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The Effectiveness of Intervention Programs for Perpetrators and Victims of Intimate Partner Violence

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In this review, we provide a descriptive and detailed review of intervention programs for intimate partner violence (IPV) perpetrators and survivor-victims. Given the extensive personal, interpersonal, and societal costs associated with IPV, it is essential that services being offered by the criminal justice, mental health, and medical communities have requisite

ONLINE TABLE: Detailed summaries of the 39 studies reviewed in this article can be found in the table available online at http://www.springerpub.com/pa. Click on the link to "The Partner Abuse State of Knowledge Project" and go to Topic 15 in the online document.

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empirical support to justify their implementation. The review involved a detailed summary of all studies published since 1990 using randomized or quasi-experimental designs that compared an active intervention program to a relevant comparison condition. These studies included 20 studies investigating the effectiveness of "traditional" forms of batterer intervention programs (BIPs) aimed at perpetrators of IPV, 10 studies that investigated the effectiveness of alternative formats of BIPs, 16 studies of brief intervention programs for IPV victim-survivors, and 15 studies of more extended intervention programs for IPV victim-survivors. Interventions for perpetrators showed equivocal results regarding their ability to lower the risk of IPV, and available studies had many methodological flaws. More recent investigations of novel programs with alternative content have shown promising results. Among interventions for victim-survivors of IPV, a range of therapeutic approaches have been shown to produce enhancements in emotional functioning, with the strongest support for cognitive-behavioral therapy (CBT) approaches in reducing negative symptomatic effects of IPV. Supportive advocacy in community settings has been shown to reduce the frequency of revictimization relative to no-treatment controls, although rates of revictimization remain alarmingly high in these studies. Brief interventions for victim-survivors have had more complex and less consistently positive effects. Several studies have found significant increases in safety behaviors, but enhanced use of community resources is often not found. It remains unclear whether brief safety interventions produce longer term reduction in IPV revictimization. Discussion summarizes the general state of knowledge on interventions for IPV perpetrators and victim-survivors and important areas for future research.

KEYWORDS: intimate partner violence; treatment; review; brief intervention; cognitive-behavioral therapy; treatment effectiveness

Given the alarmingly high prevalence of intimate partner violence (IPV; e.g., Black et al., 2011) and the serious physical, psychological, and interpersonal consequences experienced by victims of such abuse (Golding, 1999), it is critical to examine the effectiveness of attempts to rehabilitate IPV offenders, prevent recurrent abuse, and alleviate suffering experienced by survivors. Over the last 35 years, both in the United States and in many other parts of the world, increasing efforts have been made to criminalize IPV; mandate psychosocial rehabilitation for offenders; and provide safety, support, and counseling for victims. This review provides a detailed analysis of empirical research on the effectiveness of interventions designed to reduce and end perpetration of IPV and increase victim well-being and safety. The review covers, in sequence, traditional or standard psychosocial intervention programs for IPV perpetrators; novel or unconventional interventions for IPV perpetrators; and counseling, therapeutic, and advocacy interventions for IPV victims.

PRIOR REVIEWS OF THE INTERVENTION EFFECTIVENESS: PROGRAMS FOR IPV PERPETRATORS

Overview

Programs for perpetrators of IPV, often labeled *batterer intervention programs* (BIPs) or *abuser intervention programs* (AIPs), have been a topic of empirical investigation for about 25 years. While such programs share the broad goals of reducing levels of IPV and promoting victim safety, there is considerable variability in intervention methods and approaches. Many programs employ an open admissions group format, with one to two counselors facilitating group discussion and activities. Clients are predominantly referred by the criminal justice system, and program length varies widely (e.g., from 8 to 52 weeks). Traditionally, most programs are grounded in a feminist analysis of IPV. From this perspective, the patriarchal nature of social arrangements and social institutions supports male domination of women within the domestic sphere, justifying any means necessary, including physical violence, to reinforce male power, control, and privilege (e.g., R. Emerson Dobash & Dobash, 1979). This conceptual framework is reflected in the current dominant approaches to IPV perpetrator interventions as represented by programs such as the Duluth model (Pence & Paymar, 1993), and EMERGE (Adams, 1988).

The social and historical analysis of IPV has been instrumental in formulating the philosophy, structure, and goals of perpetrator intervention. Since IPV is seen as an outgrowth of normal male behavior and socialization, programs rely on a gender reeducation model rather than psychotherapeutic models that identify individual causes of violence such as behavioral deficits, trauma, or psychopathology. Traditional IPV interventions presume that violence reduction is best achieved by exposing patriarchal/misogynistic attitudes, encouraging accountability and personal responsibility for coercive tactics in relationships, and promoting gender-egalitarian attitudes and behaviors. Despite extensive debate on the core assumptions of this approach (e.g., Dutton & Nicholls, 2005; Straus, 2011), most existing intervention programs as well as state laws and guidelines that regulate IPV intervention espouse key aspects of feminist perspectives on IPV etiology and intervention (Maiuro & Eberle, 2008).

Many approaches to IPV intervention reflect a hybrid integration of feminist analysis and cognitive-behavioral therapy (CBT). These approaches maintain that IPV is associated with cognitive distortions and faulty attitudes and beliefs. A more therapeutically oriented CBT framework expands the range of treatment targets beyond patriarchal socialization to include additional factors that have been associated with IPV in empirical research. These factors include emotion dysregulation, cognitive distortions, and relationship skills deficits (e.g., Dutton, 1986; Feazell, Mayers, & Deschner, 1984; Saunders, 1984; Sonkin, Martin, & Walker, 1985). These approaches are more clearly based on cognitive therapies for psychopathology (e.g., Beck, 1976) that achieve the goal of behavior change through a collaborative therapeutic relationship, exposure and disputation of distorted cognitions, problem solving, relationship

skills training, and emotion regulation. The CBT programs for IPV perpetrators have continued to develop over the last 20 years and have been widely applied (e.g., Hamberger, 1997; Murphy & Eckhardt, 2005; Stosny, 1995; Wexler, 2006). However, it is important to note that, despite clear differences, both traditional approaches such as the Duluth model and more therapeutically oriented CBT programs often label themselves as "CBT" in their orientation and purport to achieve the goals of violence reduction via cognitive modification.

Prior Literature Reviews

The earliest empirical studies of IPV interventions emerged in the late 1980s (Dutton, 1986; Waldo, 1988). Since this time, our review uncovered only six randomized clinical trials of standard IPV perpetrator interventions. Most BIP evaluation research has been nonexperimental or quasi-experimental in nature. For example, in a qualitative review of the BIP effectiveness literature published in the *Journal of the American Medical Association*, Wathen and MacMillan (2003) found that only *1 of 10 studies* were of sufficient quality to produce unbiased results, noting that "there is an urgent need for additional research using rigorous designs to test the effectiveness of IPV interventions on important clinical outcomes" (p. 598). In an influential review of psychological treatments that may be harmful to clients, Lilienfeld (2007) noted that BIPs are in wide usage despite minimal effectiveness research, leaving open the possibility that BIPs may be potentially harmful to at least some clients.

Prior reviews have noted difficulties in arriving at clear and unequivocal conclusions regarding BIP effectiveness because of widespread shortcomings in research design, inconsistencies in definition and monitoring of the active components of interventions evaluated, and limitations in the breadth of clinical outcomes assessed and the methods used to assess them (Eckhardt, Murphy, Black, & Suhr, 2006). Even the most generally sympathetic reviews of the BIP effectiveness literature (e.g., Gondolf, 2004) note the problematic state of this research area. The accumulated research on BIP efficacy has been summarized in several prior reviews, with variable conclusions (for a more detailed overview, see Murphy & Ting, 2010). Four quantitative reviews of the BIP effectiveness literature have been published since the late 1990s and are briefly summarized in the following text.

Davis and Taylor (1999) published the first review of BIP effectiveness. They restricted inclusion to only those studies with a relevant comparison group, thus excluding single condition pretest–posttest studies in which many factors other than intervention can explain change over time. After identifying a small number of studies (five) that met their inclusion criteria, Davis and Taylor calculated an average effect size in the small-to-moderate range ($h = .41$). They concluded that the overall effect of BIP on preventing IPV was positive while noting the lack of randomized designs, high attrition rates, and lack of uniformity of follow-up assessments as critical problems for the field to address.

Babcock, Green, and Robie (2004) reviewed 22 studies that used quasi-experimental or true experimental designs and police or partner reports of violence recidivism and found that the effects of BIP on violence cessation were small, with effect sizes ranging from $d = .09$ to $d = .34$. No differences in effect sizes emerged across treatment types, suggesting that despite nominal differences in treatment labels, the actual treatments themselves may borrow extensively from other modalities and have similar content. While there was some evidence suggesting an inverse relationship between the strength of research design and the observed effect size, this trend was not statistically significant. Overall, the Babcock et al. meta-analysis suggested that standard BIPs exert only a minimal "program effect" on IPV reduction, equating roughly to a 5-percentage point reduction in violence recidivism. However, they urged caution in interpreting these findings given the methodological limitations of the studies reviewed.

Feder and Wilson (2005) also used meta-analysis to review BIP effectiveness studies. They included only randomized experiments and quasi-experimental studies that established initial equivalence between groups via matching or use of statistical controls. Feder and Wilson's analysis of the 10 studies that qualified for inclusion indicated that among experimental studies, BIP had no overall effect on victim reports of physical violence ($d = .01$) and small-to-moderate effects on official reports of spousal assault ($d = .26$). Among quasi-experimental studies, BIP had a small (but nonsignificant) *iatrogenic* effect, leading to *higher* levels of violence recidivism by victim report ($d = -.11$) and official reports ($d = -.14$) relative to no-treatment comparison groups. Quasi-experiments comparing treatment completers to dropouts revealed a different picture, with substantially less recidivism among completers than dropouts using official reports of spousal assault, resulting in a large observed effect size ($d = .97$). However, these latter results cannot reliably isolate the effects of intervention versus other offender or situational factors on violence recidivism because program dropouts likely differ from completers in many ways other than treatment exposure (e.g., motivation to change, fear of legal consequences). Efforts to control for such differences statistically are limited by inadequacies in the ability to conceive and measure factors that might explain differences in outcome for dropouts versus completers. Overall, Feder and Wilson expressed little optimism about the effects of BIP on recidivism, noting that "at this point, the existing evidence cannot ensure that these programs are, in fact, helpful and not harmful" (p. 257).

More recently, Smedslund, Dalsbo, Steiro, Winsvold, and Clench-Aas (2011) reviewed the results of only the most rigorous BIP evaluation studies. Six randomized clinical trials of BIP effectiveness, all of which were conducted in the United Stated, were included in their review. Only one of the six studies included in the review (Taylor, Davis, & Maxwell, 2001) showed a statistically significant effect of BIP on IPV recidivism. It is also important to note that the findings of that trial have been questioned by others, including the original study authors (e.g., Maxwell, Davis, & Taylor, 2010). Across all studies reviewed, the effect sizes were heterogeneous, and among those studies comparing BIP to a no-treatment control, the effects

on recidivism were small and equivocal. The authors concluded that the evidence base for BIP remains unclear:

> The research evidence is insufficient to draw conclusions about the effectiveness of . . . interventions for physically abusive men in reducing or eliminating male violence against female partners. This does not mean that there is evidence for no effect. We simply do not know whether the interventions help, whether they have no effect, or whether they are harmful. (Smedslund, Dalsbo, Steiro, Winsvold, and Clench-Aas, 2011, p. 12)

Thus, despite the substantial public health and safety burdens associated with IPV, the extensive criminal justice costs of IPV, and the promise offered by abuser interventions, the empirical status of BIPs is decidedly uncertain. As noted by Murphy and Ting (2010), no matter which review one accepts as the most definitive, the effects of standard interventions for IPV perpetrators are far weaker than we would like. As a result, it is important to comprehensively examine the evaluation research on traditional interventions to better understand the nature and heterogeneity of program effects. It is also important to examine new and innovative approaches to abuser intervention that emerged in response to the equivocal and often discouraging results of traditional interventions. This review seeks to accomplish both of these goals.

PRIOR REVIEWS OF THE INTERVENTION EFFECTIVENESS: PROGRAMS FOR VICTIM SURVIVORS OF IPV

Our search revealed several systematic reviews of research on interventions for victims of IPV. The first published review provided information on nine investigations (Abel, 2000). Although positive change was reported for some supportive interventions in variables such as self-esteem, overall the results of early investigations were quite mixed. While providing no general conclusions about the efficacy of interventions for IPV victims, Abel (2000) identified many limitations in methods and design. Most notably, only one of the nine studies had a control group.

Subsequently, Wathen and MacMillan (2003) conducted a systematic review of controlled research on interventions for perpetrators and victims of IPV. Their review was geared to a medical audience and focused on interventions to which primary health care providers might refer patients. They selected intervention studies with outcomes focused on abuse revictimization and factors thought to reduce risk for revictimization, such as social support and safety behaviors. They identified 11 studies examining four different intervention approaches. Overall, they argued that the research was inadequate to draw conclusions about the efficacy of shelter services, prenatal counseling, or vocational counseling for IPV victims. However, their conclusions regarding postshelter advocacy (e.g., Sullivan & Bybee, 1999) were more encouraging,

> Among women who have spent at least 1 night in a shelter, there is fair evidence that those who received a specific program of advocacy and counseling

> services reported a decreased rate of reabuse and an improved quality of life. (Wathen & Macmillan, 2003, p. 589)

A subsequent review by Stover, Meadows, and Kaufman (2009) examined all intervention studies for IPV that used random assignment to conditions, had at least 20 cases per condition, and examined IPV as an outcome. They identified only three victim intervention studies that met these criteria. These studies examined a community advocacy intervention for battered women leaving shelter (Sullivan & Bybee, 1999), a prenatal clinic intervention (McFarlane, Soeken, & Wiist, 2000), and a police–social service outreach program (Davis et al., 2006). Stover and colleagues concluded that postshelter advocacy produces short-term effects on violence revictimization and that the other interventions have not been shown to reduce revictimization. The limited scope of their review raises questions about the appropriate outcome variables in interventions for IPV victims. Although revictimization is a very important outcome, it focuses on behavior of the perpetrator, which may not readily change with intervention for the victim. Therefore, it is also important to consider other intervention goals, including the reduction of negative effects of abusive victimization, enhancement of personal and emotional functioning, and change in proximal risk variables, such as employment, independent living, and safety behaviors.

Several other reviews have focused on IPV interventions within medical contexts, typically considering the effectiveness of screening or assessing clients for IPV as well as interventions that may follow a positive screen. One early review by Ramsay, Richardson, Carter, Davidson, and Feder (2002) identified six intervention studies, none of which was a randomized controlled trial. They concluded that the research designs were weak and the findings inconclusive, specifically indicating "other than increased referral to outside agencies, little evidence exists for changes in important outcomes such as decreased exposure to violence" (Ramsay et al., 2002, p. 314).

Similarly, Anglin and Sachs (2003) reviewed the research literature on screening for IPV in emergency room (ER) settings. They concluded that 1%–7% of female ER admissions seek emergency services as a result of IPV, and that ER screening for IPV is feasible and increases detection rates. Nevertheless, they argued that the research was insufficient to make a strong case in favor of, or against, screening. Notably, these authors found no studies examining the effects of ER screening on morbidity, mortality, health status, or incidence of repeat violence exposure. They located only one study (Muelleman & Feighny, 1999) that examined an ER-based advocacy intervention (this study is summarized and reviewed later in this article).

O'Reilly, Beale, and Gillies (2010) reviewed the research literature on screening and intervention for IPV in pregnancy care. They identified eight publications representing four distinct investigations of intervention program efficacy. All of the studies used an intervention model developed by McFarlane and Parker (1994) and several compared it to a minimal intervention involving a note-sized card with a list of community resources. Three of the four projects were randomized experimental designs. These reviewers concluded "there was mixed evidence that the counseling

intervention was better than the resources card, no evidence that counseling was superior to standard care, and little evidence to show that mentoring was superior to counseling" (O'Reilly et al., 2010, p. 199).

In summary, prior reviews of interventions for IPV victims have been hampered by notable limitations, including the small number of available studies, limitations in research design and quality, highly limited target populations, and restrictive focus on revictimization as the key or sole intervention outcome. Unlike most prior research syntheses in this area, this review includes both brief interventions (most of which were conducted in medical contexts) as well as more extended interventions (most of which were conducted in the community or counseling service settings). In addition, our review is not only restricted to revictimization as the outcome but also examines intervention effects on symptoms that commonly result from IPV victimization (e.g., posttraumatic stress disorder [PTSD] and depression), factors presumed to influence ongoing risk for victimization (e.g., safety behaviors), and other important aspects of personal growth and change (e.g., self-esteem, social support, resource use).

GOALS OF THE CURRENT REVIEW

Consistent with the overall goals of the Partner Abuse State of Knowledge Project, the goal of this review is to provide an up-to-date, descriptive synthesis of research on the effectiveness of interventions for perpetrators and victims of IPV. Considerable emphasis is placed on presentation and descriptive summary not only of the main study findings but also the specific methodological details for each investigation reviewed. Important caveats and study limitations are also considered. The goal is to provide a concise overview of the state of knowledge in this area that we hope will be of considerable use to practitioners, policy makers, and researchers.

METHOD

Literature Search

Articles considered for inclusion in this review were identified via a two-stage search process that involved (a) a search of electronic databases for research articles meeting inclusion criteria (see in the following text) and (b) manual review of article reference sections. Several electronic databases were reviewed, including PsycINFO, PubMed/MEDLINE, Sociological Abstracts, LexisNexis Academic, and the Cochrane libraries. Relevant articles were found using multiple search terms in various combinations (intimate partner violence, IPV, abuse intervention, dating violence, partner violence, dating abuse, partner aggression, treatment, etc.) filtering out non–English language studies, dissertations, and non–peer-reviewed articles.

Batterer Intervention Program Studies. The initial search on interventions for perpetrators returned 660 articles. Two authors reviewed the titles and abstracts to retain

relevant articles. Following this initial search, electronic or paper copies of the articles were retrieved and reviewed and included if the study met the following criteria:

1. The study included one or more intervention condition for perpetrators of partner-directed abuse or violence. *All* intervention participants must have been identified as perpetrators; that is, universal interventions that may have included some perpetrators and nonperpetrators were not included. The participants could be seeking treatment voluntarily and/or as a result of a court mandate.
2. The study included one or more clearly identified comparison group in an experimental or quasi-experimental design. Nonexperimental, single-sample, pretest posttest, or posttreatment only designs, and studies comparing treatment dropout to treatment completers, were excluded because of the substantial internal validity threats posed by such designs.
3. Single-group, pretest–posttest studies were only included if they used multivariate statistical methods to reduce selection effects, such as instrumental variables analysis or propensity score matching.
4. Studies must have included at least one measure of violence recidivism (via police and/or partner report).
5. Studies were included if published in 1990 or later, unless they were deemed "significant" studies (per editorial guidelines).

Once an initial pool of studies was found to meet the review criteria, their reference sections were reviewed for additional relevant articles. As a result of these search and selection processes, 30 studies examining interventions for perpetrators of IPV were included in the current review.

Victim Intervention Studies. The initial electronic search returned 1,509 articles. Titles and abstracts were reviewed to identify potentially relevant articles. Following this initial search, articles were retained for this review if they met the following criteria:

1. The study included one or more intervention conditions targeting individuals with a reported history of IPV victimization, which could include physical assault, psychological/emotional abuse, and/or sexual abuse from an intimate partner. Studies that recruited diverse samples of family violence victims (e.g., victims of child abuse, partner abuse, and elder abuse) or participants not specifically identified as having a history of IPV victimization (e.g., all women in a prenatal clinic) were excluded.
2. The study included one or more clearly identified comparison group in an experimental or quasi-experimental design. Nonexperimental, single-sample, pretest–posttest, or posttreatment only designs, and studies comparing treatment dropout to treatment completers were excluded because of the substantial internal validity threats posed by such designs.

3. The study included one or more outcome variables in one or more of the following categories: partner abuse revictimization, behaviors thought to reduce revictimization risk (e.g., safety behaviors, community resource use), common symptomatic effects of partner abuse (e.g., PTSD, depression), and/or other important hypothesized indicators of change or recovery (e.g., self-esteem, self-efficacy, social support).
4. Studies were excluded if the outcome variable(s) focused solely on provision of intervention services or changes in providers' behavior (e.g., studies of screening protocols in which discussion of abuse and referral to services were the primary outcomes were excluded).
5. Studies examining legal system interventions that did not contain a specified counseling, therapeutic, or advocacy component were deemed outside the scope of this review, and thereby excluded. More specifically, studies of protection orders, arrest policies, and prosecution practices were excluded; studies involving an advocacy or counseling intervention conducted in concert with normal police visits or legal assistance were included.
6. Studies were included if published in 1990 or later, unless earlier research was deemed a "significant" study (per editorial guidelines).

Once an initial pool of studies was found to meet the review criteria, their reference sections were reviewed for additional relevant articles. As a result of these search and selection processes, 31 studies examining interventions for victims of IPV were included in the review, 16 examining brief interventions and 15 examining more extended interventions.

Abstraction of Data

Four of the authors (CE, CM, RS, & KW) abstracted all study data. All study information and results were checked and confirmed by a senior author (CE or CM).

RESULTS

We discuss the results of the review according to the type of intervention study. Accordingly, we divide our discussion of research articles across four areas: (a) traditional interventions for IPV perpetrators ("traditional BIP"), (b) alternatives to traditional BIP services ("alternative BIP"), (c) brief counseling or advocacy interventions for victim survivors of IPV (with a total planned duration of contact less than 3 hr; "brief victim interventions"), and (d) extended counseling and advocacy interventions for victim survivors of IPV (intervention containing more than 3 hr of contact; "victim interventions").

Traditional Batterer Intervention Programs

Samples. There were large variations in study sample sizes. The median sample size across the 20 studies was 367 (range: 59–17,999), and the mean sample size

was 1258.20 (*SD* = 828.22). Of the 20,829 participants assessed in the 20 studies reviewed, 91.3% of participants were court ordered to BIP (*n* = 19,010) and 8.7% were classified as volunteers (*n* = 1,819). All studies examined male IPV offenders only. See online Table 1 for more details on the studies reviewed.

Interventions. Of the 20 studies in this category of BIP, the active treatment condition evaluated was the Duluth/feminist psychoeducational model (i.e., "Duluth") in 14 studies, a more therapeutically oriented version of CBT intervention in 4 studies (Dunford, 2000; Dutton, 1986; Morrel, Elliott, Murphy, & Taft, 2003), a culturally focused CBT group for African American males in 1 study (Gondolf, 2007; relative to two traditional Duluth groups), and a somewhat unspecified anger management–focused group in 1 study (Chen, Bersani, Myers, & Denton, 1989). The two large-scale program evaluation studies by Babcock and Steiner (1999) and Bennett, Stoops, Call, and Flett (2007) included outcomes from males attending several intervention formats but were listed in the Duluth category because most BIPs in these jurisdictions used this format. Two pre-1990 studies were included in this review because they were deemed to be significant in the development of CBT interventions (Chen et al., 1989; Dutton, 1986).

To examine the relative effectiveness of a given active treatment condition, researchers used four different comparison group construction strategies. A no-treatment control group was used in nine studies (45%), another active BIP condition was used as a comparison in seven studies (35%), a non-BIP intervention (e.g., incarceration) was the comparison group in two studies (15%), and a dropout comparison group using a statistical control procedure (e.g., instrumental variables analysis) was used in two studies (15%).

For active intervention conditions, all 20 studies used a group format to present intervention materials. Not all studies reported on intervention length (here we refer only to the curriculum portions of the intervention). Of the 17 studies reporting this information, the mean number of sessions was 22.2 (range = 8–52). Of the 8 studies, providing information regarding session duration, each intervention session lasted an average of 118.1 min (range = 75–180 min).

Study Design. Of the 20 studies in this category, 8 studies (40%) used some form of randomized design and 12 studies used a quasi-experimental design. Of the 8 randomized trials, 7 were randomized at the individual level (including one that randomized dyads to treatment or control), and 1 study used randomized clusters of individuals.

Eight studies compared a single intervention condition to a single no-intervention control/comparison group, four studies examined two intervention groups relative to a no-intervention control, three studies compared the effectiveness of two active intervention conditions (omitting a no-treatment control group), two studies compared three active interventions relative to a single no-intervention control/comparison group, and three studies compared three interventions to a no-comparison/control group.

Outcome Data. Primary outcomes were partner-reported instances of IPV (1/20 or 5%; Jones & Gondolf, 2002), and some combination of criminal justice records and self-/partner-reported IPV (19/20 or 95%). Fifteen of the 20 studies examined criminal justice records for rearrests solely related to IPV (i.e., battery, assault with a deadly weapon, willful infliction of injury on cohabitant, violation of protective order, criminal threats, burglary, vandalism, stalking). Four studies examined criminal justice records for reoffense related to any violent behavior, including non–partner-related interpersonal violence, drug-related charges, and other criminal activity, in addition to the IPV charges listed earlier (Babcock & Steiner, 1999; Bennett et al., 2007; Labriola, Rempel, & Davis, 2008; Rempel, Labriola, & Davis, 2008).

There was a wide range of follow-up time points during which recidivism measures were collected to assess BIP effectiveness. All studies conducted some form of follow-up assessment that ranged from 0 to 54 months posttreatment (median follow-up period = 18 months). All 20 studies conducted posttreatment follow-up assessments for a period of at least 6 months. Eleven studies employed self-reported or partner-reported instances of IPV as either primary or secondary measures of recidivism and collected data prior to treatment, immediately following treatment, and again at given posttreatment follow-up intervals. Nine studies relied entirely on criminal record data as their measure of recidivism and only collected data at posttreatment follow-up intervals.

There was also considerable variation in study retention rate. The median retention rate at the last point of follow-up for partner-/self-reported recidivism was 61% (range = 25%–100%), and 100% (range = 74%–100%) for criminal justice records. The median retention rate immediately posttreatment for partner-/self-report measures was 76% (range = 51%–100%, based on four studies reporting only this outcome). The median retention rate at the 6-month posttreatment follow-up period across 6 studies was 58% (range = 48%–86%) for partner-/self-report measures and 100% (no variation) for criminal arrest records across 3 studies. The median retention rate at the 12-month posttreatment follow-up period across 7 studies was 45% (range = 25%–82%) for partner-/self-report measures and 100% (range = 98%–100%) for criminal arrest records across 11 studies. The median retention rates at the 18-month follow-up period across 3 studies were 46% (range: 38%–78%) for partner-/self-report measures, and 87% (range = 84%–100%) across 5 studies for criminal arrest records.

Effectiveness. In discussing outcomes, our goal is not to repeat all of the information presented in the Tables, but to highlight the most important and relevant findings.

Of the 20 studies examining the effectiveness of traditional BIPs, 9 studies reported statistically significant differences in recidivism rates between the active treatment and a no-treatment control group or matched dropout comparisons. Of these, 7 studies used a Duluth-based BIP as the active treatment and 2 used a CBT-based BIP. Thus, of the total number of traditional intervention studies examining each primary mode of intervention (14 Duluth and 4 CBT), half of each category reported that the active intervention was associated with significantly less IPV at follow-up relative

to a no-treatment control group. Of the two remaining studies that did not neatly fit into the Duluth or CBT frameworks, one showed a small effect for an unspecified CBT-related treatment (Chen et al., 1989) and the other indicated no differences in post-BIP recidivism rates among the active culturally focused intervention relative to Duluth model comparison groups (Gondolf, 2007). Of the studies showing significant differences favoring the active treatment, 8 of 9 used quasi-experimental research design strategies; only 1 study used a randomized design.

However, of these nine studies finding a significant effect of BIP on IPV risk reduction, three studies present with important methodological flaws that prohibit unequivocal interpretation of results. The Russell Dobash, Dobash, Cavanagh, and Lewis (1996) evaluation consisted of only 13% of offenders charged with violence toward a partner in the study time frame. No information was provided about how this sample was derived, leaving open the likelihood of selection biases affecting study outcomes. In addition, precious little information was provided about the nature of the intervention or follow-up data collection. The Palmer, Brown, and Barrera (1992) randomized trial had numerous methodological concerns, including the provision of no information about how the sample was derived, use of widely varying criteria for follow-up assessments, and use of only official records as follow-up data. Importantly, while there appeared to be an effect of treatment, the authors did not find a significant association between the number of sessions attended and reoffending, suggesting that other factors external to the intervention may have contributed to study outcomes. The randomized trial by Taylor et al. (2001) also had several irregularities, many of which were highlighted in a reanalysis of their data by Maxwell et al. (2010). While a relatively large number of cases had their treatment assignment overridden by judges, a more troubling finding concerned the nature of the significant effects. That is, similar to Palmer et al., although there was an effect of being assigned to a BIP on lower levels of IPV, there was no evidence that attendance at the BIP was responsible for the positive outcomes. While more men completed an 8-week version of the BIP than the original 26-week version, those in the 8-week BIP had recidivism rates equivalent to the control group (i.e., the lowest rate of reoffending was observed in the 26-week group). Thus, the effect observed in Taylor et al. may be one of violence suppression caused by criminal justice supervision rather than a "program" effect related to the elimination of violent or criminal behavior via BIP programming.

Six studies using a no-treatment control group or statistically controlled dropout sample reported no significant differences in recidivism rates between males assigned to BIP versus those in control conditions. Five of six studies reporting no effect of treatment examined Duluth-type programs, either alone or in combination with judicial monitoring (e.g., Rempel et al., 2008); a single study found no significant differences in IPV recidivism between a men's CBT group and a no-treatment control group (Dunford, 2000). Of studies reporting no effect of BIP on recidivism, four of six (66.7%) used a randomized design. Of these, one study appears to have methodological irregularities that prevent clear interpretation. The randomized trial reported by Feder and Dugan (2002) had a small number of cases subject to judicial

override regarding the treatment condition assigned (3.5%). In addition, there was substantial attrition at follow-up assessments; only 30% of partners were retained at the 6-month post-BIP follow-up and 22% at 12-month follow-up.

Six studies examined an active BIP condition relative to another active treatment. These comparisons involved traditional Duluth versus a longer version of Duluth (Coulter & VandeWeerd, 2009); Duluth versus racially homogeneous Duluth versus a culturally focused African American group (Gondolf, 2007); CBT versus couples treatment versus monitoring (Dunford, 2000); a Duluth versus self-help versus combined; BIP with consistent versus gradual judicial monitoring (Labriola et al., 2008); and Duluth versus a process-psychodynamic group (Saunders, 1996). *Each study failed to find significant differences between/among groups regarding IPV recidivism at follow-up*. Most studies did not provide sufficient data to indicate whether the treatments being compared were individually effective in preventing IPV, an analysis that would require either a no-treatment control group or a completer-dropout comparison using a relevant statistical matching procedure. Those studies that included such comparisons did not find significant differences between active treatments and control conditions (Dunford, 2000; Labriola et al., 2008). Studies in this section used predominantly randomized designs (5 of 6; 83.3%).

Alternative Batterer Intervention Programs

Ten studies met criteria for inclusion for this review but examined interventions other than the Feminist/Duluth or therapeutic CBT models. See online Table 2 for important details regarding each study.

Samples. As with traditional BIPs, there were large variations in study sample sizes for alternative BIPs. The median sample size across the 10 studies was 116 (range = 78–684), and the mean sample size was 245.87 (SD = 227.13). Of the 2,458 participants assessed in the 10 studies reviewed, 71.2% of participants were court ordered to BIP (n = 1,882) and 18.8% were classified as volunteers (n = 761). All studies examined male IPV offenders only.

Interventions. Of the 10 studies in this category of BIPs, half examined a supportive or motivational enhancement/stage of change-based active treatment. There were important variations in the content of these interventions. Three studies examined whether a small number (one or two) of motivational enhancement sessions could enhance outcomes as a pre-BIP intervention (Musser, Semiatin, Taft, & Murphy, 2008) or as a brief intervention designed to encourage additional change/help seeking (Mbilinyi et al., 2011; Woodin & O'Leary, 2010), whereas 2 studies incorporated stages-of-change and motivational interviewing/enhancement principles into the broader 4- or 6-month treatment program (Alexander, Morris, Tracy, & Frye, 2010; Scott, King, McGinn, & Hosseini, 2011). Three studies examined variants of couples' therapy (Brannen & Rubin, 1996; O'Leary, Heyman, & Neidig, 1999; Stith, Rosen,

McCollum, & Thomsen, 2004), 1 study evaluated a case management–based intervention (Gondolf, 2008), and 1 study evaluated a combined substance abuse and IPV intervention (Easton et al., 2007).

Unlike studies of traditional BIP, researchers investigating alternative BIPs delivered the intervention in various formats. A group format consisting of individual offenders and/or couples was examined in five studies (Alexander et al., 2010; Brannen & Rubin, 1996; Easton et al., 2007; O'Leary et al., 1999; Stith et al., 2004), a nongroup couple/dyadic approach was used in one study (Stith et al., 2004;), and an individual approach was used in three studies (Gondolf, 2008; Mbilinyi et al., 2011; Musser et al., 2008). A combined individual–dyadic method was used by Woodin and O'Leary (2010). Four studies compared a single intervention condition relative to a single no-intervention control/comparison group; one study included two intervention groups relative to a no-intervention control; and five studies compared the effectiveness of two intervention conditions (omitting a no-treatment control group).

Study Design. Of the 10 studies, 9 (90%) used some form of randomized design and 1 used a quasi-experimental cohort design. Of the 9 randomized trials, 5 randomized individual to treatment conditions and 4 randomized cluster of individuals to conditions.

Outcome Data. Self-reported instances of IPV were the sole outcome measure for two studies (Mbilinyi et al., 2011; Scott et al., 2011), and six studies combined partner-reported and self-reported IPV occurrence to assess IPV outcomes (Alexander et al., 2010; Easton et al., 2007; Musser et al., 2008; O'Leary et al., 1999; Stith et al., 2004; Woodin & O'Leary, 2010). Partner-reported IPV and official records for IPV-related charges were used as outcome measures for recidivism in two studies (Brannen & Rubin, 1996; Gondolf, 2008).

There was a wide range of follow-up time points during which recidivism measures were collected to assess BIP effectiveness. All 10 studies employed self-reported or partner-reported instances of IPV as either primary or secondary measures of recidivism and collected data prior to treatment, immediately following treatment, and again at given posttreatment follow-up intervals. All studies conducted some form of follow-up assessment that ranged from 0 to 24 months posttreatment (median follow-up period = 7.5). Nine studies conducted posttreatment follow-up assessments for a period of at least 1 month, 7 studies collected data for at least 6 months, and 3 studies collected follow-up data for at least 12 months post-treatment.

There was significant variability in study retention. The median retention rate at the last point of follow-up for partner-reported recidivism was 67.0% (range = 55%–100%), self-reported recidivism was 79.5% (range = 40%–93%), and 100.0% (no variation) for criminal justice records. The median retention rates immediately posttreatment for partner-report and self-report measures were 100.0% (range = 79%–100%) and 89.5% (range = 53%–100%), respectively. The median retention rate at the 6-month posttreatment follow-up period across seven studies was 67.0% (range: 55%–93%) for partner-report measures, 74.5% (range = 56%–93%) across three studies for self-report

measures, and 100.0% for criminal arrest records in a single study. The median retention rate at the 12-month posttreatment follow-up period across seven studies was 77% (range: 62%–84%) for partner-report measures, 84% for self-report measures in a single study, and 100% for criminal arrest records in a single study.

Effectiveness. Of the 10 studies examining the effectiveness of alternative, nontraditional BIPs, 4 studies compared an active treatment to a no-treatment control group. Of these, 3 reported statistically significant differences in recidivism rates in which participants assigned to the treatment group had lower rates of IPV perpetration at follow-up relative to those in the control group (Mbilinyi et al., 2011; Stith et al., 2004; Woodin & O'Leary, 2010). Of these, 2 studies involved brief motivational enhancement interventions, with 1 delivered via telephone counseling (Mbilinyi et al., 2011) and the other delivered as a single session feedback session with the offender for the majority of the session and then the dyad. The findings by Stith et al. (2004) indicated that IPV offenders treated in a 12-week couples' therapy context had lower recidivism rates than comparison couples who completed pretreatment and posttreatment measures but did not receive the intervention. However, their comparison group was very small (nine couples) and made up of cases that failed to attend treatment. The study was included in this review because of the comparison between the two active treatment formats. The comparison of treatment cases to noncompliant controls would not otherwise have met the standards for inclusion in this review.

One study found a marginally significant effect of treatment relative to a control group on IPV recidivism. Musser et al. (2008) compared a motivational interviewing (MI) based intake to a structured intake control group and found that at 6-month follow-up, rates of physical IPV were lower for those in the MI condition than the control condition ($p < .10$). While this difference was marginally significant by traditional means of analyzing group differences, the experimental nature of the study and the consistently positive results favoring MI on other treatment-related factors (e.g., more treatment engagement, greater responsibility assumptions) suggest that this intake approach is indeed a promising adjunctive intervention despite not meeting full criteria for statistical significance. All studies comparing an active alternate intervention to a no-treatment control condition used some version of a randomized design.

Seven studies compared the effectiveness of at least two active alternate treatments. Of these, three studies reported that the alternate treatment was superior in effectiveness to a comparison intervention. These studies involved an evaluation of couples' interventions, with one study finding that individuals assigned to couples' treatment had lower IPV recidivism rates than offenders assigned to traditional Duluth-model BIP (Brannen & Rubin, 1996), and a second study finding that offenders treated in the context of a mixed group of couples had lower IPV rates than those treated in a single couples format (Stith et al., 2004). A final study evaluated a stages-of-change-based intervention and reported that IPV offenders assigned to a stages-of-change motivational interviewing group had lower rates of physical IPV

than those assigned to a traditional Duluth model–type BIP (Alexander et al., 2010). All of these evaluations used some type of randomized design.

Four studies did not report statistically significant differences between active interventions, which involved various BIP programming styles. O'Leary et al. (1999) reported that both couples' treatment and gender-specific CBT groups were associated with significant decreases in both mild and severe levels of IPV from pretreatment to posttreatment, but no differences in effectiveness emerged between the two interventions. Similarly, while the overwhelming majority of partners in the Dunford (2000) study reported no continued IPV over the course of the study, this effect did not vary by treatment condition (in this case, an alternate conjoint/couples treatment vs. traditional CBT). Offenders assigned to a case manager had equivalent rates of IPV to those without a case manager (Gondolf, 2008). Males with comorbid substance abuse and IPV assigned to an intervention that targeted both problems had similar IPV outcomes at follow-up to men assigned to a 12-step facilitation group; however, there was a trend for offenders in combined treatment to show greater reductions in IPV relative to those in the 12-step group (Easton et al., 2007). Of these evaluations, three out of four used some type of randomization procedure to assign participants to intervention groups.

Brief Victim Interventions

Samples. The 16 articles presented in online Table 3 contain data from 13 distinct investigations of brief interventions for victims of IPV. Interventions were categorized as "brief" if they contained planned intervention consisting of three or fewer hours of contact. Three articles provided follow-up findings or specific outcomes from one of the other investigations reviewed. Across the 16 articles, the median sample size was 150 (range: 40–6,743), and the mean sample size was 570.56 (SD = 1649.08). Across the 16 articles, data were reported on a total N of 9,129 participants, representing 8,581 unique participants (subtracting those from multiple publication studies). All studies examined exclusively female victims of IPV.

Most articles on brief interventions (9 of 16) used data collected in medical contexts. Prenatal care clinics were the most common setting (5 studies), followed by emergency rooms (2 studies), primary care (1 study), and multiple medical contexts (1 study). Three of the brief intervention articles used data gathered in family violence legal clinics, 2 in the context of crisis intervention associated with community policing, and 2 were conducted in university settings with volunteers from the community.

Intervention Conditions. Brief interventions varied considerably in focus and intensity of contact. One of the other medical interventions, delivered in an emergency room context, similarly addressed safety behaviors and resource use (e.g., Muelleman & Feighny, 1999). Another medical intervention provided information and referrals in a contact lasting only a few minutes (Koziol-McLain et al., 2010), and one study examined an even more minimal protocol involving screening and information provision to the health care provider, with no explicit intervention specified (MacMillan et al., 2009).

Interventions conducted in legal clinics or as an adjunct to community policing provided IPV victims with support and advocacy. Although all of these interventions provided victims with information about community resources, safety planning was explicitly provided in some of these interventions (McFarlane et al., 2002), whereas in others, it was left up to the discretion of the providers (Bell & Goodman, 2001) and/or not clearly articulated as a component of the intervention, although likely incorporated by most providers (Corcoran & Allen, 2005). With the exception of the study by McFarlane and colleagues (2002), which involved six safety-intervention phone calls, the frequency and duration of contacts with victims were not clearly specified in the other legal or police intervention studies.

Finally, two of the studies examined relatively novel interventions delivered in university research contexts. One explored the efficacy of expressive writing about painful emotional experiences (Koopman et al., 2005). The other involved combined and separate examination of giving testimony (telling details of one's abuse to another person) and training in yogic breathing (Franzblau, Echevarria, Smith, & Van Cantfort, 2008).

Although all of the interventions were brief, the intensity and duration of contact varied considerably. Seven of the 16 articles (44%) reported on interventions conducted in a single contact, and the median number of contacts was 2.5 (range = 1–6). Ironically, the study with the largest sample and longest follow-up duration (18 months) had the most minimal intervention (MacMillan et al., 2009), which consisted only of screening and informing the treating physician about the screening results. Only 44% of the participants in that intervention condition reported that their health care provider discussed partner abuse with them.

Two of the articles did not report adequate data to determine the overall number of intervention contacts. One of these (Bell & Goodman, 2001) likely contained a degree of contact that exceeded the 3-hr cutoff for inclusion in the brief intervention category. However, the flexible nature of the services, the fact that providers were also engaged in legal representation for the IPV victim, and the relatively brief overall time frame for service provision (2–6 weeks) seemed consistent with the brief intervention category.

Total duration of contact varied from only a few minutes to 3 hr, with the median duration estimated at 80 min (range = 7 min to 3 hr). Five of the papers did not provide sufficient detail to accurately determine the total duration of contact. Duration of contact also varied within study because many of the interventions had flexible implementation (e.g., phone sessions that lasted as long as necessary) or flexible uptake (e.g., unlimited access to a counselor or mentor).

The efficacy of these brief interventions was examined relative to several types of control conditions. Services-as-usual served as the control condition in 8 of the 16 investigations, and 6 others used a minimal intervention control involving provision of a card or brochure with resource information. The two university investigations of novel alternative interventions used either no-treatment control or a specific control designed for the study (i.e., writing about daily events as a control for writing about emotionally painful experiences).

Study Design. Of the 16 investigations reviewed, 9 (56%) used random assignment to condition, and 7 (44%) used a quasi-experimental design with a control group selected from the same context or population as the intervention group. All of randomized trials assigned participants to condition at the individual (rather than group) level. Fourteen of the studies (88%) compared a single intervention condition to a single control condition; 1 study (6%) contained two intervention conditions and one control, and 1 study (6%) used a factorial design, which crossed two interventions and a control condition.

Outcome Data. A wide array of outcome variables was represented within the brief intervention studies. Interestingly, only half of the investigations (8 of 16) presented data on IPV revictimization. Half of the studies (8 of 16) provided data on community resource use as an outcome, and one-fourth (4 of 16) provided outcome data on safety behaviors. Depression was measured as an outcome variable in 5 of 16 studies (31%), PTSD symptoms in 3 (19%), and general psychological distress in 1 (6%). Physical health was an outcome in 4 studies (25%); 1 study (6%) assessed social support and 1 (6%) assessed quality of life.

Many of the brief intervention studies had significant limitations with respect to follow-up assessment. Eight of the articles (50%) reported data from a single follow-up assessment (range = 0–4). The total duration of follow-up ranged from 1 day to 18 months. The median follow-up was in the 3- to 6-month range, a value determined from investigations of prenatal samples with variable recruitment through pregnancy and a fixed (e.g., postpartum) time of follow-up. Despite the brief duration of follow-up in many of these studies, nearly half (44%) reported on follow-up intervals of 1 year or more.

Sample attrition rates varied from 0% (for investigations involving official data only) to 42%. Perhaps because of the fact that follow-up duration was often brief, the median sample attrition rate was quite low (9%). Only three studies reported attrition greater than 20%, suggesting that the findings on brief interventions as a whole are not highly biased by missing data.

Effectiveness. Results with respect to program effects are presented separately for interventions provided in different contexts. More specifically, findings are considered for studies examining brief IPV interventions in medical practice contexts, advocacy in police and criminal justice contexts, and university research settings.

Within medical contexts, the data on efficacy of brief interventions are mixed. The most consistently positive results are for increased use of safety behaviors, with positive findings reported in four of six studies. In contrast, only one of four studies reported enhanced use of community resources and that finding was specific for use of shelter and shelter-based counseling services (Muelleman & Feighny, 1999). Significant impact on abuse or violence exposure relative to control was reported in two of seven studies. Both of these favorable results were from studies of pregnant women in prenatal care and both used aspects of the intervention developed by McFarlane and

Parker (1994). One provided a relatively brief single session to women in Hong Kong (Tiwari et al., 2005) and the other used a three-session format with women in public health clinics in the United States (Parker, McFarlane, Soeken, Silva, & Reel, 1999).

Although the effects on revictimization are not entirely encouraging, several important points bear note. First, IPV has been a very refractory target of interventions in general. In addition, relatively minimal, single-session interventions were used in several of the null finding studies. Specifically, one intervention lasted 30 min (Cripe et al., 2010), one had an average duration of 7 min (Koziol-McLain et al., 2010), and one provided only screening and information to the treating clinician, with most participants receiving no direct assistance with IPV victimization (MacMillan et al., 2009). One of the other two null finding studies had a very limited evaluation of abuse revictimization (return visits to the emergency room; Muelleman & Feighny, 1999) and the final study in this category provided pregnant women with unlimited access to a counselor but did not report the extent of service uptake (McFarlane et al., 2000).

Three articles from two independent studies of brief interventions in the context of legal advocacy provide some encouraging results. The intervention studied by McFarlane and colleagues (2002) found increased use of safety behaviors that lasted over an 18 month follow-up period. Bell and Goodman (2001) found substantial reductions in abuse revictimization relative to control, along with some improvements in social support. This latter study involved assigning a pair of law students to assist battered women seeking protection orders. Although the overall level of contact and specific elements of intervention could not be readily discerned from the published evaluation of this program, it appears that the law students, on average, provided many hours of contact during a 2- to 6-week period, and that their work involved extensive help beyond the legal representation for protection orders.

The two studies of advocacy interventions provided in the context of community policing had mixed results. No clear benefits were found with respect to community resource use or risk for IPV revictimization, although increased use of legal system interventions and help seeking for children exposed to IPV was found in one investigation (Stover et al., 2009).

Finally, the studies of nontraditional brief interventions for IPV victims are mixed and limited in scope. Four sessions of expressive writing did not improve emotional or mental health functioning relative to controls who wrote about daily activities (Koopman et al., 2005). In contrast, two brief sessions in which participants told their stories of abuse to a research assistant and learned yogic breathing techniques produced significant effects on depressive symptoms relative to a no-treatment control, but follow-up was conducted only 1 day after completion of the intervention (Franzblau et al., 2008).

Victim Interventions

Samples. The 15 articles presented in online Table 4 contain data from 14 distinct investigations of more extended interventions for IPV victims, with 1 study (Bybee &

Sullivan, 2005) providing long-term follow-up from one of the other studies reviewed (Sullivan & Bybee, 1999). Across the 15 articles, the median sample size was 70 (range = 20–643), and the mean sample size was 135.73 (*SD* = 160.59). Data were reported on a total *N* of 1,886, representing 1,745 unique participants. All studies examined exclusively female victims of IPV.

Studies of extended counseling, therapeutic, and advocacy programs for victim survivors were conducted in a wide range of contexts. Three studies (20%) were conducted within the context of a battered women's shelter; three (20%) examined samples that were recently discharged from shelter; three (20%) relied primarily on community recruitment; one (7%) was conducted in a non-shelter counseling agency for battered women; one (7%) recruited from multiple organizations and shelters; one (7%) was conducted in a career counseling center, one (7%) in a large public hospital, one (7%) in a prenatal clinic, and one (7%) examined a home visitation program for new mothers.

Intervention Conditions. A wide array of intervention approaches is included in these studies. Three articles (representing two separate investigations) examined effects of a postshelter community advocacy program developed by Sullivan and Bybee (1999). For this intervention, trained paraprofessionals were assigned to provide community and in-home advocacy services for battered women. In the main trial, advocates provided an average of 6.4 hr/week of advocacy services over a 10-week intervention period.

Several studies examined variations of CBT. Two of the investigations (Kubany, Hill, & Owens, 2003; Kubany et al., 2004) examined a cognitive trauma therapy designed for IPV survivors with PTSD. This intervention incorporates many features from standard CBT therapies for PTSD, including education, stress management, exposure therapy, and restructuring of guilt- and shame-related cognitions. Johnson, Zlotnick, and Perez (2011) developed and investigated a CBT-based intervention for women in shelter. Their program addresses safety issues, PTSD symptoms, quality-of-life concerns, and postshelter goals. One other study provided all participants with a standard set of CBT intervention strategies, adding an exposure therapy component for those in the experimental condition and a communication skills component for those in the comparison condition (Crespo & Arinero, 2010).

The other investigations evaluated a diverse set of interventions, including a culturally informed empowerment group for African American survivors of IPV (Kaslow et al., 2010), a crisis intervention model (Kim & Kim, 2001), forgiveness therapy (Reed & Enright, 2006), interpersonal therapy (Zlotnick, Capezza, & Parker, 2011), social support groups (Constantino, Kim, & Crane, 2005), feminist-oriented counseling and grief resolution counseling (Mancoske, Standifer, & Cauley, 1994), and career counseling and employment support offered with and without additional focus on critical consciousness raising (Chronister & McWhirter, 2006). One investigation addressed IPV in the context of Healthy Start, a home visit program for new mothers (Bair-Merritt et al., 2010).

Five of the 15 investigations (33%) examined interventions delivered in a group format, and the other 67% used one-on-one service delivery. The intensity and duration of interventions varied in important ways. About half of the studies (47%) examined interventions with a fixed number of sessions delivered over a fixed duration of time, whereas the others (53%) studied interventions designed to vary in the amount of contact. Among studies with fixed treatment exposure, the number of sessions ranged from 5 to 10 (median = 8), and the total duration of contact ranged from 5 to 15 hr (median = 10 hr). Among studies with variable intervention formats, the number of meetings and total contact was not discernable for two investigations. In the remaining studies, participants received between 10 and 20 contacts, on average, with total contact varying from 10 to 126 hours (median = 15 hr). Intervention services were delivered over a period from 5 weeks to 3 years in duration; in 9 of 15 studies (60%), treatment lasted for 10 weeks or less; in 4 studies (27%) treatment lasted between 11 and 16 weeks, and only 2 studies (13%) examined treatments lasting more than 16 weeks.

The efficacy of interventions was examined relative to various control conditions. Services-as-usual served as the control in 4 of the 15 investigations (27%). Four (27%) used a no-treatment control, 3 (20%) used a wait-list control, 1 (7%) used an attention/placebo control, and 3 (20%) compared two active treatments to one another with no traditional control group.

Study Design. All but 1 of the 15 investigations (93%) used random assignment to condition, and the other was a quasi-experimental design with the treatment and control group selected from two different shelters. All of randomized trials assigned participants to condition at the individual (rather than group) level, and most used some form of pre-randomization matching (i.e., block randomization) or adaptive randomization strategy to promote similarity across conditions. Eleven studies (73%) compared a single intervention condition to a single control condition, 3 studies (20%) compared two active treatment conditions and contained no control group, and 1 study (7%) contained two active treatment conditions and a control condition.

Outcome Data. Victim intervention studies used a wide array of outcome variables. Interestingly, fewer than half of the investigations (40%) presented data on IPV revictimization. Depression was the most common outcome variable, included in 75% of the articles reviewed, followed by PTSD symptoms (47% of articles), self-esteem (47%), and social support (40%). Other emotional functioning outcome variables included anxiety (20% of articles), general distress (13%), shame/guilt (13%), and anger (7%). Other outcome variables included general quality of life (20% of articles), global self-efficacy (13%), empowerment (13%), resource acquisition (13%), attitudes toward feminism (7%), physical health functioning (7%), and career functioning (7%).

The number of follow-up assessments ranged from 1 to 9 (median = 2). Three studies (20%) provided data at posttreatment only, with no further follow-ups. At the other extreme, one study (Bair-Merritt et al., 2010) reported annual follow-up data for 9 years

after a Healthy Start intervention. Of the studies reporting follow-up data beyond posttreatment, 3 (20% of studies) had a total follow-up interval of 3 months or less; 3 (20%) followed participants for 4–6 months; 3 (20%) followed participants for 7–12 months; and 3 (20%) followed participants for 2 years or longer. Attrition is more of threat in this set of investigations than in the brief intervention studies because of the longer intervention periods. Two studies provided no data on attrition. The other 13 reported rates of sample attrition from follow-up assessment ranging from 5% to 45% (median = 14%). Four of the 13 studies reported sample attrition greater than 30%, a level that is likely to introduce substantial biases into estimates of treatment effects.

Effectiveness. Program effectiveness findings are presented separately for distinct interventions. Specifically, findings are considered for studies examining CBT approaches, postshelter advocacy services, feminist-informed therapies, and various other approaches to working with survivors of IPV. In addition, it is important to consider intervention efficacy relative to the target population; for example, studies that require PTSD diagnosis for inclusion or those that require individuals to have ended the abusive relationship. Finally, the goals or change targets must be considered; for example, reduction of abuse revictimization, reduction of abuse-related symptoms, or enhanced quality of life.

Studies of CBT approaches for working with IPV survivors have produced a number studies with positive findings. Most notable are two programs, Kubany and colleagues' (2003; 2004) Cognitive Trauma Therapy for Battered Women (CTT-BW) and Johnson and colleagues' (2011) Helping to Overcome PTSD through Empowerment (HOPE) program. The CTT-BW targets formerly battered women who have PTSD and have ended the abusive relationship. The HOPE, in contrast, addresses more acute concerns and needs of women currently in shelter. In both clinical trials, CTT-BW has had excellent effects, leading to very substantial and significant reductions in PTSD diagnosis, PTSD symptoms, depressive symptoms, and trauma-related guilt. Gains have been observed through 6 months of posttreatment follow-up. The main limitations of evidence for CTT-BW thus far are that its effects have not been independently replicated by a different research team, and maintenance of gains beyond 6 months has not yet been studied.

Initial research on the HOPE intervention is also very encouraging. Physical IPV revictimization, during the 6 months after shelter, was reduced from 82% in the control group to 47% in the HOPE condition. Findings for PTSD symptoms were more complex and mixed, although those who received at least five sessions of HOPE displayed lower levels of some categories of PTSD symptoms. Lower levels of depression and higher levels of social support were also associated with the HOPE intervention. The final CBT study examined the specific effects of exposure to memories of trauma versus training in communication skills for IPV survivors in the community (Crespo & Arinero, 2010). Both of these intervention components were delivered in concert with a standard set of CBT strategies. Although both interventions were associated with substantial reductions in symptoms, exposure had some isolated benefits in reducing avoidance and hyperarousal symptoms of PTSD, but not reexperiencing symptoms.

Similar to CBT, postshelter advocacy services provided in the community have shown considerable promise in enhancing well-being and quality of life in multiple investigations (Sullivan & Bybee, 1999; Sullivan, Bybee, & Allen, 2002). In the large-scale study by Sullivan and Bybee (1999), women receiving advocacy services also had significantly lower IPV revictimization than controls over a 2-year follow-up period. However, although positive effects on social support and quality of life were sustained at a 3-year follow-up for a subsample of the original study, condition differences in IPV revictimization were no longer significant (Bybee & Sullivan, 2005). As with CTT-BW, the main limitation thus far for research on the community advocacy intervention is that effects have not yet been replicated in a different research setting by independent investigators. Otherwise, this intervention shows considerable promise in assisting battered women to make the transition from shelter to independent life in the community.

The remaining victim intervention studies address a diverse set of interventions, with mixed, but generally favorable, results. Only one measured IPV as an outcome. A significant reduction in IPV, for both perpetration and victimization, was found in the Healthy Start home visitation program during the 3 years in which the intervention was delivered. However, these effects were no longer significant during follow-up years 7–9 (Bair-Merritt et al., 2010).

A culturally informed group intervention for African American women who were suicidal and had experienced IPV had significant positive impact on depressive symptoms and suicidal ideation over a 1-year follow-up (Kaslow et al., 2010). Supportive group counseling has been associated with significant effects on social support and psychological distress (Constantino et al., 2005), and crisis-oriented group intervention with a strong problem-solving component was associated with reduced anxiety (Kim & Kim, 2001). Interpersonal therapy, delivered during pregnancy, was associated with reductions in PTSD symptoms but not depressive symptoms relative to controls (Zlotnick et al., 2011). Forgiveness therapy, provided to women who had experienced psychological, but not physical, IPV and were out of the relationship for at least 2 years, was associated with significant increases in self-esteem and decreases in anxiety, depression, and PTSD symptoms (Reed & Enright, 2006). Although their sample was relatively unique, these results are notable given that the control group received a credible alternative therapy focused on life concerns, IPV victimization, assertiveness, and interpersonal skills.

In summary, the research literature on extended (as opposed to brief) counseling and advocacy interventions for IPV victims provides several encouraging findings. Several well-specified interventions have been associated with significant changes in outcome variables such as PTSD symptoms, depression, and quality of life. Postshelter community advocacy and home visitation for new mothers have also been associated with significant reductions in IPV revictimization. Although more limited, the research also indicates that supportive group interventions can have measurable impact on social support and emotional distress. On the whole, the research literature on counseling/therapeutic and advocacy interventions for IPV victims is relatively sparse, but provides encouraging findings for a range of intervention approaches.

DISCUSSION

In this review, we attempted to provide a descriptive and detailed review of intervention programs for IPV perpetrators and survivor-victims. Given the extensive personal, interpersonal, and societal costs associated with IPV, it is essential that the services being offered by the criminal justice, mental health, and medical communities have requisite empirical support to justify their implementation. Are such programs effective at preventing new episodes of violence and improving the lives of survivor-victims? As will be discussed in the following text, the evidence reviewed provides a somewhat equivocal answer to this question.

Interventions for IPV Perpetrators

Of the 30 studies of BIP effectiveness meeting our criteria for inclusion in this review, the data provided very mixed conclusions regarding BIP effectiveness that resists a simple summation. In terms of *traditional intervention programs* for IPV offenders based on either gender-themed or therapeutically oriented CBT orientations, about half of studies show that BIPs are more effective than a no-treatment control condition in preventing new episodes of IPV. Thus, evaluation studies suggest that traditional CBT-oriented BIP programming will perform better as often as it performs "no better" than a no-treatment control group at preventing IPV. If we were to eliminate the 3 studies with notable methodological flaws from the list of studies showing positive effects for BIPs then this conclusion becomes more pessimistic, with most studies suggesting that traditional BIPs show no evidence of effectiveness relative to a no-treatment control group. It is worth noting that these conclusions represent group effects—within any traditional BIP group, there will be substantial variability in progress from person to person; lives will indeed change and success stories of personal growth will be apparent. What this review is suggesting is that the probability that samples drawn from the larger population of IPV perpetrators and assigned to a traditional BIP will refrain from IPV is about the same as the IPV likelihood of those not assigned to BIP.

The findings also indicate that there is little effectiveness evidence that would favor one type of traditional intervention over another. While one study (Shepard, Falk, & Elliott, 2002) found that more intensive Duluth-type treatment was more effective than the standard version of Duluth at preventing IPV, other studies showed that there is little empirical basis to champion, or to downgrade, other standard forms of BIP. This conclusion is not restricted to the question of how Duluth model and therapeutic CBT BIPs compare; data from a randomized trial suggest that having IPV perpetrators meet with, and be monitored by, probation officers works as well as Duluth-model BIPs in preventing new instances of IPV (Labriola et al., 2008). Thus, the results of this review stand in stark contrast to the efforts and assumptions that appear to exist among state anti-domestic violence coalitions that would restrict the types of BIPs eligible for state certification. For example, the standards for BIP

content in Minnesota explicitly require as a basis for certification that counselors discuss the sociopolitical factors that underlie IPV, including "underlying political and sexist devaluing of women in organized religions" and "the myth of provocation," and which restricts discussion to only male violence against women (Minnesota Center Against Violence and Abuse, 1997). There is no empirical basis for the centrality of Duluth-model program effectiveness, or even for specific elements of this model in predicting IPV cessation (Eckhardt & Schram, 2009). States that choose to implement empirically based guidelines for BIP content should therefore be open to various CBT-based programming, regardless of how it aligns with a particular ideology.

It is also worth noting that the type of research design used in effectiveness research with traditional BIPs appears to be relevant to understanding the pattern of significant versus nonsignificant results. Most studies using a randomized design failed to find significant differences in BIP effectiveness; the opposite pattern was observed among quasi-experimental studies, which were more likely to show evidence of effectiveness relative to no-treatment control groups. A similar pattern was noted in the meta-analytic review by Babcock et al. (2004)—as methodological rigor of BIP effectiveness research increases, the likelihood of finding evidence of effectiveness appears to decrease. However, as noted by several authors (e.g., Gondolf, 2010), it need not always be the case that the only worthwhile studies are those that use randomized designs. Various designs that use statistical controls for selection biases present in nonrandomized designs (e.g., propensity score analysis) can be useful in examining questions of BIP effectiveness, and in this review had some of the strongest evidence of a program effect (e.g., Jones & Gondolf, 2002).

Our review revealed some cause for optimism with respect to *alternative BIP* interventions that address motivation and readiness to change. Several studies produced evidence of successful impact on change-relevant attitudes, treatment engagement, and/or abusive behavior. Three of these interventions were delivered in traditional BIP contexts and included brief motivational interviewing during BIP program intake (Musser et al., 2008), a 6-week initial BIP group for change-resistant batterers (Scott et al., 2011), and a 26-week BIP stage-of-change BIP program (Alexander et al., 2010). In addition, two studies found encouraging results using motivational interviewing in nontraditional intervention contexts, including a brief couples' intervention program for college students experiencing dating aggression (Woodin & O'Leary, 2010) and a brief phone intervention for abusive men recruited from the community (Mblinyi et al., 2011). Although each of these studies has limitations, taken as a set they provide strong initial support for the conclusion that well-conceived efforts to address motivation and readiness to change have specific benefit in work with IPV perpetrators (Stuart, Temple, & Moore, 2007).

This conclusion runs counter to a recent overview of alternative approaches to batterer interventions in which Gondolf (2011) argued that the concepts of stages of change or readiness for change have not received strong support in research on IPV offenders. However, Gondolf (2011) only considered descriptive and predictive studies and did not review any of the controlled intervention trials covered in this

review. In addition, Gondolf's (2011) critique was based primarily on the observation that IPV perpetrators cannot be simply categorized into discrete stages of change, and measures of change readiness at the outset of treatment do not invariably predict treatment response. Although his critiques highlight the fact that readiness for change is both dynamic over time and difficult to measure or categorize precisely, these challenges in no way undermine the potential value of motivational interventions, particularly given the lack of evidence for traditional approaches. One need not have precise measures of change readiness, nor precise prediction of treatment response from initial change readiness, to successfully apply intervention strategies designed to enhance motivation to change and resolve ambivalence about change.

The overall pattern of findings among studies evaluating the effectiveness of interventions for IPV perpetrators is difficult to interpret. While the data regarding traditional BIPs suggests that they are as likely to work as not work relative to a non-BIP control group or to another type of intervention, the results of studies examining programs offering alternatives to traditional BIPs based on readiness to change constructs are more promising across a broad range of useful outcomes. But across all studies, there are serious limitations to existing research that limit the confidence with which any strong claims can be supported. Two primary limitations deserve mention. First, there are very few methodologically adequate studies of BIP effectiveness. If one appropriately eliminates nonexperimental, pretest–posttest evaluations, we were only able to identify 30 published studies of BIP effectiveness for inclusion in this review, and some of the studies we include had many serious threats to internal validity. As noted by other reviewers of this literature (e.g., Smedslund et al., 2011), almost all BIP effectiveness studies have been conducted in North America, typically involve a relatively small number of participants, and make limited use of randomized designs. For various reasons, there have been few systematic linkages between BIP researchers and practitioners (for a review, see Eckhardt et al., 2006). Over the last 35 years, research on BIP effectiveness has struggled to keep up with the overwhelming demand to implement programs for the growing number of IPV offenders. "[D]ue to the rapid expansion of batterer intervention programs and the rush to implement them by the criminal justice system, these programs were already in wide use before rigorously evaluating their efficacy" (Stuart et al., 2007, p. 561). As a result, the reciprocal influence of research and practice so valued in the development of psychotherapies for mental health problems has never been integral to the development of BIPs. In turn, there have been very few studies evaluating interventions for IPV perpetrators and many more are needed before confident conclusions can be reached.

Second, as can be seen in the tables, most studies had serious implementation problems. These issues are perhaps unsurprising given the inherent difficulties in conducting effectiveness research in criminal justice settings, and in evaluating samples coerced into, and often unmotivated for, treatment. These implementation difficulties were especially problematic among randomized studies of BIP effectiveness, with problems concerning judicial overrides of condition assignment (Feder & Dugan,

2002; Taylor et al., 2001), low rates of partner-based follow-up data on recidivism (Feder & Dugan, 2002), and concerns about sample generalizability (Dunford, 2000; Taylor et al., 2001). Studies of alternative interventions had fewer such problems, but practical questions regarding how these interventions can be broadly implemented in varied criminal justice jurisdictions remain.

These limitations point to what is perhaps the most conservative conclusions that one can make concerning the effectiveness of intervention programs for IPV perpetrators: (a) the available data from a relatively small number of studies, many with serious methodological limitations, simply do not allow for clear conclusions about effectiveness, and (b) there are simply too few clear, unbiased studies with sufficient evidence of internal and external validity to properly answer the research question of whether BIPs are effective at preventing future episodes of IPV (Smedslund et al., 2011).

Interventions for Victim/Survivors of IPV

In contrast, the research literature on interventions for survivors of IPV provides considerable encouragement regarding the use of counseling and structured therapy in reducing negative effects of abuse, including PTSD symptoms and depression. Structured interventions using cognitive-behavioral strategies have been quite efficacious in this regard (Kubany et al., 2003; 2004; Johnson et al., 2011). Postshelter community advocacy provided by paraprofessional helpers has also been associated with lasting improvements in social support and quality of life (Sullivan & Bybee, 1999). Less widely investigated approaches, including forgiveness therapy (Reed & Enright, 2006), culturally informed empowerment groups (Kaslow et al., 2010), and social support groups (Constantino et al., 2005) have also produced encouraging results on measures of emotional and social functioning.

However, greater circumspection is needed in drawing conclusions about intervention effects on abuse revictimization. The intensive community-based postshelter advocacy program developed and studied by Sullivan and colleagues (2002) has been shown to have significant effects on revictimization relative to controls. Despite these encouraging experimental findings, the rate of violence revictimization was very high in the advocacy intervention (72% during the first 2 years of follow-up), and significant condition differences in revictimization were not found after the first 2 years of follow-up (Bybee & Sullivan, 2005). The Healthy Start home visitation program for new mothers has also been shown to have significant effects on partner assault during the 3-year period of its implementation (Bair-Merritt et al., 2010), but not over a longer period of follow up.

The limited scope of research and limited findings on abuse revictimization warrant more careful consideration. Notably, such efforts rely on mediational causal logic in which the intervention is expected to change the behavior of the abuse perpetrator, who is not directly receiving services, by changing the victim. As with any mediational model, these effects require a complex, two-stage process. First, the intervention must produce relevant proximal changes in the victim client. Second, these changes

in the victim must in turn alter the behavior of the perpetrator. Thus, the efficacy of intervention can break down at either or both levels—failing to produce the desired changes in the victim and/or changing the victim in ways that fail to produce desired changes in the perpetrator's behavior. For example, partners may fail to implement relevant safety behaviors, and/or these behaviors may not, in fact, enhance safety. Even leaving the relationship and hiding may not be sufficient to stop some abusers from stalking and revictimizing an ex-partner.

Interestingly in this regard, only 1 of the 31 studies on interventions for IPV victims evaluated the survivor's perpetration of relationship aggression as an outcome (Bair-Merritt et al., 2010). Obviously, the survivor's own use of aggression may not be particularly relevant to interventions targeting emotional effects of prior abuse victimization. However, the survivor's aggression may be a more important factor in efforts to reduce revictimization if patterns of mutual aggression are present in the couple, or if the survivor goes on to perpetrate aggression with a new partner in the future.

Also interesting in a related vein is the fact that 100% of perpetrator intervention studies examined only male perpetrators, and 100% of victim intervention studies examined only female victims. Thus, none of the 61 empirical studies included in this review included a single female-designated abuse perpetrator nor a single designated male abuse victim. These sample characteristics are consistent with prominent social and historical analyses of IPV, but may not reflect other prevalent patterns, including abuse in gay and lesbian relationships and female perpetration in heterosexual relationships.

The data on efficacy of brief interventions, many of which are connected to screening protocols in medical settings, are more complicated and inconsistent than the generally positive effects found for extended counseling and advocacy interventions. The most consistent finding is that brief interventions can have beneficial effects on participants' implementation of safety behaviors. However, the extent to which these safety behaviors reduce risk for ongoing abuse has not been convincingly established. In general, interventions that provide brief screening and only a few minutes of intervention have not had significant or substantial effects within the health context. However, in some (but certainly not all) studies, more extended interventions that provide several supportive contacts over time have had significant benefits, including reduced abuse revictimization (Parker et al., 1999).

Several important distinctions may prove beneficial in future efforts to determine the necessary and sufficient ingredients of brief interventions for IPV victims. First, it may be useful to distinguish between participants who are engaged in active and explicit help seeking for IPV from those who are not. Examples of the former include individuals who call the police, seek protection orders, or call a helpline. Examples of the latter include individuals who are screened positive for IPV victimization during routine medical care or while seeking treatment for other problems (e.g., substance abuse). The opportunities for change and barriers to change may differ considerably across populations and contexts, and interventions may need to be adapted to maximize benefits.

A second important distinction can be made between interventions that provide only a single contact and those that provide ongoing contact over time. Although some supportive evidence is available for single-episode interventions (e.g., Tiwari et al., 2005), and multicontact interventions are not invariably effective, simply screening for IPV or providing minimal information and a list of resources have not been shown to produce substantial benefits. In fact, uptake of community resources was one of the variables least consistently impacted by brief interventions in general. Although ongoing supportive contact can be complicated in the context of IPV victimization, efforts should be made to develop and study interventions that provide multiple points of contact and the opportunity to develop a collaborative helping relationship to reduce the isolation and lack of social support experienced by many victims of IPV. More research is needed to develop and validate interventions that can provide a bridge between initial detection (e.g., screening) or initial help seeking (e.g., police calls) and the types of extended interventions that have been more clearly and consistently successful with IPV victims.

To date, reviewers have been very reticent to recommend for or against screening and intervention for IPV in medical contexts. Their hesitancy is threefold, resulting from (a) the narrow scope, methodological limitations, and mixed findings of available studies; (b) the high standards required to support firm recommendations within medical practice, most notably decreased morbidity or mortality; and (c) the finding that routine screening, in the absence of routine intervention, does not appear to produce a measurable impact on morbidity or mortality (MacMillan et al., 2009). Although this review likewise highlights methodological problems and inconsistencies in results, we would argue that the current state of research, on the whole, supports the idea that routine intervention for IPV in medical contexts can have measurable benefits in terms of mental health, physical health, and safety. However, more research is needed to identify the best contexts in which to implement these interventions, the effective elements of intervention, and the most appropriate target populations. Simply doing what is expedient or least costly in terms of time or training, however, is not likely to meet the standards required for adoption in routine medical practice. Finally, it is interesting to note that many commonly used interventions for IPV victims, such as help lines, brief crisis counseling, and shelter services, have not been systematically investigated in experimental research that met the inclusion criteria for this review.

In summary, researchers have evaluated various intervention programs for perpetrators and victims-survivors of IPV. These programs are based on a wide range of theoretical perspectives, have been implemented using quasi-experimental and randomized designs, and have been evaluated on tens of thousands of participants. Interventions for perpetrators show equivocal results regarding their ability to lower the risk of IPV, in part because of widespread methodological flaws, although more recent investigations of novel programs with alternative content relative to traditional programs appear to show promising results. Among interventions for victims-survivors of IPV, structured counseling programs appear to reduce the frequency of

revictimization, although rates of revictimization in some of these programs remain alarmingly high. The effectiveness of brief interventions for victim-survivors is more difficult to summarize, for while many studies find significant effects of such programs on immediate safety planning behaviors, it remains unclear whether such efforts meaningfully relate to longer term IPV reduction. Together, these results suggest a research area that is early in its development, yet energetic and innovative in its immediate efforts, but with considerable distance left to travel on the journey toward the goal of effective programs to eliminate IPV.

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