003; Shepard, Falk, & Elliott, 2002). Although there has been considerable debate about the advantages and disadvantages of setting standards for an evolving intervention technology, the overriding need for some form of quality control and monitoring for public health purposes and the need to prioritize the safety of victims has continued to spur such efforts (Campbell et al., 2002; Cattaneo & Goodman, 2005; Coker et al., 2002).

According to previous surveys conducted by Austin and Dankwort (1999) and Maiuro, Hagar, Lin, and Olson (2001), standards development has, in and of itself, been an evolving

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enterprise. Despite the good intentions of such standards, the results of previous surveys have identified nearly as many problems as potential benefits for them (Bennett & Vincent, 2001; Geffner & Rosenbaum, 2001; Gelles, 2001; Hamberger, 2001; Holtzworth-Munroe, 2001; Saunders, 2001; Tolman, 2001). As nearly 7 years have passed since the most recent survey, an updated review and critique appeared timely. The overriding questions were whether and how the field had progressed given the continued upswing of research on domestic violence and the additional years of experience in implementation and management of treatment standards.

METHODS

Existing standards for treatment of perpetrators of domestic violence across the United States were compiled and then empirically analyzed. Several categories of interest were examined including: the presence and scope of the standards across the states; the governing or administrative entity for certifying the standards; required screening and risk assessment protocols; the minimum length of treatment specified; specification of theoretical or conceptual orientation; treatment methods and content; preferred or allowable modalities of treatment; whether research findings were mentioned or endorsed as a basis for development of treatment standards; and methods for revising standards. The minimum education and training required for providers was also included as an area of interest to describe the pool of practitioners targeted for regulation. Given the presumed advantages and benefits of treatment standards, available program evaluation studies examining the actual impact of standards were also summarized.

Survey results were compiled and descriptive statistics computed in terms of response categories. Excerpts were drawn from various state standards for illustration, critique, and discussion purposes. A content analysis of the standards was then performed with regard to existing peer-reviewed research in the field. The results are discussed in terms of the strengths and weaknesses of current standards and trends examined in previous surveys (Maiuro et al., 2001). Where the respective databases permitted, findings were compared *between* the present and previous survey conducted by the current investigator. We also compared percentages *within* the standards in existence at the time of the prior survey versus those developed in the past 6 years. Further research and development areas are identified and specific recommendations are made regarding steps that might be useful to improve efforts that ensure sound practices and good standards of care.

RESULTS AND DISCUSSION

Despite controversies regarding the development of treatment standards, the present survey indicates that standards continue to proliferate. Forty-five states, including the District of Columbia, now have standards and/or regulations governing the treatment of those convicted of or identified as having engaged in violent behavior toward a spouse or intimate partner. There are only five states that do not have such standards: Arkansas, Connecticut, Mississippi, New York, South Dakota, and Wyoming. This number (Figure 1) represents an increase over previous reports of 25 (Austin & Dankwort, 1999) and 30 (Maiuro et al., 2001) based upon surveys conducted between 6 and 8 years ago. One state (California) has more than one set of treatment standards, as some counties in the state have developed

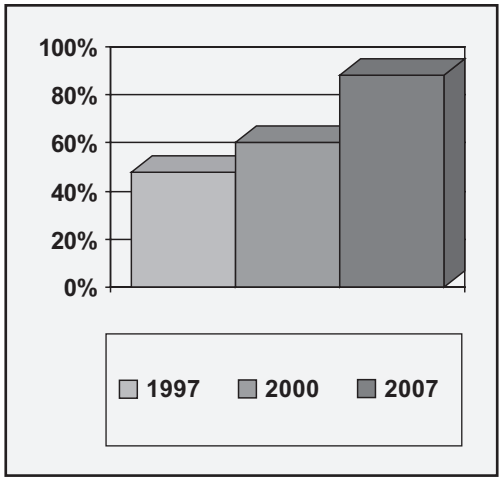

Figure 1. Percentage of states with standards or guidelines.

their own jurisdiction and protocols for handling domestic violence (e.g., San Diego and Santa Clara counties). An exception to the trend of increased proliferation of standards is New York. In contrast to the prior survey, this state no longer has standards or guidelines for such intervention, having withdrawn recognition and regulation of any type of formalized treatment program on an apparent philosophical basis in favor of advocacy for general social change and strict criminalization and associated penalties for perpetrators.

Standards vary according to the administrative bodies involved and the means of regulation. While some states, such as North Dakota, have opted for direct oversight of perpetrator treatment by a Council for Abused Women, most states include representatives from victim programs among a more broadly based and multiagency committee in an attempt to implement a "coordinated community approach" to the problem (65%). These collaborative coalitions consist of key system players such as victim advocates, women's shelter workers, prosecutors, probation staff, and perpetrator treatment providers who serve as an advisory board. In some cases, this group may have been formed as a result of legislative action at local and national levels. As a result, acts of domestic abuse and legal protocols for managing domestic violence may have become codified into legal statutes. Standards for perpetrator treatment, however, may not always be formalized within legal statute, existing instead as a policy or set of guidelines for programs receiving public funding or referrals (e.g., Illinois).

In some cases (12%), the administrative entity is a judicial board (e.g., in Colorado) or another criminal justice body such as the department of corrections (e.g., Georgia, Maine). More states regulate treatment standards through social and health agencies (23%) such as a public health department (e.g., Massachusetts) or a child and family services department (e.g., Florida, Washington, Wisconsin). Standards formally codified in legal statute or administrative code are more likely to be regulated by the courts or social and health services. In instances in which community coalitions regulate the standards, they also include or prioritize the court and social and health systems as key stakeholders. Such regulation is congruent with recognition of domestic violence as a public health concern requiring both social sanctions and behavioral–emotional intervention.

General Scope and Content of Standards

As in prior studies, the scope of current standards continues to vary across states, ranging from general guidelines (Maryland) regarding treatment philosophy, length of intervention, and required safety assessments to detailed descriptions of required theoretical foundation, treatment modality, technique, and content. Congruent with the finding that state standards have continued to proliferate, standards have also continued to expand in scope and detail. Our prior survey revealed a minority of states (27%) providing some direction with regard to treatment approach and content; that number has now increased to a clear majority of states (76%). This increase is not simply a result of states with more recently developed standards being more detailed. Treatment approach and content is not only delineated in most of the 13 states with newly developed standards (75%) but also the clear majority of those previously surveyed (77%).

The treatment philosophy receiving primary emphasis in most state standards (Figure 2) is based upon the conceptualization of domestic violence as an abusive form of power and control (95%). Although some programs list power and control as the sole conceptual framework (27%), the majority include it in combination with some form of social psychological theory (68%). As a result, there is an emphasis upon cultural and patriarchal factors with regard to etiology and intervention.

Social psychological approaches (emphasizing violence-condoning and sexist attitudes, interpersonal and problem-solving skill deficits, and faulty modeling in the perpetrator's family of origin) are ranked second in terms of treatment philosophy. In such cases, they are again usually mentioned in combination with power and control dynamics. Only about 5% of the states surveyed (Colorado and Marine) have adopted a third treatment philosophy, which relies on evidence-based cognitive behavioral models devoid of sociopolitical influences related to power and control.

Although psychological and psychopathology factors (Fitz & O'Leary, 2004; Maiuro, 2001) are recognized as possible contributing influences in some standards, many states forbid the primary use of treatments based upon mental health or "disease" models, psychodynamic theory, impulse control disorders, codependency, family systems, or addiction

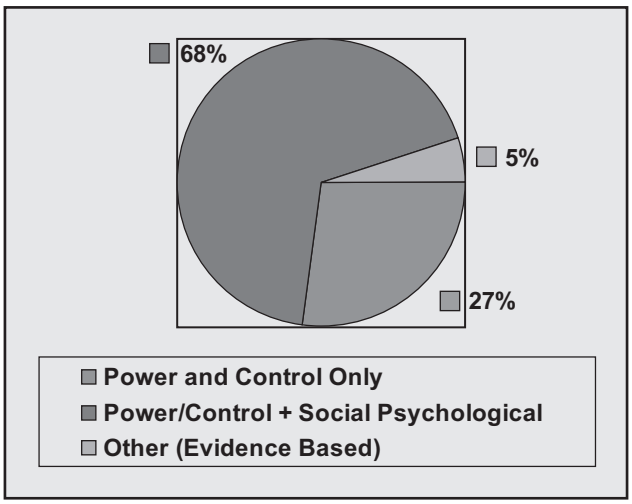

Figure 2. Primary theoretical/conceptual orientation of treatment.

models (35%). The common rationales for limiting the use of such approaches have to do with minimizing the perpetrator's sense of responsibility or potential endangerment of the victim (Hart, 1988). Oregon's standards (Oregon Administrative Rules, 2005, 137-087-0045) illustrate this position by forbidding the following:

> Identifying any of the following as a primary cause of battering: poor impulse control, anger, past experience, unconscious motivations, substance use or abuse, low self-esteem, or mental health problems of either participant or victim . . . Viewing battering as a bi-directional process with responsibility shared by the victim . . . Viewing battering as an addiction and the victim as enabling or codependent in the battering.

In what may be a trend among either newly developed or revised standards, or those formalized in legal code, a number of states describe domestic violence solely in pragmatic and empirical terms without referring to a theoretical model of causation (North Carolina, Oklahoma, South Carolina, Tennessee).

Whatever the conceptual basis put forth to explain domestic violence, virtually all standards require that the treatment provider:

- Prioritize the safety of the victim
- Require that the perpetrator or participant refrain from blaming the victim
- Hold perpetrators solely responsible for their abusive behavior (accountability)
- Have perpetrators understand that they have to learn nonabusive alternatives for resolving conflict
- Help perpetrators learn alternative, nonviolent coping behaviors

Length of Treatment

Survey results (Figure 3) indicated that the recommended treatment duration varies from state to state, ranging from a minimum of 12 weeks (Utah) to 1 year or more (19% of

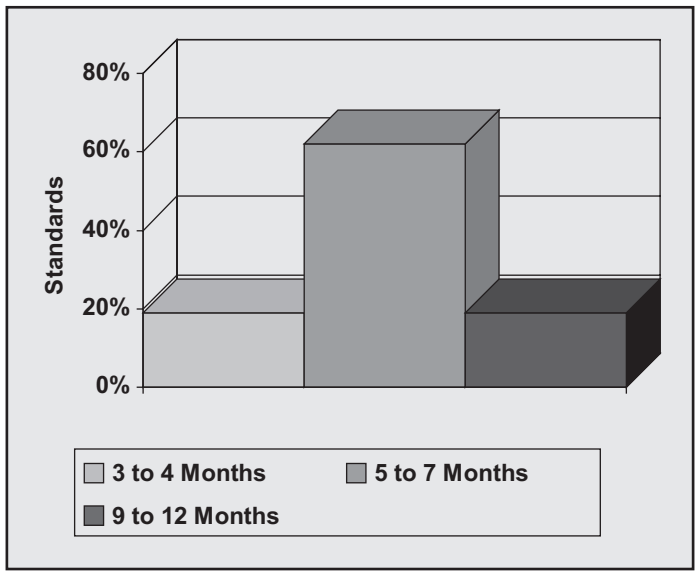

Figure 3. Duration of treatment required.

standards). In a number of instances the period of time goes unspecified in favor of completion criteria defined in the contractual arrangement with the provider. In contrast to our prior survey in which it was noted that the majority of states (77%) surveyed required 16 or more weeks of treatment, the majority of standards (56%) now require a minimum of 24 to 26 weeks. In most cases, the number of weeks specified also refers to the number of sessions of treatment, as a once a week schedule is assumed. The number of hours specified per session ranges from 1 to 2, with many (50%) endorsing a 90-minute session. Thus, the trend has been for required treatment periods to become longer in duration, with the majority of states (62%) requiring a minimum of 6 months. Where longer treatment periods are specified, the prevailing rationale is the need to have a longer time to monitor outcome and intervene in cases of recidivism.

Modalities of Treatment

While the state standards surveyed mention a number of modalities of treatment, 98% of the guidelines now emphasize group therapy as the preferred and primary choice for intervention (Figure 4). Despite the lack of clear outcome data with regard to the superiority of a particular modality of treatment (Murphy, 2001; Norlander & Eckhardt, 2005; O'Leary, 2001; Rosenbaum & Maiuro, 1989), a couple of state standards prohibit the use of individual treatment (5%) and require the exclusive use of group intervention during the course of the program (Georgia, Maine). Some states allow individualized, albeit violence-specific, sessions to be substituted under certain conditions (23%). Delaware allows such sessions when the provider or agency is unable to offer group sessions. Colorado, Hawaii, Massachusetts, Minnesota, South Carolina, and Washington allow provider discretion given an attending evaluation or justification that specifies the need for individual sessions. Only Arizona allows either group or individual sessions, or an eclectic mix, to be offered without the need for explanation.

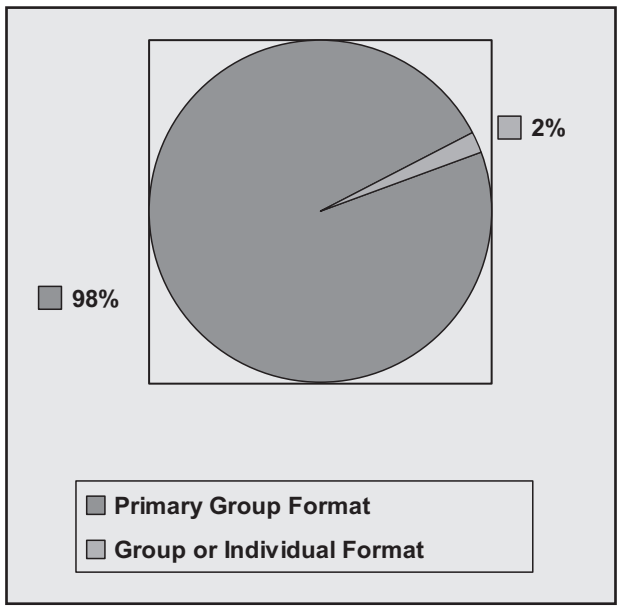

Figure 4. Preferred modality of treatment.

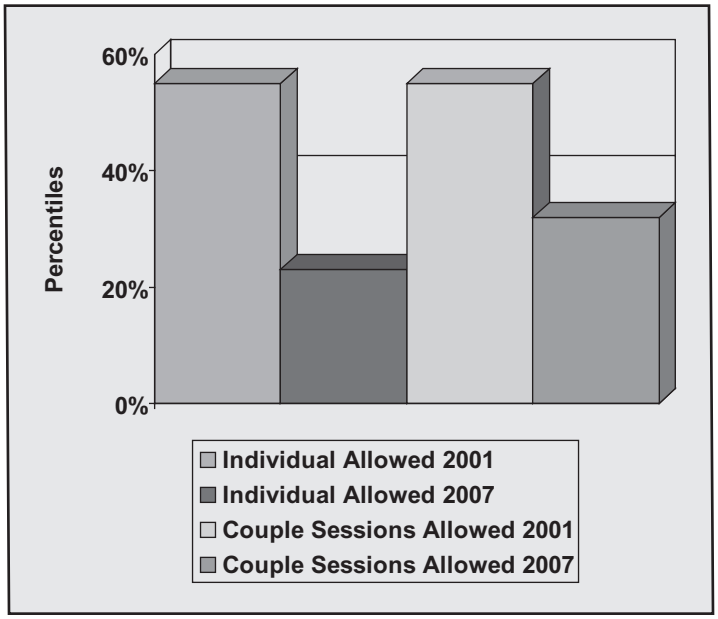

Figure 5. Modalities other than group intervention allowed?

The matter of couples or family therapy modes is much more controversial (Figure 5). In this respect, the discussion does not focus upon preferred modality but "counterindicated" modes of treatment. The majority of states surveyed (68%) explicitly prohibit any type of couples sessions or therapy during the course of the primary domestic violence intervention. The remaining 32% either say nothing to exclude or limit such sessions or allow supplemental sessions to be conducted subject to particular conditions, after a specified period of time, when the perpetrator has been violence-free, and/or when victim's safety is properly assessed and reasonably assured (California, Colorado, Illinois, Kansas, Nevada, Rhode Island, Washington, West Virginia). In some of these cases, the victim or partner may participate in joint sessions with the perpetrator only with the proviso that the sessions not be conducted as traditional couples therapy in which joint responsibility for violence and abuse may be implied or assumed.

Specification of Assessment Requirements

Intake Protocol. The majority of the states (75%) require an intake evaluation or assessment to determine a prospective participant's appropriateness for treatment and/or need for adjunctive services such as alcohol or substance abuse treatment prior to initiating the intervention. Unlike the typical mental health process in which information is solely obtained from the client, a domestic violence initial assessment typically requires a review of police reports or available court documents when the participant has been arrested or charged with a domestic violence offense. Many states additionally require a review of previous contacts with relevant health providers as well as victim input into the assessment process. However, regardless of the intake assessment findings, most states (91%) dictate a uniform course of treatment for all perpetrators. Only three states allow for differential

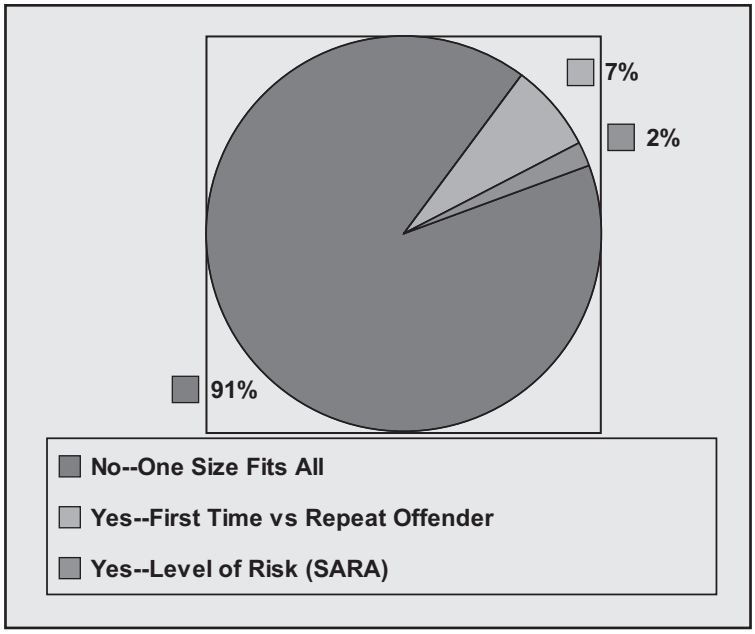

Figure 6. Treatment varied by type of offender?

treatment assignment based upon whether the perpetrator is a first time or a repeat offender (Figure 6). Colorado requires longer treatment for perpetrators identified as high risk through the Spousal Abuse Risk Assessment (SARA) (Dutton & Kropp, 2000; Kropp & Hart, 2000; Kropp, Hart, Webster, & Eaves, 1999).

One primary purpose of state standards is to help ensure the safety of victims of domestic violence (identified most commonly as women and children). Consistent with this goal is the finding that 93% of the standards require some type of victim contact. Only a few states forbid such contact (e.g., New York), arguing that "obtaining and using a victim's report actually undermines the goal of victim safety." This contact must be formally documented by a letter, telephone call, or personal interview in 88% of the standards reviewed. All standards require that the victim information be kept confidential and not be disclosed to or be discoverable by the perpetrator.

The major emphasis on victim contact centers upon issues of notification and risk assessment rather than upon participation in treatment. As indicated previously, most standards limit the conditions under which the victim may be a participant in either couples or conjoint sessions. Most states forbid "required," "mandatory," or otherwise "coerced" participation of the victim by the treatment provider. Alabama further clarifies that victim participation is forbidden even if it is on a "voluntary" basis.

Thus, the purpose of victim contact is limited to a primary emphasis upon notification of the perpetrator's enrollment in the program, compliance, completion, the need for a safety plan, and ensuring that information regarding supportive resources is available to victims. Most standards (85%) have explicit "duty to warn" the victim and police when there is a threat of danger to the victim. Some standards (18%) now inform the victim of treatment limitations so the victim will not assume a false sense of security and safety from further abuse.

Tennessee (Tennessee Department of State, Rules of Domestic Violence State Coordinating Council, 1999, Chapter 0490-1-.05f) is typical of states that describe victim and partner contact as follows:

> Certified programs shall not attempt to act as a service provider to the victims or the current partners of the batterers that they serve. Certified program personnel should make reasonable efforts to ensure that victims of domestic violence with whom they are in contact are referred to appropriate battered women's programs, victim advocates, or programs that are designed to provide victim services . . . Contacts with batterer's victim and batterer's current partner shall accomplish the following:
>
> (i) Inform them of the limitations of batterers intervention programs in assuring their safety (i.e., the possibility of continued danger).
>
> (ii) Inform them of domestic violence resources and services.
>
> (iii) Assist with safety planning and be confidential.

The majority (75%) of the states with standards require a formal risk of danger or lethality assessment (Roehl & Guertin, 2000). In comparing states with more recently adopted standards (86%) with those previously surveyed (69%), the trend is for more recently developed standards to have explicit attention to risk factors. The protocol usually requires the provider to collect information on a list of factors felt to be associated with risk for injury or lethality (such as homicidal thinking, suicide attempts, or frequency of abuse) and/or to obtain prior histories of relationship abuse, violence, and other general criminal behaviors (Arizona). Review of the content in risk assessment reveals that about a third (35%) of the states specifically identify many of the risk factors reported by Hart (1988) and Campbell (1995) as factors associated with a greater likelihood of danger or lethality. As such, the factors are empirically based but usually combined in some nonstandardized fashion. These factors include:

- Threats of homicide or suicide
- Fantasies of homicide or suicide
- Possession, access, and/or past use of weapons
- Imminent or recent separation/loss of partner and/or children
- Belief that victim has no right to life separate from him/her (i.e.—"Death before divorce," "If I can't have you no one will," and "You belong to me and no one else.")
- Obsessive preoccupation with partner evidenced by stalking or violation of no contact orders
- Idolization and extreme dependence on victim
- Inability to envision life without victim or separation from victim causes great despair and/or rage
- Experiences acute depression and sees little hope for moving beyond depression
- Dangerous behavior increasing with little apparent regard for consequences
- Access to victim and children
- Alcohol and/or drug abuse
- History of prior violence, prior calls to police, and hostage-taking

Colorado standards are unique in that they call for a standardized measure of intimate partner violence, the Spousal Assault Risk Assessment (SARA) developed by Kropp, Hart, Webster, and Eaves (1999).

Despite the association between particular psychiatric/psychological diagnoses such as clinical depression and personality disorders (borderline, narcissistic, and antisocial)

to domestically violent behaviors (Fortunata & Kohn, 2003; Lawson et al., 2003; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988), only about half of the standards (55%) require that a mental health assessment or screening be conducted with the perpetrator. Although there is a trend for more of the recently developed standards (64%) to require evaluation of mental health issues over the previously reviewed standards (50%), only a few states (e.g., California–San Diego County, Nevada) specify or recommend the use of standardized measures of psychopathology as part of the screening protocol.

Screening for alcohol and substance abuse problems is required in most standards (63%). In keeping with clinical research literature indicating that substance abuse, particularly alcohol, can be associated with a greater likelihood of domestic violence and more severe abuse (Thompson & Kingree, 2004), there is a trend suggesting that more recently developed standards (71%) are more likely to include such provisions than standards developed and reviewed previously (58%). Many states (e.g., Illinois, Washington) also specify that group members must be free of alcohol or drugs during the course of treatment sessions. As in the case of mental health screening, only a few states specify or recommend the use of standardized measures of alcohol or drug addiction as part of the screening protocol (e.g., Nevada).

Confidentiality and release of information policies are explicitly addressed in most existing state standards (78%). There appears to be a trend toward a greater degree of attention to such legal and ethical process as evidenced by the fact that a higher percentage of recently developed standards (93%) attend to such matters as a condition of treatment than those previously reviewed (69%). There are differences, however, in how this matter is handled across states. Only a minority of states provide privacy regarding treatment similar to that assured in traditional mental health settings (20%). Most standards (68%) require the participant to sign a release to allow contact with the victim and relevant court officials as a condition of treatment. Such limitations in confidentiality are justified in terms of issues of victim safety, criminal-justice system compliance, and the need for accountability by participants. In line with a coordinated community response intervention model, some states allow only very limited confidentiality (Georgia, Ohio, New York, Washington), requiring a written release to a host of community service agencies that go beyond the customary victim and court system contacts. Such agencies not only include prior providers but also the police, child service agencies, and victim advocates. New York additionally requires that domestic violence groups be open to direct monitoring by representatives of the standards development committee. Only half (50%) of the states require a formal written treatment contract between the participant and the provider beyond the issue of confidentiality.

Most of the states have adopted a comprehensive definition of domestic violence and abuse beyond simple acts of physical violence and assault. Thus, domestic violence is addressed as a recurring pattern of behavior consisting of abusive behaviors that include acts of general physical, sexual, verbal, and various forms of psychological and financial abuse toward adult intimates, children, pets, and property. The goals and outcomes specified clearly involve the cessation of violence in the domestic relationship. In some cases, the cessation of "controlling behavior" is also identified as an index of progress or success.

The area where state standards appear to differ relates to the theoretical approach and attending methodology that should be employed to effect these changes. An analysis of current standards indicates that most states (67%) recognize that domestic violence is determined by multiple factors with an attending need to intervene in multiple areas. There also appears to be a trend toward requiring multifaceted intervention protocols. Whereas 59% of

the state standards reviewed currently allow for a treatment focus beyond power and control dynamics, 79% of the more recently developed standards currently allow and require more expanded content. Thus, although the theoretical preamble may emphasize sociocultural power and control dynamics as the primary area of concern, treatment content may focus upon a variety of psychological, communication, and coping deficits in at least one or more areas beyond power and control in two-thirds of the standards reviewed.

For example, Virginia's standards (Virginia Standards for Batterer Intervention Programs, 2007, p. 9) describe the goals of intervention as being "the cessation of batterers' coercive, dominating, violent, and abusive behavior." The content areas of intervention for accomplishing these goals may include a focus upon a variety of areas including both power and control and anger dynamics:

- Identification of all forms of physical, emotional, economic, sexual and verbal abuse, and violence
- Impact of domestic violence on the victim and the abuser
- Impact of domestic violence on children, including children who are abused and children who witness domestic violence
- Emphasis on the responsibility of the batterer for his violence and abuse
- Identification of personal, societal, and cultural values and beliefs that legitimize and sustain violence and oppression
- Alternatives to violence and controlling behaviors
- Identification of healthy relationships
- Promotion of accountability, self-examination, negotiation, and fairness
- Examination of the relationships between mental illness and domestic violence
- Identification of the behavioral, emotional, and physical cues that precede escalating anger

Nevada's standards (Nevada Domestic Violence Treatment Standards, 2000, p. 15) are even more broad-based in content, not only requiring the treatment provider to focus upon power and control dynamics but also:

> Family of origin intergenerational patterns that model and transmit violence as a taught and learned behavior, the use of time-outs to help curb impulsive violence, stress management, conflict resolution strategies, communication skills training, skills for improving intimacy in relationships, guilt and shame issues, as well as identifying danger signs of relapse behavior and how to prevent it.

Although the remaining one-third advocate a strict focus upon power control dynamics, a particular protocol such as the Duluth Model (Pence & Paymar, 1993) is not explicitly named, although the content of treatment is very similar to this approach.

A common theme apparent in standards that restrict program content to power and control dynamics is the issue of what type of emphasis should be placed upon anger as a target of treatment. As in the previous survey (Maiuro et al., 2001), much discussion on this topic takes the form of a debate regarding the motivation for domestic violence, with some proponents suggesting that a focus upon anger detracts from the abuser's accountability for power and control tactics he uses to dominate women.

A number of standards explicitly and understandably disapprove of anger management as the primary focus or sole explanatory model of domestic violence treatment (Alabama, Arizona, Florida, New Hampshire, North Carolina). However, at least one state (West

Virginia, Batterer Intervention Prevention Programs in West Virginia, 1992) goes so far as to prohibit anger management as part of a batterer's intervention:

> "Anger management" theory and methods are never appropriate for use in batterer intervention services as they do not accurately reflect the cause of battering and are a reflection of the batterer's desire to camouflage his choice to batter. Further, anger management theory suggests provocation, fails to account for premeditation, diffuses responsibility, implies that there is a quick fix, misrepresents the depth of the problem in the community, and fully misses the link to the larger issue of sexism and patriarchy.

Despite these claims, when one examines the research literature it becomes clear that arguments for the exclusion of anger, such as those appended to the New Hampshire standards, have little or no documented empirical basis. In fact, there appears to be strong empirical support for a focus upon anger as a component of intervention in a significant percentage of domestically violent men. In this respect, not only have significant levels of anger and hostility been found to be characteristic of domestically violent men across samples but also with a variety of different measures (Boyle & Vivian, 1996; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Hanson, Cadsky, Harris, & Lalonde, 1997; Hershorn & Rosenbaum, 1991; Maiuro, 1996; Maiuro, Cahn, & Vitaliano, 1986; Maiuro et al., 1988; Margolin, John, & Gleberman, 1988; Norlander & Eckhardt, 2005).

Some of the debate in this area appears to be due to confusion regarding the differences between state anger (situationally provoked or experienced) and trait anger (a general tendency to respond to events with anger regardless of presence of provocation). In this regard, it is important to note that research data supporting the presence of anger problems in batterers have never been interpreted to suggest that the "victim" is to blame for this anger by somehow provoking the perpetrator's angry and violent behavior. Rather, current findings support the presence of anger as a perpetrator trait associated with negative reactivity, limited coping and conflict resolution skills, and negative family of origin influences such as abuse-related trauma. Moreover, as increased attention focuses upon psychological and emotional forms of abuse in domestically violent relationships, few clinical researchers would question the role of anger in psychological and emotional abuse, verbal attacks to self-esteem, and threats to harm.

Similarly, there is no sound empirical support for the use of "rage release" methods as an appropriate intervention technique for addressing anger in perpetrators of domestic violence. Thus, 38% of existing standards forbid the use of ventilation strategies such as punching pillows, hitting with batakas, and other cathartic methods because they inherently encourage the use of aggressive behavior to resolve conflict.

Despite the general consensus that children are negatively affected by domestic violence, state standards for perpetrator treatment are quite limited in requirements focused upon assessments or interventions for children in the family. Less than half of the states (41%) require that children be discussed during the intake process. In comparing the previous states surveyed (41%) to the newer states with standards (40%), it would appear that no change has occurred that would include children as topics to cover during the intake assessment process.

A greater number of standards (63%) include focus upon children in the curriculum content. In comparing the previous standards surveyed (58%) to the sample of more recently developed standards (73%), there is an increased emphasis on making sure that strategies focused on the negative effects of abuse upon children are occurring as supported by research (Cunningham, 2003; Gewirtz & Menakem, 2004; Lee, Kotch, & Cox, 2004; Tajima, 2002). Only about a quarter of the states (22%), however, cover other types of

negative or abusive parenting behavior during the interventions. There has been no change when comparing previous survey states (23%) with the newer states (20%) in that regard.

Kansas (Kansas Coalition Against Sexual and Domestic Violence, 2001) is an example of a state that emphasizes children in both its theoretical overview and curriculum requirements as follows:

> Children who grow up in violent homes have higher risks for behavioral problems, including suicide, substance abuse, and juvenile delinquency; boys who witness battering are more likely to batter their female partners as adults than boys raised in nonviolent homes . . . Each program shall have specific written curriculum, which includes . . . Identification, discussion, confrontation and change of abusive and controlling behavior to victims, including partner and children . . . Identification and discussion of the effects battering has on victims, including children who witness such violence. The short- and long-term effects of abuse and violence are to be presented . . . The goal of these exercises shall be to build empathy . . . Identification and practice of cooperative and nonabusive forms of communication, positive communication skills, long-term solutions, and responsible ways of treating partners, children, and others.

Training requirements for "facilitators" or treatment providers vary, but almost half of the states (40%) specify a bachelor's degree in a human services field and a specific number of hours of instruction or experience in the area of domestic violence. Another 15% of the states (California, Kentucky, North Dakota, Utah, and Washington) indicate that professional licensure, usually at master's level or above, is required. The remaining states (33%) do not have specific educational requirements but require training and experience working at a domestic violence agency. Where mentioned, supervisor requirements are generally higher, requiring either a master's degree (20%) or several years of experience (generally ranging from 2 to 8 years).

As the field evolves, there appears to be a trend toward requiring more formal education as a minimum prerequisite for the work. While most standards still do not require the minimum of a bachelor's degree to be credentialed (40%), the figure of 40% that do represents a significant increase when compared to our prior survey (20%). However, the development of domestic violence perpetrator treatment specialization continues to remain outside the domain of any particular health care degree or professional discipline. As Illinois states, "Professional degrees alone do not guarantee these basic competences, as most college and university curricula do not adequately address domestic violence issues." The competences required of staff include general interpersonal skills, knowledge of human behavior, and specific knowledge about domestic violence with specified hours of specialized training. All states require staff to be violence free (usually for 2 to 3 years prior to employment) and not abusing alcohol or using illegal drugs. Some states (45%) further specify continuing education requirements with these requirements reported in numbers of hours ranging from 8 to 20 per year. Recertification is generally required every 2 to 3 years.

As in our prior survey, the majority of standards (75%) are composed without authoritative references or documentation for the positions taken regarding practice. Of the 25% that include references, half of the standards have references that are quite dated (over 10 years ago) or limited in number (three or fewer citations). Although not as frequently observed as in our prior survey, there continue to be a few instances where the lack of references by the assertion of certain positions as "known facts" or "absolutes" without clear basis. The area in which this mainly occurs involves an unconditional exclusion of a particular approach or treatment content. For example, Vermont (Vermont Statewide Standards for Domestic Abuse Intervention, 2005) states:

> It is important to emphasize that modalities traditionally used in the mental health field, which are excellent for dealing with a wide range of problems, are not appropriate for batterer programs. These modalities include stress management, anger control, psychotherapy, couples counseling, communication skills building, mediation and conflict resolution.

West Virginia (West Virginia Coalition Against Domestic Violence, 1992) states: "Dr. David Adams and other reputable batterer experts now report that less than 5 to 10 percent of batterers have poor impulse control or an anger problem; rather it is, as mentioned above, a planned pattern of coercive control."

Although the need for further research or program evaluation was rarely observed during our previous review of standards, a third of the existing standards (33%) now mention program evaluation and/or research as a desirable activity. However, despite enhanced recognition of such efforts as instrumental to the development of the field, only a few standards (18%) require actual data collection related to the effectiveness of the programs or promote the development of research on new or innovative methods of intervention.

Below are some states that endorse the development of research or program evaluation to help determine best practices and the efficacy of domestic violence intervention.

- Colorado's standards (2005) explicitly state that the Domestic Violence Offender Management Board, created in July 2000 by the legislature, makes a commitment to continuing to "explore the developing literature and research on the most effective methods for intervening with domestic violence offenders and to identify best practices in the field."
- North Carolina (2004) requires quarterly reports of completion rates, reasons for termination of participants, and program impact including reoffense rates.
- Ohio (1998) also has a monitoring structure to examine program impact specifically through recidivism rates; the Ohio Domestic Violence Network also publishes "The Self-Evaluation Tool for Batterers Intervention Programs," which is a question-and-answer resource guide that provides program evaluation rationales and strategies based upon a review of existing research.
- Virginia (2007) in its rationale recommends that data collection and research occur to improve the interventions.

Although Alabama (2001) standards do not require a specific evaluation methodology to determine program effectiveness, the following strategies are suggested:

- Obtaining records of arrest, after completion of the program, of participants for an act of domestic violence
- Issuance, after completion of the program, of protection orders restraining participants from acts of domestic violence
- Revocation of probation due to reoffense with present or future partner
- Consideration of subsequent convictions for acts of domestic violence
- Obtaining information, after completion of the program, from a domestic violence shelter identifying a perpetrator who has participated in the program
- Submitting perpetrator evaluations of the program to a neutral party
- Evaluating program effectiveness by way of reports on the percentage of perpetrators who complete the program and the percentage who are dismissed or who fail to complete the program

Also noteworthy are Oregon and Texas provisions to explicitly allow clinical research testing of new modes or comparative methods of treatment, improved methods of case

management, or "best practice" demonstration projects as long as there is a documented protocol for due diligence and protections for victim safety.

There has only been one published study to date examining the impact of treatment standards. A 3-year "ecological" study in the state of Illinois was guided by three questions: (a) How have the standards affected the way intervention programs deliver services to men who perpetrate domestic violence? (b) How have the standards impacted community efforts to prevent violence? (c) How have the standards affected judicial sentencing for domestic violence?

The study focused upon changes at the system rather than individual level. Both quantitative and qualitative data were collected from local victim services programs, the local courts, as well as treatment programs. The evaluation research documented that the Illinois state standards do, in fact, affect the way batterers programs deliver services in that the required content and methods were specifically mentioned as components of treatment by both providers and recipients. However, the primary mechanism by which Illinois standards most affected the treatment programs was requiring, and thus facilitating, formal linkage to victim service agencies and the court system. Another interesting development was the creation of new "dual diagnosis" intervention programs in response to the requirement that both substance abuse and violence and abuse issues be addressed. These outcomes are consistent with the emerging trend away from viewing the contribution of perpetrator treatment programs as stand-alone efforts but as critical elements of a broader community response to the prevention and/or reoccurrence of violence (Gondolf, 1997; Gondolf, 2002; Maiuro & Avery, 1996).

CONCLUSIONS AND RECOMMENDATIONS

Development of standards for treatment of perpetrators of domestic violence has continued to proliferate with a significant increase in the number of states having standards or guidelines. The advantages of having such standards (Table 1) include extending the priority of victim safety beyond customary victim support networks and an overloaded court system to include specialized treatment providers directly involved with assessment, monitoring, and intervention with the perpetrator; an attempt to encourage, through required interdisciplinary contacts, a more coordinated community systems approach to intervention; an attempt to establish quality control and precautionary guidelines in a treatment area with above average risk management concerns; and formalized recognition of domestic violence perpetrator treatment as a specialty that requires training and experience not

TABLE 1. Positive Trends in Standards Development

- Despite Theoretical Basis, Most Treatment Protocols Are Now Multivariate in Content
- More Standards Now Require Intake Assessment Before Treatment
- More Standards Now Require Danger/Lethality Assessment to Help Manage Risk
- Increased Recognition of Need for Program Evaluation and Research
- Some Standards Now Require Collection of Standardized Data Sets
- Increase in Minimum Level of Education Required for Treatment Providers

routinely offered or adequately subsumed in the training curriculum of many social and health care professions.

There is also a clear trend for the scope of standards to become broader and more detailed in terms of dictating the principles, preferred modality, and required content of treatment. This particular area has precipitated most of the controversy in the field. Some clinical researchers have questioned whether such dictates are premature and without valid underpinning and empirical support. This debate has been so intense that at least one state (Maryland) adopted general operational guidelines related to victim safety and case management rather than detailed standards regarding modality, length of treatment, and program content (Murphy, 2001). Concurrent with this position was the appointment of a research task force to gather research and use empirical data to inform a best practices approach to intervention.

As in the case of our prior survey, the majority of standards currently reviewed were composed without authoritative references or, on occasion, very dated sources to document the positions taken regarding practice. It should be noted that the absence of references does not necessarily mean that the standards were composed without consulting the literature. However, it is likely that the burden of proof required for developing policy may be less informed and critically based when the need to substantiate or document a position by empirical data and reliable sources is absent. Without this documentation comes increased risk of repeating clinical lore, the "woozle effect," the use of factoids or unsubstantiated assumptions about the causes and correlates of domestic violence, overgeneralization of limited findings to all cases, as well as premature dismissal of potentially useful treatment strategies on the basis of feared but empirically unexplored side effects (cf. Maiuro et al., 2001). The inclusion of an established researcher familiar with the rapidly growing body of domestic violence literature on the standards development committee (along with the usual array of victim support, perpetrator treatment, and criminal-justice personnel) may improve the quality of the database for standards development.

On a positive note, there appears to be evidence of more integrative thinking and fewer instances of blatant misinformation in the current sample of standards. Although there continues to be a primary emphasis upon sociocultural factors related to power and control theory as the preferred explanatory framework for domestic violence, the clear majority of standards now include a focus on multifaceted and interdisciplinary content. Such practice would be in keeping with research literature that supports multivariate rather than single-factor models of domestic violence. This would argue for an inclusive rather than exclusive approach to treatment guidelines (Hamberger, 1996; Maiuro & Avery, 1996), if for no other reason to address the diversity of profiles present in samples of domestically violent men.

In what may be a trend among either newly developed or revised standards or those formalized in legal code, a number of states describe domestic violence solely in pragmatic and empirical terms without referring to a theoretical model of causation. This approach could be further enhanced if there were clear directives requiring the provider to develop a client-centered intervention plan informed by the specific intake assessment data of the case rather than a "one-size-fits-all'' approach entirely based in preconceived theory. In this respect, there are current advances in instrument development that could allow the treatment provider to assess the degree to which such factors as relationship-specific power and control dynamics, trait anger, jealousy, and assertiveness skill deficits may operate in the individual case and fashion an intervention plan accordingly (Hamel & Nicholls, 2006; Maiuro, Cahn, & Vitaliano, 1986; Maiuro, Vitaliano, & Cahn, 1987; Mathes & Severa, 1981; Spitzberg, 2006).

Thus, although the process and regularity by which standards are updated and revised is not always clearly articulated, the present survey indicates that such evolution is taking place. This progress is evident in several areas including recognition of the need for multiple targets of intervention in most standards, an increase in the number of standards that require formal assessment and intake protocols, greater attention to danger/lethality assessments to help manage risk to victims, increased recognition of the need for program evaluation and empirical research to advance the field, and an increase in the minimum level of education required for treatment providers. There is also evidence that more recently developed standards are somewhat better articulated in these areas than those initiated earlier. Thus, there appears to be noticeable improvements in the art of providing guidelines for treatment providers if not the science of conducting more effective treatment, per se.

Despite evidence of positive trends in the development of standards, there are many areas that could be updated, enhanced, and better informed by current research and existing instruments (Table 2). Since victim safety is the primary goal of standards of care, it is gratifying to see that most standards now require some type of risk assessment to help determine the level of danger present in a particular case. In most instances, the list of criteria is empirically based and relatively thorough. However, the reliability of such assessments may be limited by the use of nonstandardized checklists and assessment protocols (Dutton & Kropp, 2000; Roehl & Guertin, 2000). It is also unclear exactly what sources should be employed by the provider for obtaining this data (e.g., direct perpetrator report, supplemental information from the victim, existing records). Victim perceptions and input can be very important in efforts to determine the risk of reassault (Campbell et al., 2003; Gondolf & Heckert, 2003). Only one state standard (Colorado) uses a standardized risk assessment protocol with clear instructions regarding the preferred source and systematic weighting of individual criteria, the SARA (Kropp, Hart, Webster, & Eaves, 1999).

It is also a concern that greater attention during the assessment and treatment process is not focused upon the well-being of children potentially exposed to domestic violence. Despite trends toward greater attention to victim safety through increased use of risk assess-

TABLE 2. Recommendations for Improving Standards

- Formalize Procedures for Regular Updates and Revision
- Expand Standards Committee to Include Researcher Familiar With Current DV Literature
- Improve Risk Assessment by Using Standardized Checklists, Enhanced Focus Upon Parent/Child Issues, Partner Pregnancy, and Pet Abuse
- Enhance Screening and Referral for "Dual-Diagnosis" Issues of Alcohol/Drug Abuse and Mental Health Problems (Depression, Personality Disorder)
- Expand Theoretically Conceived "One Size Fits All" Treatments to Allow Client-Centered, Evidence-Based Multivariate Content and Case Management
- Establish Victim-Safety Sensitive Protocols for Allowing and Evaluating New Treatments, Treatment Variance, Expanded Modalities, Innovative Case Management Strategies
- Develop Systematic Program Evaluation Protocols
- Develop Modified Standards for Women Perpetrators, Military, Gay and Lesbian, and Minority Populations

ments, attention to children's issues has lagged behind, with child abuse assessment and parenting issues attended to by only a minority of treatment standards. Available research indicates there is considerable risk for concomitant child abuse in cases of domestic violence (Herrenkohl et al., 2004; Lee, Kotch, & Cox, 2004; Margolin & Gordis, 2003; Pittman & Lee, 2004; Tajima, 2002), a variety of psychological impacts in cases where direct physical abuse may be absent (Bancroft & Silverman, 2002; Gewirtz & Menakem, 2004), and the eventual possibility of intergenerational transmission of domestic violence (Cunningham, 2003; Ehrensaft et al., 2003). Even in cases that progress to marital dissolution, assistance may be necessary to help foster a healthy partnership-in-parenting and guard against parental alienation of the child by the abuser or, in some cases, a victim who may be suffering from unresolved emotional trauma (Mertin & Mohr, 2002). There also appears to be a disconnect between nearly all of the standards reviewed and the existing and growing literature showing heightened risk for violence, serious injury, and a host of health concerns for women who are abused during pregnancy (Martin, Mackie, Kupper, Buescher, & Moracco, 2001).

Pet abuse is also conspicuous in its absence from nearly all standards for assessment of perpetrators of domestic violence. Although specified and defined clinically by early investigators as part of the cluster of abuse behavior (Rosenbaum & Maiuro, 1989), this type of abuse has not received the attention it deserves. Available evidence suggests that pets may be appropriately considered family members (Albert & Bulcroft, 1988; Triebenbacher, 1998), are commonly identified by women who seek shelter as additional victims of maltreatment (Ascione, Weber, & Wood, 1997), and may be considered markers for increased risk of serious and injurious forms of abuse among the women and children sharing a household with them (Maiuro, Eberle, Rastaman, & Snowflake, 2008). Treatment standards could benefit from enhanced assessment and case management protocols in this area as well.

As previously mentioned, domestic violence perpetrator treatment continues to be a specialty requiring training and experience not routinely offered or adequately subsumed in the training curriculum of many social and health care professions. However, it is equally important to realize that there is overlap among domestic violence, mental health, and alcohol/drug abusing populations as well as the technologies needed to serve them. Although domestic violence is more appropriately and productively viewed as a public health problem, there is considerable data suggesting that psychological assessment of personality disorders (Fortunata & Kohn, 2003) and clinical levels of depression (Maiuro et al., 1988; Vivian & Malone, 1997) may be important in determining level of risk, process of treatment, and case management needs for a considerable number of cases. Adjunctive psychopharmacological treatments by collaborating mental health professionals may be critical to achieving effective outcomes in such cases (Maiuro & Avery, 1996). Existing standards could benefit from routine and upgraded screening protocols and the addition of mental health and alcohol/drug abuse professionals to the coordinated community approach emphasized in many standards (Thompson & Kingree, 2004; Vivian & Malone, 1997). Moreover, it could be argued that attention to these issues should be mandatory since these issues have been empirically associated with risk of dropout, risk of reoffense, and greater levels of injury (Dowd, Leisring, & Rosenbaum, 2005; Heckert & Gondolf, 2005). The potential value of "dual-diagnosis" programs is ripe for further research and program evaluation and can be instrumental in evolving more effective treatments for higher-risk and difficult cases.

Another positive development seen in the current review of standards is increased recognition of the need for program evaluation and research to evolve the field. Although such efforts are endorsed in only a number of states to date, the fact that some standards now

require the collection of standardized datasets is encouraging. The State of Illinois study validates that treatment standards can help foster a systematic and coordinated community response to domestic violence (Bennett & Vincent, 2001).

Despite the geometric increase in research activity related to domestic violence in recent years, the field remains young and is in need of further research related to intervention and outcome. Most of the research to date is descriptive and related to etiologic vulnerabilities and characteristics rather than to process or outcome. Only recently have investigators begun to conduct qualitative studies to explore key variables and experiences that have led some perpetrators to modify their attitudes and behavior related to domestic violence and abuse (Silvergleid & Mankowski, 2006). Moreover, other than the well-established study of "treatment dropouts," there is little research focused on actual "treatment amenability," failures, or methods that decrease the risk for negative outcomes. Clearly, more research is needed with regard to these critical issues to provide a relevant database for practice and intervention.

Based on the current state of the art and science, few practitioners would argue that the preferred method or cure for domestic violence has been proven or discovered. Given this reality, one might question whether the paradigm for perpetrator treatment is sufficiently developed to warrant detailed dictates regarding preferred modes of treatment or to preclude others. The clinical consensus on the advantage of group modalities has left the merits of both individualized therapy and safety-guided, conditional use of couple-based methods relatively ignored and in need of further investigation. In this sense, one wonders whether the original intent of guidelines to help ensure the safety of victims has been overextended to areas of practice that are premature to regulate. If safety permits, and until otherwise "known," it may be important to preserve flexibility in methods for purposes of consumer choice, diversity of programming, and creative evolution of treatment technology. In this respect, it would seem appropriate for all standards to follow the lead provided by Oregon and Texas in establishing victim-sensitive safety protocols for allowing new treatments, treatment variance, expanded modalities, and innovative case management strategies to be conducted and evaluated.

Present standards are also limited by the fact that they are largely based upon research and clinical studies involving male-to-female violence in heterosexual and civilian populations. Although available research suggests considerable similarity and overlap with respect to patterns, vulnerability, and risk factors for domestic violence and victimization across populations, there is a need for further work delineating the special needs and modifications of existing standards for female perpetrators (Hamberger, 2005), military service personnel (Campbell et al., 2003; Marshall, Panuzio, & Taft, 2005; McCarroll, Ursano, Fan, & Newby, 2004), gay and lesbian (Renzetti & Miley, 1996), and cultural minority groups (Asbury, 1999).

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