Section 4: Chapter 3

Understanding and Intervening with Partner Abuse

John Hamel, LCSW
Private Practice, San Francisco, CA
johnmhamel@comcast.net

Research on Perpetrator Programs

For several decades, domestic violence, otherwise known as Partner Abuse (PA) has been recognised as a major public health issue in the United States, and more recently in Europe and the rest of the world (Esquivel-Santovena, Lambert & Hamel, 2013). PA includes both physical and non-physical forms of aggression among dating, cohabitating and married couples in opposite-sex and same-sex relationships and from every ethnic minority group (Hines, Malley-Morrison & Dutton, 2013; West, 2012). In the United States, the standard intervention paradigm has consisted of a vigorous law-enforcement response for perpetrators that includes victim services almost exclusively to women, and arrest and prosecution for men, as well as mandatory participation in psychoeducational treatment programs commonly known as *batterer intervention programs*, or BIPs (Buzawa, Buzawa & Stark, 2011; Shernock & Russell, 2012). Most offenders join these programs following release from incarceration, although some individuals serving longer sentences are able to complete at least some of their required treatment in a correctional setting.

The most recent, reliable outcome studies indicate that, in general, these perpetrator treatment programs are only moderately successful in reducing rates of recidivism. Quasi-experimental designs have yielded the highest effect sizes (Gondolf, 2012), while random-assignment-to-conditions studies find BIPs to reduce recidivism by only 5% over the 35% rate found among non-treated controls (Eckhardt, Murphy, Whitaker, Sprunger, Dykstra & Woodard, 2013). Outcome data on female perpetrators are

virtually non-existent (e.g. Carney & Buttell, 2006). Although women currently account for only 10%-13% of court-mandated perpetrators (Buttell, Hamel, Ferreira, & Cannon, 2016, in press), rates of physical PA and most forms of non-physical PA (except sexual abuse) by women are about the same as men in the general population (Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012).

The large majority of individuals in abusive relationships do not come into contact with the criminal justice system, and little is known about the services they receive or treatment outcomes when they voluntary seek help from mental health professionals. However, psychologists and other mental health professionals appear to be poorly informed about PA, prone to the same biases and drawn to the same overall treatment paradigm as BIPs, anchored in the twin beliefs that PA is primarily a gender issue and that it is a unitary phenomenon (American Psychological Association, 2012; Follingstad, DeHart, & Green, 2004; Hamel, Desmarais, Nicholls, Malley-Morrison, & Aaronson, 2009). For example, a fact sheet available at the website the Association of Marriage and Family Therapists (AAMFT, 2013) presumes, incorrectly, that men are always the perpetrators in coercive relationships where one party seeks dominance over the other. Likewise, the National Association of Social Workers (2013) reports on its own online fact sheets that domestic violence has "devastating consequences for women, children and families" (p. 1), but fail to acknowledge that men incur about half of lesser domestic violence-related injuries (Lawrence, Oringo & Brock, 2012).

The most up-to-date, reliable and comprehensive source of information on PA comes from the Partner Abuse State of Knowledge Project (PASK), a 2,400-page review of the domestic violence research literature in 17 topics areas, written by 40 scholars from 20 universities and research institutions in the USA and Canada (Hamel, Langhinrichsen-Rohling, & Hines, 2012). PASK findings indicate that the most common form of PA in the United States, known as *situational couples violence*, is bidirectional and involves minor acts of physical violence with lesser or no injuries and arises from conflict situations and poor impulse control. The other major type of PA is *controlling-coercive violence*, or simply *battering*, which can also be bidirectional but is characterised by

more serious physical assaults and an effort by one or both parties to dominate the other (Hamel & Russell, 2013; Kelly & Johnson, 2008; Johnson & Leone, 2005). As indicated in table 1, gender symmetry exists in many, but certainly not all, aspects of partner abuse.

Table 1. Symmetry and Asymmetry Across Gender: Results from the Partner Abuse State of Knowledge Project

Symmetry	**Asymmetry**	**Mixed/Inconclusive**
Rates of physical abuse	Rates of sexual abuse	Impact of emotional abuse
Rates of emotional abuse	Rates of physical stalking	Abuse in non-Western countries
Rates of non-physical stalking	Impact of physical abuse on partners	
Risk factors		
Self-reported motives		
Impact on children/families		

Evidence-Based Treatment of Partner Abuse

The term *evidence-based practice* has been defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273); and, from the social work perspective, as "a systematic process that blends current best evidence, client preferences (wherever possible), and clinical expertise, resulting in services that are both individualised and empirically sound" (Shlonsky & Gibbs, 2004, p. 137). Information is readily available on evidence-based treatment for various mental health and behavioural disorders (e.g., SAMHSA, 2013). Until recently, however, this has not been the case for interventions in relationship violence, which may explain the generally mediocre treatment outcomes.

In the United States, perpetrator treatment guidelines and standards for court-ordered offenders are set by the various states, based not on the body of empirical social science research but rather on recommendations from battered women's advocates, and steeped in sociopolitical theories of gender roles and patriarchy. Assumptions about the prevalence, causes, dynamics, and consequences of partner abuse are based on crime studies rather than general population studies, seemingly 'cherry-picking' from outdated studies (Corvo, Dutton, & Chen, 2008, 2009; Hines, 2014), as well as the opinions and clinical impressions provided by a selected subset of BIPs. Consequently, issues of gender role socialisation and patriarchy, while important, are grossly over-emphasised, while evidence-based approaches (e.g. anger management) and modalities (couples counselling) are discouraged or outright banned (Maiuro & Eberle, 2008). Furthermore, although all offenders are referred to as "batterers", mandatory and pro-arrest laws have led to an increase in arrests of lower-level offenders who do not fit a "batterer" profile; even before mandatory arrest laws were fully implemented, a meta-analysis found that these "family only" perpetrators accounted for 50% of all offenders in batterer intervention (Holtzworth-Munroe & Stewart, 1994). Approximately half of the partners of men arrested for partnership violence in one major American city said they were minimally or only slightly afraid, or thought that their partner would be violent in the future (Apsler et al., 2002). It is also the case that partnership violence usually desists over time rather than increase in frequency (Morse, 1995; O'Leary et al., 1989), while a small percentage of offenders account for the large majority of repeat offences (Maxwell et al., 2001) (Hamel, 2014a, p. 15).

Recommendations for Evidence-Based Practice in Partner Abuse

Recently, a major step forward was made in advancing evidence-based practice in work with PA perpetrators. In the Spring of 2014, the author, acting in capacity as Senior Editor for the journal, *Partner Abuse*, invited scholars with an expertise in perpetrator intervention to conduct empirical research on BIPs, and to propose evidence-based standards and best practice recommendations based on their findings (Babcock et al., in press, 2016). All major aspects of perpetrator treatment were investigated, including:

overall effectiveness, length of treatment/ length of group sessions, ideal number of group participants and number of facilitators, group format and curriculum, assessment protocol and instruments, victim contact, modality of treatment, differential treatment, working with female perpetrators, working with perpetrators in racial and ethnic minority groups, working with lesbian, gay, bisexual and transgender (LGBT) perpetrators, practitioner-client relationships, and required practitioner education and training.

The recommendations were based on a careful analysis of the literature, giving a higher priority to data from random assignment to conditions experimental designs, and secondarily to quasi-experimental designs. Correlational research on risk factors was also taken into account, along with relevant outcome data from interventions with related populations (e.g. substance abusers, general criminal offenders). The least amount of consideration was given to the clinical experience of BIP treatment providers (Buttell et al., 2016, in press). Based on their findings, the scholars put forth a general set of best practice guidelines for perpetrator intervention standards, as described below:

1. Partner abuse may consist of discrete physical and/or non-physical assaults, or a pattern of such assaults that, at more serious levels, is known as *battering.*
2. Perpetrators are a heterogeneous population, and can be either male or female and vary in personality, social demographics, violence history and level of threat to victims.
3. Victims may include child witnesses or the entire family system.
4. Physical PA, and some types of emotional and sexual abuse, constitute criminal offences.
5. Holding offenders requires a multi-system response, including incarceration, judicial monitoring and/or treatment.
6. Perpetrator treatment is one part of a coordinated community response that includes law enforcement, victim advocates, mental health professionals and social service agencies.

7. Regardless of legal status, treatment should be based on the needs of the individual and the extent to which he or she presents a threat to current and future victims.
8. Treatment should be delivered by providers with current and accurate knowledge of partner abuse prevalence rates, characteristics, causes, dynamics and impact on victims and families.
9. Perpetrator treatment plans should be determined through a thorough psychosocial assessment.
10. Treatment should be based on current best practices, which at a minimum, include the use of a strengths-based, client-centered approach such as Motivational Interviewing in conjunction with interventions and educational curricula that address empirically-determined risk factors.

John Hamel & Associates Perpetrator Program

The author's own programme for court-mandated domestic violence offenders has been frequently revised over the years, to incorporate relevant findings from both clinical experience and the social science research literature (Hamel, 2005; 2014b). The program was recently updated, to take more fully take into account the Babcock et al. findings (Hamel, 2015).

Given the priority of an accurate assessment, all clients, whether court-mandated or voluntary, are carefully assessed prior to treatment. Every intake interview begins with an oral psychosocial history that includes a client's PA history with their current or most recent intimate partner as well as in past relationships, abuse in their family of origin, substance abuse and criminal history, mental health status, and parenting abilities. This is followed by administration of several validated written questionnaires that measure rates of emotional abuse and control, client readiness to change, motivation and reasons for violence, and degree of attachment insecurity (Hamel, 2014b). Given that PA does not occur in isolation, and that aside from the victim partners there may also be children who witness the abuse, the nature and impact of PA has to be considered in

the context of the entire family system (Hamel, 2014b). The astute practitioner will want to investigate the following areas of family functioning:

Family beliefs about anger and abuse: A substantial body of research evidence finds high correlations between violence among the parents and the use of corporal punishment on children (MacDonnel & Watson, 2012; Sturge-Apple, Skibo, & Davies, 2012), so the assessment should investigate the parents' disciplinary practices. Beyond this, the practitioner ought to determine if verbal or physical abuse is overtly or tacitly approved under certain circumstances. For example, when someone has become violent after being criticised, or had a sibling take away his or her toys. In many families, PA is regarded as "normal" behaviour.

Each individual's ability to cope with anger, stress, and conflict: Are there dominant family members whom everyone fears, not certain if at any moment and under the slightest provocation they might lash out by yelling, hitting, or throwing things? Not surprisingly, in such an environment people are easily hurt and hyper-vigilant, yet may also be critical and negative and listen to one another only when then there is anger, thereby reinforcing the abusive behaviour patterns (Potter-Efron, 2005). To determine whether a couple's relationship aggression is of the situational violence type and potentially amenable to treatment via couples therapy, an excellent questionnaire is the Situational Violence Screening Tool, or SVST (Friend, Bradley, Thatcher, & Gottman, 2011).

Family structure: Are the roles of each family member clearly differentiated and appropriate to their age and level of development? In dysfunctional, high-conflict families, roles can easily be blurred, as when a school-age child must step up to care for a battered parent. Are there proper boundaries and hierarchies between the parental and child subsystems, diffuse enough to encourage healthy communication but at the same time rigid enough to assure the exercise of parental authority? The practitioner should enquire as to whether there is not enough involvement, or too much, among individuals in the two subsystems, or whether there exist unhealthy alliance

between a particular parent and child. It is also important to ascertain if the degree to which the family's boundaries with the outside world allow for privacy while allowing for the kinds of corrective influences that generate growth and prevent family codes of secrecy that inhibit victims from getting help.

Couple's abuse dynamics: How does each partner communicate anger and address conflict? As will be discussed in a later section, relationship conflict is a major predictor of interpersonal aggression. Issues may be brought up as criticisms rather than complaints, or there may be resistance by one person to being influenced by the other. Do conflicts tend to quickly escalate, sometimes leading to violence, or are there "repair attempts" and efforts to de-escalate? (Gottman, 1998) An important consideration is each partner's attachment style, and their interaction effects. Who tends to cling to the other out of a fear of being abandoned, and who withdraws from emotionally-laden situations out of a desire to avoid intimacy? Particularly worrisome is evidence of both a disorganised attachment style, with anxiety over abandonment and intimacy, often accompanied by Borderline personality features. Does fear of abuse influence any individual's behaviour?

The trajectory of conflict and abuse over time: Children get older and family members move through the various stages of development. The practitioner will want to know if new alliances have been built and old ones have come to an end, altering the balance of power among the family members. Has the angry person around whom everyone used to fear finally learned to behave, while others have begun to act out, causing new points of conflict and new interaction dynamics?

Treatment Options

With the caveat that treatment may be restricted, as we have seen, by rigid state standards or with populations housed in correctional settings, modality and treatment focus are determined by the nature and severity of the abuse, the characteristics and personalities of the perpetrators, and the extent to which it is primarily unilateral or bi-

directional. Although hard outcome data is limited on some possible intervention options, the recommendations below are in line with Babcock et al.'s (2014) best practice guidelines.

In *unilateral battering*, the abuse involves serious, injury-producing violence with high and consistent levels of emotional abuse and control, including jealous, isolating behaviours, threats and attempts to degrade the partner. The perpetrator may have an extensive criminal history and antisocial tendencies with little or no remorse for his or her behaviour; or the abuse may be driven by deep-seated insecurities, shame-based coping and other Borderline personality characteristics. Regardless, a longer-term group would be appropriate for either type of perpetrator, along with intensive individual psychotherapy with a clinician specialising in both domestic violence and personality disorders. Supportive counselling should be provided for the victim and affected family members, with a priority on keeping them safe. In *mutual severe battering***,** the characteristics of this PA type are the same as in unilateral battering, except that the abuse is bidirectional and the power structure symmetrical. Treatment should begin with separate batterer groups for each partner and, when possible, intensive individual psychotherapy. Couples counselling can follow, after each party has ceased their violence and built a sufficient level of trust and goodwill through the use of rudimentary emotion-management and conflict containment skills. Supportive counselling for the children, perhaps in the form of a therapeutic play group, should begin immediately.

In cases of *unilateral situational violence*, there may be a marked power imbalance in the relationship, but the violence is less severe, and is more *expressive* than *instrumental*, involving poor impulse control lack of relationship skills rather than efforts to degrade and dominate the partner. The perpetrator is emotionally insecure and may suffer from moderate levels of anxiety or depression, but unlikely to have a pronounced personality disorder. An appropriate treatment plan would require the perpetrator to join a psychoeducational group for 12-26 weekly sessions, depending on severity of violence, extent of power/control. The victim would benefit from supportive therapy and, if they are willing, participate in couples or family therapy once the perpetrator has

shown evidence of sufficient treatment progress. Finally, other than a more balanced relationship power structure, and abuse that arises from mutually-escalating relationship conflicts, *mutual situational violence* shares the same characteristics as unilateral situational violence. Depending on the intensity and frequency of the abuse and each partner's emotional management skills, treatment may begin immediately with couples counselling (there is some outcome data indicating the superiority of a structured multi-couples format, in which clients not only learn relationship skills but also benefit from the support they get from the other participants (Stith, McCollum & Rosen, 2011); or require separate short-term psychoeducational groups for some period of time, followed by traditional couples work with a clinician experienced in PA dynamics. Other family members may be brought in separately, or the entire family can be seen together.

Group Format and Curriculum

The John Hamel & Associates psychoeducational group program can be taught over a period of between 16 and 52 weeks, using either a 90-minute or 120-minute format, and is appropriate for both male and female clients. We seek to individualise our program, beginning with a thorough assessment to help clients identify areas of strength and weakness and establish personal goals, and by having them record their progress in their workbook log pages, through which they also gain insight into their particular abuse dynamics. We also require clients to complete Cognitive-Behavioral Therapy (CBT) logs so we, and they, can monitor their treatment progress. Among the more robust predictors of treatment failure, along with poor attendance, are a client's refusal to participate in group activities or to complete homework assignments (e.g. see Gondolf & Wernik, 2009). On the other hand, there is evidence from one CBT outcome study that homework compliance predicts lower levels of psychological abuse after treatment (Taft, Murphy, King, Musser, & DeDeyn, 2003). In keeping with Motivational Interviewing and other client-centered approaches that have been found effective in reducing recidivism, our facilitators engage in 'connection, not collusion', assigning responsibility rather than blame, with an emphasis on client strengths. When clients are treated with respect, they are more likely to trust, overcome their fear of change,

become open to learning and to ‘own’ their behaviour, resulting in lasting change (Eckhardt et al., 2013).

Our group curriculum consists of 16 core lessons and 29 in-class exercises, divided into three major sections: Weeks 1-3: Characteristics, Causes and Consequences of Domestic Violence; Weeks 4-9: Managing Emotions; Weeks 10-16: Building Relationship Skills (see table 2). Clients who are mandated for more than 16 weeks review the educational material for up to two more times during the course of a year, but with different exercises to keep the lessons fresh.

Table 2. John Hamel & Associates psychoeducational group program curriculum.

Lesson	**Class Exercises**
1. Characteristics / Causes, Part 1	When is Violence Justified?/Defenses Against Accountability
2. Causes, Part 2	Socialisation/Gender Roles/Impact of Gender Role Socialisation
3. Consequences	Consequences of Abuse/Impact of Domestic Violence on Children
4. Emotions	Identifying Emotions in Oneself/Jealousy
5. Understanding anger	Positive and Negative Functions of Anger/ Myth of the Pressure Cooker
6. Aggression and the brain	
7. Anger and stress management, Part 1	Warning Signs of Anger/Time-Outs
8. Anger and stress management, Part 2	Overcoming Irrational Self-Talk/Challenging Irrational Beliefs/Review Sample Progress Log
9. Anger and stress management, Part 3	Grounding Meditation/Progressive Relaxation/ Meditation and Visualisation
10. Abuse dynamics, Part 1	Who is the Dominant Aggressor?
11. Abuse dynamics, Part 2	Identifying Abuse Dynamics
12. Listening skills/empathy	Paraphrasing/Developing Empathy

13. Speaking skills/ assertiveness	Assertiveness Versus Aggressiveness/ Dealing with “Blocking Maneuvers”
14. Positive communication/parenting	The Relationship Bank Account/Good Parenting
15. Conflict resolution, Part 1	Importance of Meta-Communication
16. Conflict resolution, Part 2	Problem Solving

Regardless of the modality, successful intervention requires the practitioner to address the primary risk factors for relationship abuse. This is particularly important when working with groups, where individual or family treatment is limited. Our program seeks to address the treatment needs of most offender types within a curriculum that is comprehensive and at the same time based on the research evidence, addressing the risk factors most closely correlated with domestic violence (Capaldi, Knoble, Shortt, & Kim, 2012). Those factors are discussed below, along with research-based curricula that address them.

Stress, especially from low income and unemployment. Between a fourth and a third of individuals currently enrolled in BIPs are unemployed (Buttell et al., 2016). The CBT programs determined to have been the most effective in reducing IPV recidivism feature stress reduction components in their curriculum (Babcock et al., 2004; Eckhardt et al., 2013). Therefore, we teach clients relaxation and meditation exercises, inform them about the importance of good physical health and lifestyle balance (lesson 9), and assist them in acquiring the communication and problem solving skills necessary to ameliorate the problems that generate stress (lesson lessons 12-16).

Risk factor: Poor impulse control. Using a pretest-posttest design, the outcome study by Hamberger and Hastings (1988) found that male graduates of perpetrator programs engaged in lesser rates of relationship violence at a one-year follow-up if they had previously learned to lower their anger levels. In a related study (Saunders & Hanusa, 1986), male offenders who completed a 20-week Process/CBT group with an anger

management component also exhibited reduced rates of recidivism upon a post-graduation follow-up. Although neither study used a true experimental design with a proper control group, the results provide some empirical evidence for educating clients on ways to identify and manage anger. We first teach them about the function of human emotions, including the positive and negative functions of anger and the "ventilation" myth (lessons 4-5), and then summarise relevant neuropsychological findings on aggression (lesson 6). This is followed by a discussion of basic anger management strategies (e.g. the 'time out,' where an individual physically removes him/herself from a situation when the sense they may lose control) and, later, the cognitive distortions that fuel and reinforce anger responses (lesson 7.) The monthly CBT logs help clients discover and understand for themselves the interconnection between thoughts, feelings and behaviour.

Risk Factor: Depression. Evidence-based treatments for depression have been well-documented (e.g. in the Cochrane Reviews; http://www.cochrane.org/search/site/depression?f[0]=bundle%3Areview). While our program is not intended to treat depression directly, we provide case management services and referrals, and we make every effort to de-stigmatise the problem by framing it as a mental health disorder treatable by psychotherapy (such as CBT) and psychotropic medication.

Risk Factor: Emotional insecurity. Outcome research has not yet been published on interventions that specifically target emotional dependency and insecure attachment styles, but the effectiveness of anger management, as previously mentioned, has been empirically demonstrated, along with relationship skill-building (Babcock et al., 2004; Eckhardt et al., 2013). We therefore educate clients about the difference between secure and insecure attachment, and how these styles can manifest themselves into abusive behaviours. We use the pyramid of needs, first developed by Abraham Maslow (1987), to remind clients about universal human needs and teach them the emotion management, communication, assertiveness and conflict-resolution skills with which they can meet those needs without harming others (lessons 5-16).

Having an aggressive personality characterised by a desire to dominate, hostility toward the opposite sex or attitudes that support violence. Literature reviews have failed to find a significant correlation between male perpetrators' traditional sex-role beliefs and relationship violence, but do indicate that pro-violent attitudes and a need to dominate predict the use of physical PA (Capaldi et al., 2012; Straus, 2008; Sugarman & Frankel, 1996). Given these findings, and a body of research evidence showing that identifying and overcoming cognitive distortions and irrational beliefs is a central component of effective CBT programs (Babcock, Green, & Robie, 2004; Eckhardt et al., 2013), we help our clients examine their antisocial, irrational and/or sexist attitudes. We do this by educating them about healthy relationships and the ways that aggressive behaviours compromise their efforts to get their needs met (lesson 8). Our clients also learn to overcome jealousy, a primary motive for PA (lesson 4), while increasing their ability to empathize with others (lesson 12).

Risk Factor: Alcohol and drug abuse. A wide variety of programs, professional and self-help, are available to clients who struggle to control their use of alcohol and other mind-altering substances (e.g. see: http://www.addictionrecoveryguide.org/; http://www.samhsa.gov/ebp-web-guide/substance-abuse-treatment). As with depression and other mental health disorders, we provide referrals to treatment resources in the community. Given that the core skills taught in our program are among the same skills taught in relapse prevention, our program may in some ways directly assist clients in overcoming chemical dependency issues.

Risk factor: Having witnessed violence between one's parents as a child, or having been abused or neglected by them. Psychotherapeutic approaches to perpetrator treatment have not been well-studied. However, outcome research on the Compassion Workshop, which focuses on clients' issues of childhood abuse and trauma, has reported decreased dropout rates as well as decreased levels of physical and emotional abuse among male PA perpetrators who were helped to overcome shame-based anger through self-reflection and acquisition of emotional management skills (Stosny, 1995;

2005). Within a more psychoeducational approach, we teach clients skills and strategies with which to identify and overcome the dysfunction and abusive patterns of behaviour they acquired in their childhood of origin, and to overcome the toxic effects of shame leading to self-destructive behaviours and interpersonal aggression. We also teach them positive parenting practices (lesson 14), and help them understand how their behaviours impact on their children, contributing to the intergenerational cycle of abuse (lesson 3).

Risk Factor: Being in an unhappy or high conflict relationship. There is a substantial body of research finding significant correlations between relationship violence and unresolved conflict and relationship dissatisfaction. Laboratory experiments have identified the negative reciprocal interactions and poor communication styles that maintain unhealthy dependencies and lead to physical violence (e.g. Babcock, Waltz, Jacobson, & Gottman, 1993; Burman, John, & Margolin, 1992; Cordova, Cornelius, Shorey & Beebe,2010; Jacobson, Gottman, Rushe, & Cox, 1993; Margolin John, & Gleberman, 1993; Ridley & Feldman, 2003). The literature reviews by Babcock et al. (2004) and Eckhardt et al. (2013) have found lower recidivism rates for CBT programs that incorporate into their curriculum essential communication and conflict resolution skills, and there is evidence that improved communication skills reduces physical PA among partner-violent men (Follette & Alexander, 1992; Robertson & Murachver, 2007) and couples (Bradley, Drummey, Gottman, & Gottman, 2014; Gordis, Margolin, & Vickerman, 2005). Lessons 4-16 present and explain these emotion management and relationship building skills in detail, addressing the myriad types of abuse dynamics, from the classic three-phase cycle (Walker, 1983) to the mutual cycles noted above.

At group completion participants take part in a final one-on-one exit interview, during with they are given a final exam to test their knowledge of the course curriculum. They are also asked to complete the same assessment instruments administered at intake and to discuss the results with their group facilitator, to determine how far they have progressed and what they will need to keep working on.

Conclusion

Although abuse between intimate partners is a significant public health problem throughout the world, it has been most thoroughly researched in the United States, where it is addressed through a vigorous criminal justice response. Court-mandated rehabilitation programs for perpetrators, a major component of this response, have been only marginally effective in reducing recidivism rates, largely due to the politicization of the issue. However, emerging outcome research and recent large-scale literature reviews have identified a variety of promising, evidence-based interventions that, it is hoped, will come to the attention of responsible policy-makers everywhere.

References

American Association for Marriage and Family Therapists (2013). Domestic violence. Retrieved January 3, 2013 from: http://www.aamft.org/imis15/content/ Consumer_ Updates/Domestic_Violence.aspx

American Psychological Association (2012, October). National domestic violence awareness month. *In the Public Interest Newsletter*. Retrieved January 5, 2013 from:http://www.apa.org/pi/about/newsletter/2012/10/domestic-violence-awareness.aspx

APA Presidential Task Force on Evidence-Based Practice (2006). Evidence based practice in psychology. *American Psychologist*, 61 (4), 271-285.

Babcock, J., Bannon, S., Buttell, F., Cantos, A., Hamel, J.,Kelly, D., Lehmann, P., Leisring, P., Murphy, C., O'Leary, K.D., Salis, K.L., Solano, I. (2016 in press). Domestic Violence Perpetrator Programs:A Proposal for Evidence-Based Standards in the United States. *Partner Abuse*.

Babcock, J., Green, C., & Robie, C. (2004). Does batterers' treatment work: A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, 23, 1023-1053.

Babcock, J., Waltz, J., Jacobson, N., & Gottman, J. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology*, 61(1), 40-50.

Bradley, R., Drummey, K., Gottman, J.M., & Gottman, J.S. (2014). Treating couples who mutually exhibit violence or aggression: Reducing behaviors that show a susceptibility for violence. *Journal of Family Violence,* 29, 549-558.

Buttell, F. P., Hamel, J., Ferreira, R. J., & Cannon, C. (2016, in press). A survey of domestic violence perpetrator programs in the U.S. and Canada: Findings and implications for policy intervention. *Partner Abuse*.

Burman, B., John, R. & Margolin, G. (1992). Observed patterns of conflict in violent, onviolent, and nondistressed couples. *Behavioral Assessment*, 14,15-37.

Buzawa, E., Buzawa, C. & Stark, E. (2012). *Responding to Domestic Violence: The integration of criminal justice and human services*, 4th edition. Thousand Oaks, CA: Sage.

Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*, 3, 231–280.

Carney, M., & Buttell, F. (2006). An evaluation of a court-mandated batterer intervention program: Investigating differential program effect for African American and White women. *Research on Social Work Practice*, 16 (6), 571-581.

Cordova, J., Jacobson, N., Gottman, J., Rushe, R., & Cox, G. (1993). Negative reciprocity and communication in couples with a violent husband. *Journal of Abnormal Psychology*, 102(4), 559-564.

Cornelius, T., Shorey, R., & Beebe, S. (2010). Self-reported communication variables and dating violence: Using Gottman's marital communication conceptualization. *Journal of Family Violence*, 25, 439-448.

Corvo, K., Dutton, D., & Chen, W. (2008). Toward evidence based practice with domestic violence perpetrators. *Journal of Aggression, Maltreatment, and Trauma*, 16 (2), 111-130.

Corvo, K., Dutton, D., & Chen, W. (2009). Do Duluth model interventions with

perpetrators of domestic violence violate mental health professional ethics? *Ethics & Behavior*, 19 (4), 323-340.

Desmarais, S.L., Reeves, K.A.,Nicholls, T.L.,Telford, R. & Fiebert, M.S. (2012). Prevalence of physical violence in intimate relationships - Part 2: Rates of male and female perpetration. *Partner Abuse*, 3(2), 170-198.

Eckhardt, C.I., Murphy, C.M., Whitaker, D.J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, 4(2), 175 – 195.

Esquivel-Santovena, E., Lambert, T., & Hamel, J. (2013). Partner abuse worldwide. Partner Abuse, 4(1), 6-75.

Follette, V. M., & Alexander, P. C. (1992). Dating violence: Current and historical correlates. *Behavioral Assessment,* 14(1), 39-52.

Follingstad, D., DeHart, D., & Green, E. (2004). Psychologists' judgments of psychologically aggressive actions when perpetrated by a husband versus a wife. *Violence and Victims*, 19 (4), 435-452.

Friend, D., Bradley, R., Thatcher, R., & Gottman, J. (2011). Typologies of intimate partner violence: Evaluation of a screening instrument for differentiation. *Journal of Family Violence*, 26 (7), 551-563.

Gondolf, E. (2012). *The future of batterer programs: Reassessing evidence-based practice*. Boston, Northeastern University Press.

Gondolf, E., & Wernik, H. (2009). Clinician ratings of batterer treatment behaviors in predicting reassault. *Journal of Interpersonal Violence*, 24, 1792-1815.

Gordis, E. B., Margolin, G., & Vickerman, K. (2005). Communication and frightening behavior among couples with past and recent histories of physical marital aggression*. American Journal of Community Psychology*, 36(1-2), 177-191.

Gottman, J. (1998). *The marriage clinic*. New York, N.Y.: W.W. Norton & Company.

Hamberger, L. K., & Hastings, J. E. (1988). Skills training for treatment of spouse abusers: An outcome study*. Journal of Family Violence*, 3(2), 121-130.

Hamel, J. (2014a, May/June). Batterer intervention: Creating evidence-based programs. *The Therapist*.

Hamel, J. (2014b). *Gender inclusive treatment of intimate partner abuse, 2nd edition:*

Evidence-based approaches. New York: Springer Publishing.

Hamel, J. (2015). John Hamel & Associates Teaching Non-Violence Programme. Unpublished Manual.

Hamel, J., Desmarais, S.L., Nicholls, T.L., Malley-Morrison, K., & Aaronson, J. (2009, July). Domestic violence and child custody: Are family court professionals' decisions based on erroneous beliefs? *Journal of Aggression, Conflict and Peace Research*, 1(2), 37-52.

Hamel, J., Langhinrichsen-Rohling, J., & Hines, D. (2012). More than a literature review: The partner abuse state of knowledge manuscripts and online data base. *Partner Abuse, 3*(2), 131-139.

Hamel, J., & Russell, B. (2013). The Partner Abuse State of Knowledge Project: Implications for law enforcement responses to domestic violence. In: B. Russell (Ed.), Perceptions of Female Offenders: How Stereotypes and Social Norms Affect Criminal Justice Responses (pp. 157-180). New York: Springer.

Hines, D. (2014). Extent and implications of the presentation of false facts by domestic violence agencies in the United States. *Partner Abuse*, 5 (1), 69-82.

Hines, D., Malley-Morrison, K., & Dutton, L. (2013). *Family violence in the United States: Defining, understanding, and combating abuse* (2nd Edition). Thousand Oaks, CA: Sage.

Johnson, M. & Leone, J. (2005). The differential effects of patriarchal terrorism and common couple violence. *Journal of Family Issues*, 26 (3), 322-349.

Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review*, 46(3), 476–499.

Lawrence, E., Oringo, A., & Brock, R. (2012). The impact of partner abuse on partners. *Partner Abuse*, 3(4),406-428.

MacDonnel, K. Watson (2012). The combined and independent impact of witnessed interparental violence and child maltreatment. *Partner Abuse*, 3(3), 358-378.

Maiuro, R., & Eberle, J. (2008). State standards for domestic violence perpetrator treatment:Current status, trends, and recommendations. *Violence and Victims, 23*(2), 133- 155.

Margolin, G., John, R., & Gleberman, L. (1993). Affective responses to conflictual discussions in violent and nonviolent couples. *Journal of Consulting and Clinical Psychology*, 56(1),24-33.

Maslow, A. (1987). *Motivation and personality* (3rd edition). New York, NY: Addison-Wesley.

National Association of Social Workers (2013b). Help starts here: About family safety. Retrieved January 3, 2013 from: http://www.helpstartshere .org /kids-families/family-safety/about-family-safety.html

Potter-Efron, R. (2005). *Handbook of anger management: Individual, couple, family and groups approaches*. New York: Haworth Clinical Practice Press Ridley, C. & Feldman, C. (2003). Female domestic violence toward male partners: Exploring conflict responses and outcomes. *Journal of Family Violence*, 18(3), 157-170.

Robertson, K., & Murachver, T. (2007). It takes two to tangle: Gender symmetry in intimate partner violence. *Basic and Applied Social Psychology*, 29(2), 109-118.

SAMHSA (2013). A pocket guide to evidence-based practices (EBP) on the Web. Retrieved January 7, 2013 from: http://www.samhsa.gov/ebpwebguide/ appendixB_Treatment.asp

Saunders, D. G., & Hanusa, D. (1986). Cognitive-behavioral treatment of men who batter: The short-term effects of group therapy. *Journal of Family Violence*, 1(4), 357-372.

Shernock, S., & Rusell, B. (2012). Gender and racial/ethnic differences in criminal justice decision making in intimate partner violence cases. *Partner Abuse*, 3(4), 501-530.

Shlonsky, A., & Gibbs, L. (2004). Will the real evidence-based practice please stand up? Teaching the process of evidence-based practice to the helping professions. *Brief Treatment and Crisis Intervention*, 4 (2), 137-153.

Stith, S., McCollum, E., & Rosen, K. (2011). *Couples therapy for domestic violence: Finding safe solutions*. Washington, DC: APA.

Stosny, S. (1995). *Treating attachment abuse: A compassionate approach*. New York: Springer.

Stosny, S. (2005). Group treatment of intimate partner abusers. In G.L. Greif & P.H. Ephross (Eds.), *Group work with populations at risk, 2nd ed*. (pp. 226-237). New York: Oxford University Press.

Straus, M. (2008) Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children and Youth Services Review*, 30(3),

Sturge-Apple, M.L., Skibo, M.A., & Davies, P.T. (2012). Impact of parental conflict and emotional abuse on children and families. *Partner Abuse*, 3(3), 379-400.

Sugarman, D., & Frankel, S. (1996). Patriarchal ideology and wife-assault: A meta-analytic review. *Journal of Family Violence*, 11(1), 13-39.

Taft, C.T., Murphy, C.M, King, D.W., Musser, P.H., & DeDeyn, J.M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. Journal of Consulting and Clinical Psychology.71:812-20.

Walker, L. (1983). The battered woman syndrome Study. In D. Finklehor (Ed.), *The dark side of families* (pp. 31-48). New York: Springer.

West, C. (2012). Partner abuse in ethnic minority and gay, lesbian bisexual, and transgender populations. *Partner Abuse*, 3(3), 336-357.