

Couples Treatment for IPV:

A Review of Outcome Research Literature and Current Clinical Practices

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Abstract

Conjoint couple treatment for Interpersonal Partner Violence (IPV) remains controversial despite a growing body of research and practice experience indicating that it can be effective and safe. In addition, developing typologies of couples who are violent suggest that a “one size fits all” treatment approach to IPV is not appropriate and conjoint treatment may have a place in the treatment of at least some couples. In this paper, we review the experimental studies and clinical practices of conjoint treatment. Based on this review, we suggest current best practices for this approach to treatment. Best practices include couples treatment as part of a larger community response to IPV, careful screening of couples for inclusion in couples treatment, modification of typical conjoint approaches to promote safety and on-going assessment of safety with contingency plans for increased risk.

Couples treatment when there has been intimate partner violence (IPV) remains controversial and objections to it have generally taken two forms – one pragmatic and one philosophical. On the pragmatic side, the assumption has been widely made that conjoint treatment sessions increase the likelihood of violence. Adams (1988) states plainly, “Many battered women report that past family therapy sessions were followed by violent episodes” (p. 187). The mechanism proposed is that women are asked to be open and honest about their complaints and grievances in a conjoint session – sometimes with a false sense of security arising from the fact that the man has agreed to treatment – only to face retaliatory violence after the session for embarrassing or challenging him.

The philosophical objection to conjoint treatment is based on a critique of the systemic paradigm that underlies most relationship therapy. Critics propose that, as Bograd (1992) puts it, “Systems formulations still either implicate the battered woman or diffuse responsibility for male violence” (p. 246). By looking at violence in an interactional context, critics fear that women will be put in the position of having to help control their partner’s violent behavior of which they are a victim. In addition, instead of the man being held squarely responsible for his actions, his responsibility may evaporate in discussions of couple interaction patterns, conflict resolution skills, family of origin issues, and the myriad other things that comprise couples therapy.

The critique of couples treatment has been influential with clinicians, state certification bodies, and other policy makers who have often opted for the presumably safer standard treatment of gender-specific groups for male batterers and female victims. Currently, 44 states have promulgated standards for batterer intervention. In a 2005 analysis of these standards, Maiuro and Eberle (in press) report that 68% of states with

standards expressly prohibit couples treatment during the time that primary domestic violence intervention is on-going in favor of gender-specific treatment. This actually represents an increase in the percentage of states prohibiting couples treatment since Maiuro and colleagues' 2001 survey of state standards (Maiuro *et al.*, 2001). However, as Saunders (in press) points out, there is not yet sufficient evidence for the efficacy of male-only batterer intervention programs. Thus, other promising treatments like conjoint couples treatment are being foreclosed in favor of traditional but not necessarily effective approaches.

The Case for Couples Treatment

We take the safety – both physical and psychological – and the empowerment of our clients to be fundamental in all the clinical work that we do. At the same time, we have been involved in developing and studying couples treatment for domestic violence for a number of years. How do we justify our commitment to couples treatment in light of the many objections to it? We have a number of reasons for this stance.

In our view, the primary philosophical objection to couples treatment – that a systemic approach blames the victim and relieves the perpetrator of responsibility for his acts – is based on a simplistic and out-dated understanding of systems models. Simplistic circular causality models of interaction have given way to more complex and layered models – models that include the individual and the social context along with the interactions between partners. Sprenkle (1994) contends that few, if any, systemic family therapists would consider a woman's actions the cause for her partner's violence against her, nor would they eschew taking a firm stand against violence in favor of "systemic neutrality." The models of couples treatment for IPV described in this paper have begun

to operationalize this theoretical position and provide ways to both hold violent partners accountable and examine couple interaction.

A second aspect of our consideration for the use of couples therapy is the growing realization that not all violence in intimate relationships is the same. In the 1980's and early '90s, a number of typologies of male batterers emerged driven by data from national random surveys and by the widening societal definition of violence that has brought a much broader spectrum of violent acts to the attention of the courts and treatment providers. Holtzworth-Munroe and Stuart (1994) aggregated these typologies to propose 3 profiles of male batterers based on the severity and frequency of the violence within the relationship, whether the man is only violent in intimate relationships or also outside the relationship, and whether or not psychopathology is present.

Johnson (1995) proposed a simpler model, delineating two types of violence in intimate relationships – “*patriarchal terrorism*” (now called *intimate terrorism*) and “*common couple violence*” (now called *situational violence*)¹. Intimate terrorism is a pervasive attempt to dominate one's partner and generally exert control over the relationship with violence being the foundational, but not sole, tactic of the abuser. Johnson and Leone (2005) suggest that Pence and Paymar's (1993) Power and Control Wheel is the most succinct description of the actions of an intimate terrorist. Fear on the part of the victim and pervasive control by the abuser are the two distinguishing characteristics of intimate terrorism. In contrast, situational violence is defined as violence in intimate relationships that is not embedded in a pervasive pattern of control and domination. Situational violence occurs as a result of an escalating conflict that gets out of hand resulting in one or both partners using physical aggression. While either type

of violence can result in lethal or gravely injurious acts, Johnson and Leone report that situational violence (compared to intimate terrorism) has a lower frequency of occurrence per couple, is not as likely to escalate over time, is not as likely to involve severe violence, and is not as likely to involve unilateral male-to-female assault.

What do typologies tell us about the use of couples treatment? The fact that batterers and couples in which violence occur are heterogeneous groups suggests that the strategy of prescribing the same intervention for all cases of IPV (male-only, pro-feminist psychoeducation) may not be sound. Johnson's work, in particular, suggests that a significant portion of IPV springs from relationship conflict, leading us to conclude that efforts to change relationship dynamics may be the most appropriate treatment for a carefully selected subset of couples in which there has been violence.

We see three dangers when partners in relationships in which situational violence occur are treated separately. First, the role of the woman's aggression may be ignored or downplayed. In intimate terrorism situations, women are less likely to assault their partners. When they do use aggression, they typically do so in self-defense, and tend to stop when their own violence makes their partner's violence worse. In contrast, women and men in relationships in which situational violence occurs tend to assault each other with nearly the same frequency and assaults often arise from conflict and efforts to exert control *over a specific situation and not as part of a pervasive pattern of domination* (Johnson, 1995). Not attending to women's aggression in this latter situation leaves out a major piece of the interactional puzzle since cessation of violence by one partner is highly dependent on cessation of violence by the other partner (Feld & Straus, 1989; Gelles & Straus, 1988). An equally important finding is that when women assault their

partners, they increase their risk of injury by their partners significantly (Feld & Straus, 1989; Gondolf, 1998).

A second reason to consider the use of couples treatment is the role that marital discord plays in IPV. Marital discord itself is a strong predictor of IPV. Pan, Neidig and O'Leary (1994) found that for every 20% increase in marital discord, the odds of mild partner assault rise 102%, and the odds of severe assault rise 183%. Treating the couple separately, without attention to their relational patterns, may not adequately address the marital discord that is adding to the potential for on-going violence.

The final reason to consider conjoint couples therapy in the wake of IPV, springs from the real world experience of professionals who work daily with men and women who assault one another and/or are the victims of partner assaults. Rather than the first act of violence being a signal to end a distressed relationship or leave a domineering oppressor, violent couples tend to stay together. Feazelle, Mayers and Deschner (1984) report that from 50% to 70% of assaulted women stay with their abusive partners or return to them after separating. Thus, in addition to managing violence, these couples continue to face the day-to-day stresses of parenting, running a household, and maintaining jobs and income – all sources of marital conflict. Conjoint therapy holds the potential to help mitigate such stresses, and it is often requested couples who want to rid themselves of the violence in their relationship but not of the relationship itself. Treating the man in isolation leaves the couple on their own to do this difficult work.

In the rest of this paper, we examine both the outcome literature and current clinical practices to suggest best practices when couples treatment is used with IPV.

Experimental Studies Evaluating the Effectiveness of Conjoint Treatment for IPV

Four groups of studies have used experimental designs (i.e., couples are randomly assigned to two or more treatment conditions) in examining the effectiveness of conjoint treatment for IPV. In each of the published studies the couples treatment condition was at least as effective in ending violence as the comparison approach. In this section of the paper we examine: (1) the research conducted at the Families and Addiction Program, Harvard Medical School and the Research Institute on Addictions, University at Buffalo, SUNY, by Timothy O'Farrell and William Fals-Stewart; (2) studies examining a version of Peter Neidig's Domestic Conflict Containment Program (DCCP) or the revised Physical Aggression Couples Treatment (PACT) conducted at the State University of New York: Stony Brook by Daniel O'Leary, Peter Neidig, Richard Heyman and Steven Brannen; (3) studies examining the Domestic Violence Focused Couples Treatment program conducted at Virginia Tech, Falls Church, by Sandra Stith, Eric McCollum and Karen Rosen; and (4) the only study which included a "no treatment control group" conducted through the Navy by Frank Dunford.

Intervening to End IPV through Substance Abuse Treatment

A strong relationship has been found between IPV and substance abuse. Across male substance abusing inpatient samples, the prevalence of IPV in the year prior to assessment ranged from 58% to 84% (Bennett *et al.*, 1994; T. G. Brown *et al.*, 1998; Gondolf & Foster, 1991). In outpatient samples of male alcoholics, the prevalence of male-to-female violence in the year before treatment ranged from 54% to 66% (Murphy & O'Farrell, 1994; Murphy *et al.*, 2001; Stuart *et al.*, 2003). Furthermore, research indicates that on those days an abuser drinks, he is more likely to be abusive. One study

indicates that among men entering treatment for IPV or for substance abuse, IPV was 5 to 10 more likely on drinking days than on non-drinking days (Fals-Stewart, 2003).

During the past 10 years, a variety of studies documenting the effectiveness of Behavioral Couples Therapy (BCT) for substance abuse on reducing IPV have been undertaken at the Families and Addiction Program, Harvard Medical School and the Research Institute on Addictions, University at Buffalo, SUNY (Fals-Stewart *et al.*, 1996; Fals-Stewart *et al.*, 2002; O'Farrell *et al.*, 2004; O'Farrell & Murphy, 1995). BCT has been delivered in a variety of forms in the course of this research. It is primarily a behavioral program of couples treatment aimed at providing couples with skills and changing dysfunctional interaction patterns in order to provide a family environment that will support long-term alcohol and drug abstinence. BCT is typically delivered in 15-20 outpatient conjoint couple sessions over 5 to 6 months but may also be delivered in an outpatient multi-couple group format (Fals-Stewart *et al.*, 2004). Inclusion criteria for BCT varied according to the study undertaken, but generally included: the couple had to be in a stable relationship with each other for at least one year; the male partner had to meet abuse or dependence criteria for at least one substance and agree to refrain from using psychoactive substances during treatment and also refrain from seeking additional substance abuse treatment during the treatment period except self-help meetings. Couples were excluded if the female partner also met the criteria for a substance abuse disorder within the past 6 months; either partner had a psychotic disorder or evidence of organic impairment sufficient to impair project participation; or either partner was participating in a methadone maintenance program. Since the original work, the Harvard and Rochester groups have also chosen to exclude couples in instances where the

reported violence is significant enough to result in serious injury or intimidation, or when participants do not agree to refrain from engaging in partner violence during treatment.

The findings from this body of research concerning IPV are consistent and telling. Each of the studies that examined the effect of BCT on IPV has supported the efficacy of BCT in reducing IPV for substance abusing couples. For example, in a study of the natural history of domestic violence before and after alcoholism treatment, O'Farrell, Van Hutton, and Murphy (1999) followed couples receiving an early version of BCT for two years. Comparison rates of domestic violence for a matched nonalcoholic sample were derived from a nationally representative survey of violence in American families (Straus & Gelles, 1990). In the year before BCT, the alcoholic group had a significantly higher prevalence of violence than did the nonalcoholic comparison group. In the treated group, however, the percentage of couples experiencing any violent act decreased from 61.3% in the year before BCT to 22.7% in the first year after BCT and 18.7% in the second year after BCT. Additionally, the prevalence and frequency of violence by alcoholics were no longer significantly higher than among their counterparts in the nonalcoholic comparison group. In another study, Fals-Stewart and colleagues (2002) randomly assigned 80 married or cohabiting drug-abusing couples to either individual treatment or BCT. While violence was reduced in both treatment conditions, couples attending BCT were significantly less likely to be violent in the year after treatment than couples in which only the male substance-abusing partner attended treatment.

How can we explain the fact that an intervention that does not directly focus on IPV achieves such significant reductions in it? Fals-Stewart and Kennedy (2005) suggest that one reason conjoint treatment is more effective than individual treatment in reducing

IPV is that when only the identified patient is in treatment, the reduction in violence is a result of only the substance abuser remaining abstinent. However, when both partners are in treatment, the partner learns coping skills and measures to increase safety when faced with a situation where the likelihood of violence increases. “In particular, emphasis is placed on using behaviors that reduce the likelihood of aggression when a partner is intoxicated (e.g., leaving the situation, avoiding conflictual and emotionally-laden discussion topics when a partner is intoxicated)” (p. 11). Fals-Stewart and Kennedy go on to assert that conjoint therapy for partner-violent couples with concurrent substance abuse problems can be a significant improvement over traditional treatment approaches. They describe five exclusion criteria for substance-abusing clients who have engaged in intimate partner violence: one or both partners report fear of injury, death, or significant physical reprisal from their significant other; severe violence (defined as resulting in injury and/or hospitalization) has occurred within the past 2 years; one or both partners have been threatened and/or harmed by their significant other using a knife, gun, or other weapons; one or both partners are fearful of participating in couples treatment; and one or both partners want to leave the relationship due, in whole or in part, to the degree and severity of partner aggression. Interestingly, while they agree with most intimate partner researchers that conjoint therapies are contraindicated for certain couples, they report that they have rarely had to exclude couples on these grounds (Fals-Stewart & Kennedy, 2005) .

Neidig, O’Leary, Heyman Models

A series of studies have examined the effectiveness of Peter Neidig’s Domestic Conflict Containment Program (DCCP) and various revisions of it (Brannen & Rubin,

1996; P. D. Brown *et al.*, 1997; Heyman *et al.*, 1999; Heyman & Neidig, 1997; Neidig, 1985; O'Leary *et al.*, 1999; Schlee *et al.*, 1998). Neidig (1985) developed the initial program in response to a request from the U.S. Marine Corps. The DCCP is a highly structured skill building program for couples experiencing IPV. Much of the program is devoted to teaching participants skills to contain conflict since Neidig believed that most violence occurs during conflict escalation. Participants are taught to identify cues which signal that violence is likely, and they rehearse alternative responses to various steps in their violence sequence.

The DCCP multi-couple group consists of 6 to 8 couples and meets weekly for two hours for 10 weeks (Neidig, 1985). The core curriculum is designed to help participants: “accept personal responsibility for violent behavior; contract for a commitment to change; develop and utilize time-out and other security mechanisms; understand the unique factors involved in the violence sequence; master anger-control skills; and develop the ability to contain interpersonal conflict” (p. 199-200). The training approach includes three basic components, instruction, rehearsal, and feedback from the facilitator. Outcome studies indicated that 8 out of 10 participants remain violence-free at four month follow-up. However, since Neidig’s work took place in the military where a great deal of monitoring occurred and the consequences of missing sessions or repeat violence may have been more powerful than in the civilian community, it was not clear how well this program would translate to the civilian community.

Brannen and Rubin (1996) were the first to systematically test Neidig’s DCCP treatment model and to compare it with a gender-specific treatment program in the civilian community. They randomly assigned 49 court ordered civilian men and their

partners who wanted to stay in the relationship to either a multi-couple group based on Neidig's treatment model or a gender-specific group based on a model developed at the Domestic Abuse Project (DAP) (Rusinoff, 1990). In the DAP condition, the female partners participated in a group designed to increase empowerment and enhance safety. Both gender-specific and multi-couple groups met weekly for 90 minutes for 12 weeks.

The most important change Brannen and Rubin (1996) made to Neidig's (1985) model was adding treatment components designed to enhance the safety of female victims. A separate orientation was held for victims. During this time victims were given information about shelters and were given phone numbers of the local law enforcement agencies. Each week both partners completed separate questionnaires concerning continued physical and psychological abuse, and were asked whether any issues raised during treatment led to physically or psychologically abusive arguments. If any woman appeared to be in danger, a follow-up phone call was made and she was encouraged to make use of resources discussed in the orientation session.

The next group of researchers to study a modification of Neidig's (1985) model was a team from the University of New York, Stony Brook (P. D. Brown et al., 1997; Heyman et al., 1999; Heyman & Neidig, 1997; O'Leary et al., 1999; Schlee et al., 1998). They called their modification of Neidig's model Physical Aggression Couples Treatment (PACT) (Heyman & Neidig, 1997). In their description of the program, they argue that therapeutic efforts to reduce anger and to increase competence in relationship skills will reduce the risk for physical violence.

To qualify for the treatment program a wife must, in a separate interview, indicate that she is comfortable with conjoint treatment, not fearful of speaking in front of her

husband, and has not needed to seek medical attention for injuries from IPV. Couples are also screened out if the husband meets the criteria for alcohol abuse or dependence, if the wife reports that the husband has a drinking problem, if the couple is not married or is separated, if either partner has an untreated serious mental illness or violent criminal past, or if the screening clinician judges that the wife will not be safe. Despite these stringent criteria, only five couples were excluded (O'Leary et al., 1999).

PACT is delivered by a male-female professional co-therapy team. The first half of PACT is focused on anger management skills. The last seven sessions focus on couples' issues such communication, fair fighting, gender differences, sex and jealousy. The purpose of the second half is to decrease conflicts and increase alternatives that may reduce the likelihood of violence (Heyman & Neidig, 1997).

A number of studies have tested the efficacy of DCCP or PACT using a sample of military personnel (Neidig, 1985), court-ordered civilians (Brannen & Rubin, 1996), and couples seeking help voluntarily (O'Leary et al., 1999). Each of these studies reported the treatment program was effective in helping men reduce their level of violence. In addition, the series of studies that compared DCCP or PACT with a gender specific treatment, with the exception of a finding by Brannen and Rubin, reported no significant differences between gender specific or conjoint groups in dropout or violent recidivism rates. Brannen and Rubin found that for court-ordered participants with a history of alcohol abuse, the multi-couple intervention was more effective than the gender-specific intervention in reducing the levels of violence within the marital relationship.

Domestic Violence Focused Couples Treatment

Sandra Stith, Eric McCollum, and Karen Rosen at Virginia Tech, Falls Church, developed and tested a couples treatment program for IPV, Domestic Violence Focused Couples Treatment (DVFCT) which is based on a solution-focused treatment approach (Rosen *et al.*, 2003; Stith *et al.*, 2002; Stith *et al.*, in press; Stith *et al.*, 2004; Tucker *et al.*, 2000). The program is designed for couples in ongoing relationships where mild-to-moderate violence has occurred and both partners want to remain together and end the violence in their relationship. The primary goal of the program, like most other programs described here, is to end violence of all kinds. A secondary goal is to help couples improve the quality of their relationship whether they stay together or separate.

Couples are excluded if either partner has used severe violence that resulted in a need for medical care, if they are unwilling to remove handguns from their immediate access, if they have problems understanding English, or if they have severe untreated psychopathology that prevents them from being able to participate in a group treatment program. In addition, each partner participates in gender-specific treatment most of the time during the first six weeks of the program. Ongoing screening occurs during these six weeks to ensure that the couple is appropriate for conjoint treatment.

Topics for the first six weeks include developing a vision of a healthy relationship or their “miracle”, safety plans, types of abuse, escalation signals, dealing with anger, mindfulness meditation, motivational interviewing around substance abuse (if appropriate), and developing a negotiated time-out plan (Rosen *et al.*, 2003). After the six mostly separate sessions, the couple works together either in a multi-couple group or as an individual couple with two co-therapists. To enhance safety, each session begins and ends with a gender-specific meeting. If the couple is receiving individual couple

treatment, the male client meets with one therapist and the female client meets with the other therapist. If they are a part of a multi-couple group, the men meet together with one therapist while the women are meeting with the other therapist. The purpose of the pre-session meeting is to find out if there has been any violence, if there are major issues that need to be discussed in the conjoint session, or if any couple should not participate in the conjoint session that day for safety reasons. After the pre-group meeting, the therapists meet and finalize the plan for the conjoint session. At the end of the conjoint session, separate meetings are held to make sure everyone feels safe and calm. If either partner is distressed, he or she is encouraged to use the previously developed safety plan or to use meditation which is a part of the beginning of every session, and each partner has an opportunity to discuss distressing feelings before leaving.

To test the effectiveness of DVFACT, Stith, et al. (2004) randomly assigned 42 couples to individual couple treatment (n=20) or to multi-couple group (n=22). Nine couples who completed pre-tests and follow-up tests but did not begin treatment served as a no-treatment comparison group. Drop out rate did not differ between treatment groups (30% for individual couple; 27% for multi-couple group). At pre-test scores of the couples in the different conditions did not differ on any of the dependent measures (i.e., marital aggression (psychological, minor physical or severe physical), marital satisfaction, attitudes about wife beating). Results of the study indicated that participants in the multi-couple group showed positive changes across all three dependent measures. Neither individual couple treatment nor the untreated comparison group reported any significant changes in these variables. Stith et al also found that, according to female partner reports, men who participated in either of the two couples treatment programs

were less like to recidivate than men in the comparison group at both the 6-month and 2-year follow-up. In fact, only one of the 19 women contacted (5.4%) who had participated in either couple treatment program reported that her partner had been violent since the 6-month follow-up.

The Navy Study

Frank Dunford (2000) has conducted the only experimental study to date that included a conjoint treatment condition and a “no treatment” control group. He randomly assigned 861 Navy couples to one of four interventions: a 26-week cognitive behavioral therapy (CBT) men’s group followed by six monthly sessions, a 26-week CBT multi-couple group followed by six monthly sessions, a “rigorously monitored” group, and a control group. The control group did not receive any formal intervention. Victimized wives in the control group were contacted by the military agency responsible for preventing and responding to domestic violence in the Navy—the Family Advocacy Center (FAC)—as soon as possible after the event occurred to ensure that the women were not in immediate danger. FAC provided the women with safety planning information. No other formal intervention was offered.

In the rigorously monitored group, a social worker at FAC saw perpetrators monthly for 12 months and provided individual counseling. Every 6 weeks a record search was completed to determine if a re-arrest had occurred. Wives were called monthly and asked about repeat abuse. At the end of each treatment session, social workers sent progress reports to perpetrators and their commanding officers, specifying the presence or absence of instances of abuse.

Treatment in the men's groups was based on curriculum developed by Saunders (1996) and Wexler (1999). Each session had a series of tasks that the group leader was expected to complete including both didactic and process activities. The multi-couple group curriculum was also based on the cognitive behavioral model and was developed by Geffner and Mantooh (2000). The interventions were similar to those used in the men's group, with the expectation that the presence of wives would alter the dynamics of the conjoint group interventions. It was expected that with wives present there would be less "women bashing" and that empathy would be enhanced. "In addition, the ability of wives to witness authority figures confronting the offensive and oppressive nature of spouse abuse, as well as address constructive ways to deal with conflict, were proposed as sources of empowerment and confidence not available to women whose husbands were assigned to the other interventions" (Dunford, 2000, p.469).

FAC records indicated that 71% of the cases were judged as having successfully completed treatment. Fifteen percent of the men were discharged from the Navy and did not complete treatment. Thus, 14% were considered as not having completed treatment. No significant differences were found in victim reports of having been injured, hit or pushed, or having felt endangered between participants in any of the four experimental conditions (i.e., men's group, multi-couple group, rigorous monitoring, and "no-treatment control group") at either the 6-month or one year follow-up period.

Two issues limit the usefulness of this study for understanding the effectiveness of conjoint treatment in the general population. First, this study was conducted with active duty military members. When repeat violence occurs, commanders are notified and recidivism can affect the offender's career. Thus, it is not clear that a "no treatment"

condition really exists when the offender is identified and his violence is a part of his military health record. Also, a major problem with this study's assessment of the conjoint intervention is that the number of wives actually attending the treatment was relatively low. The ratio of women to men was 2 women for every 5 men. Thus, in actuality, few couples actually participated in the conjoint treatment condition. The active duty husbands were mandated to treatment but the wives, mostly civilian, were not mandated and may not have volunteered to participate. Rather than being a systemic intervention focused on addressing couples issues, the treatment seemed to involve treating men with wives as observers. However, the study did provide some suggestion that conjoint treatment was as effective as any other type of treatment.

Clinical Approaches to Couples Treatment of IPV

Much of the clinical work currently being done in the area of couples treatment for IPV has developed not on the basis of a research program but from clinical practice and the application of both feminist and systemic theoretical models to this difficult issue. In this section we review two such approaches that have been used widely enough that they can help suggest best practices.

The Ackerman Institute Model

Virginia Goldner and her colleagues at the Ackerman Institute (Goldner, 1998; Goldner *et al.*, 1990) represent one effort to integrate feminist and systemic thinking in the couples treatment of domestic violence. From the feminist perspective, the Ackerman group makes clear that they see male violence toward women as the central problem to address in therapy. They invoke an ethical framework in their work – holding men responsible for their use of violence and intimidation, and women responsible for their

own safety. They are clear, however, that a sociopolitical stance alone does not fully explain the complexities of violence in intimate relationships and add psychological and systemic approaches in a therapy that may move from “a feminist narrative highlighting issues of power and control, and then reconfigure into another gestalt that brings forth the issues of vulnerability and despair” (Goldner, 1998). Thus, this model sidesteps the typology issue by seeing all male violence as both an attempt at power and control and an expression of escalation within the dyad. Given this understanding, social control, re-socializing men to egalitarian views, and psychological and systemic understandings all have a place in treatment.

Greenspun (2000) provides the most systematic description of the Ackerman model. Therapy is provided in an outpatient setting with one or two therapists actually working with the couple face-to-face while a consultant or consulting team observes. Therapy begins with a three-session evaluation during which a determination is made concerning whether or not couples therapy should be attempted. Couples are excluded from treatment for the following reasons: severe substance abuse by either partner, man’s history of head injury or other neurobiological condition necessitating treatment, man’s history of sociopathy, woman’s severe eating disorder or PTSD secondary to childhood trauma, the woman being coerced into treatment or not feeling safe in treatment, or the man’s unwillingness to take responsibility for his violence. The assessment occurs in both conjoint and individual interviews with individual interviews occurring first and being used to explore the extent of the violence and the exclusion criteria.

If the therapists judge that proceeding with conjoint sessions is justified, couple sessions are used to explore relational patterns and to begin the process of the man

acknowledging to his partner his responsibility for his violence. Of particular importance is assessing the strength of the romantic bond between the partners. If an emotional bond no longer holds the couples together (and they remain for financial or parenting reasons alone), they are unlikely to have the motivation to continue with the difficult work of couples therapy.

The Cultural Context Model

Almeida and Durkin (1999) report on an approach to couples treatment that relies on a multi-layered cultural analysis to understand the genesis of male violence against women. This model is based on Almeida's cultural context model (Almeida *et al.*, 1998)– a framework that takes as its goal not just intervening with batterers, couples, or families, but “fostering the development of safe, respectful, nurturing, and empowering relationships for all participants in community and family life” (Almeida & Dolan-Del Vecchio, 1999). We include this model as an approach to couples treatment of IPV because the cultural context model grew from work in treating IPV and couples treatment plays a prominent role in it.

The specific couples treatment model for IPV originally described by Almeida and Durkin (1999) sees the termination of abusive or coercive acts of all kinds as the ideal outcome of treatment. Thus, accountability is an overarching theme for the work with male perpetrators. During the initial phase of treatment, an assessment of couple functioning is conducted. Since many couples come to treatment without presenting violence as a concern, the first step is to assess for it. Using both conjoint and individual interviews with the partners, the extent of violence is ascertained as well as the potential for immediate danger to the woman. Safety planning (including the man leaving the

home and the use of restraining orders if necessary) is accomplished and the stage is set for the couple's entry into the separate men's and women's group phase of the program.

Men's groups begin with psychoeducation about the role of violence and other forms of control and include a process of "sponsorship." Men who have successfully completed treatment, as well as non-abusive men from the community are recruited to participate along with current clients. Sponsors both represent the clients' own cultures and the beliefs and traditions coming from them as well as help hold clients accountable for their abusive actions and attitudes. Women's groups also include psychoeducation but the focus is on empowering women and encouraging them to become less responsible for the overall well-being of their families. Anger, not guilt, is proposed as the appropriate response to violence and oppression (Almeida & Durkin, 1999).

The final phase of treatment begins when men demonstrate appropriate changes in their attitudes and behavior – moving to a non-violent, non-coercive stance – and their female partners corroborate those changes in the women's group. The program sets a minimum of 36 weeks of gender-specific treatment for men who are mandated to treatment by the judicial system. Couple or family sessions may begin during the later stages of the 36 weeks if the therapists feel the men are accepting responsibility both for their violence and for their use of non-violent control tactics. Regardless of when conjoint therapy starts, both partners remain involved in their gender-specific groups during the course of couples work.

Almeida and Durkin (1999) report that in the 15 years of its operation, at the time of their 1999 article, "no woman participating in our program has ever been physically hurt" (p. 321). They offer no information on how this finding was arrived at (e.g.

whether systematically measured or informally assessed) nor on any other aspect of treatment outcome such as completion rates or changes in marital satisfaction, etc.)

Best Practices

Coordinated community response

None of the treatment programs described in this manuscript is meant to be used in isolation. Best practices for treatment of IPV include collaborating with local domestic violence programs and would involve a full-range of options. For some offenders, legal sanctions are most appropriate options and for some victims restraining orders and shelters are most appropriate. The coordinated community response also includes victim advocates, prevention programs, support groups, batterer intervention programs, programs for child witnesses and other programs tailored to the needs of each individual in the community. No single program or type of program can work in isolation and, as Vetere and Cooper's (2001) work in the U. K. illustrates, community agencies can be effectively included in couples treatment as a resource to both clients and therapists.

Careful Screening of Clients for Conjoint Treatment

One of the most consistent findings which emerged from our review of both empirical and clinical papers regarding conjoint treatment of IPV is the importance of careful assessment and screening for the appropriateness of this treatment modality. Although most programs serving voluntary clients found that they only had to exclude a small number of clients, all programs emphasized the importance of screening. Best practices would include individual assessments of male and female clients and the use of screening tools that allow participants to report thoroughly on the violence they have experienced

or used. In addition, when either partner is afraid of the other, or concerned that they may not be able to express themselves freely in front of the partner; individual treatment should precede, or replace, conjoint treatment. No clients should ever feel coerced into participating in conjoint treatment. Throughout this manuscript exclusion criteria used by each program have been reported. Common exclusion criteria include a history of severe violence, weapon use in previous violent incidents, and sociopathy or untreated serious mental illness of the offender. None of the programs reviewed here advocate for conjoint treatment as the only treatment offered for IPV. All recommend that this approach is most appropriate for a specific group of couples who have been carefully screened to meet clearly developed criteria.

Modification of Typical Conjoint Practice to Support Safety

Best practices for the use of conjoint treatment of IPV include modifications of typical conjoint treatment to support safety. In addition to careful screening and selection, most of the programs reviewed here teach specific violence reduction strategies such as time-out and safety planning. Clinicians doing conjoint treatment of IPV need to be well-versed in both systemic treatment and also in IPV. They also need to be aware of risk factors for escalating violence and to be sensitive to the real danger that can occur from allowing angry confrontations to proceed in the conjoint session. All of the treatment discussed here is delivered by experienced couples therapists with knowledge of IPV and is not traditional marriage counseling or couples therapy. Rather, it is specifically focused on eliminating violence in relationships and modified to safely achieve that goal.

On-going assessment of safety with contingency plans for increased risk or recurrence

Best practices for providing conjoint treatment for IPV also include a process of ongoing assessment of safety with contingency plans for increased risk or recurrence. Many of the programs discussed here include regular check-ins (either in writing or in person) to insure that neither violence, nor risk of violence, is escalating. Programs offering conjoint treatment need to include an ongoing discussion among providers regarding these issues and a protocol for addressing increased risk and/or recurrence of violence. Data may emerge during the course of treatment that leads therapists to temporarily suspend, or completely discontinue, couples work. For instance, the therapists may discover that substance abuse is more severe than was originally reported, or another assault may occur. In these cases, re-evaluation of conjoint work is needed.

Summary

In reviewing the literature on conjoint treatment of IPV, it is clear that couples treatment can be used safely to end IPV. In this review, we have provided both an overview of clinical experience and outcome research that supports the use of conjoint treatment in certain conditions. In fact, in all of the empirical studies, conjoint treatment proved to be at least as effective as traditional men's treatment programs. The research conducted in the field of substance abuse provides a particularly compelling case that conjoint treatment may be the treatment of choice for many violent couples. Furthermore, withholding conjoint treatment as an option for some couples may not serve them well if we believe in the evidence produced by a variety of typology studies including Michael Johnson's work which separates intimate terrorism from situational couple violence.

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Footnotes

1. Johnson (2005) later expanded his typology to include “violent resistance” in which victims of intimate terrorists strike back at their abusers. These acts remain embedded in the context of pervasive control that characterizes intimate terrorism, however, and thus are different than the bi-directional assaults that occur in situational violence.