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Behavioral Health and Domestic Violence: Toward Evidence-Based Practice

By
Liz Cantor, Ph.D.

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Introduction

The fields of domestic violence research and intervention are complex and controversial. Understandably, this issue evokes strong feelings and perspectives about how best to understand the phenomenon and how best to intervene. In addition, research results, in the area of batterer intervention programs as well as among studies of the nature and prevalence of domestic violence, have been inconsistent. It is, therefore, difficult for behavioral health professionals (i.e. social workers, counselors, psychologists, and psychiatrists) to know what "best practices" are for the range of intervention opportunities that arise in working with these families. A behavioral health professional might intersect with a family or family member that has experienced domestic violence in a variety of ways: through crisis intervention; working with batterers, women victims, and children in group or individual therapeutic settings; conducting psychological assessments, danger assessments, or substance abuse evaluations; and, providing consultation or training services to other professionals.

Beyond the lack of clear guidelines and the sometimes confusing research literature, there are many challenges in implementing behavioral health interventions for batterers and their victims, and communities are struggling to meet the needs of these populations. While there have been many improvements in law enforcement and criminal justice response to domestic violence, and in victim services, battering continues to be a significant drain on society and its victims continue to suffer devastating consequences. Unfortunately, batterer intervention programs have not had the significant impact on decreasing assaultive and abusive behaviors that had been hoped when these programs began proliferating 25 years ago. This does not mean that no

batterers improve with program interventions, but it does mean that a substantial proportion of men who attend batterer intervention programs go on to reassault intimate partners in the future. Even though we are not where we want to be in terms of confidence in batterer intervention programs, the good news is that there is some evidence that can help guide intervention decisions and hopefully maximize effects. In general, research suggests that the "one size fits all" approach to batterer intervention programs is not the most effective and that there are specific ways of identifying batterers who might need different, more individualized, or supplemental programs. Research also suggests that there are techniques that can be used to help retain batterers in programs in order to maximize their benefits.

There has been far less research attention to the effects of programs and interventions intended to benefit women and child victims directly. However, here, too, there is evidence that comprehensive and individualized advocacy and treatment programs can be effective in reducing the risk of reassaults.

Research limitations

While there are always challenges and constraints when conducting social science research, the research on domestic violence is a particularly difficult area to navigate for several reasons. First, there are many components to the community system and, unfortunately, the research to date has most often focused on only one element at a time. While many studies examine the role of demographic characteristics such as age and race, they do not generally measure the range of criminal justice and community service variables that may also play a role in determining whether a victim is reassaulted. These variables include the victim's experiences with the criminal justice system; the type,

length, degree, or quality of victim services received; the criminal justice response to batterer noncompliance, and any adjunct services the batterer or victim may receive for substance abuse or psychopathology. For example, the effects of a mental health intervention program for women victims might be evaluated without controlling for whether the victim is still involved with her abuser or whether her abuser is involved in any form of treatment; batterer intervention programs might be compared to each other for efficacy without evaluating the role of different criminal justice consequences for treatment noncompliance.

A second concern is that most studies in the area of domestic violence are not truly "experimental" so that conclusions about findings are limited. An experimental study *randomly* assigns subjects to either the intervention condition or a non-intervention condition, so that the subjects have an equal chance of receiving or not receiving the intervention. This way, any differences between the two groups in changes in the behavior in question can be attributed to the intervention and not to another variable, like age or race. When researchers cannot use an experimental design (because of either ethical or practical issues) a "quasi-experimental" design is often used instead. This means that there is no *equivalent* control group with which to compare the subjects; for example, batterers who complete a program might be compared with those who don't. As a result, it is not possible to identify, with as much confidence, that the intervention is the variable most likely responsible for the difference since the two groups of batterers most likely differ in a variety of ways even before an intervention is implemented.

Third, there is controversy within and between research fields (most notably between feminist and family violence researchers) regarding the assumptions about

domestic violence vis a vis gender; this has implications for setting research agendas and for interpreting research findings. Specifically, there is seemingly competing and contradictory information about the number of women who are abusive to men, the frequency and severity of such abusive behavior, and the degree to which couples engage in mutual violence rather than unilateral violence. Many studies have found much higher levels of female-to-male violence than expected (e.g. Slep & O'Leary, 2005; Straus & Gelles, 1990); women, in fact, sometimes initiate violent episodes within their intimate relationship. However, what is clear is that men are significantly more likely to inflict injury upon a female than vice versa (Archer, 2000). It is also the case that partner violence is often measured without regard for context, so motives and circumstances that lead to female-to-male aggression are not well understood. (See Dasgupta, 2001 and Belknap & Melton, 2005) for more detailed discussions). What is clear is that if both partners are aggressors it cannot be assumed that the violence or its consequences are equivalent; in the sections that follow, batterers refer to men who hurt women.

Because batterers are often mandated to treatment, batterer intervention programs (BIPs) are often the core intervention for families, while women and children may or may not come into contact with health or other service professionals. Therefore, the first step in designing effective services may be to determine what kinds of batterer interventions have been demonstrated to be useful for decreasing reassaults.

Batterer Intervention Programs

Evaluation of programs – Overview

There have been numerous studies examining the effectiveness of specific batterer intervention programs as well as reviews of the literature on the effectiveness of batterer intervention programs in general. Results are confusing and seemingly contradictory since some studies show positive effects while others show minimal or no effects. However, a recent meta-analysis of the effects of batterer intervention programs concludes that, *overall*, batterers in these programs do not demonstrate significant changes in battering behavior compared to batterers who do not participate in such programs (Babcock, Green, & Robie, 2004). Babcock et al. reviewed 22 experimental and quasi-experimental studies of the impact of treatment on men who had been engaged in domestic violence, and results indicated "current interventions have a minimal impact on reducing recidivism beyond the effect of being arrested" (p. 1023). Feder and Wilson (2005) also recently conducted a meta-analysis of the effects of BIPs and they found different levels of effectiveness depending on the nature of the studies (experimental vs. quasi-experimental) and the source of data for reassaults (official vs. victim). However, the positive effect they reported from *experimental* studies using *official* reports disappeared when *victim* reports (which are routinely higher and more accurate) were used as an outcome measure. In addition, the positive effect they reported from quasi-experimental studies in which treatment completers were compared to men who dropped out or were rejected from treatment, were most likely due to effects or variables other than effectiveness of the BIPs. Studies consistently demonstrate that batterers who stay in treatment are significantly less likely to reoffend than are batterers who drop out of the

program; this may be due to a range of factors besides the BIP – motivation, for example – so that the difference does not actually tell us whether the BIPs themselves are important for behavior change. The authors conclude that there is little evidence to support the effectiveness of BIPs. Although an earlier meta-analysis (Davis and Taylor, 1999), concluded that there was evidence of positive effects of BIPs from both experimental and quasi-experimental studies, their pool of studies was much smaller than that of the two more recent meta-analyses. Another reason for the different outcomes of meta-analytic reviews is that the researchers developed different criteria for inclusion into their studies; therefore, each meta-analysis analyzed data from different groups of studies. Overall, results from reviews suggest that BIPs, as a whole, do not necessarily provide an incremental benefit. However, what this may mean is that the "one size fits all" approach to BIPs is not supported by the evidence. It does not mean that all BIPs are ineffective for all batterers.

Despite the general lack of effects of programs overall, there are many compelling studies that demonstrate positive effects of specific program interventions (e.g. Babcock & Steiner, 1999; Davis, Taylor, & Maxwell, 1998; Lyon, 2005). The many reasons for the lack of clarity include different research methods that are hard to compare (e.g. experimental vs. quasi-experimental); the use of different outcome measures (e.g. victim reports of reassaults vs. police reports; completion vs. noncompletion of program); the use of widely varied timelines (e.g. reassaults during a program's duration vs. post-program); and, the fact that evaluations of batterer intervention programs simply do not measure and cannot control the myriad of variables that exist outside its purview (e.g. the criminal justice response, victim services, substance abuse, mental illness, etc.) that likely

have an effect on the batterer, his behavior, and his victims. As a result of the mixed messages that practitioners and policy makers have been confronted with, batterer intervention programs have been developed with good intention and common sense rather than from solid evidence that a particular model or program is more effective than another, and for whom. Specific variables may be important in planning interventions for batterers.

Batterer variables

What do we know about batterers themselves that might predict how likely it is that they will reassault their partner or complete a mandated program? Individual studies have pointed to a variety of factors that predict reassaults, but these factors do not consistently have predictive power across studies. For example, Gondolf (2002) found that a batterer's history of arrests, severe psychopathology at intake, and drunkenness predicted future reassaults in a study of several hundred batterers in four cities. Shepard, Falk & Elliott (2002) found that demographic factors did not predict recidivism, but being court-mandated into treatment or not completing treatment did predict higher reassault rates. In a study of any violent recidivism in a sample of batterers, researchers found that predictive variables were similar to those generally found for other criminal populations: being younger; having a criminal history, unstable finances and housing; and substance abuse (Hanson & Wallace-Capretta, 2004).

Personality and psychopathology

Holtzworth-Munroe and Meehan (2004) have posited that there are different "types" of batterers and that this typology has some predictive power in identifying who is most likely to complete treatment and who is most likely to reassault in the future.

Their research has identified four kinds of batterers who differ in terms of severity of violence and psychopathology. Although other researchers have identified different typologies (e.g. Chase, O'Leary & Heyman's Reactive-Proactive model, 2001), Holtzworth-Munroe and Meehan have shown how there is significant overlap among categories in terms of violence severity and personality features.

Indeed, researchers have identified a specific subgroup of batterers who seem "different" from the rest in terms of their anti-social nature, general propensity toward violence, and resistance to treatment efforts. Gondolf (2002) reported that 80% of the men treated in his study of batterer programs in 4 cities did not reassault at all during the previous year at a four-year follow-up, but that 20% of the batterers reassaulted repeatedly. Although this group was not easy to differentiate from the group of men who did not reassault, the researchers noted that risk markers included: history of severe previous assault, more extensive criminal record, severe mental disorder, drunkenness during follow-up, and the victim's predictions of reassault. Shepard et al. (2002) divided their sample into four categories based on the level of severity of violence, and their results indicated that, treatment "success" was inversely related to level of violence. That is, the less violent the offender, the more successful the intervention. Unfortunately, in this study, the sample size of the most serious offenders was too small (n=4) to draw conclusions about the most serious offenders in this particular analysis. Nonetheless, the implication is that more serious offenders are likely harder to treat and are more likely to reassault.

Substance abuse

What about substance abuse? Research certainly demonstrates a consistent and strong link between alcohol and/or drug abuse and intimate partner violence (e.g. Bennett & Williams, 2003; Kantor & Straus, 1990; Leonard & Senchak, 1993; Moore & Stuart, 2004; Murphy, Winters, O'Farrell, Fals-Stewart & Murphy, 2005). Heavy and frequent (male) drinkers are more likely to assault their partners than are men who do not drink (Kantor & Straus, 1990; Gondolf, 2002). And, alcohol consumption may be more likely to be related to *severe* intimate partner violence among men with antisocial personality disorder than among men without this disorder (Fals-Stewart, Leonard, & Birchler, 2005). In one study, men's use of alcohol increased the risk of *injury* to the woman in violent incidents (Thompson & Kingree, 2006). And, as already mentioned, drunkenness during treatment in a batterer intervention program predicted future reassaults, according to one large study (Gondolf, 2002). Substance abuse treatment has been shown to decrease intimate partner violence in samples of batterers who are not involved in batterer intervention programs (e.g. Stuart, Ramsey et al., 2003) as well as in samples of batterers who are receiving batterer intervention (Gondolf, 2002).

How alcohol and domestic violence are related is not completely clear, and numerous theories have been suggested to explain this relationship. What does appear clear is that the relationship can be complex and the mechanisms or processes are likely not the same for all substance abusers. It is not necessarily the case that a person who is drinking becomes disinhibited and cannot control aggressive impulses. There may be physiological effects of alcohol that contribute to violence, such as impaired perceptions and disinhibition. There may also be situational factors that increase the likelihood of

violence when someone has been drinking, such as increased conflict. Research has also shown that people who drink may have an *expectation* of disinhibition which may contribute to expressions of negative behaviors which could, in fact, be controlled (Lang, Goeckner, Adesso & Marlatt, 1975). In other words, it may be an *excuse* to be aggressive (Fals-Stewart & Kennedy, 2005). Temporal links have been found, so that a woman is much more likely to be assaulted on days that her partner drinks (Fals-Stewart, 2003).

Are there demographic factors that are useful in predicting future violent behavior? Research suggests that these factors better predict whether a batterer will drop out of treatment than whether they will reassault in the future (see below).

Dropout

Since research has consistently shown that batterers who complete treatment are less likely to reassault than are "drop-outs" (e.g. Gordon & Moriarty, 2003; Shepard et al., 2002), what variables seem to predict whether a batterer will stay in treatment or leave? Is it related to personality characteristics or motivation? Is it simply related to how swiftly and severely the system implements consequences for noncompliance? This is important for several reasons: 1. dropout rates are generally quite high (from 30% to over 50% in some studies); 2. dropouts are often not included in the final analysis of program effectiveness, so actual reassault rates of men *referred* to BIPs may be quite a bit higher than studies often suggest; and, 3. if efforts are to be made to keep would-be dropouts in treatment, it is important to develop interventions that are likely to be effective. Daly and Pelowski (2000) reviewed 16 studies published between 1986-1999 to determine patterns in reports of factors that were related to drop out. They found that some factors consistently predicted drop out while others were inconsistent across

studies. Consistent predictors included being unemployed, unmarried, and childless; having lower income and less education; and, problems with substance abuse, criminal history, and psychopathology. Inconsistent predictors included age, race, and the batterer's own exposure to violence as a child, as well as referral status (court ordered vs. self-referred). More recent studies have shown attrition rates related to race, with African American men or other ethnic minorities more likely to discontinue treatment than Caucasian men (Gondolf, 1999; Taft, Murphy, Elliott, & Keaser, 2001). Surprisingly, the actual legal consequences for dropping out of a program is a factor that is rarely included in analyses, so it is unclear what role this may play in batterers' treatment compliance.

Program variables

Research generally indicates that differences among treatment programs as they are currently being implemented are not significant in their ability to predict reassaults. However, the current "one size fits all" approach is clearly not working as well as expected, so efforts are being made to try to understand just which program factors might need to be addressed differently. What does the research tell us about specific factors that, if individualized or approached in varying ways, might lead to a reduction in recidivism? Is it matching certain types of batterers to certain types of interventions, or is it supplementing current approaches with more individualized interventions? Specific studies have compared the efficacy of the most commonly adopted cognitive-behavioral approach with a "process-psychodynamic" approach (Saunders, 1996), and with both a conjoint group treatment approach and "rigorous monitoring" (Dunford, 2000). Gondolf (2002) also reported on a multi-site study in which didactic and discussion approaches

were compared. Results from all of these studies found that no one approach was more effective than another *overall*. However, interestingly, researchers nonetheless raise the question of whether certain kinds of interventions might be more appropriate for certain kinds of batterers. In fact, Saunders (1996) found that men with “dependent personalities” fared better in a process-psychodynamic group, while men with “antisocial traits” did better with a cognitive-behavioral approach.

One of the most compelling and useful concepts to emerge in the psychological treatment literature is the Transtheoretical Model proposed by Prochaska (see e.g. Prochaska & Norcross, 2001 for a brief summary). The idea is simply that behavior change is a process and that clients progress through different stages of change. Thus, clients enter treatment at different stages of readiness to change their behavior, and it becomes part of the treatment goal to help the individual move closer to readiness since trying to implement certain interventions prematurely will inevitably fail. This model may offer valuable insight into the reasons why BIPs are effective for some, but not most or many, batterers. When batterers are “screened” for entry into a BIP, which has a proscribed structure and lesson plan, they may be evaluated for substance abuse, lethality, or mental illness, but they are not routinely evaluated for their particular stage of change with regard to their battering behavior. Some researchers have raised the question of how to use this model to help better individualize batterers’ treatment interventions (e.g. Daniels & Murphy, 1997; Murphy & Baxter, 1997) so that batterers who are in the earlier stages of change are presented with interventions that are intended to help them move toward readiness, while batterers who are more ready for change are presented with strategies and interventions that promote positive action. Researchers have even

developed measurement tools for assessing stage of change in this population (Levesque, Gelles & Velicer, 2000).

Scott & Wolfe (2003) found that stage of change was significantly related to outcome in BIPs in a sample of men who completed treatment; in addition, Scott (2004) analyzed the larger sample of men, including those who dropped out of treatment (61%), and found that stage of change also predicted whether batterers would remain in treatment. Men who were the farthest from readiness to change (referred to as being in the "precontemplative" stage) were much more likely to drop out of treatment than were men in the "contemplative" and "action" stages, as determined by counselor ratings.

Another important clinical concept is the therapeutic alliance. Research has consistently shown that the alliance between the client and the therapist is predictive of treatment success (Martin, Garske & Davis, 2000). Researchers have applied this construct to batterer interventions in order to determine whether the quality of the therapeutic alliance might predict retention in batterer treatment and/or reassault rates. Taft and colleagues have investigated these questions and results indicate that interventions intended to foster therapeutic engagement and alliance can result in decreased drop out (Taft, Murphy, Elliott & Morrel, 2001) and lower reassault rates (Taft et al., 2001; Taft, Murphy, King, Musser & DeDeyn, 2003). (Conversely, it has been shown that batterers are more likely to recidivate when they demonstrate a "negative attitude toward helpers" (Hanson & Wallace-Capretta, 2004).) In addition, links between readiness to change and working alliance have been found in studies of alcohol treatment (Connors, DiClemente, Dermen et al., 2000) and batterer's intervention (Taft, Murphy, Musser, & Remington, 2004). In the latter study, readiness to change was a strong

predictor of therapeutic alliance so that subjects who were more motivated to change had stronger working relationships with their therapists. In the same study, psychopathic characteristics were strongly negatively related to readiness to change and to the therapeutic alliance, which is consistent with previous findings that batterers with more psychopathology or anti-social tendencies are less likely to benefit from a traditional BIP.

Specific motivation-enhancing techniques that have been used to increase retention in batterers' treatment programs include pre-treatment interventions such as videos (Stosny, 1994) or an intensive 8-hour workshop (Tolman & Bhosley, 1990), as well as ongoing extra contact and support during treatment (Taft, Murphy, Elliott & Morrel, 2001). Taft and colleagues compared a group of batterers who received treatment retention interventions with a group who received treatment as usual on treatment completion and outcome. Retention efforts included initial handwritten notes and phone calls expressing interest in working with the clients, and then ongoing efforts to communicate support, encouragement, and interest in the client's participating and remaining in treatment. Overall, the clients who received retention interventions attended significantly more treatment sessions than did those in the control group and had significantly lower drop out rates (15% vs. 30%). The difference in drop out rates was especially notable for ethnic minority clients (10% vs. 42%) suggesting the importance and effectiveness of making specific efforts to retain minority clients in batterer programs.

In the literature on BIPs and their effectiveness, evaluators and implementers vary in their descriptions of BIPs as "education" or "treatment." However, any clinician or educator knows that these terms are not interchangeable even if the goal (behavior

change) is roughly the same. This is an important distinction, since each one represents a set of different attitudes and calls for different intervention strategies. The purpose of education is to provide needed information and teach skills and strategies; the purpose of treatment is to change those behaviors which are unlikely to change without intervention. It behooves professionals in the field to articulate just what they are doing – is it educating or it is treating, or is it an attempt at integrating both – in order to develop programs to meet those goals. The therapeutic concepts of working alliance and stages of change are more relevant to treatment efforts than to education efforts, although the concepts can still be useful. What is critical for the implementation of these programs is recognizing the basic clinical truth that behavior change rarely occurs just because a client receives information. Behavior change requires motivation (either internal or imposed externally). Clearly, batterers vary in the degree of motivation they possess (or develop) to change their behavior and, as a result, the effectiveness of the interventions may be differentially successful.

Summary

In sum, the data on the effectiveness of BIPs and relevant batterer and program factors suggest that BIPs, as they are currently being implemented, are effective for some batterers some of the time. There appears to be a small group of batterers who engage in continuous and severe assaults and who are generally not responsive to intervention programs. There are also batterers who do not reassault even without intervention. If anything, the data seem to indicate that the "one size fits all" model of programming requires reevaluation. Research has demonstrated that a client's level of motivation, the quality of the therapeutic relationship, as well as a host of other factors such as income,

substance abuse, previous criminal history, and psychopathology, all contribute to whether a batterer is more or less likely to stay in treatment and/or reassault his intimate partner. However, it is also the case that the batterer and the victim also experience a range of "interventions" from law enforcement, the criminal justice system, social services, and the community, and the impact of these systems also need to be considered. Unfortunately, the role of each component in predicting reassaults is usually considered alone in research efforts, so the interactions and additive effects of each piece of the interventions cannot be determined.

Women Victims

Effects of domestic violence

The effects of battering on women's mental and physical health are wide ranging and potentially devastating. A large percentage of battered women experience Post-Traumatic Stress Disorder as well as a host of other mental disorders such as Depression, or depressive symptoms, and Substance or Alcohol Abuse. Estimates are that over 60% of battered women exhibit PTSD symptoms, and close to half experience Depression (see Golding, 1999 for results of a meta-analysis of these findings). In a national survey study of over 5,000 couples, it was found that women who had a history of severe assaults by their husbands were more than 5 times more likely to have attempted suicide than women who did not report being assaulted (Gelles & Straus, 1990). Some longitudinal research suggests that mental health problems are likely to be longstanding; after five years, women who had experienced intimate partner violence (or who continued to experience it) were significantly more likely to demonstrate depressive

symptoms, low self-esteem, decreased life satisfaction, and functional impairment than were women who had not experienced domestic violence (Zlotnick, Johnson & Kohn, 2006). However, research also suggests that symptoms might be at their worst during the first 6 months post-separation (Lerner & Kennedy, 2000).

Domestic violence is a complex phenomenon and the direction of causality among variables measured is not always clear. In fact, outcome variables (e.g. depression, anxiety, self-esteem) may be multidetermined. For example, some researchers have raised the question of the role of emotional or psychological abuse in determining health outcomes for women victims. Lewis, Griffing, Chu et al. (2006) found that lowered self-esteem and depressive symptoms could not necessarily be fully attributed to physical assaults, since psychological abuse (in both childhood and in the current violent relationship) predicted depressive symptoms in their sample.

In terms of physical effects, trauma itself can alter physiological and biological systems that may compromise immune functioning (Woods, 2005); physical battering may lead to traumatic brain injury, and subsequent cognitive impairment, in a larger than recognized number of victims (Jackson, Nuttall, Philp & Diller, 2002; Valera & Berenbaum, 2003); and, battering is associated with injuries, disability, and a wide range of physical ailments and conditions (Plichta, 2004), and general poor health (Demaris & Kaukinen, 2005). In the national survey study mentioned above, severely assaulted wives averaged almost twice as many “days in bed due to illness” as did nonassaulted wives, and they reported three times more often that they were in poor health (Gelles & Straus, 1990). It has also been shown that people who suffer from PTSD (due to a wide

range of traumas) are at greater risk for physical health problems and mortality than are people who do not suffer from PTSD symptomatology.

Protective Factors

What kinds of experiences or factors predict how a victim will cope with an abusive relationship and its sequelae? Researchers have identified "protective factors" that lead to better outcomes for battered women, and these include high self-esteem (Roberts & Roberts, 2002), social support (Kocot & Goodman, 2003; Meadows, Kaslow, Thompson & Jurkovic, 2005; Roberts & Roberts, 2002), "practical support" (Levendosky et al., 2004), cognitive (Roberts & Roberts, 2002) or "problem-focused" (Kocot & Goodman, 2003) coping strategies, and financial independence (Bybee & Sullivan, 2005; Goodman, Dutton, Vankos & Weinfurt, 2005). A range of protective factors (coping skills, hope, family and social support, spirituality, and successfully accessing resources) have been shown to be related to whether battered, socially disadvantaged African American women attempt suicide, and there is some evidence that the more protective factors a woman has the less likely she is to attempt suicide (Meadows, Kaslow, Thompson & Jurkovic, 2005).

Longitudinal studies have also demonstrated the effects of protective factors over time. In one study, higher levels of social support were related to decreased rates of reabuse (across a one-year period) for the ¾ of women who suffered lower levels of abuse, *but not for the ¼ of the women who were victims of the most severe abuse.* In addition, reabuse rates were lower for women who were employed and living separately from their abusers (Goodman, Dutton, Vankos & Weinfurt, 2005). Social support and

employment were associated with decreased risk of reabuse after 3 years follow up in another longitudinal study (Bybee & Sullivan, 2005).

Risk Factors

Are there factors related to the victim, other than proximity, that predict reassault rates? Longitudinal research suggests that women with fewer material resources are at greater risk for reabuse over time, and that using direct confrontation as a way to prevent further violence might, in fact, raise the risk of injury (Goodman et al., 2005). Other risk factors for battered women, over time, include having difficulty accessing needed resources, social contact with people who make their lives "difficult," and women who experience problems with the state's welfare system (Bybee & Sullivan, 2005).

Staying or leaving

Studies have shown that many women return to their abusive relationship after separating, and that women often separate multiple times (Anderson & Saunders, 2002; Griffing et al., 2002). What predicts whether a victim will leave or stay with her abuser? Anderson & Saunders (2003) reviewed the literature on this question and found, overall, that the woman's material resources - income and employment - are the most robust demographic predictors of whether she stays or leaves her abuser. She is more likely to leave if she is employed and/or has some expectation of financial independence. In general, the research is consistent in showing that absolute levels of violence do not predict leaving. However, one study investigating cognitive processes indicated that women (in a shelter) who perceived that the violence had *worsened* and who also believed that the batterer was to blame and is not going to change, were more likely to express the firm intention of leaving the relationship (Pape & Arias, 2000). The study

did not follow these women over time, however, and so it is unclear whether the intention to leave actually resulted in a permanent separation. Women who were involved in a community assistance program were more likely to end the relationship when the abuser had weapons in the home, and when there had already been a criminal justice intervention (e.g. arrest, prosecution) (Stroshine & Robinson, 2003). Psychological abuse, but not physical abuse, predicted whether victims (nonsheltered) in one study terminated their relationships with their abuser; in addition, women who had experienced child abuse were more likely to remain with their abusive partners than were women who had not (Raghavan, Swan, Snow & Mazure, 2005).

Several recent studies conceptualize leaving as a *process* which may involve a number of separations before the "final" one; given that battered women often face significant obstacles to leaving, these researchers focus on the cumulative efforts that women make and the gradual shift in how they experience and interpret their relationship (see Anderson & Saunders, 2003 for a review of this body of literature). The Transtheoretical Model of Change already discussed in relation to Batterer Intervention Programs has also been applied to the population of battered women. Researchers suggest that women progress through stages of change and readiness to leave and that this can take months or years (e.g. Lerner & Kennedy, 2000).

Importantly, some research has suggested that battered women may often underestimate their own likelihood of returning to a battering relationship. In a study of low income shelter residents, for instance, the majority reported returning to the batterer at least once in the past, with most reporting more than one return. However, the

majority also described themselves as "not at all likely" to return to the abusive relationship this time (Griffing, Ragin, Sage, Madry, Bingham & Primm, 2002).

Victim Services

Individual therapy

There is very little empirical evidence of the effects of specific treatment interventions on battered women. Recent research has identified one promising individual therapy intervention for battered women with PTSD, called Cognitive Trauma Therapy (Kubany, Owens, McCaig, Hill, Iannce-Spencer & Tremayne, 2004). Battered women who received this treatment met full criteria for a PTSD diagnosis (as a result of partner abuse), but they were not involved with the abuser any longer. They were substance-free and did not suffer from other serious psychopathology such as schizophrenia or bipolar disorder. Results indicated that the vast majority of women (87%) experienced significant reduction of PTSD symptoms and no longer met full criteria for the disorder; in addition, patients maintained these gains at 3- and 6-month follow ups. The treatment approach was effective across ethnicities and with a range of therapists.

Group Treatments

There is also very little empirical evidence regarding the efficacy of support groups for battered women, despite the fact that they are widely used. There is some research that demonstrates positive results from group treatment for women with PTSD; however, many of the subjects suffered from this disorder due to childhood, rather than spouse, abuse (e.g. Bradley & Follingstad, 2003; Nisbet Wallis, 2002). There is also some preliminary evidence that coping skills training groups for women with alcoholic

partners who are also violent can be effective in reducing women's depression as well as decreasing her partner's drinking and violent behavior (Rychtarik & McGillicuddy, 2005).

Couples therapy

Controversy exists about whether it is ever appropriate to offer couples therapy to couples who experience intimate partner violence (Berliner, 1996). Concerns are that it might inaccurately suggest that both partners are to blame for uni-directional violence, and that it could further endanger the woman if conflict raised in therapy leads to aggression outside of therapy. At the same time, there is a growing research base demonstrating the effectiveness of couples therapy to treat substance abuse, and it is the case that many of these couples also present with violence within their relationship (estimates are 40-60%) (Fals-Stewart & Kennedy, 2005). Therefore, these violent couples are, de facto, in couples treatment even though the "presenting problem" is substance abuse rather than relationship violence. What does the research tell us about the kinds of interventions that are effective for couples who experience violence but not substance abuse, and for couples who experience both?

Although there are several proponents of couples therapy for violent couples, they seem to agree that while couples treatment can be beneficial, it is contraindicated for couples who experience severe abuse (e.g. Bograd & Mederos, 1999; Greene & Bogo, 2002; Greenspun, 2000; Stith, Rosen, & McCollum, 2003). An important concept that has risen out of the family and marital therapy literature is the distinction between couples whose violence is characterized by mutual aggression but a lack of fear ("common couple violence") and those characterized by systematic male violence which

produces fear and intimidation ("patriarchal terrorism") (Johnson, 1995). A similar distinction is made between "expressive violence" which is characterized by lack of control (by either or both partners) when angry, and "instrumental violence" whose purpose is to control and intimidate (Greenspun, 2000). These distinctions parallel domestic violence researchers' efforts to distinguish among men (and couples) whose level and type of violence varies in order to try to identify what kinds of interventions would be most useful for whom and why. It seems that, across fields, there is consensus that men who inflict severe injury, who have anti-social tendencies, who intimidate and scare, and who have criminal histories are the hardest to treat and are the men whose partners are at highest risk of severe reabuse regardless of intervention efforts.

In the field of domestic violence, there is little attention paid to "common couple violence," which often involves mutual aggression, likely because this behavior is often not perceived as criminal and it does not generally result in injury. In other words, it is not "battering" as defined in the domestic violence literature, since battering implies a pattern of aggressive behaviors intended to maintain control over the partner.

So, for whom is couples therapy recommended, according to marital and family therapists? It may be most useful for those experiencing very mild violence (Bouchard, 1999; Stith et al., 2003), and it may be beneficial when there is "mutual abuse" (McMahon & Pence, 1996). Some argue that couples must want to stay together and that the man must be able to take responsibility for his violence and want to change in order for couples therapy to be effective, or even recommended (Greenspun, 2000). Marital therapy may help couples who experience "common couple violence," where there is no fear or severe abuse (Bograd & Mederos, 1999; Greene & Bogo, 2002; O'Leary, 1996). I

could not identify a single article supporting couples therapy for couples that include a severely abusive male. However, researchers point out that while clinical samples of violent couples more often include male to female battering, “community” samples of violent couples more often involve mild and/or mutual violence. These are the couples most likely to seek marital therapy voluntarily (Greene & Bogo, 2002).

Proponents argue that one benefit of couples treatment for this population is that it addresses bi-directional violence. In cases where both partners are aggressive, treating only one partner may not be enough to secure change in patterns of violent behavior (Stith et al., 2003). Second, since so many wives in violent relationships (regardless of severity) want to stay with their husbands or partners (and vice versa), it might be more effective for them to be a part of the treatment in order to learn new skills (including self-protection) and strengthen the relationship (Stith et al., 2003). Researchers and therapists agree that screening and assessing the appropriateness of couples treatment for those who have experienced violence is critical in order to minimize the chance that it is offered to a couple for whom it could be harmful (Bograd & Mederos, 1999; Greene & Bogo, 2002; Greenspun, 2000; Stith et al., 2003). Researchers in the field of marital and family therapy have voiced concern that maintaining a stance that couples treatment is always inappropriate for couples who have experienced intimate partner violence is like “throwing the baby out with the bath water.” In fact, there are several states that have standards prohibiting such treatment options (Healey, Smith & O’Sullivan, 1998).

Despite the controversy, there is little recent empirical evidence on the effectiveness of couples therapy for violent relationships (see Stith et al, 2003 for a detailed review of the few existing studies), and whether it is either beneficial or harmful

when compared to traditional gender-specific treatment. Some research on multi-couples group therapy (i.e. groups of couples seen together) indicates that it can be as effective as traditional treatments and it does not appear to make things worse in samples of both court mandated and self-referred couples (e.g. Brannen & Rubin, 1996; Dunford, 2000; O'Leary, Heyman & Neidig, 1999). In a small study comparing the effects of multi-couple group therapy and individual couples therapy in groups of married couples with mild to moderate violence, the group who received the multi-couple treatment fared particularly well, although both treatment groups reported significantly less (husband to wife) recidivism than did those in the control group (Stith, Rosen, McCollum & Thomsen, 2004).

Behavioral couples therapy (BCT) for substance abuse has been found to result in substantial reductions in violence (as a secondary benefit) both one and two years subsequent to treatment, and this reduction is more notable in couples where the man does not relapse in his alcohol use. In fact, in one study, the reductions in violence in couples where the man did not relapse reached a level that was similar to that of the nonalcoholic comparison group (O'Farrell, Murphy, Stephan, Fals-Stewart & Murphy, 2004). Proponents of BCT acknowledge that it is an appropriate treatment for couples who are committed to staying together, who include only one alcohol abusing partner, and who do not have a history of *severe* intimate partner violence (Fals-Stewart, O'Farrell & Birchler, 2004).

Worth noting is that marital violence also seems to decrease when alcoholic husbands are treated *individually* for their alcoholism either in an outpatient setting (O'Farrell, Fals-Stewart, Murphy & Murphy, 2004) or in a partial hospitalization

program (Stuart et al., 2003). As already mentioned above, women of alcoholic and abusive husbands might benefit from their *own* involvement in a coping-skills training intervention even if their partners are *not* involved in treatment; women who participated in a coping skills program experienced a decrease in violence from their partners and their partner's drinking also decreased (Rychtarik & McGillicuddy, 2005). There is some evidence that including female partners in men's individual treatment can also be beneficial. Alcoholic men who received "spouse involvement in treatment" had significantly fewer "heavy drinking days" than did men who received individual treatment; however, couples who experienced severe domestic violence were screened out of this study, and violence itself was not measured in the remaining sample (Walitzer & Derman, 2004).

Children may also benefit when their parents are involved in treatment for their alcohol and substance abuse disorders. In one longitudinal study of the benefits of treatment for alcoholic fathers, results indicated that the children's functioning improved overall when their fathers received treatment. Over time, in comparing children of fathers who relapsed vs. those who remitted, the children whose fathers remitted demonstrated significantly better psychosocial adjustment than did children whose fathers relapsed. In fact, the former group demonstrated the same, if not better, adjustment as the matched controls (Andreas, O'Farrell, & Fals-Stewart, 2006). Another study indicated that Behavioral Couples Therapy for substance abusing fathers was more effective in reducing children's adjustment problems than was individual therapy for the father (Kelley & Fals-Stewart, 2002).

In sum, in the literature on the effects of alcohol treatment on marital violence, results consistently demonstrate significant (and similar) levels of decreased violence following both individual and couples treatment, from pre-treatment violence prevalence rates of 54-60% to rates of 21-25% one year post treatment (O'Farrell, Fals-Stewart et al., 2003; O'Farrell, Murphy, et al., 2004; Stuart, Ramsey et al., 2003). It may be the case that it is premature to make conclusions or recommendations of one treatment over another since there are so many factors that play a role, such as available services, comorbid pathology, level and type of violence, and marital functioning and commitment. What is clear is that there are promising results in the field of alcohol treatment, for both individuals and couples (and their children), for decreasing both alcohol abuse and marital violence.

Victim Advocacy & Support

What is advocacy? Its purpose is "to help survivors of domestic violence navigate the systems involved in the community response as they attempt to acquire needed resources" (Allen, Bybee & Sullivan, 2004). Battered women often require behavioral health services, but they also often require an array of other community services as well, from immediate access to emergency shelters, help with safety planning, and support in the criminal justice system, to accessing resources for legal, financial, housing, education, health, or child care needs. But, often, they do not know what services exist or how to access them. Typically, local domestic violence service agencies provide crisis hotlines, counseling, advocacy, and emergency shelters, all of which have been shown to be useful to clients (Bennett, Riger et al., 2004). However, some research suggests that women are often in need of "life skills training" including learning how to

manage finances and finding a place to live, and that the lack of competence in these areas may contribute to victims' returning to their abusers (Gorde, Helfrich & Finlayson, 2004).

Battered women may "disclose" their abuse to the "system" in a variety of ways: for example, through involvement with law enforcement, a domestic violence shelter, a therapist, or a physician. The response they (and their batterer) receive may vary depending on the context of the disclosure and whether the woman wants the police involved. (According to one large national survey, only about a quarter of intimate partner assaults are actually reported to the police; Tjaden & Thoennes, 2000). Some women will enter domestic violence shelters in order to be safe, while others will go to a friend or family member's home. Some women will need medical attention while others may not; some may present with acute psychiatric symptoms while others may not. Given the range of experiences and resources that battered women have, they will also present with a range of needs. Once again, a one-size-fits-all approach to services and advocacy will likely not be the most effective.

There is some evidence that comprehensive and individualized approaches to advocacy are most effective in helping women access needed services (Allen, Bybee & Sullivan, 2004). This approach acknowledges that women have differing priorities and that advocacy efforts need to take this into account. Advocacy efforts for women exiting a shelter have been found to be effective not only in helping them take advantage of a range of community resources (Allen et al., 2004), but also in reducing future violence (Sullivan & Bybee, 1999). Advocates working with this approach would, therefore, connect victims with needed, but specific, behavioral health services.

Helping women navigate a particular system and access particular services is critical. However, also important is *coordinating* these services so that relevant service providers can refer women within and among systems in a seamless manner. For example, if the police are called to investigate a domestic violence incident, their response may include removing the perpetrator from the home, but it could also include pointing the woman in the direction of needed services either by immediately providing an advocate, arranging transportation to a shelter, etc. Referring agencies and professionals, such as the police, hospitals, and mental health treatment providers must have accurate information about appropriate places and programs to refer battered women, including shelters, legal services, housing, alcohol or substance abuse treatment, etc. (Roberts & Roberts, 2002).

Efforts have been made to coordinate services in a variety of ways. Shepard (1999) describes three types of coordination efforts that have generally been made around the country: Community Intervention Projects, which are based within advocacy organizations and which focus on coordinating systems in order to maximize victim safety; Coordinating Councils, which are made up of representatives from a wide range of criminal justice and community service agencies in order to increase interagency communication and cooperation; and, reforms based within the criminal justice system. Examples of criminal justice reforms include integrating case management, and "vigorous" prosecution for probation or restraining order violations. Allen (2006) investigated the effectiveness of 41 coordinating councils in one mid-western state and found that they were more likely to focus on criminal justice issues than other, equally important, issues such as advocacy and children's protective services. Overall, what little

empirical evidence there is suggests that coordinated efforts are more effective in reducing violence than is any individual component (Shepard, 1999).

Children Who Witness Domestic Violence

Effects of domestic violence on children's behavior and mental health

According to recent estimates, more than 15 million children live in homes in which partner violence has occurred, and almost half of these children live in families with severe partner violence (McDonald, Jouriles et al., 2006). There have been a number of studies examining the effects of witnessing domestic violence on a variety of child outcomes over the past 25 years, and results generally indicate detrimental effects. A recent meta-analysis indicated that "about 63% of child witnesses were faring more poorly than the average child who had not been exposed to interparental violence" and that children who were exposed to domestic violence demonstrated similar outcomes to those children who had experienced direct physical abuse (Kitzmann, Gaylor, Holt & Kenny, 2003, p. 345). In general, children who witnessed violence in the home were more likely to demonstrate internalizing, externalizing, academic, and social problems. A second meta-analysis conducted with more stringent criteria and which, therefore, included fewer studies, drew similar conclusions (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). However, there were no compelling differences in overall effects by gender or by age/developmental level in either meta-analysis despite significant findings in individual studies.

Meta-analyses are useful in identifying overall effects and trends, but they often miss more subtle findings since studies are not homogeneous or equivalent in populations

or measures. There is no question that witnessing domestic violence places children at risk for a range of behavior and mental health problems; however, there are many factors that are important in trying to understand how domestic violence affects children and, therefore, how to intervene. Most importantly, children who witness parental violence are at greater risk for being physically abused themselves (Appel & Holden, 1998; McCloskey, Figueredo & Koss, 1995), and there are often multiple types of violence within the same home (McCloskey, Figueredo & Koss, 1995; Slep & O'Leary, 2005). In addition, children in violent homes may be at greater risk of being victimized outside the family (McCloskey, Figueredo & Koss, 1995) and of witnessing community violence (Saunders, 2003). Therefore, there may be a range of physical as well as psychological sequelae that must be addressed.

There is little research that indicates specific outcomes of witnessing domestic violence for specific groups of children; some research suggests that children from violent homes are at increased risk for either full Post Traumatic Stress Disorder or some PTSD symptoms (Chemtob & Carlson, 2004; Graham-Bermann & Levendosky, 1998), while other studies indicate that these children are also at risk for a wide range of externalizing and other internalizing disorders (e.g. Grych, Jouriles, Swank, McDonald & Norwood, 2000; McCloskey et al., 1995). In a longitudinal study in New Zealand, for example, 18 year olds who witnessed domestic violence when younger reported higher levels of mental health problems, substance abuse, and criminal behaviors than did children who did not witness family violence (Fergusson & Horwood, 1998). Again, it is important to remember that children who experience violence in one form are at risk for

experiencing violence in multiple forms and of developing multiple problem outcomes (e.g. PTSD *and* substance abuse) (Saunders, 2003).

There is also a group of children who, despite intense family stressors, do not appear to have notable adjustment difficulties (Kitzmann et al., 2003). Researchers acknowledge that children's outcomes are likely a result of a variety of variables, including age, SES, gender, nature of the violence, parenting factors, protective factors, genetic and other vulnerabilities, and future research efforts should focus on identifying more specific developmental pathways (Margolin, 2005).

Impact of DV on parenting

Marital conflict

While there is some research that has examined the relationship between domestic violence and parenting behaviors and effectiveness, there is a more extensive literature in the area of general interparental conflict and parenting. For example, a recent meta-analysis examining the relationship between marital conflict and parenting behaviors found that, in general, high levels of interparental conflict were associated with poor parenting. Specifically, the parenting behaviors most likely to be associated with interparental hostility and conflict were increased harsh punishment and decreased child acceptance (Krishnakumar & Buehler, 2000). Worth noting is that this meta-analysis was not able to consider interparental violence or aggression as a separate variable. However, these results are nonetheless informative and suggest that marital conflict can interfere with parenting skills. One study even suggests that chronic marital conflict can significantly interfere with both parents' ability to form a secure attachment with their infant (Owen & Cox, 1997).

Effects of violence on parenting

In looking at violent families, one study found that husband-to-wife aggression was related to coercive parenting by *both* parents. This study also indicated that parenting tended to be more disrupted the more aggression risk factors there were in the family (family of origin aggression, husband-to-wife aggression, child abuse potential) (Margolin, Gordis, Medina & Oliver, 2003). Similarly, McCloskey, Figueredo, & Koss (1995) found that children of abused mothers were more often physically punished and more often physically punished by both parents than were comparison children. In an observational study with a community sample of families, domestic violence was related to more "hostile-withdrawn" and less "positive" co-parenting (Katz & Low, 2004).

Effects of violence on mothering

Researchers have identified maternal parenting stress as a potentially important mediator between parental violence and child functioning. For example, in a sample of African American 8 – 12 year olds who lived in violent homes, their adjustment problems could partially be explained by mother's parenting stress (Owen, Thompson & Kaslow, 2006). The researchers note that this has important implications for intervention with both children and mothers. An observational study involving abused mothers and their school-age children found that mothers' experiences of both psychological and physical abuse predicted observed maternal warmth, such that reports of more abuse predicted less maternal warmth. In addition, psychological abuse appeared to be more "damaging" to parenting skills than physical abuse in this sample (Levendosky & Graham-Bermann, 2000). Similarly, in a study of 4 to 9 year olds who witnessed parental violence, maternal supportiveness and the mother's own PTSD symptoms were related to child outcomes:

greater maternal supportiveness was related to fewer trauma symptoms and behavioral difficulties in the children, and mothers' PTSD symptoms were related to more PTSD symptoms and more internalizing difficulties in the children (Rossman, Bingham, & Emde, 1997).

Effects of violence on fathering

In a study which relied on maternal reports, violent fathers were found to be significantly more "irritable" and more likely to use physical punishment on their children than were fathers who were not reported to be violent against their wives (Holden & Ritchie, 1991). This sample of children was also at greater risk for maltreatment by both parents, although more so from the fathers.

Risk of child abuse

Estimates are that about 40% of families in battered women's shelters have experienced child abuse, while there is about a 6% overlap between spouse abuse and child abuse in community samples (Appel & Holden, 1998). Given the high incidence of child abuse within partner-violent families, researchers have tried to identify risk factors or processes that might help predict which children are more likely to be physically hurt by their parents when there is partner violence, and, if so, by which parent. Conversely, it is also important for professionals in other systems to know when it is important to screen for domestic violence given this link. For example, it has been demonstrated that for mothers referred to child protective services for child maltreatment, rates of intimate partner violence (44.8% over the lifetime) are significantly higher than in community samples (Hazen, Connelly et al., 2004) suggesting that children who are maltreated, or

for whom there is a suspicion of physical abuse, have a high risk of living in a home with interparental violence.

So, are mothers or fathers in maritally violent homes more likely to abuse their children and under what conditions? In their review of the empirical literature, Appel & Holden (1998) found that in homes with marital violence children were at risk for abuse from both parents, especially when there was mutual parental violence. However, there is also some evidence that when the father is the sole perpetrator, he is more likely to be the one who is physically abusive toward the child. Of concern is that research has not consistently been clear on these issues; for example, in some studies, subjects were not asked to specify whether mother, father, or both parents engaged in abusive behaviors toward the child.

One recent study found that husband-to-wife violence was related to child abuse potential in *both* parents when family stress levels were high, but not when they were low. In addition, wife-to-husband violence was related to mothers' child abuse potential but only in the context of high stress (Margolin & Gordis, 2003). Investigators have examined parents' cognitive processes in an effort to identify how their views of their children might impact their risk for maltreating them. For example, one study found that parents who experienced domestic violence during their child's first year of life developed a significantly more "negative" view of their child than did parents who did not experience violence. In turn, this negative view was related to increased "family risk" of abuse (McGuigan, Vuchinich & Pratt, 2000), although it was not clear whether father, mother, or both parents demonstrated higher child abuse potential.

In a recent study examining marital violence and physical abuse directed toward clinic-referred *adolescents*, two-thirds of the adolescents who lived in a home with marital violence had experienced "severe acts of physical aggression by at least one parent" during the previous year, and the incident rates of mothers vs. fathers as the aggressor were the same (Mahoney, Donnelly, Boxer, & Lewis, 2003). In addition, mothers were more likely to be physically abusive when they, themselves, were the victims of marital violence, while fathers were physically abusive regardless of whether they were primarily aggressors or victims.

Substance Abuse

Although there is substantial research identifying linkages between parental alcohol/substance abuse and domestic violence (see above), parental alcohol/substance abuse and child maladjustment (see e.g. Johnson & Leff, 1999 for a review), and parental alcohol/substance abuse and child maltreatment (Locke & Newcomb, 2003; Walsh, MacMillan & Jamieson, 2003) or child abuse potential (Ammerman, Kolko, Kirisci, Blackson, & Dawes, 1999), it is not clear whether parental alcohol or substance abuse in families *with marital violence* increases the risk of child abuse above and beyond the risk that exists due to either interparental violence or alcohol/substance abuse alone. However, some research has shown that substance-abusing mothers who report 5 or more risk factors, such as domestic violence, depression, homelessness, incarceration, etc., compared with substance abusing mothers with fewer risk factors, during their child's first 2 years, are more likely to demonstrate higher levels of parenting stress and child abuse potential (Nair, Schuler , Black, Kettinger, & Harrington, 2003). This suggests that

there may be "cumulative" risk to their children, at least for women who abuse substances.

Summary

It is clear from the research that children who are exposed to domestic violence are at risk for developing a range of mental health and behavioral problems, and they are also at particular risk for being physically victimized themselves. However, empirical studies on the effects of violence on children have often focused on single forms of violence (witnessing parental or community violence, physical abuse, sexual abuse, etc.) and have failed to take into account that many children are victimized in more than one way. Therefore, it is very difficult to conclude that, for example, witnessing domestic violence leads to particular outcomes since potentially confounding variables, such as parent substance use or child physical abuse, are not considered and controlled. Much work needs to be done in fleshing out different "developmental pathways" (Margolin, 2005) as well as integrating ideas, findings, and future research efforts from disparate professional fields (Saunders, 2003).

Child and parenting interventions

It has already been shown that treating fathers with substance abuse disorders can help improve partner relationships and children's psychosocial adjustment (Kelley & Fals-Stewart, 2002; Andreas et al., 2006). However, in the literature on both batterer intervention programs as well as treatment efforts for victimized women, the measurement of indirect effects of these treatments on children is noticeably absent. Instead, efforts have been made to implement and evaluate a variety of support groups and therapies provided to children directly, most often in shelter settings. In one recent

review of available studies on this topic (Graham-Bermann & Hughes, 2003), the authors identified several interventions but only three comprehensive interventions that have been evaluated over time and which have demonstrated effectiveness. One program by Sullivan and her colleagues (Sullivan, Bybee & Allen, 2002) involved two parts: Advocacy (for mothers) and The Learning Club (for children). The Advocacy piece was briefly described above in the *Advocacy* section; The Learning Club (TLC) is a 10-week support and education group for school-aged children, implemented when the families exited a shelter. Results from this program suggested that the children's feelings of self-competence improved after this program, when compared to the control group, but all children who received the TLC intervention also had mothers who received the Advocacy intervention; therefore, it is hard to determine whether one or both interventions were responsible for the children's improvement.

A second identified program, Project SUPPORT, developed by Jouriles and colleagues, specifically targets oppositional and conduct disordered children, ages 4-9 years of age. As in Sullivan et al.'s program, families were eligible when they exited shelters and were no longer living with the batterer. This program involves intensive home-based services, including primarily providing support/advocacy, education, and parent training to mothers, and the intervention lasted up to 8 months. In the most recent evaluation of the long-term effects of this intervention, results indicated ongoing benefits 2 years following the termination of services (McDonald, Jouriles, & Skopp, 2006). Compared with the families who received "existing services", in the group who received the intervention fewer children demonstrated conduct disorder and were less likely to

demonstrate significant internalizing symptoms, and mothers were less likely both to use aggressive parenting strategies and to return to their abusive partner.

The third intervention that has been empirically evaluated is The Kids Club, which is a 10-week support group for children ages 5-13. The purpose is to help children develop coping skills and to educate them about IPV (interparental violence) (Graham-Bermann & Hughes, 2003). In addition, the model includes separate parenting support groups, and the outcome research included evaluation of children who received the intervention, children who received the intervention and whose mothers also received the intervention, and a control group. Program recipients included both shelter and community samples. In their evaluation, the authors reported that the children whose mothers also participated in the intervention were found to demonstrate the greatest reduction in both internalizing and externalizing symptoms.

In sum, it appears that children who have witnessed domestic violence are more likely to experience symptom reduction when their mothers are involved in intervention efforts that address parenting skills and/or advocacy efforts. What is not yet clear is how to tailor interventions for specific subpopulations (e.g. by ethnicity, age, gender, specific symptom presentations, type(s) of violence, etc.). Developmental researchers and theorists have consistently recommended that assessments and interventions be developmentally appropriate. The youngest victims (ages 0-3 and 3-5), school-aged children, and adolescents all need assessments and interventions that are developed specifically for them (Kerig, Fedorowicz, Brown, & Warren, 2000; Rossman, Graham-Bermann, & Butterfield, 2004). Although there are several programs developed for preschoolers, outcome data are sorely lacking (see Rossman, et al., 2004 for a review).

In addition to educational and mental health interventions for children who have witnessed domestic violence, there is also a need for thoughtful safety planning. It is important that safety plans not only consider the needs of the mother but also the needs of her children, especially in determining the nature of their contact with the father/batterer. Again, individual assessments must be done, so that the child's age, behavioral and psychological status, physical health, and relationship with the father are all considered in making a plan that is in the child's best interest. And, danger assessments must consider the degree of risk to both mother and child(ren) (Hardesty & Campbell, 2004).

Conclusions and recommendations

Despite the fact that domestic violence perpetrators and victims encounter so many systems (including law enforcement, criminal justice, protective services, mental and medical health systems, and victim services), and that so many factors play a role in domestic violence and its individual course (e.g. demographics, substance abuse, mental illness, perpetrator characteristics), research tends to neglect this complexity and focus, instead, on individual elements. For example, batterer intervention programs are often evaluated in isolation; effects of witnessing domestic violence on children are often evaluated without regard to other, likely, confounding factors such as direct experience of physical abuse; substance abuse is often ignored in evaluating both predictors of violence, treatment compliance and benefits, and outcomes for both batterers and their victims. As a result, the research often seems contradictory, making it difficult to identify the kinds of behavioral health interventions that are most effective and for whom. However, what evidence does exist certainly suggests that the "one-size-fits-all"

approach, as commonly used, to treating batterers and their victims is not appropriate given that there are important differences among batterers and among victims that have critical implications for a range of outcomes. We do know enough about batterers, their victims, and the effectiveness of existing treatment efforts to make informed and educated decisions about how best to intervene. The following are highlights of research findings that have direct implications for how behavioral health services should be delivered.

Important findings regarding batterers:

- There is a group of batterers who demonstrate sociopathic tendencies, who are resistant to traditional treatments, and who are the most likely to reassault their partners.
- A large proportion of men who batter also exhibit substance/alcohol abuse or other psychiatric disorders that require treatment.
- Specific interventions aimed at engaging and maintaining batterers in treatment are effective for retention efforts.
- Stage of change predicts staying in, and benefiting from, batterer's treatment.
- Individual and couples' substance abuse/alcohol treatments for mild to moderately violent husbands are effective for decreasing substance/alcohol abuse, decreasing violence, and improving children's functioning.

Important findings regarding women victims:

- Many battered partners would prefer to stay with their partner than leave for a variety of reasons, including emotional attachment.

- Many battered partners would prefer to leave their partners but do not do so because of financial dependence, poor "life skills," or other stressors (such as psychiatric disorders, substance abuse, or lack of social support) that decrease the victim's ability or willingness to live independently; those who wish to leave and do so often undergo multiple separations before leaving for good.
- Women victims are likely to need both physical and mental health assessments, and both advocacy and therapeutic intervention efforts are most effective when they are tailored to address the woman's individual needs.

Important findings regarding children:

- Children who witness domestic violence are at increased risk for a range of behavioral, social, and academic problems and for being victims of multiple forms of violence.
- Children are likely to need both physical and behavioral assessments given the large proportion of child witnesses who are also physically abused.
- Assessments, safety planning, and behavioral interventions must be implemented with the child's specific presentation and needs in mind; they must be developmentally appropriate and sensitive to the child's strengths and weaknesses.
- Children tend to benefit more from mental health, behavioral, and trauma treatment interventions when their mothers are also involved in treatment that focuses on improving parenting skills and strengthening the parent-child relationship; parent training is especially important for children with disruptive behaviors.

Important findings about service delivery systems:

- When services are better coordinated and when batterers and victims receive more of the services and interventions that they need, there is a demonstrable benefit in terms of both reduced violence and improved functioning for everyone in the family.
- Coordination of services requires communication between systems but also education and training that allow systems to work together in more seamless and effective ways (e.g. the Child Development-Community Policing model, discussed below).

Recommendations

Given these findings, there are several general recommendations that can be made in the area of behavioral health and domestic violence, although existing service providers will have to determine how to integrate findings within their own systems. Recommendations are intended as a first step toward improving services to these families and answering questions providers may have about how to work toward a "best practices" model of service.

Recommendations for batterers and BIPs

- Before beginning a general BIP, batterers should be routinely screened and evaluated for lethality, substance use, psychopathology, and stage of change.
- Supplemental treatment(s) for substance abuse or other psychiatric conditions should be provided where necessary.
- BIPs should be tailored to specific populations; it should not be assumed that there is only one appropriate program for all batterers. Batterers who are more

reluctant and less ready to change might, for example, benefit from pre-treatment efforts focusing on motivation. Batterers who are more lethal and who have longer histories of violence might do best in a highly structured program that provides intensive monitoring and implements harsher consequences for noncompliance.

- Retention efforts (e.g. phone calls, letters) should be made in order to maximize the chance that a batterer will stay and complete treatment.
- Careful monitoring by the criminal justice system of treatment compliance is important for all batterers, and noncompliance should be dealt with swiftly and with sufficient severity to achieve compliance and safety.

Recommendations for women victims

- Women victims would benefit from individualized and comprehensive advocacy and support services. Relevant training and support for achieving financial independence and learning basic "life skills" are critical.
- Women victims should be screened for physical (e.g. brain injury), mental health, and substance abuse problems, and treatment(s) should be tailored to the woman's individual symptom presentation and goals.
- It must be acknowledged that many women do not want to leave their abuser although they want the violence to stop. In cases where the couple is committed to staying together, and there is no report of severe violence (with or without alcohol involvement), behavioral couples therapy, *with a trained behavioral couples therapist*, should be considered a treatment option.

Recommendations for child victims/witnesses

- Children need to be assessed for both physical and behavioral effects of violence, and professionals must be aware of the likelihood that child witnesses have experienced other forms of violence as well.
- Child assessments and interventions should be developmentally appropriate and they must take into account that behavioral and mental health symptoms are likely to peak during a crisis and, therefore, may not be representative of the child's general, or optimal, functioning.
- Safety planning MUST consider the needs of the child and not just the mother.
- Individual or group therapy might be helpful for children who need emotional support, education, or an outlet for emotional expression, but *parenting interventions are clearly indicated and recommended* to address child behavior problems, especially disruptive behavior.

Recommendations for coordination of services

- Services for batterers and their families should be, as much as possible, individualized, comprehensive, and coordinated.
- Service agencies and academic researchers (especially *local* researchers) should establish ongoing communication in order to facilitate both subject recruitment and appropriate treatment referrals.

Final Note

In this review, several topics were not covered explicitly but are nonetheless important to consider when both evaluating the effects of domestic violence and planning for intervention. These include domestic violence in same-sex couples and in the elderly, cultural differences and needs, women batterers, sexual violence as a separate (but sometimes co-existing) form of abuse, and the role of prevention.

In addition, a full description of the law enforcement and criminal justice responses to domestic violence is beyond the scope of this paper. However, the police and the criminal justice system obviously play a critical role in determining domestic violence outcomes and reassault rates. One example of how a coordinated community effort between the police and a child mental health delivery system has resulted in increased services for children is the Child Development – Community Policing Program (CD-CP) developed in New Haven and currently being implemented in Rhode Island as well. Briefly, the program involves training police in child development and bringing mental health professionals to the scene of a domestic assault when a child is present in order to provide crisis intervention services and to facilitate referrals to appropriate services (Erstling, 2006). Research on the original program in New Haven yielded positive results in terms of linking children with appropriate and timely mental health services.

Research linking mental health outcomes and criminal justice responses, however, seems lacking and might be a fruitful area for future focus. That is, we need more information about how a victim's experiences within the criminal justice system create, exacerbate, or ameliorate mental health functioning. One study demonstrated that the

more time the victim spent with the prosecutor, the more likely she was to cooperate in prosecuting her batterer and the more likely the batterer would be found guilty; in fact, victims were often "more afraid of the courts...than…of the danger posed by the offender" (Belknap et al., 1999 as cited in Buzawa & Buzawa, 2003, p.206). Research has often highlighted how not "user-friendly" the criminal justice system is to women victims of domestic violence, and there are many models for change that have become widely discussed (but less widely implemented). These range from simply sensitizing court and prosecutorial staff to developing comprehensive programs including specialized domestic violence courts and probation departments. Although these developments are not focused on behavioral health issues per se, the potential impact on behavioral health seem clear, especially when the programs effectively *empower* victims in the criminal justice process (Buzawa & Buzawa, 2003). One valuable resource would appear to be the National Center for State Courts (www.ncsconline.org) which provides information about best practices in the court system in general, and in the area of family violence in particular.

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