A CONTENT ANALYSIS OF BATTERING INTERVENTIONS: DEVELOPMENT OF A UNIFIED FRAMEWORK FOR TREATING RELATIONALLY VIOLENT MEN

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF PSYCHOLOGY AND PHILOSOPHY

COLLEGE OF ARTS AND SCIENCE

BY

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DENTON, TEXAS

DECEMBER 2020

DEDICATION

For my wife, Kelly, thank you for your continued patience, love and support – I most definitely would not have made it to this point without you.

ACKNOWLEDGMENT

I would like to thank my dissertation committee, Drs. Claudia Porras Pyland, Sally Stabb, and Danica Harris for their support and encouragement throughout this process. Thank you for believing in the value of this project.

ABSTRACT

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DECEMBER 2020

Men's violence against women in the form of intimate partner violence (IPV) has been an ongoing concern worldwide. While awareness of IPV and interventions for survivors of IPV have grown over the last several decades, relatively little attention has been given to improving battering intervention programs (BIPs) that address men's violence. Existing data from BIPs show that relationally violent men (RVM) can be a very difficult population to treat. Meta-analyses across BIPs with differing theoretical ideologies show that these programs tend to struggle to retain RVM and have small effects on decreasing recidivism. The current dissertation conducted a content analysis of the available BIP literature addressing men's violence to develop a more wholistic and unified psychotherapy approach for treating RVM. Propositions related to the causes of IPV, hypotheses regarding treatment, and corresponding operational definitions of interventions were identified in the BIP literature focused on treatment interventions. From this content analysis, a unified model of treating RVM was developed. The resulting unified approach for treating RVM may help to inform future treatment directions and improve the effectiveness of BIP programs in reducing men's violence and preventing drop out. By allowing therapists and BIP facilitators to respond more flexibly and encouraging a more wholistic view of RVM, it is also hoped that this unified

approach will aid facilitators looking to expand their repertoire of skills and conceptualization of RVM.

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CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) is a world-wide public health and human rights concern with significant economic and social costs (Abramsky et al., 2011; García-Moreno et al., 2013; McCollister et al., 2010). Taken together, collective reports estimate that approximately a third of women world-wide have experienced some form of IPV within their lifetime (García-Moreno et al., 2013). Additionally, global reports indicate that close to 40% of all murdered women's lives were terminated by their intimate partners (García-Moreno et al., 2013). Within the United States (US), it is estimated that over a third of women (37.3%) and over a quarter of men (30.9%) have experienced some form of IPV within their lifetime, including any form of physical violence, sexual violence, and/or stalking (Smith et al., 2017). In an overwhelmingly vast majority of cases, this violence is perpetrated by men (Adams & Cayouette, 2002; Breiding et al., 2014; Centers for Disease Control and Prevention [CDC], 2014; Katz, 2006, 2012; Smith et al., 2017). While there are many survivors of IPV that identify as men, most male survivors have experienced violence from other men in their life, whether that be from a male partner or male figures in their family of origin (Katz, 2006, 2012; Smith et al., 2017). The prevalence of IPV also generates significant social and monetary costs to the US related to its numerous impacts. IPV victimization has been associated with a number of mental and physical health problems including depression, substance abuse/ addiction, contraction of sexually transmitted diseases, post-traumatic stress disorder, suicide risk,

physical injuries, gastrointestinal problems, chronic pain, fear for one's safety, and death (Breiding et al., 2014; Campbell, 2002; CDC, 2014; García-Moreno et al., 2013; Smith et al., 2017). Approximately a quarter of women (27.4%) and a little over one-tenth of men (11.0%) report experiencing an impact related to IPV, such as those mentioned above (Smith et al., 2017). It is estimated that there are upwards of five million domestic violence cases per year in the US, costing the nation approximately $460 billion annually (McCollister et al., 2010). Between court costs, medical bills, pain and suffering, and the potential lost productivity of perpetrators who may be imprisoned, each sexual assault is estimated to cost roughly $240,000.

Though IPV is a concern across the globe, incidence rates and reporting may vary by geographical location. For instance, cross-cultural data collected across 15 sites world-wide suggests that IPV rates may range from a low of 15% in Ethiopia to a high of 71% in Japan (Abramsky et al., 2011). However, these results should be interpreted with caution, as a number of factors can impact IPV reporting, including cultural norms that encourage keeping IPV secret and hidden from others. Similarly, reported incident rates for IPV across race and ethnicity may vary slightly, but are generally similar (Breiding et al., 2014; Catalano, 2012). It should be noted that racial and ethnic minorities do not perpetrate or experience IPV to a greater degree compared to White communities. However, racial and ethnic minority communities do tend to be disproportionately impacted by IPV and overrepresented in the criminal justice system due to factors related to structural and institutionalized racism, such as a lack of access to legal and counseling services, and the over policing and over incarceration of racial and ethnic minority men

(Coker & Macquoid, 2015; Nellis, 2016; Petrosky et al., 2017). This law enforcement response bias often translates to these men being overrepresented within treatment centers for IPV. Most importantly, it should be noted that IPV cuts across social location, impacting people of all race, class, and age groups.

Though historically there has been debate regarding gender differences in IPV perpetration between family violence and feminist researchers (Seamans et al., 2007; Winstok, 2011), a majority of sources and data suggest that men perpetrate the vast majority of IPV (Adams & Cayouette, 2002; Breiding et al., 2014; CDC, 2014; Katz, 2006, 2012). Additionally, it is unanimously agreed upon by scholars that women tend to experience far greater negative impacts related to IPV perpetration, such as post-traumatic stress, depression, injury, and death, as compared to men (Breiding et al., 2014; Smith et al., 2017; Winstok, 2011). It is important to note that men, women, gender-diverse individuals, and children may all be impacted by men's violence (Katz, 2012). Data also suggest that men's violence contributes to the next generation of relationally violent men (RVM), as several studies have shown that boys who experience childhood violence tend to be at risk for perpetrating IPV as adults (Herrenkohl & Jung, 2016; Jewkes et al., 2015; Lawson, 2008).

Relationally Violent Men

Apart from experiencing childhood violence and abuse, several other factors may impact men's susceptibility in perpetrating IPV. According to the literature, an increased risk of IPV perpetration has been associated with alcohol/ substance abuse, unemployment, poor education, cohabitation, young age, having attitudes and values

supportive of IPV, having outside sexual partners, experiencing childhood abuse, growing up in a home with domestic violence, experiencing or perpetrating other forms of violence in adulthood, having a history of arrests, and having ex-partner status (Abramsky et al., 2011; Campbell, 2002; Jewkes et al., 2015). Additionally, cultural values and gender messages that endorse men's dominance over women tend to increase the risk of IPV perpetration (Jewkes et al., 2015).

Considerable variability and diversity exist among men who perpetrate IPV. Several different subtypes of RVM have been proposed over the last two decades (Day & Bowen, 2015; Ennis et al., 2017; Graña et al., 2014; Holtzworth-Munroe, 2000). These subtyping schemes often conceptualize and categorize RVM in terms of the severity of IPV, specificity versus generality of violence, and severity of psychopathology (Day & Bowen, 2015; Graña et al., 2014). One subtyping scheme has even found physiological evidence to classify RVM (Gottman et al., 1995; Jacobson & Gottman, 1998) in terms of RVM who experience heart rate acceleration during IPV and RVM who experience decreased heart rate while perpetrating IPV. Researchers have since labeled these two groups pit-bulls (heart rate acceleration) and cobras (decreased heart rate; Gottman et al., 1995; Jacobson & Gottman, 1998).

History of IPV Intervention

Prior to the 1980s, many believed IPV was considered a private matter that should be dealt with behind closed doors (*State vs. Oliver*, 1874, cited in Rosenfeld, 1992). On occasion, couples sought treatment for IPV by marriage and family therapists, but these therapists were often unequipped to handle the complex issue of IPV (Adams, 1988;

Mederos, 2002). Women's disclosure of abuse within couple's therapy settings often led to retaliation from their partners, immediately following therapy sessions (Adams, 1988; Mederos, 2002). However, in the 1980s following increased awareness of IPV and its impact, advocacy groups began to develop an understanding of IPV as being rooted in patriarchal culture, where men's power and control over women is maintained (Mederos, 2002). It became understood that institutionalized and structural gender inequality in social, political, legal, and economic domains reinforced men's violence against women (Adams, 1988; Miller, 2010). With this increased awareness, advocacy groups developed some of the first networks of women's shelters and battering intervention programs (BIPs) to address men's violence against women (Mederos, 2002). Since the emergence of these first BIPs, numerous BIPs diverged from these original formats to develop varied theoretical and philosophical understandings and interventions for IPV.

Though there is considerable variability between BIPs today, traditional pro-feminist BIP models, such as the Duluth model, tend to be the treatment of choice in most cases (Barner & Carney, 2011; Geffner & Rosenbaum, 2001; Stuart et al., 2007), while couple's therapy for IPV tends to be the most controversial intervention format given the risks this format imposes on survivors (Adams, 1988; Armenti & Babcock, 2016; Mederos, 2002). Traditional BIP models for treating RVM often utilize a time-limited psychoeducational group format and consider the mechanism of treatment education and consciousness raising, versus psychotherapy treatment (Geffner & Rosenbaum, 2001; Mederos, 2002; Rosenbaum & Leisring, 2001).

In these groups, RVM are challenged to examine and replace their patriarchal belief systems, which promote men's power and control over women, with belief systems rooted in equality and egalitarianism (Mederos, 2002). Traditional pro-feminist BIP models, such as the Duluth model also have a considerable amount of overlap with cognitive-behavioral perspectives on treating RVM (Babcock et al., 2004; Gondolf, 2007; Palmstierna et al., 2012; Rosenbaum & Leisring, 2001). Some have even suggested that these theoretical perspectives overlap to the extent that they are identical (Gondolf, 2007), and have often been referred to as gender-based cognitive-behavioral interventions (Gondolf, 2011). Although the Duluth model tends to be the treatment of choice in most U.S. states, many scholars have criticized the Duluth model for having a one-size-fits-all perspective towards treating RVM (Armenti & Babcock, 2016; Crane & Easton, 2017; Crockett et al., 2015; Gondolf, 2011).

Rationale for Focusing on Treatment for Relationally Violent Men

To date there has been a tremendous amount of attention aimed at treating and developing interventions for survivors of IPV (Trabold et al., 2018), while there has been relatively less attention on interventions for perpetrators of IPV. Efficacious treatments for RVM are needed in order to reduce IPV globally. Survivors should not be held responsible for reducing IPV, rather men should be the primary target of intervention since they perpetrate the vast majority of IPV (Adams & Cayouette, 2002; Breiding et al., 2014; CDC, 2014; Katz, 2006, 2012). Additionally, by focusing on survivors, and neglecting treatment for perpetrators, more women are at risk for victimization. RVM often continue abuse after their partners have returned from shelters or find new partners

to abuse if their partner ends up leaving the relationship (Geffner & Rosenbaum, 2001). Therefore, to get at the root of the problem interventions should be focused on those perpetrating IPV. Several meta-analyses examining the efficacy of traditional BIP interventions for RVM have found limited treatment success in terms of recidivism (Babcock et al., 2004; Stover et al., 2009). Due to controversy over the efficacy of traditional BIPs, many authors have advocated for the need for newer, efficacious and more client specific treatment approaches (Babcock et al., 2004; Bernardi & Day, 2015; Crane & Easton, 2017; Gondolf, 2011; Graña et al., 2014; Herman et al., 2014; Holtzworth-Munroe, 2000). Several new approaches have emerged for treating RVM, but relatively little empirical testing has been conducted on these newer approaches.

Purpose and Rationale of the Current Study

The current researcher conducted a content analysis of the BIP literature addressing interventions for RVM and developed a unified framework for working with RVM from data gathered in the content analysis. Results from this dissertation may potentially serve multiple uses. Several BIP models have been criticized for having a one-size-fits-all approach to intervening (Armenti & Babcock, 2016; Gondolf, 2011). Results from this dissertation may aid in the development of a more complete perspective towards intervening with RVM. It is hoped that a more holistic approach may aid in boosting the efficacy of BIP treatment in terms of reducing RVM's recidivism rates. Furthermore, data synthesized in this dissertation may also highlight areas for future research, such as illuminating which intervention strategies may need to be further researched to examine their efficacy. Additionally, results of this dissertation may also

aid new and experienced practitioners in developing or expanding their repertoire of skills for treating RVM. Results from this dissertation may serve as a catalog of interventions from which BIP facilitators can draw and incorporate in their BIP groups. Finally, this dissertation may help to expand upon a previous unified approach towards treating RVM (Harris et al., 2016) and provide confirmation of the strategies and framework described within that model.

Definition of Terms

For the current study, certain terms are operationally defined as follows:

- **Relationally Violent Men -** For the purposes of this dissertation the term relationally violent men (RVM) refers to men who perpetrate violence against their partners.
- **Intimate Partner Violence -** Intimate partner violence (IPV) refers to a pattern of controlling and abusive behaviors including physical, verbal, emotional/ psychological, sexual and financial abuse, and stalking behaviors.
- **Battering Intervention Programs -** Battering Intervention Programs (BIPs) refer to community programs specifically designed to treat and educate RVM to reduce and eliminate partner violent behaviors.
- **Treatment Model or Modality -** Treatment model or modality refers to brand name psychotherapy theories, such as Cognitive-Behavioral therapy (Beck, 2011), or Emotion-Focused therapy (Greenberg, 2002). This also refers to specific models for treating RVM, such as the *Relating Without Violence* program (Bierman & Cheston, 1996).

- **Multitheoretical Psychotherapy -** Multitheoretical psychotherapy (MTP) refers to an integrative psychotherapy model that explores thoughts, actions, and feelings within the context of interpersonal relationships, as well as, family and cultural systems (Brooks-Harris, 2008).
- **Focal Dimensions** - Focal dimensions refer to theoretical boundaries created in MTP to help therapists conceptualize and draw from related treatment interventions. These focal dimensions are based on a multidimensional model of human functioning that looks at thoughts, actions and feelings within the context of interpersonal relationships, as well as, family and cultural systems (Brooks-Harris, 2008).
- **Propositions of Cause -** Propositions of cause refers to ideas about what causes partner violence.
- **Treatment Hypothesis or Intervention** - The term treatment hypothesis may be used interchangeable with treatment intervention. Treatment hypotheses are psychotherapy interventions predicted to reduce partner violent behaviors.
- **Operational Definitions of Interventions** - Operational definitions of interventions refers to descriptions of treatment hypotheses, including how a therapist or group facilitator might implement that treatment hypothesis and what one might observe if that treatment hypothesis were being implemented.
- **Treatment Studies** - The term treatment studies refers to primary sources that contain treatment hypotheses and operation definitions of psychotherapy interventions. Non-treatment studies are those that only contain propositions

related to the causes of IPV or those that do not contain psychotherapy related treatment hypotheses and operational definitions.

CHAPTER II

LITERATURE REVIEW

This literature review covers the prevalence, impact, and costs associated with IPV, controversies over gender differences in the perpetration of partner violence, and controversies over definitions and terms used within the field. Following this, several issues regarding RVM are covered, including their subtypes, risk factors for perpetrating violence, and the history and development of various BIPs, which aim to address men's violence against women. The review concludes with a summary and a rationale for the proposed study.

Intimate Partner Violence

Men's IPV against women is a public health and human rights concern across the globe (Abramsky et al., 2011). Contrary to the myth that violence occurs within the context of strangers, most acts of violence are perpetrated by someone the survivor knows, often an intimate partner (Langhinrichsen-Rohling, 2005). According to Smith et al. (2017) at the National Center for Injury Prevention and Control, and the CDC, over one in three women (37.3%) in the US have experienced physical violence, sexual violence, and/or stalking by an intimate partner at some point in their lifetime. Additionally, over one in four women (27.4%) report experiencing an impact related to IPV, such as injury or post-traumatic stress symptoms. The impact and incidence rates of IPV may be even higher knowing that experiences of IPV are often underreported for

various reasons (Smith et al., 2017). While there are many survivors of IPV that identify as men, most male survivors have experienced violence from other men in their life, whether that be from a male partner or male figures in their family of origin (Katz, 2006, 2012; Smith et al., 2017). While historically there has been some debate regarding gender differences in IPV perpetration (Winstok, 2011), the general consensus is that a vast majority of those who perpetrate this violence identify as men (Breiding et al., 2014; CDC, 2014; Katz, 2006, 2012).

IPV has been associated with a number of health concerns including depression, post-traumatic stress, substance abuse/addiction, physical injuries, suicide risk, sexually transmitted diseases, gastrointestinal problems, chronic pain, fear of one's safety, and death (Breiding et al., 2014; Campbell, 2002; CDC, 2014; García-Moreno et al., 2013; Smith et al., 2017). In McCollister et al.'s (2010) study, economists calculated that the average cost of a single sexual assault in the US amounted to $240,776 — from the victim's pain and suffering, medical bills, lost productivity, judicial system expenses and the lost productivity from the incarcerated offender. One aggravated assault costs society about $107,020, with $95,023 from pain and suffering, plus the burden of increased risk of homicide. On the basis of this lower figure alone, the total cost to the US of the almost five million domestic violence cases per year is about $460 billion. Women who experience IPV from their partners often suffer additional repercussions from losing their employment, housing, and support system. Additionally, it also important to note the potential lethality of IPV. For instance, in the US over half of all female homicides (55.3%) were IPV-related (Petrosky et al., 2017).

In the 1970s, during the second wave of feminism within the US, programs known as BIPs emerged to address men's violence (Mederos, 2002). Prior to this movement, very little attention was paid to IPV intervention. IPV was primarily thought of as a private matter dealt with behind "draw[n] curtains" (*State vs. Oliver*, 1874, cited in Rosenfeld, 1992, p. 207). During the women's movement, however, this ideology was heavily scrutinized as awareness of IPV grew (Mederos, 2002). This ultimately paved the way for the emergence of BIPs, women's shelters, and legal protections for women. Though violence against women has often been viewed as a women's issue, several scholars have advocated shifting this global perspective towards seeing violence as a men's issue, since men perpetrate a vast majority of violence (Adams & Cayouette, 2002; Katz, 2006, 2012).

Various terms have been used, often interchangeably, to describe IPV. Some of these include: battering, relationship violence, relationship aggression, domestic violence, dating violence, partner abuse, spouse abuse, wife abuse, and wife battering (Geffner & Rosenbaum, 2001; Sartin et al., 2006). The lack of a single agreed upon term has contributed to some difficulty within the field, especially in terms of making it difficult to make comparisons across research studies (CDC, 2003; Sartin et al., 2006). To further complicate things, it is noted that some researchers use these terms interchangeably, while others have specific definitions for each of these terms (Sartin et al., 2006). This has led to some confusion as each research study may have a slightly different operational definition of IPV.

Another challenge within the field has been in developing a definition of IPV that encompasses all forms of abuse (CDC, 2003). Early researchers typically defined IPV in terms physical abuse. For example, Gelles and Straus (1979) operationally defined battering as any act "carried out with the intention of, or perceived as having the intention of, physically hurting another person (p. 554)." This definition, however, neglects to include various forms of emotional/psychological, verbal, and financial abuse, as well as stalking. Later feminist conceptions of IPV defined IPV more broadly to include physical, verbal, sexual, and psychological/emotional forms of abuse (Adams, 1988). As an example, a feminist conception of IPV might be defined as any act that causes the survivor to do something they do not want to do, prevents them from doing something they want to do, or causes them to feel afraid. As another example, with the emergence of first wave BIPs, battering was redefined as an ongoing pattern of control, which included intimidation, psychological/emotional abuse, and a sense of entitlement that RVM maintain through violence (Mederos, 2002). While definitions of IPV have varied over decades, conceptions of psychological abuse have, in particular, been subject to controversy (Winstok & Sowan-Basheer, 2015).

Though definitions of IPV have expanded to include more forms of abuse, many studies within the research literature have focused primarily on physical forms of IPV (Sartin et al., 2006). Unfortunately, psychological/emotional abuse, verbal abuse, stalking, and financial abuse have often been ignored within the research literature. This may partly be due to the controversy over defining psychological abuse (Winstok & Sowan-Basheer, 2015). Most definitions of psychological abuse tend to be vague and

unclear making it a far more difficult construct to measure with psychological instruments.

For the purposes of this dissertation the terms mentioned above, such as IPV, partner abuse, and battering will be used interchangeably. IPV will refer to any form of physical, sexual, financial, or verbal/psychological/emotional abuse, and/or stalking towards a current or former intimate partner (e.g., spouse, dating partner; Sartin et al., 2006). In addition to definitional concerns, another controversy in the IPV literature surrounds gender differences in the perpetration of IPV.

Gender and IPV

As briefly mentioned earlier, historically there has been some debate regarding gender differences in IPV perpetration (Seamans et al., 2007; Winstok, 2011). The debate has primarily been divided into two camps. The first camp, often referred to as the feminist scholars camp, views the problem of IPV asymmetrically in terms of gender (Winstok, 2011). They maintain that IPV is primarily perpetrated by men against women. The opposing camp, often referred to as the family violence researchers, contend that IPV is symmetrical in terms of gender. They maintain that both men and women perpetrate IPV at more-or-less similar rates, in what is often referred to as situational couple's violence. Both groups often point to different sources of evidence to back their claims and have made arguments suggesting that the other's samples and sampling methods are biased. While family violence researchers often use data derived from large-scale epidemiological or general surveys, feminist researchers often use data derived from agency and community samples, as well as, crime statistics and hospital emergency room

studies (Seamans et al., 2007; Winstok, 2011). Large-scale epidemiological surveys used by family violence researchers often show more equal rates of IPV perpetration, as well as, increased rates of mutual violence. On the other hand, data from national crime statistics, crime studies, hospital emergency room studies, as well as community and agency samples used by feminist researchers, often find that men perpetrate a vast majority of IPV.

Feminist critics of the large-scale surveys argue that these studies find mutual IPV more often because of how survey questions are asked (e.g., often indicating that a single act of violent behavior is enough to count as IPV; Winstok, 2011). Furthermore, feminist scholars also argue that the high rates of survey refusal are likely from couples with asymmetrical IPV. RVM likely refuse to take these surveys because doing so would implicate them, while their partners may not take the survey in fear of retaliation from their partners. Finally, feminist researchers also maintain that women's violence is often in self-defense from their partner's violence, but that large-scale surveys are unable to detect this by how they are structured (Seamans et al., 2007; Winstok, 2011). Winstok (2011) concludes that the controversy may never be resolved given that it "stems from differing and competing paradigmatic outlooks that disagree over the identification, definition, and understanding of partner violence" (p. 306).

One finding that has been relatively noncontroversial between these two groups is the finding that women tend to suffer significantly more injuries from IPV than men (Winstok, 2011). Both camps agree that the more severe form of IPV, often referred to as intimate terrorism, is overwhelming perpetrated by men towards women (Armenti &

Babcock, 2016; Winstok, 2011). U.S. survey data shows that women experience far more negative impacts related to IPV, such as physical injuries and post-traumatic stress symptoms, than men do (Breiding et al., 2014; Smith et al., 2017). Given these data and the discussion above, the present researcher has determined that proceeding with the proposed investigation under the view that men's violence against women is disproportionately frequent and harmful is reasonable.

Relationally Violent Men

For the purposes of this dissertation the term RVM is used predominately given the sociocultural context that men perpetrate a vast majority of IPV (Breiding et al., 2014; Katz, 2006, 2012). This term was first used by Harris et al. (2016) and was adapted from Bierman and Cheston (1996) who used the term domestically violent men. There is some research that suggests that separating violent behavior from one's identity may decrease the risk of recidivism. Some research (Boots, 2016; Boots et al., 2016) has shown that RVM convicted of IPV (e.g., served jail time) were more likely to recidivate as compared to RVM who received some form of conditional dismissal from having a conviction on their record (e.g., conditional dismissal via BIP or some other conditions). The term RVM is used instead of batterer in order to achieve this separation of violent behavior from one's identity. The author of this dissertation may also use terms such as, men who perpetrate IPV or IPV perpetrators interchangeably with RVM.

Although men perpetrate a vast majority of IPV, it is important to note that not all men perpetrate IPV (Jewkes et al., 2015). Several factors are thought to increase men's susceptibility in perpetrating IPV. For example, it is believed that certain

conceptualizations of masculinity increase men's risk towards perpetrating IPV (Jewkes et al., 2015). More specifically, the acceptance of cultural messages that emphasize dominance and control over women are thought to be most associated with IPV. Therefore, men who ascribe more to these cultural values may be at an increased risk of perpetrating IPV. Contexts that provide peer approval of IPV may also exacerbate risk of IPV perpetration (Herrenkohl & Jung, 2016).

Though IPV is perpetrated cross-culturally, data collected globally suggests that certain demographic characteristics may also be more associated with IPV perpetration (Abramsky et al., 2011). According to one study, alcohol abuse, cohabitation, young age, having attitudes supportive of IPV, having outside sexual partners, experiencing childhood abuse, growing up with domestic violence, and experiencing or perpetrating other forms of violence in adulthood, were associated with an increased risk of IPV. On the other hand, having more social class privilege, secondary education and being married seemed to decrease the risk of IPV. Cultural values across various geographical locations may also impact IPV, or alternatively, the reporting of IPV. Abramsky et al. (2011) noted that lifetime prevalence of IPV ranged significantly from a low of 15% in Ethiopia to a high of 71% in Japan. Other studies have found IPV perpetration to be associated with a history of arrests, substance abuse, poor education, unemployment, and ex-partner status (Campbell, 2002). With all of that said, it is important to note that a host of factors can impact reporting of IPV, including values that encourage keeping IPV secret or hidden from others. Therefore, the reported incident rates in many of these

studies should be interpreted with caution. It is also important to note that IPV occurs across social location, impacting people of various age, race, and class groups.

A significant amount of literature also suggests that boys exposed to abuse during early childhood are at an increased risk of developing aggression, impulsivity, a lack of empathy, and engaging in IPV later in life (Herrenkohl & Jung, 2016; Jewkes et al., 2015; Lawson, 2008). Among the most severe RVM offenders there appears to be an association with a greater level of insecure attachment, lower family cohesion, experiences of more childhood physical abuse, experiences of witnessing parental violence in childhood, and more hostile-dominant interpersonal problems, compared to less severe RVM offenders and non-abusive men (Lawson, 2008). In this study, IPV severity was associated with attachment insecurity across three dimensions. These included comfort with interpersonal closeness, comfort with depending on others, and anxiety about being rejected/abandoned. These results suggest that various forms of insecure attachment, such as avoidant or anxious/ambivalent, may be related to IPV perpetration.

Another study examining whether exposure to family violence and insecure attachment styles may be predictors of IPV perpetration found mixed results (Lee et al., 2014). In this study, exposure to family violence was found to be a direct predictor of IPV perpetration among men, while evidence of attachment style mediating this relationship was not found. Finally, a meta-analysis examining mental health factors associated with IPV perpetration, as well as victimization found that depression, anxiety, post-traumatic stress disorder, anti-social personality disorder, and borderline personality

disorder were associated with both IPV perpetration and victimization (Spencer et al., 2017). Anti-social and borderline personality disorder were found to be significantly stronger correlates of IPV perpetration than victimization. While anxiety and post-traumatic stress disorder were stronger correlates with victimization.

A majority of RVM enter BIPs via court-order (Barner & Carney, 2011; Geffner & Rosenbaum, 2001; Sartin et al., 2006). A much smaller percentage voluntarily seek treatment and often do so with pressure from their partners. It is also common for couples to seek treatment with the primary concern being anger issues or anger management from the men in these couples. Denial, minimization, and partner blaming tend to be hallmark characteristics of RVM that first enter treatment (Scott & Straus, 2007; Stuart et al., 2007). For this reason, RVM are often recognized as a highly treatment resistant population with high rates of attrition (Geffner & Rosenbaum, 2001).

RVM Sub-Types

Several different subtypes of RVM have been proposed over the last decade or so. These models often conceptualize subtypes based on factors such as the severity of violence, the contexts in which violence is enacted, and severity of psychopathology (Day & Bowen, 2015; Graña et al., 2014). One of the earliest subtyping systems distinguished RVM in terms of those who perpetrated patriarchal terrorism and those within couples who shared in common couple's violence (Johnson, 1995). This conceptualization of IPV helped pave the way for researchers to develop more complex subtyping classification systems. Another early classification system grouped batterers into one of four subgroups (Holtzworth-Munroe, 2000). These subtypes included family

only, low-level antisocial, borderline disorder/dysphoric, and generally violent/antisocial (Holtzworth-Munroe, 2000). Further research has shown that both the borderline/dysphoric subtype and the generally violent/antisocial subtype are significantly more likely to drop out of treatment as compared to the other subtypes (Eckhardt et al., 2008).

Several other systems for classifying batterer subtypes have been developed since then (Day & Bowen, 2015; Graña et al., 2014). These typologies often revolve around classifying RVM in terms of IPV severity, frequency, or generality of abuse (e.g., domestically abusive vs. more generally violent in other contexts as well). For example, Ennis et al. (2017) conceptualize RVM in terms of being either reactive or instrumental with their violence. RVM who are reactive enact IPV when they perceive that they are under threat. On the other hand, RVM who are instrumental tend to enact IPV that is well planned out, methodical, and goal directed. Research has found that RVM who enact instrumental violence tend to have more IPV supportive attitudes and offense characteristics. Reactive RVM, on the other hand, tended to have significantly more early life trauma (e.g., witnessing family violence in childhood) and enacted less severe IPV as compared to the instrumental subtype.

One subtype scheme actually utilizes physiological measures to classify RVM (Gottman et al., 1995; Jacobson & Gottman, 1998). The cobra (heart rate decelerators) and pit-bull (heart rate accelerators) has often been used to describe this scheme. It is suggested that a majority of RVM may be classified as heart rate accelerators (80%), whereas a much smaller percentage include heart rate decelerators (20%). Results from

their study also suggest that heart rate decelerators (cobras) tend to be more generally violent across contexts, enacting violence on friends, strangers, co-workers, and bosses (Gottman et al., 1995). These RVM also tend to have more signs of antisocial behavior and sadistic aggression compared to their pit-bull counterparts.

Gondolf (2011) suggests that the batterer subtypes might be better conceptualized as a continuum rather than as distinct categories. For example, from more or less severity of violence and exhibiting more or less psychopathology. Newer models of batterer subtypes tend to focus more on this aspect, classifying batterers in terms of violence severity/lethality and psychopathology (Graña et al., 2014).

Given the tremendous amount of suffering and economic costs associated with IPV, interventions addressing perpetrators of this violence are greatly needed. These intervention programs are reviewed next.

Battering Intervention and Prevention Programs

BIPs first emerged from the battered women's movement in the 1970s (Mederos, 2002). This movement grew out of the larger women's liberation movement of the late 1960s and early 1970s, which in turn grew out of earlier civil rights and anti-war movements. During this time, the battered women's movement led to the construction of women's shelters, crisis centers, hotlines, and safe home networks, as well as protective legislation for women including protective orders and restraining orders. Abuse or assault within relationships was redefined to include any use of force. Public awareness over the issue of men's violence against women grew and promoted scrutiny of judiciary and law enforcement practices that ignored men's violence against women. Several court cases in

the 1980s, such as *Thurman vs. City of Torrington* (1984) and *Watson vs. City of Kansas City* (1988), set higher standards for law enforcement responses to IPV (Barner & Carney, 2011). Additionally, advocates pushed for mandatory arrest policies throughout most states, the first of which was successfully lobbied for in Duluth, Minnesota. Mandatory arrest policies required that a law enforcement officer arrest a suspect if there was probable cause, regardless of the victim's consent or objection.

In addition, it was during this time where men's violence against women began to be conceptualized from a feminist perspective in terms of power and control (Mederos, 2002). Men's violence against women was redefined as a manifestation of cultural patterns that established and maintained men's supremacy and women's subordination. This new understanding challenged earlier conceptions of IPV that focused on intrapsychic or relational issues (Adams, 1988; Mederos, 2002). Early first wave pro-feminist BIP interventions included programs such as *emerge* and *raven*, which eventually gave rise to a second wave of pro-feminist BIP models, such as the *Duluth model* and *manalive* (Mederos, 2002). These second wave models not only emphasized holding men accountable for stopping violence, but also emphasized movement towards equality and interruption of ongoing patterns of control (Mederos, 2002). Unlike the first wave BIPs, the second wave BIPs worked in conjunction with the criminal justice system, which added external pressure and reinforcements for men to enter and complete BIPs (Mederos, 2002).

A majority of current BIPs employ a time limited men-only psychoeducational format (Mederos, 2002; Rosenbaum & Leisring, 2001). Programs vary considerably in

terms of session length, ranging anywhere from a low of 10 weeks to some lasting well over a year (Rosenbaum & Leisring, 2001). Often times program length is dependent upon state laws or court order. However, 12 to 52 weeks seems to be the recommended length of treatment in most cases (Babcock et al., 2004). Programs also vary in terms of group leadership, with the gold standard consisting of one female and one male co-facilitator (Rosenbaum & Leisring, 2001). This dynamic allows for modeling of shared power and egalitarianism between men and women. However, with limited funding, many programs can only afford to have one group facilitator per group. Additionally, BIP group leaders also vary considerably in terms of their background and education (Mederos, 2002; Geffner & Rosenbaum, 2001). Many leaders identify as social justice advocates or as community/outreach/social services counselors (Mederos, 2002). Relatively few group facilitators identify as licensed mental health professionals. Training standards of BIP facilitators vary by state, but generally do not require a professional degree or licensure (Babcock et al., 2004). No known outcome data has been collected comparing different leadership arrangements (Rosenbaum & Leisring, 2001).

Earlier BIPs tended to identify themselves as an educational approach, rather than as providing psychotherapy (Barner & Carney, 2011; Herman et al., 2014). The primary mechanism of education was through consciousness raising. Since then, there has been some debate regarding whether or not BIPs should be psychotherapeutic or strictly educational (Geffner & Rosenbaum, 2001). While some approaches, such as the Duluth model and other pro-feminist models (Barner & Carney, 2011) identify their approach as

being educational, other approaches, such as those who advocate for attachment-based interventions (Sonkin & Dutton, 2003), identify as being psychotherapy.

Many BIP groups also utilize an open-group format where new members are continuously added as other members graduate from the program (Rosenbaum & Leisring, 2001). The content of sessions is often assumed to be didactic and acquirable in any order. Therefore, a new member entering the group at week five, for instance, is expected to receive all the same content by the time he graduates as members that had started the group earlier. Groups usually consist of anywhere from 8-15 group members, along with one or two group facilitators (Gondolf, 2011).

Though a considerable amount of variability exists between BIPs, a majority follow either a pro-feminist/Duluth model or a cognitive-behavioral theoretical orientation (Babcock et al., 2004; Gondolf, 2011). With that said, however, the distinction between these two formats has been unclear at times (Babcock et al., 2004) and some argue that BIPs claiming to follow either of these formats tend to overlap to the extent that they are identical (Gondolf, 2007). Additionally, some have noted that BIPs given the same categorical designation (e.g., Duluth) can differ significantly in terms of their structure (Mederos, 2002; Rosenbaum & Leisring, 2001). Variability among local state standards for BIPs and BIP monitoring officials imposing their own program requirements accounts for a sizeable portion of this variability (Mederos, 2002).

Though programs vary considerably in terms of their underlying philosophical and theoretical approaches, a majority do use some form of the following intervention strategies, including: discussion of power and control, identifying anger cues, time-outs,

communication training, processing the costs of aggression and violence, identifying emotions that often underlies anger, relaxation and stress reduction techniques, parenting skills, and assertiveness training (Rosenbaum & Leisring, 2001).

BIP Outcomes

Several meta-analyses and reviews of IPV treatment efficacy have found BIP completion to have minimal impacts on recidivism (Babcock et al., 2004; Stover et al., 2009). As an example, in a meta-analysis of 22 studies examining the efficacy of BIPs, Babcock et al. (2004) found that BIP completion tended to produce small effect sizes in successful treatment outcomes. In their analyses, Babcock et al. (2004) compared effect sizes across true experimentally designed studies, quasi-experimental studies, studies where recidivism was based on police report, and those where recidivism was based off of partner report. Finally, they also compared treatment type (e.g. the Duluth model vs. Cognitive-Behavioral therapy [CBT] vs. other). They used Cohen's *d* as a measure of effect size, which measures the difference between two sample means in terms of standard deviation. In terms of Cohen's *d*, effect sizes of 0.20 are considered small, 0.50 medium, and 0.80 large (Cohen, 1988). Babcock et al. (2004) found that true experimental design studies (overall police report $d = 0.12$; overall partner report $d = 0.09$) tended to have smaller effect sizes as compared to quasi-experimental studies (overall police report $d = 0.23$; overall partner report $d = 0.34$). There was no significant difference in effect size between experimental and quasi-experimental studies however. Across quasi-experimental studies with police report, the Duluth model had an overall effect size of $d = 0.32$, CBT had an effect size of $d = 0.12$, and the other category had an

effect size of d = .027. Across true experimental studies with partner report of recidivism, the Duluth model had an overall effect size of d = 0.12, other category had an effect size of d = 0.03, and CBT did not have enough studies to make a calculation. Across quasi-experimental studies with partner report, the Duluth model had an overall effect size of d = 0.35, CBT an effect size of d = 0.29, and the other category did not have enough studies for this analysis. The Duluth model was the only modality that had enough studies to calculate an overall effect size for experimental studies with police report and found an effect size of d = 0.19. Significant differences between groups were not found in any of these analyses. Overall the researchers calculated that successful completion of a BIP treatment program translated into a 5% decrease in the likelihood of recidivism. Additionally, Babcock et al. (2004) concluded that any claim of one theoretical modality being superior to any other was unwarranted based off of findings in this meta-analysis.

Another meta-analysis of BIP outcome studies found greater variance in the efficacy of treatment across studies (Cunha & Goncalves, 2014). In this analysis, success rates of BIP intervention across studies ranged from 39.4-97%. However, the authors noted that a majority of the studies had several limitations to consider that may have artificially inflated treatment success. Most notably, many studies had simple pre-posttest designs, failed to include a control or comparison group, or failed to gather long-term follow-up data. When there were comparison groups, these usually consisted of RVM who had dropped out of treatment. It was also noted that a significant amount (30%) of the studies found no significant effect of treatment, with the more rigorously designed

studies usually finding no significant effect. The wide range of methodologies used is thought to have produced the wide range in treatment successes.

Although some studies have reported finding decreased levels of physical and verbal aggression among participants at post-treatment (Cunha & Goncalves, 2014), long-term follow-up studies tend to find equal recidivism rates among program completers and non-completers (Herman et al., 2014). One study following participants from a battering intervention program for 9 years found that over one third of participants that completed the program eventually reoffended (Herman et al., 2014). In this study, recidivism between program completers and program non-completers was not found to be significantly different. Low program efficacy in terms of recidivism among program completers versus non-completers has led to a call for more effective treatment interventions for RVM (Babcock et al., 2004; Gondolf, 2011; Herman et al., 2014).

In a review of alternative treatments for RVM, such as psychodynamic therapy, couples therapy, models based on stages of change, batterer subtype, or culturally-modified protocols, Gondolf (2011) concluded that these forms of intervention tend to perform as well as the standard gender-based cognitive-behavioral approaches towards treating RVM. Given the lack of research support for a majority of these alternative approaches, Gondolf (2011) advocated for the continued use of standard gender-based cognitive-behavioral approaches due to their efficiency. Gondolf (2011) argues that most of the alternative approaches require far more resources and time in conducting extensive screening procedures to implement, which most programs cannot afford.

Limitations of Past BIP Research

Overall there are several limitations to consider when attempting to measure the efficacy of BIP programs. Low response rates, drop-out, lack of random assignment, and difficulty conducting follow-up interviews with victims and perpetrators contributes to a majority of these limitations (Babcock et al., 2004; Gondolf, 2004; Gondolf, 2007; Rosenfeld, 1992; Sartin et al., 2006; Stover et al., 2009). Another important thing to consider is that BIPs often only account for one component of the community response towards IPV (Babcock et al., 2004; Gondolf, 2007). Lack of response from any other component in the community response, such as from law enforcement, can have an impact on treatment effects. Most notably, a lack of strong legal enforcement has been suspected of increasing the percentage of drop-outs in several studies (Babcock & Steiner, 1999; Gondolf, 2007). The involvement of several other community responses (e.g., victim advocacy, arrest policy, sentencing policy), however, also makes it difficult to isolate the effect of BIP treatment by itself (Sartin et al., 2006). It is likely that these other community responses have an impact on recidivism even in the absence of BIP treatment.

Research procedures can have an impact on BIP efficacy as well. Results can vary dramatically depending upon the sampling method used to recruit participants (Sartin et al., 2006). Most studies utilize one of four possible sample sources including, community, general clinical (e.g., couples seeking counseling), clinical (e.g., BIP treatment), or court mandated sample. Each sample source can be associated with unique characteristics to consider and may impact an outcome study's results. For example,

those within a court mandated sample may be less willing to disclose information knowing it could have legal consequences as compared to other sampling sources. The level of IPV severity may also vary considerably between sampling sources, for instance. Often only more severe forms of IPV are reported to police, suggesting that court mandated samples likely have increased severity of IPV.

Another challenge arises in trying to determine and compare the efficacy of various BIP theoretical formats (e.g., Duluth vs. CBT vs. solution focused). Researchers have noted that considerable variability exists between BIPs, even in programs that claim to have the same theoretical orientation (Geffner & Rosenbaum, 2001; Rosenbaum & Leisring, 2001). This heterogeneity of BIPs and interventions makes comparison across studies difficult. Additionally, BIPs with differing theoretical ideologies still tend to have significant overlap as well (Babcock et al., 2004; Rosenbaum & Leisring, 2001) making comparison difficult. An example includes the debate that Duluth and CBT programs tend to be one and the same, or at the least, heavily integrated (Gondolf, 2007; Stuart et al., 2007).

Another problem limiting the comparability of studies across one another includes the use of different definitions and measurements of violence and abuse. Some researchers have noted vague and inconsistent definitions of IPV and psychological abuse across studies and psychological measurements designed to measure IPV (CDC, 2003; Sartin et al., 2006; Winstok & Sowan-Basheer, 2015). Furthermore, measurements of IPV also vary in terms of the source data, which may impact reliability of that data. For instance, some studies and measurements rely upon self-report from either partners or

RVM themselves, while others look at criminal records to see if a participant has recidivated (Sartin et al., 2006). Each method of measuring recidivism has limitations to consider. RVM may severely underreport the severity and frequency of IPV, while partners may also underreport if under threat from their partner (Rosenfeld, 1992; Sartin et al., 2006). Looking at legal/criminal records may be more reliable, but fails to include incidences of violence that may go unreported to police and may not include recidivism of emotional, verbal, or psychological abuse (Sartin et al., 2006).

Additionally, studies vary in regards to what they consider successful treatment completion (Babcock et al., 2004). Babcock et al. (2004) noted that several studies within their meta-analysis had different definitions of program completion. Some considered attending 70% of BIP sessions as completion, while others had more conservative cutoffs of attending at least 80%, while some failed to specify. Babcock et al. (2004) noted that the use of a dichotomous variable to measure recidivism (recidivism vs. no recidivism) may be an overly conservative estimate dampening the effect size of BIP treatment. However, the inclusion of continuous variables to measure treatment effects also has limitations. Continuous variables for measuring IPV, such as using the Conflict Tactics Scale (CTS; Straus, 1979), are often dependent on BIP members' self-report, meaning that IPV is often underreported with continuous variables. Additionally, RVM have been shown to often fake-good on various measures of social desirability further biasing variables that rely on RVM's self-report (Rosenfeld, 1992). Few studies have been known to control for this social desirability bias.

Finally, given the involvement of the legal system in IPV, achieving random assignment or other components of an experimental design are difficult, if not impossible in a majority of cases (Rosenfeld, 1992; Sartin et al., 2006). This makes it almost impossible to have a true experimental design examining the efficacy of a BIP program. The main issue with a true experimental design is that it could potentially be considered unethical to have participants randomly assigned to a no treatment group, since this could have negative consequences for survivors of IPV. Additionally, more severe offenders are more likely to be court mandated to complete treatment, meaning this group may not be a representative sample of the entire population of RVM (Sartin et al., 2006). Earlier BIPs and outcome research also had a tendency of refusing treatment to RVM with comorbid alcohol/substance abuse, mental illness, or general lack of motivation, which may also limit the representativeness of these earlier samples (Rosenfeld, 1992). Finally, even if a true experimental design were possible, high attrition rates often attenuate internal validity and effect sizes of outcome studies (Sartin et al., 2006). Some have reported upwards of 40% of RVM dropping out of treatment.

Given the difficulty in conducting true experimental design studies within the field of battering intervention, a majority of studies examining the efficacy of BIP programs tend to be quasi-experimental in design (Babcock et al., 2004; Rosenfeld, 1992). This produces several limitations to consider as well. Quasi-experimental designs often compare treatment completers to drop-outs. This creates a bias where the most motivated RVM are being compared to the least motivated, which can artificially inflate the effect size of BIP treatment (Babcock et al., 2004). Research further shows that there

are differences between RVM who choose to complete treatment versus those that dropout. BIP completers tend to be more well educated, tend to be employed, be married, White/European, and are less likely to have a criminal record compared to RVM that drop out of treatment (Babcock et al., 2004).

Another phenomenon that makes examining the efficacy of BIPs difficult is the finding that a large portion of RVM show no signs of recidivism with no treatment what so ever (Cunha & Goncalves, 2014). It is possible that as much as one third of RVM improve without BIP treatment (Sartin et al., 2006). This makes it difficult to know whether or not BIP completion has an effect on recidivism or if BIP members would have remained nonviolent either way, without treatment. Lack of re-offending also makes comparisons to control groups more difficult to interpret.

Measuring Violence in BIP Studies

Many studies examining the efficacy of BIPs have utilized the CTS (Straus, 1979), or one of its revised forms, to measure verbal and physical partner abuse (Langhinrichsen-Rohling, 2005). The CTS is a 21-item self-report measure. CTS asks respondents if a behavior has ever occurred and how often that behavior has occurred within the last 12 months. Respondents report the occurrence of each behavior on a 7-point scale ranging from (0 = *never*, 1 = *once*, 2 = *twice*, 4 = *3-5 times*, 8 = *6-10 times*, 25 = *over 20 times*). The CTS was first developed by Straus in 1979 and since then has aided researchers' ability to make comparisons across BIP studies (Langhinrichsen-Rohling, 2005). The newer version of this measure, the CTS2 (Straus et al., 1996), also added items related to sexual aggression. Other researchers have developed their own

instruments for measuring partner abuse. Herman et al. (2014), for example, developed the Relationship Beliefs Scale (RBS) and the Perpetrator Behaviors Scale (PBS) to measure attitudes, beliefs and controlling behaviors thought to be associated with intimate partner violence. These measures have less empirical support.

Intervention Models

Since their emergence in the 1970s BIPs have evolved and diverged in terms of theoretical and philosophical orientation. Several different BIP models and theoretical perspectives have been developed, which are described here in more detail.

Emerge

One of the first pro-feminist BIP models known as emerge served as an important precursor to the well-known Duluth model (Rosenbaum & Leisring, 2001). Founded in 1977, emerge was the first program in the US to focus on the treatment of RVM (Adams & Cayouette, 2002). Having an important influence on the development of the Duluth model, the emerge model had very similar characteristics as Duluth. Emerge utilized a psychoeducational group format similar as Duluth. Like Duluth, it also has an emphasis on power and control, viewing violence within a social context of men's dominance over women. Additionally, emerge also conceptualizes battering as a learned behavior (Adams & Cayouette, 2002), similar to cognitive-behavioral perspectives (Mihalic & Elliott, 1997). These programs start with a 30-minute check-in period where RVM in the group share information about the violent behaviors they have enacted on their partners, as well as, the impact these behaviors have had on their partners and children (Rosenbaum &

Leisring, 2001). Several prominent figures within emerge went on to help establish the Duluth model in Duluth, Minnesota in 1980, which will be discussed next.

Duluth Model

The Duluth model originated within the community of Duluth, Minnesota during the early 1980s (Mederos, 2002). Founded in 1980, the Domestic Abuse Intervention Project (DAIP) paved the way for the development of the Duluth curriculum, which launched in 1990 (Mederos, 2002). Early Duluth advocates trying to distance themselves from mainstream psychology regarded the Duluth program as education, rather than psychotherapy (Barner & Carney, 2011; Herman et al., 2014).

The Duluth model prioritizes survivors' safety above all else including BIP member's confidentiality. It is common for many Duluth programs to contact BIP members' partners to assess if further violence has occurred. Duluth advocates assert that violence does not simply result from men's anger or individual characteristics, but from a more complex institutionalized and structural gender inequality in social, political, legal, and economic realms (Adams, 1988; Miller, 2010). The Duluth curriculum includes lesson plans for 27 weekly, 2-hour sessions, including three orientation sessions (Mederos, 2002). Each lesson focuses specifically on an abusive behavior and facilitates learning of alternative non-violent egalitarian behaviors. The Power and Control Wheel (see Figure 1) is introduced early on as a tool for educating the men about violent and abusive behaviors used to maintain power and control over their partners (Gondolf, 2007). Likewise, its counterpart, the Equality wheel (see Figure 2), describes alternative non-violent egalitarian behaviors that are taught to replace violent and controlling

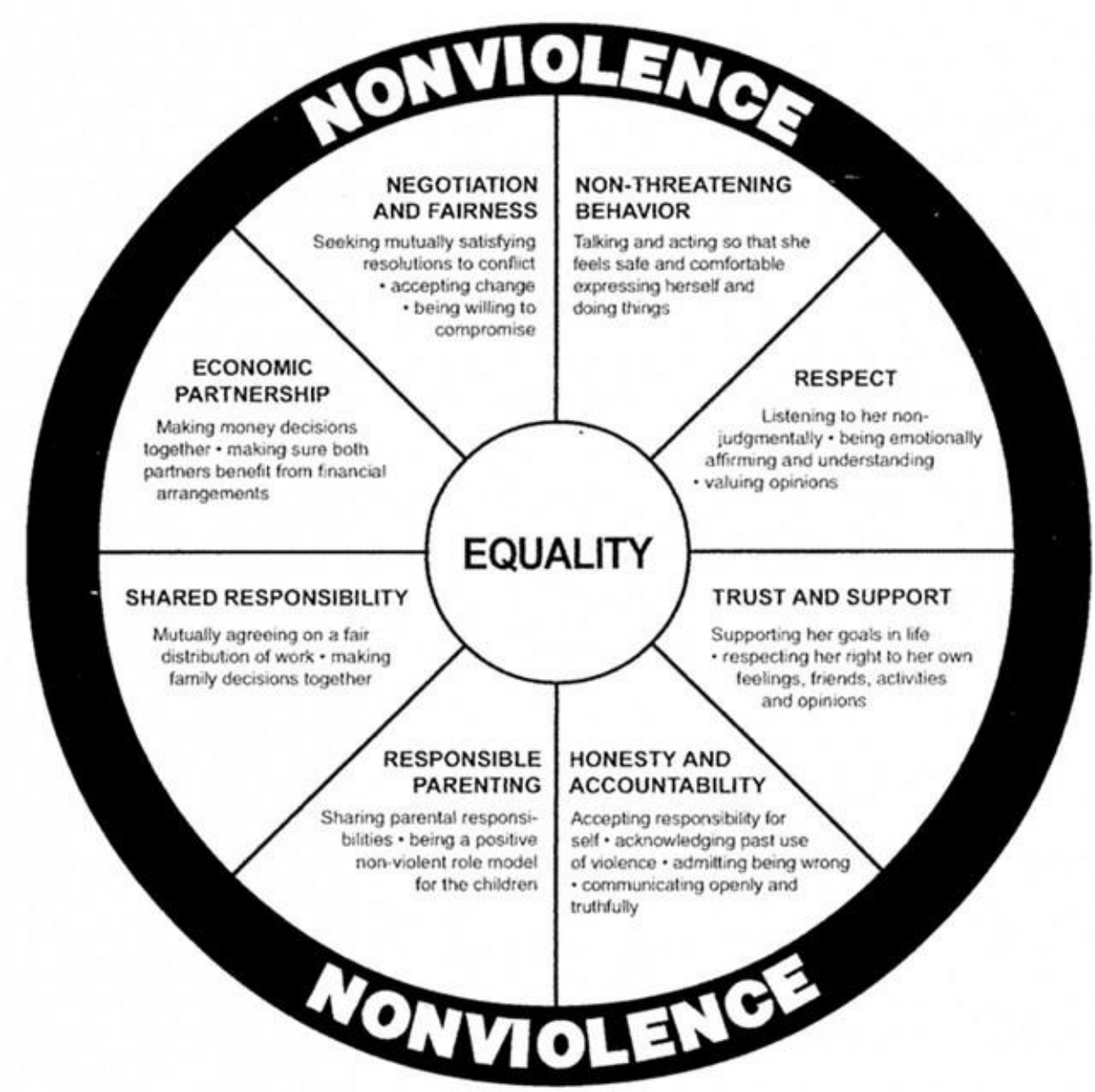
behaviors (Gondolf, 2007). The Power and Control Wheel was originally designed by over 200 women survivors of IPV in Duluth (Pence & Paymar, 1993). It illustrates that physical violence is part of larger pattern of controlling behaviors including intimidation, emotional abuse, isolation, minimization, using children, using male privilege, economic abuse, and coercion (Rosenbaum & Leisring, 2001). Finally, each week's lesson includes a specific theme or topic of discussion (Herman et al., 2014). Examples of these include: (a) negotiating and fairness, (b) non-threatening behaviors, (c) trust and support, (d) honesty and accountability, (e) responsible parenting, (f) respect, and (g) economic partnership.

Figure 1

Power and Control Wheel

Figure 2

Equality Wheel



Conceptually, the Duluth model is often considered a feminist cognitive-behavioral approach (Mederos, 2002). Duluth is considered feminist since it

conceptualizes battering as a form of oppression against women and endorses egalitarianism as an alternative within relationships. It is considered cognitive-behavioral since it also focuses on changing men's beliefs that support men's oppression of women and on changing the subsequent abusive and controlling behaviors that follow from these beliefs. The cognitive components of Duluth were adapted from Paulo Freire's self-reflective and critical dialogue approach (1970), which were initially used to help peasants critically analyze beliefs that justified the oppressive hierarchal system in which they resided. The Duluth curriculum was also heavily influenced by an earlier BIP called emerge (Rosenbaum & Leisring, 2001). Several activists from emerge including Joe Morse and Miguel Gil acted as consultants helping to establish the Duluth program.

A major component of Duluth curriculum is the utilization of control logs. Control logs were first developed by Pence and Paymar (1993) as part of the Duluth curriculum. Along with video case vignettes, control logs are used to help RVM in BIP programs break down and analyze various abusive situations (Adams, 1988; Miller, 2010; Rosenbaum & Leisring, 2001). Control logs help RVM to analyze the specific actions, intentions, beliefs, feelings, and consequences related to each of the men in these video vignettes. Facilitators then help RVM to apply their own experiences using abusive behaviors to these videos and control logs.

The Duluth model tends to be one of the most popular BIP program formats or theoretical orientations (Geffner & Rosenbaum, 2001; Stuart et al., 2007) and preferred standard of treatment in most states (Barner & Carney, 2011). Most BIPs have at least elements of the Duluth curriculum embedded within their program. Due to the feminist

and cognitive-behavioral aspects of the Duluth curriculum it has also been labeled a gender-based cognitive-behavioral approach (Gondolf, 2011).

Duluth Model Criticism and Limitations

Some critics assert that the Duluth model fails to provide RVM with alternative strategies for changing dysfunction relational dynamics, such as skills for responding appropriately to disagreements, coping with anger, and utilizing more effective communication strategies (Armenti & Babcock, 2016; Crockett et al., 2015). Others criticize Duluth programs for being overly shaming and confrontational, making it difficult to develop a therapeutic relationship with clients (Crockett et al., 2015; Dutton & Corvo, 2007). These critics also argue that the Duluth model has failed as a treatment modality for RVM, pointing to several outcome studies showing no significant effects for Duluth treatment (Dutton & Corvo, 2007). They also propose that the Duluth ideology has a very polarized and negative view of men. Critics argue that from a Duluth standpoint, IPV perpetrated by men is always assumed to have originated from men, while IPV perpetrated by women is always seen as being in response to men's violence. In defense of the Duluth model, Gondolf (2007) argues that critics (e.g., Dutton & Corvo, 2007) have selectively chosen outcome studies that support their views and failed to include more recent data that supports the Duluth model. Additionally, on the Duluth model's website it notes that while some programs may have misused the curriculum to shame men, it is not intended that interventions be shaming. Shame dehumanizes and results in resistance to change.

Another major criticism of the Duluth model, along with CBT or gender-based CBT BIPs, is the argument that these perspectives tend to have a one-size-fits-all approach to treating RVM (Armenti & Babcock, 2016; Crane & Easton, 2017; Crockett et al., 2015). Critics contend that not all violence may be characterized as patriarchal terrorism and that many couples exhibit signs of mutual or situational violence instead (Armenti & Babcock, 2016; Johnson, 1995). Rather than following from a motivation to control one's partner, situational violence is thought to occur as a result of situational stressors within an intimate relationship. Situational violence is often conceptualized as occurring at lower frequencies and lower intensities of violence. Situational violence has been conceptualized to include behaviors such as pushing, grabbing, and slapping.

Another final criticism of the Duluth model is that it fails to address other potential factors that may have an impact on IPV, such as poverty or childhood trauma (Crockett et al., 2015). Many researchers have noted that RVM often have experiences of witnessing violence during childhood in their family of origin, which may have an impact on them perpetrating violence (Crockett et al., 2015; Ennis et al., 2017). Similarly, many have noted higher rates of IPV among impoverished clients, suggesting that the stress of poverty may play a role in IPV perpetration (Crockett et al., 2015). Mederos (2002) notes that earlier BIPs, such as Duluth, tended to have a narrowed vision of accountability and intervention that did not take into consideration race/ethnicity, class, or other contextual issues such as history of oppression, immigration or past trauma experiences. Third wave BIPs such as AMEND, manalive, and Almeida's cultural reintegration model were considered more holistic approaches that were better at taking into consideration how

RVM's social locations and life contexts might impact their abusive and controlling behaviors (Mederos, 2002).

Cognitive-Behavior Therapy

Based heavily on social learning theory, CBT perspectives for treating RVM often view violence and aggression as learned behaviors (Adams, 1988; Babcock et al., 2004; Mihalic & Elliott, 1997). Similarly, non-violence is seen as something that can be learned in place of violence and aggression. Much like Duluth, CBT BIPs tend to have a psychoeducational format educating RVM about the negative consequences of IPV, as well as, providing non-violent alternatives. Programs often vary in regards to which nonviolent alternatives and skills they emphasize. Some advocate more for systematic relaxation training, others assertiveness training, and others self-observation, where group members work to identify their physical, emotional, and cognitive cues that precede violence (Adams, 1988; Edleson, 1984; Rosenbaum & Leisring, 2001). CBT BIPs also vary in terms of how much they attend to issues of power and control (Adams, 1988). While some specifically define battering as a form of power and control and discuss how systemic sexism plays a role in battering, other programs completely ignore these discussions. Finally, as mentioned earlier, CBT BIPs tend to have significant overlap with Duluth and other pro-feminist identified BIPs (Babcock et al., 2004). Therefore, several of the interventions described here are also utilized within many self-identified Duluth and pro-feminist BIPs.

Behavioral Components

Behavior therapy interventions for RVM often emphasize helping men become aware of the specific cues that precede their violent behavior (Rosenbaum & Leisring, 2001). This may involve, for instance, exploration of physiological cues (e.g., racing pulse, sweaty palms, headache, tensing body muscles), behavioral cues (e.g., pacing, clenching fists, holding breath), emotional cues (e.g., feeling scared, sad, or ashamed), and situational cues (e.g., sleep deprivation, feeling hungry, "hot" topics) that precede violent behavior. Awareness of these cues can help RVM interrupt their violent behavior before it occurs and replace violence and aggression with non-violent alternatives (Palmstierna et al., 2012; Rosenbaum & Leisring, 2001). Alternative behavioral strategies, such as time-outs and cool downs, are often taught in BIPs to replace violent behaviors (Babcock et al., 2004; Edleson, 1984; Rosenbaum & Leisring, 2001). During a timeout, for example, the client is able to identify his cues, call a time out with his partner and remove himself from the situation before escalating to violence or aggression. Some additional steps to a timeout might include: (1) discussing what a timeout is with one's partner before needing to call a timeout, (2) having a plan of what alternative strategies to use when becoming escalated, and (3) re-evaluating the plan for what worked and what areas may need improvement. Stress reduction and various relaxation techniques, such as progressive muscle relaxation and systematic relaxation, also tend to be the focus for alternative behaviors (Edleson, 1984). Systematic relaxation, for example, offers a procedure for tensing and relaxing sets of muscle groups that enable clients to more easily identify internal cues associated with tension (Novaco, 1978).

Anger Management

Many of the CBT strategies utilized within BIPs today, such as recognizing internal and external cues and providing relaxation training, resemble several traditional anger management techniques (Babcock et al., 2004; Novaco, 1978). Anger control interventions have often emphasized identifying situations that trigger anger, self-monitoring of internal and external cues, as well as developing alternative coping skills (Novaco, 1978). Distinguishing anger from aggression and processing the difference between justified versus non-justified anger also tend to be emphasized in anger management groups.

Critical Moment

Apart from exploring escalation cues and skills training in alternative behaviors, many CBT BIP groups also focus on identifying and processing specific interpersonal conflicts where group members have become violent in the past (Edleson, 1984). These groups often process something called the *critical moment*. This is the moment where the group member could have chosen to act differently. After the critical moment is identified, group members work towards generating a list of possible alternative non-violent actions that could have been used in place of violence. Finally, group members identify the likely outcome of each of these non-violent alternatives. These alternative non-violent behaviors can then be modeled by more advanced or skilled BIP members and practiced through role plays. Other group members can provide feedback to help members modify and enhance specific behaviors. In addition, the short-term and long-term costs and benefits are discussed for these violent versus non-violent behaviors

(Rosenbaum & Leisring, 2001). For example, the short-term consequences of violence may be reinforcing in that violence can lead to compliance from men's partners, as well as a sense of power and control. However, having clients explore the long-term consequences of violence can help them to see the negative impact it has on others and themselves.

Cognitive Restructuring

Cognitive restructuring tends to be another important aspect of CBT intervention for RVM (Palmstierna et al., 2012; Weldon & Gilchrist, 2012). This often involves challenging patriarchal beliefs thought to be associated with IPV, but may include other thoughts and beliefs related to violence, such as "violence is acceptable" (Weldon & Gilchrist, 2012, p. 762). In a qualitative study examining schemas related to IPV perpetration, Weldon and Gilchrist (2012) identified 11 implicit theories or schemas related to IPV perpetration. Some of these include: (a) the belief that violence is normal and acceptable, (b) beliefs related to seeing women as objects who are there to serve and satisfy men, (c) beliefs related to seeing the male sex drive as uncontrollable and needing to police their partner, (d) beliefs viewing women as provoking IPV, (e) beliefs related to diminished personal responsibility from external factors (e.g., substance use), (f) beliefs related to thinking their partner would abandon them, and (g) beliefs related to a need to stay in control. Through cognitive modification or restructuring RVM learn to recognize automatic thoughts and core beliefs that contribute towards IPV and challenge those beliefs (Palmstierna et al., 2012).

Mindfulness

Mindfulness-based approaches have also been applied to working with RVM. These interventions are often included under the umbrella of CBT (Tollefson & Phillips, 2015). One such intervention program includes Mind-Body Bridging (MBB; Tollefson & Phillips, 2015). Mindfulness and somatic awareness are at the core of these interventions. This program includes other intervention strategies as well, such as relaxation training, the use of visual imagery, meditation, yoga, biofeedback, group support, and other traditional CBT interventions. In one study examining the efficacy of MBB, researchers found that RVM were significantly less likely to drop out of treatment if they attended the MBB group (9.1% drop-out) versus a comparison group (23.9% drop-out; Tollefson & Phillips, 2015). Additionally, researchers found that less RVM recidivated in the MBB group (2.3%) as compared to the control group (10.9%), though this difference was not statistically significant.

Other forms of mindfulness-based interventions include Dialectical Behavior Therapy (DBT; Waltz, 2003) and Acceptance and Commitment Therapy (ACT; Zarling et al., 2015). DBT utilizes both concepts from Zen and dialectical philosophy to achieve a balance between promoting acceptance and behavioral change (Waltz, 2003). From a DBT perspective, the consequences of violent behavior may be explored, but in a non-judgmental or non-moralistic way. DBT uses strategies similar to other behavioral perspectives, such as behavioral analysis to dissect violent events, including the thoughts, feelings, and behaviors leading up to and following an instance of IPV. These analyses,

for instance, are very similar to control logs used in Duluth programs (Adams, 1988; Miller, 2010).

Similar to DBT, ACT for partner aggression utilizes mindfulness and acceptance-based interventions to increase the psychological flexibility of RVM (Zarling et al., 2015). This is achieved through six processes: (a) present moment awareness, (b) acceptance of difficult or uncomfortable emotions and thoughts, (c) decreased attachment to thoughts, (d) perspective-taking, (e) identification of values, and (f) committed action consistent with one's personal values. One randomized control trial comparing ACT intervention to a support and discussion control group found that participants in the ACT group reported significant declines in both physical and psychological aggression compared to the control group (Zarling et al., 2015).

Criticism of CBT

Feminist critics of CBT models stress the importance of including discussions of how power and control play a role in IPV perpetration (Adams, 1988). Critics argue that many CBT programs fail to make this the central point of their program. Similarly, feminist scholars often criticize CBT programs for not including discussions of how gender socialization impacts IPV perpetration. Feminist critics argue that poor coping skills or interpersonal skills deficits cannot explain why women are often the sole target of these men's violence. Additionally, these skills deficits cannot explain why many men with these skills deficits never abuse their partners or engage in IPV. However, Adams (1988) does acknowledge that CBT interventions can be helpful when integrated with feminist models of treating IPV.

Emotion-Focused Interventions

Early models of treating IPV focused on attending to men's anger and were often referred to as ventilation models (Adams, 1988). These treatment models were based on the assumption that violence could be reduced by allowing men to vent their anger. These models were heavily criticized by feminist scholars for failing to address issues related to power and control that contributed to men's violence (Adams, 1988). Moreover, feminist critics argued that venting anger, rather than reducing anger, only spurs more anger and aggression. Research supports both the ineffectiveness of venting to reduce anger and its potential to increase actual aggression (Lohr et al., 2007).

Some researchers have more recently attempted to adapt emotion-focused interventions towards working with relationally violent men. For example, one such model includes a program called Relating Without Violence (RWV; Bierman & Cheston, 1996; Pascual-Leone et al., 2011). RWV is a program that was first implemented within the prison system with incarcerated men who had a history of perpetrating IPV. Unlike many other BIPP programs, RWV has a secondary aim of addressing childhood trauma. Some of the main goals for this 12-week program are to help the men identify their feelings, express those feelings in healthier ways, and develop empathy for their partners. RWV is divided into two 6-week long modules with the first module focusing primarily on emotional change and the second module focusing primarily on relational change. During the initial phase of treatment, a technique similar to Gendlin's (1981) focusing exercise is used to help group members identify their feelings. An exercise similar to Hendrix's (1990) chair dialogues is then used to help members practice expressing their

feelings to an imagined partner in healthy ways. During the second phase of treatment, group members break out into pairs and practice their newly developing skills. Each member in the dyad takes turns role-playing either the empathizer/helper or the helpee to help build their empathy skills. One potential limitation of this program is that group members are supposed to be at a point where they genuinely want to change and have already developed at least some accountability for their behaviors. It is recommended that confrontation of members' denial, minimization, and blame precede RWV treatment. This requirement is in contrast with most BIPs who will accept most men into their programs regardless of men's readiness for change.

Some of RWV's main goals of building empathy and focusing on RVM's own trauma are not far off from a majority of BIPs. For example, most BIPs utilize various strategies to help group members develop empathy for their partners (Rosenbaum & Leisring, 2001). This may include, for instance, confronting sexist language that dehumanizes their partner. Additionally, some programs will focus on RVM's own experiences of trauma and abuse (often from the men's own fathers growing up) as an avenue towards developing empathy for their partner and/or children. An outcome study examining the efficacy of the RWV program found that men who had completed the RWV program had significantly lower rates of recidivism at 7 and 8-month post-release, versus those that had not taken the program (Pascual-Leone et al., 2011).

Emotion-Focused therapy (EFT) researchers have also provided helpful conceptualizations in working with problematic anger, hate and rage often exhibited by relationally violent men (Pascual-Leone et al., 2013). In the case of IPV, anger is seen as

a secondary emotion covering more vulnerable primary emotions, such as shame and fear. Within this conceptualization of anger as a secondary emotion, anger is seen as a reactive emotion to a primary emotion, which allows a man to avoid the uncomfortable primary emotion. Men are often socialized to avoid vulnerable primary feelings such as sadness, fear, and shame (Rosenbaum & Leisring, 2001). In contrast, men are often socialized to express anger and aggression and therefore may express these more often and in place of other less comfortable emotions. Many BIPs discuss this conceptualization of anger as a secondary emotion (Rosenbaum & Leisring, 2001) and often utilize metaphorical tools, such as the anger iceberg or anger funnel (Rosenbaum & Leisring, 2001), to help teach this concept. Though it has been argued that IPV is not about anger (Adams, 1988; Pence & Paymar, 1993), most BIPs use a combination of anger management techniques, such as identifying anger cues, using time-outs, and the idea of viewing anger as a secondary emotion (Rosenbaum & Leisring, 2001). Many programs then help RVM to identify and express these core emotions. As an example, it is far more constructive for men to express their fear to their partner than anger and aggression.

Couples Therapy

Early marriage and couples counselors treating violence within relationships were criticized for putting battered women at further risk of violence from their partners by encouraging open communication within the couple (Mederos, 2002). The promotion of open communication within sessions often led to assaultive retaliation from their partners immediately following sessions. Pro-feminist perspectives also criticized couples

interventions for splitting blame between the couple, which resulted in victim blaming (Adams, 1988; Armenti & Babcock, 2016). Couples therapy for IPV tends to be the least preferred format utilized by BIPs today (Mederos, 2002) and is restricted in many states (Armenti & Babcock, 2016; Babcock et al., 2004). Recently however, some researchers have advocated for inclusion of multi-couples group and couples-oriented group interventions (Armenti & Babcock, 2016). To some extent, ideas from early couples and marriage therapy perspectives are still utilized by many BIPs today. For example, most BIPs include some form of communication training in their program (Rosenbaum & Leisring, 2001). One hypothesis related to IPV includes the idea that RVM have poor communication skills and resort to violence as a conflict resolution strategy (Rosenbaum & Leisring, 2001). Since men are often socialized to tie their sense of self-worth with being right, they may resort to violence as a way to win an argument when they have trouble communicating.

Proponents of couples counseling for IPV suggest that some men drop out of BIP groups due to experiencing violence from their partners as well (Gondolf, 2011). Newer forms of couples counseling for IPV tend to have extensive screening procedures and only allow couples with low levels of violence to participate in couples counseling (Gondolf, 2011; Stuart et al., 2007). Some have a 2-hour interview process for each partner. Additionally, these interventions are often only allowed if the woman in the relationship agrees to participate and does not show any signs of fear in regards to discussing the relationship (Armenti & Babcock, 2016; Stuart et al., 2007). Screening also entails ruling out controlling behaviors, fear, severe abuse, drug and alcohol abuse,

and personality disorders (Armenti & Babcock, 2016). If any individual in a couple exhibits any of these behaviors the couple is not permitted to enter couples counseling for IPV. The Situational Violence Screening Tool (SVST; Friend et al., 2011) is one newly developed measure that is often used to screen couples before entering counseling.

Relationship researchers developed the Creating Healthy Relationships Program (CHRP), a multi-couple group psychoeducational program, that revolves around teaching couples various relationship enhancement skills, such as communication training, assertiveness, and conflict management skills, as well as, skills for building intimacy and friendship (Bradley & Gottman, 2012; Bradley et al., 2011). Compared to a no-treatment control group, couples that have completed the CHRP have reported significant gains in relationship satisfaction, use of healthy relationship skills, and reduced conflict and violence (Bradley & Gottman, 2012; Bradley et al., 2011). Similar healthy relationship training programs have found comparable results (Antle et al., 2011).

Some conjoint therapy programs utilize traditional BIP interventions, such as time-outs, but argue that these interventions are better implemented within a couples setting (Rosen et al., 2003). Couples therapists here argue that partners of RVM often fail to understand or support the purpose of a time-out. It seems that RVM often fail to negotiate the terms of a time-out with their partner before it is needed in a situation, which often leaves their partners confused about the purpose or reasoning behind a time-out. Additionally, couples therapists also argue that when used unilaterally RVM can use time-outs as another way to exert power and control over their partners. A couples setting, on the other hand, allows for the facilitation of a safe environment where the

couple can negotiate the terms of a time-out more clearly. This is thought to lead to better implementation of a time-out when needed.

Criticisms of Conjoint Treatment

Critics of these couples interventions note that it seems highly impractical to devote so much energy and resources into screening for couples that might fit the specified category, when it might be far more efficient in terms of time and resources to have RVM take part in a BIP group (Gondolf, 2011). Critics also argue that getting reliable information from these screening procedures may be difficult if a woman is in crisis or under threat from her partner. The tendency of RVM to underreport the severity of violence, especially at intake, is an additional problem, as noted earlier. Finally, although couples-intervention advocates are often quick to criticize the Duluth model and other BIPs, they have yet to present any evidence to show that couples-interventions are superior to other BIP models (Armenti & Babcock, 2016). Couples and multi-couples interventions for IPV tend to be as effective as other BIP intervention modalities (Armenti & Babcock, 2016).

Counter Arguments to Criticism of Conjoint Treatment

In response to criticism of couples-oriented interventions blaming the victim, couples-intervention advocates argue that there is a risk of victim blaming occurring no matter the treatment context (Armenti & Babcock, 2016). Some even suggest that traditional men's groups for IPV provide a context where victim blaming can occur more often. For example, RVM in BIP groups may potentially find justifications for their violence from other men in the group. Additionally, in almost any RVM's group there

may be a risk of facilitators colluding (Adams, 2012; Barnardi & Day, 2015). Couples advocates also suggest that by screening for situationally violent couples versus more asymmetrical violence from men, couples interventions may go beyond the one-size-fits-all approach that most BIPs take with RVM (Armenti & Babcock, 2016). Advocates also point out that couples groups could be more cost effective than providing intervention to individual couples.

Treatment of Comorbid Addiction and Substance Abuse

Alcohol and substance abuse tend to be associated with IPV perpetration in many cases (Klostermann et al., 2010; Langhinrichsen-Rohling, 2005). In response to this, some models of treating IPV perpetration also aim to treat comorbid addiction and substance abuse behaviors exhibited by RVM (Klostermann et al., 2010; Ronel & Claridge, 2003). Grace therapy (Ronel & Claridge, 2003), for instance, utilizes a similar structure as 12-step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), to address both addiction and battering. Programs such as this point out that initial treatment of substance addiction early on significantly decreases the occurrence and severity of future violence (Crane & Easton, 2017; Ronel & Claridge, 2003). However, substance addiction treatment alone does not necessarily eliminate IPV, pointing to a need for a unified approach that addresses both addiction and battering (Ronel & Claridge, 2003). Furthermore, proponents of treating addiction and IPV together point out similarities in the presentation of both RVM and people addicted to substances, such as denial, minimization, and a lack of motivation to change (Ronel & Claridge, 2003). Additionally, as in many BIPP groups, more experienced veterans tend

to act as mentors to new members in 12-step programs. In the Grace therapy model, battering is conceptualized as resulting from a spiritual imbalance, which is often defined as self-centeredness. The path towards a better life is conceptualized as an inner struggle that slowly moves away from self-centeredness and towards God-centeredness. Furthermore, as with addiction, IPV can be viewed as an attempt to have control, but paradoxically leads to a state of feeling of being out of control and powerless. Ronel and Claridge (2003) note that seeing IPV as being out of control and powerless may at first seem problematic, but suggest that as with addiction treatment, the process of admitting powerlessness actually leads to accepting greater responsibility. As with addiction in the AA and NA community, treatment involves progression though several stages of recovery.

Alcohol and substance abuse are often discussed BIPs, though there is a considerable amount of variability in how BIPs handle this issue (Rosenbaum & Leisring, 2001). Some BIPs require that members be enrolled in concurrent substance abuse treatment or complete an addiction/substance abuse treatment program before being allowed to enter a BIP program. Other BIPs may include a module discussing the relationship between substance abuse and violence. The advantage of programs that combine battering and addiction treatment is that when treatments are separate, a majority of clients who receive referrals for either a BIP program or an addiction program fail to follow through with seeking treatment at the referral site (Kolstermann et al., 2010). For example, if clients are getting treatment at a BIP they often fail to follow

through with a referral to an addiction treatment center and if they are receiving treatment at an addiction center, clients often fail to follow through with a referral to BIP treatment.

Solution-Focused Interventions

Solution-focused perspectives often encourage RVM to develop and work on implementing an interpersonal goal throughout treatment (Lee et al., 2003). These interpersonal goals must be (a) specific behaviors that the men can engage in regularly (e.g., at least a few times weekly), and (b) measurable to the extent where the men can report back to the group about their progress (Lee et al., 2003). These goals are intended to go beyond stopping a behavior (e.g., not being violent, or not drinking/not using drugs). The behaviors are intended to be new healthier alternatives that will take the place of violent and unhealthy behaviors. For example, when participants in a solution-focused BIP report a goal that involves the absence of a behavior, such as to *not be violent*, facilitators might ask participants what they will do instead of acting violently — what behavior will replace the violence and aggression. These more effective actions should be observable and measurable, as well as aimed at enhancing a particular relationship. Participants often, through trial and error, come to realize that goals aimed at changing their own behavior tend to be accomplished more easily than ones aimed at changing their partner or others' behavior. For example, a client will find that a goal to “make my partner happy” is much more difficult than one to work on “reflecting my partner's feelings at least five times per day.”

Motivational Interviewing and Readiness for Change

Drop-out rates tend to be a major concern in many BIPs (Babcock et al., 2004; Gondolf, 2004; Gondolf, 2007; Rosenfeld, 1992; Sartin et al., 2006; Stover et al., 2009). In response to this fact, some have advocated for the use of motivational interviewing and readiness for change based interventions to improve RVM's attendance in BIPs (Babcock et al., 2005; Scott et al., 2011). One such model includes the transtheoretical model (TTM; Babcock et al., 2005). The TTM of behavior change for perpetrators of IPV suggests that change occurs as perpetrators move through five stages (Babcock et al., 2005). These stages include: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, and (e) maintenance. Precontemplation can be described as a state where perpetrators have no intention of changing their behavior. Contemplation, on the other hand, marks the point where perpetrators become aware that a problem exists and are interested in changing, but have not made a commitment towards active change yet. During the preparation stage, perpetrators intend to act in the near future and are making decisions about what will be the best course of action to take. In the action stage, perpetrators actively work towards behavior change. Finally, during the maintenance stage perpetrators have made behavioral changes and are working to prevent relapse.

Perpetrators of IPV vary considerably in how quickly they move through the stages and it is relatively common to return to an earlier stage (Babcock et al., 2005). While the TTM was traditionally applied to working with chemical addiction (Prochaska & DiClemente, 1992; Prochaska et al., 1992), researchers have started to apply this model to several other behaviors including IPV perpetration. TTM also outlines 10

specific processes that lead to change, which are grouped into two categories: experiential or behavioral. Experiential processes entail thinking about and reacting emotionally to the problem. In the case of IPV, this might include the impact that one's violence has on their partner and/or children. Experiential processes include: (a) consciousness raising, which entails increasing awareness of the problem and one's role in the problem, (b) self-reevaluation, which entails how one feels and thinks about the self in the context of the problem, (c) dramatic relief, which involves a cathartic release and experiencing of feelings related to the problem, (d) self-liberation, which entails increasing awareness of new alternatives and choosing these alternatives, and (e) environmental reevaluation, which involves evaluation of how one's behaviors impacts others. Behavioral processes on the other hand, entail behavior change and alteration of the environment in favor of facilitating that behavioral change. Behavioral processes include: (a) reinforcement management, which involves providing rewards for new alternative behaviors, (b) helping relationships, which includes having social support and opening up to safe others, (c) counterconditioning, involving substituting problem behaviors with healthy alternatives, (d) stimulus control, which entails avoiding stimuli that might trigger the problem behaviors, and (e) social liberation, involves increasing awareness of alternative behaviors.

These 10 processes are often utilized at different stages of change (Babcock et al., 2005). For example, in the contemplation stage, IPV perpetrators might be involved in consciousness raising about the impact their violence has on their family. They may also experience dramatic relief, such as feeling guilty or ashamed about how their behavior

has impacted others. During the action stage, IPV perpetrators might utilize more behavioral processes.

Other BIP interventions focus on strategies derived from Motivational Interviewing (MI; Miller & Rollnick, 2013). Motivation enhancement treatment (MET; Scott et al., 2011), for example, utilizes intervention techniques such as: (a) expressing empathy, (b) developing discrepancies between RVM's current behaviors and desired outcomes, (c) rolling with resistance, which often involves avoiding confrontation, and (d) supporting RVM's self-efficacy for change. Emphasis is also placed on developing and maintaining a strong working alliance with RVM, which these interventions are intended to facilitate.

The effectiveness of TTM and other motivational interviewing-based interventions for IPV is uncertain. One study, for example, showed that pre-BIP readiness for change had less of an effect on BIP completion as batterer subtype did (Eckhardt et al., 2008). Another study (Scott et al., 2011), however, found that highly resistant RVM who completed a motivational enhancement group had a significantly higher group completion rate (84.2%), as compared to a standard Duluth treatment group (46.5%) and a group of less resistant RVM in standard Duluth treatment (61.1%). These differences were maintained even after controlling for demographic and lifestyle related predictors of attrition.

Attachment Focused Psychotherapy

Some have hypothesized that IPV results from insecure attachment and advocate for the use of attachment-based psychotherapy interventions when treating RVM (Sonkin

& Dutton, 2003). Some research has substantiated the link between attachment insecurity and IPV (Lawson, 2008; Lee et al., 2014). Attachment-based treatment often involves exploration of current and past attachment relationships within the safety of the therapeutic relationship (Sonkin & Dutton, 2003). In-the-moment exercises are often used to highlight RVM's attachment patterns and where these patterns may have originated from. After clients' awareness of their attachment patterns have increased, they can then begin to explore more adaptive responses to their attachment patterns and attachment anxiety. Authors note that these interventions can be implemented either within an individual or group format. Within this framework, RVM are conceptualized into one of three insecure attachment style categories. These include: preoccupied, dismissing, and fearful attachment styles. Change is thought to have occurred once RVM are able to reevaluate their internal working models of self and others, learn more adaptive ways of regulating their attachment anxiety, and begin to experience intimate relationships in new and healthier ways.

Attachment focused psychotherapy for RVM also provides one way to address the one-size-fits-all criticism of other BIP approaches (Sonkin & Dutton, 2003). RVM may exhibit different insecure attachment styles, each requiring a specific treatment approach. For example, RVM who present with an overly dismissive attachment style may benefit from interventions aimed at connecting them with their emotions and building their empathy. Alternatively, RVM who present as having an anxious/pre-occupied attachment style might benefit from interventions aimed at building greater self-sufficiency and less reliance on their partner for security.

Resolution Counseling Intervention Programs

Some BIP models utilize a majority of traditional BIP techniques and interventions, but have made significant changes to a few foundational aspects. Resolution Counseling Intervention Programs (RCIPs; Crockett et al., 2015) utilize a lot of similar BIP interventions as a majority of other BIPs, such as having RVM build accountability for their violent behaviors, learning about the impact of violence on families, creating safety plans, and anger management techniques. RCIPs, however, include topics on family of origin violence, conflict resolution, respectful communication, which are not taught in all Duluth identified BIPs. Additionally, a major tenant of this program is to avoid shaming clients and therapists work hard to develop a trusting and safe environment. RCIP utilizes a lot of interventions from a variety of BIPs, but does not claim a theoretical approach. Like the Duluth model, RCIP uses a psychoeducational same-gender group format for 21-30 weeks. Using a pre-posttest design, researchers found that RCIP treatment significantly reduced self-reported levels of psychological and physical abuse. However, it is noted that this study had high levels of attrition (41.1%), but is comparable to most other studies (Crockett et al., 2015).

Treatment Based on Batterer Sub-types

Also, in response to criticisms of the predominant gender-based cognitive-behavioral approach of BIPs having a one-size-fits-all approach towards treating RVM, some researchers have advocated for treatment to be tailored to specific sub-types of RVM (Bernardi & Day, 2015; Gondolf, 2011; Graña et al., 2014; Holtzworth-Munroe, 2000). For example, Day and Bowen (2015) introduced the concept of offending

competency, which classifies RVM based on how much they use violence instrumentally. They suggest that identification of RVM that use violence more instrumentally may be helpful for treatment, as these men may need additional and prolonged intervention. Similarly, Bernardi and Day (2015) suggest that RVM who exhibit a broader pattern of anti-sociality may benefit from an increased focus on the development of interpersonal skills and emotional regulation. These researchers also contend that this subgroup of RVM may also benefit from a more comprehensive treatment approach that address criminal attitudes, community functioning and personal stability. Others contend that the amount of assessment needed to tailor therapy to batterer subtypes would be too time consuming for most BIPs (Armenti & Babcock, 2016).

BIPs for Specific Cultural Groups

Cultural factors in IPV present a complex picture. While an in-depth discussion of this topic is outside the scope of the proposed study, it is important to note at least two things. First, rates of IPV vary by race and ethnicity (Breiding et al., 2014; Catalano, 2012), no doubt for a host of intersecting reasons; recent data shows that American Indian, Alaskan Native, and Black/African American women experience the highest rates of IPV victimization (Breiding et al., 2014; Catalano, 2012). Second, it is of notable concern that men of color are disproportionately arrested and incarcerated for most crimes (Coker & Macquoid, 2015; Nellis, 2016), which impacts not only who may be seen in BIP programs but how those individuals may respond to intervention. Again, it is important to note that non-White communities are likely over represented in the literature

and disproportionately impacted by IPV due to factors related to structural and institutionalized racism (Coker & Macquoid, 2015; Nellis, 2016).

Scholars have noted that certain minority groups, such as Latino immigrant men, tend to have higher drop-out rates within traditional Duluth BIPs (Hancock & Siu, 2009) and that little, if any, accommodations are given to these groups (Barner & Carney, 2011). This is concerning especially given that minority populations tend to be overrepresented in many BIPs (Barner & Carney, 2011) and that there is some evidence of differential response to treatment (Scott & Easton, 2010). To address this concern some have developed specialized BIPs that tailor interventions to specific cultural groups (Hancock & Siu, 2009; Whitaker, 2007). For example, Hancock and Siu (2009) developed a BIP model for relationally violent Latino immigrant men. In this program, healing from personal trauma and negative experiences related to acculturation were important for these RVM's treatment. Within this specific population, negative acculturation experiences, poverty, substance abuse, intergenerational violence, and loss of familiar surroundings and support systems were thought to exacerbate IPV perpetration. Though this program has not been formally evaluated, Hancock and Siu (2009) noted having much lower rates of attrition among participants and lower rates of repeat enrollment in the program.

Additionally, some have advocated for a restorative justice approach while working with RVM from cultural minorities. Within a restorative justice approach, solutions for IPV are generated and implemented within RVM's own communities and in accordance with these communities' specific cultural values (Barner & Carney, 2011).

Some programs, such as the Collaborative for Abuse Prevention in Racial and Ethnic (CARE) Minority Communities Project (Pratt et al., 2007) for example, rely on local mental health providers to develop innovative strategies for working with specific cultural groups and communities. Sometimes specific psychotherapy strategies are harder to identify within these programs, likely due to most of these strategies being implemented at the system or cultural level. For instance, though, the CARE project identified strategies such as developing trust with the community and community leaders, hiring bilingual and bicultural counselors to implement interventions, and placing an emphasis on self-healing and spirituality for some communities and cultural groups.

Unified Approach to Treating RVM

A unified psychotherapy approach attempts to combine all major theoretical modalities into a single holistic approach (Critchfield et al., 2017; Henriques, 2011; Magnavita & Anchin, 2014). As far as the author of this dissertation is aware, there has only been one unified approach developed towards treating RVM. Unified psychotherapy for IPV (Harris et al., 2016) draws from multiple theoretical perspectives on working with RVM. These intervention strategies were originally developed by Porras et al. (2014) and presented at the Texas Psychological Association annual convention, titled as *A Multitheoretical Conceptualization of Intimate Partner Violence.* Later these key strategies were more thoroughly described in *Unified Psychotherapy for Intimate Partner Violence: An Integrative Approach to Treating Batterers* (Harris et al., 2016). This model proposes that BIP facilitators working with RVM may be better equipped by utilizing a more comprehensive and holistic framework of intervening (Harris et al., 2016). This

model introduces five sets of clinical hypotheses and corresponding key strategies that facilitators can implement while working with offenders of IPV. Interventions are drawn from five major theoretical modalities including: emotion-focused, cognitive, behavioral, interpersonal-systemic and cultural interventions. Unified psychotherapy for IPV examines RVM's thoughts, feelings, and actions within the context of interpersonal relationships and culture. So far, no outcome data has been collected examining this model's efficacy. Working from an integrative or unified approach with RVM, however, is not necessarily a novel concept. As discussed previously, many BIPs that claim a single theoretical identification often utilize a variety of interventions from other theoretical perspectives as well (Babcock et al., 2004).

This multidimensional framework for viewing human functioning was originally developed in MTP (Brooks-Harris, 2008). MTP is an integrative model of psychotherapy, which suggests that thoughts, actions, and feelings continuously interact and influence one another. These thoughts, actions, and feelings are furthermore influenced by various contexts, such as biology, interpersonal relationships, systemic patterns, and cultural messages. MTP introduces specific key strategies that are extracted from various theoretical modalities, such as Beck's (2011) cognitive therapy, Greenberg's (2002) emotion-focused therapy, and Wolpe's (1990) behavior therapy. These key strategies are theoretically-derived interventions that can be learned, practiced and implemented by psychotherapists (Brooks-Harris, 2008).

In addition to unified psychotherapy for RVM, there have been at least two other BIP programs that identify with multiple theoretical perspectives. One of these includes

an integrated cognitive-behavioral and psychodynamic approach to treating RVM (Lawson et al., 2012). This approach integrates several intervention strategies already discussed related to CBT perspectives with psychodynamic interventions that focus on attachment and interpersonal patterns.

Another approach that draws upon multiple perspectives includes a program from Europe called Reading Safer Families (Vetere, 2011). The Reading Safer Families program draws upon several theoretical perspectives including: family systems theory, systemic practice, feminist theory, attachment theory, social learning theory, and CBT (Vetere, 2011). This program originated in the city of Reading, England, where it has been utilized for over 16 years. Like most other BIPs, Reading Safer Families helps perpetrators of IPV develop accountability for their abusive behaviors, confronts denial, minimization and blame of IPV, helps perpetrators identify triggers or cues that precede IPV, and teaches alternative strategies such as time-outs. No-violence contracts and additional safety planning are also important components of this program. Unlike most BIPs, however, Reading Safer Families relies on what is called a *stable third*, who is actively involved in the treatment process and provides trustworthy information about the family to the BIP program. For most families a stable third is usually the referral source, a community worker, or an outside family member. It is unclear what the primary mode of intervention (e.g., individual, group, couples or family therapy) is in Reading Safer Families. It seems possible that they utilize a combination of formats.

Summary and Rationale for the Current Study

It is clear from the review of BIP interventions that there are a host of both related and disparate elements to these programs. A major criticism of existing models is that many tend to have a one-size-fits-all approach towards treating RVM (Armenti & Babcock, 2016; Gondolf, 2011). This dissertation hopes to introduce multiple perspectives towards working with RVM that counters a one-size-fits-all approach. This dissertation intends to provide a more complete perspective on IPV intervention by collecting and unifying the data on existing theoretical frameworks for working with RVM.

Results of this dissertation are additionally important as they may potentially serve multiple purposes. This catalog may be a helpful teaching tool for new BIP facilitators looking to find detailed information over the various BIP interventions available. Interventions described here may also be of use to experienced BIP facilitators looking to add additional skills or interventions to their repertoire. Additionally, it is also hoped that this dissertation may illuminate potential interventions for future efficacy research. Interventions described here have various degrees of research support. Future directions may aim to evaluate the efficacy of newer and less empirically validated interventions, as well as interventions that simply may not have been evaluated yet.

CHAPTER III

METHOD

The author of this dissertation consulted Reynolds' (1971) *A Primer in Theory Construction*, while developing the framework and coding process for this theoretical model. Two additional sources on theory construction were also consulted to compare and contrast conceptions of scientific theory. These sources include Dubin's (1978) *Theory Building* and Mullin's (1971) *The Art of Theory: Construction and Use.*

Reynolds (1971) describes several ways of conceptualizing a scientific theory based on various views or paradigms within the scientific community. One of the dominant conceptions describes theory as "a set of well-supported empirical generalizations or laws" (Reynolds, 1971, p. 10). The other popular conception views theory as "an interrelated set of definitions, axioms, and propositions" (Reynolds, 1971, p. 10). The first conception of theory is often referred to as the *set-of-laws* form of theory, while the second conception of theory is often referred to as the *axiomatic* form of theory based on its origination in the field of mathematics. A third conceptualization of scientific theory includes the view of theory "as a set of descriptions of causal processes" (Reynolds, 1971, p. 10-11), also known as the *causal processes* form of theory. Reynolds (1971) contends that any of these paradigmatic views of theory could be utilized when developing a theory.

According to Reynolds (1971), scientific knowledge should have three important elements, which include: (a) abstractness, (b) intersubjectivity, and (c) empirical

relevance. Abstractness refers to the importance of scientific knowledge being independent of time and space, so that other scientists can replicate findings at a future time and space. Intersubjectivity includes having an acceptable amount of agreement about the meaning of constructs. Intersubjectivity also refers to the logical rigor or agreement about the relationship of these constructs. More specifically, logical rigor refers to the agreement about how statements should be combined to form predictions and explanations. Empirical relevance refers to the ability of some aspect of a theory (e.g., scientific statement, prediction or explanation) to be compared to empirical data, such as some form of data that can be retrieved via sensory input.

Other sources tend to have similar conceptualizations of scientific theory. Dubin (1978) for example, suggests that theories contain units, laws of interaction, boundaries, system states, and propositions. According to Dubin (1978), units are basically things or variables whose interaction constitutes the subject matter of attention. Units in a psychotherapy theory might look like thoughts or beliefs. Laws of interaction specify how these units interact. An example of this within a psychological theory might be that patriarchal beliefs have a positive relationship with IPV perpetration. Boundaries describe in which contexts a theory is applicable. For example, theories about the causes of IPV typically focus on violence within the context of intimate relationships, as opposed to theories about violence in other contexts, such as in war or genocide, or violence perpetrated outside of the context of intimate relationships. However, sometimes boundaries can overlap. For instance, some RVM may be violent outside of the context of intimate relationships (Day & Bowen, 2015; Graña et al., 2014; Holtzworth-Munroe,

2000). Similarly, some aspects of violence perpetrated in war and genocide, such as the dehumanization process, may be applicable to IPV as well (LeShan, 2002; Rosenbaum & Leisring, 2001). System states describe how various units interact with one another in relation to the portion of the real world they intend to model (Dubin, 1978). The final piece includes propositions, which are described as conclusions that represent logical deductions about the model in operation. On the empirical side of theory construction, propositions must be converted to empirical indicators and testable hypotheses. Empirical indicators replace terms within a proposition with variables that can be measured in real life. An example of an empirical indicator might be utilizing the CTS (Straus, 1979) to measure IPV or police records to measure IPV recidivism. Finally, hypotheses are propositional statements that have had these empirical indicators substituted within the statement to make it testable in the real world.

Similarly, Mullins (1971) suggests that theories are basically groups of ideas that often originate from some form of personal experience, someone else's experience, or other theories. Mullins (1971) suggests that propositions are declarative statements that can be checked against reality, while operational definitions help link measurable variables to abstract concepts.

Scientific theories allow researchers to investigate abstract statements from previous scientific knowledge by generating hypotheses and operational definitions that can be empirically tested (Reynolds, 1971). Taken together, sources (Dubin, 1978; Mullins, 1971; Reynolds, 1971) indicate that theories can be specified with (a) propositions, (b) hypotheses, and (c) operational definitions. Therefore, a psychotherapy

theory should have a similar structure including propositions of causes, hypotheses about treatment approaches, and operational definitions of interventions.

Theory Construction Process

Using Reynolds' (1971) depiction of a scientific theory, the author of this dissertation coded primary sources for (a) focal dimensions identified by the original author(s), (b) propositions related to the causes of IPV, (c) hypotheses about relevant treatment interventions, and (d) operational definitions of specific treatment interventions. See Table 1 for a summary and examples of each theory component.

Focal Dimensions

Focal dimensions originally described within the MTP framework (Brooks-Harris, 2008) were used as a basis for focal dimensions in this dissertation. However, the author of this dissertation was also open to the identification and inclusion of new focal dimensions if they emerged from the research literature. Focal dimensions identified within the MTP framework include: (a) thoughts, (b) actions, (c) feelings, (d) biological, (e) interpersonal, (f) systemic, and (g) cultural. Focal dimensions may be similar to Dubin's (1978) conception of boundaries in a scientific theory. Focal dimensions help to categorize interventions based on boundaries where that intervention is thought to be impactful. Primary sources were coded with one or more of these focal dimensions based on how the original author(s) described their interventions or theoretical framework. When a focal dimension was not provided by the original author(s), the author of this dissertation consulted his dissertation committee to identify a focal dimension. Additionally, when multiple focal dimensions were identified by the original author(s),

the author of this dissertation consulted his dissertation committee as well, to find the best fit and noted that an intervention could potentially be labeled with multiple focal dimensions. All coding decisions were logged in the form of a code book and/or analytic memos. Finally, given the purpose of this dissertation was to create a psychotherapy theory, the biological focal dimension was not included in this dissertation.

Theoretical Propositions about Cause

Propositions are derived from the most basic form of abstract statements often referred to as axioms (Reynolds, 1971). Axioms combine to form more complex statements, which make up a proposition. Therefore, propositions are basically abstract statements contained within a theory. Similarly, Mullins (1971) suggests that propositions are declarative statements that can be checked against reality. Propositions related to a psychotherapy theory might aim to describe what causes IPV. Therefore, for the purposes of this dissertation, the author tracked propositions related to IPV causes. For example, a pro-feminist proposition of cause asserts that IPV arises from societal power inequalities between men and women which are reinforced by patriarchal culture (Mederos, 2002; Miller, 2010). Another example, from a couple's perspective includes the proposition that RVM have poor communication skills and resort to violence as a conflict resolution strategy (Rosenbaum & Leisring, 2001). See Table 1 for an additional summary and examples of theoretical propositions of cause.

Hypotheses About Treatment

According to Reynolds (1971), hypotheses are statements selected for comparison against empirical data collected in real life. Hypotheses are often derived from axioms or

propositions. Since hypotheses are subjected to empirical testing, they must be measurable and have operational definitions that can be applied to concrete situations. According to Dubin (1978), hypotheses are propositional statements that have empirical indicators substituted into the statement in order to make the statement testable empirically. Within the context of a psychotherapy theory, a hypothesis may predict that a specific treatment approach or intervention will be helpful in reducing IPV. See Table 1 for an additional summary and examples of treatment hypotheses.

Operational Definitions in Practice

Reynolds (1971) defines operational definitions as "a set of procedures that describes the activities an observer should perform in order to receive sensory impressions (sounds, visual or tactile impressions, etc.) that indicate the existence, or degree of existence, of a theoretical concept" (Reynolds, 1971, p. 52). Operational definitions are important for allowing scientists to replicate and verify scientific claims empirically by making concepts measurable and more concrete. Similarly, Mullins (1971) suggests that definitions help link measurable variables to abstract concepts. In terms of a psychotherapy theory, operational definitions are important for helping therapists and researchers implement a particular intervention. For the purposes of this dissertation, operational definitions were identified by reviewing ways that treatments based in various theoretical approaches use intervention strategies in the treatment of RVM. See Table 1 for an additional summary and examples of operational definitions of interventions from another unified approach for addressing sexual minority stress (Gargurevich, 2017).

Table 1

Descriptions and Examples of Proposition of Cause, Treatment Hypotheses, and Operational Definitions of Interventions.

	Propositions of Cause	Treatment Hypotheses	Operational Definitions of Interventions
Definition in the Philosophy of Science	• Abstract statements contained within a theory (Reynolds, 1971). • Declarative statements that can be checked against reality (Mullins, 1971).	• Able to be subjected to empirical testing (Reynolds, 1971). • Contains operational definitions that can be applied to concrete situations (Reynolds, 1971).	• "A set of procedures that describes the activities an observer should perform in order to receive sensory impressions (sounds, visual or tactile impressions, etc.) that indicate the existence, or degree of existence, of a theoretical concept" (Reynolds, 1971, p. 52).
Psychotherapy Theory Regarding IPV	• Ideas about what causes IPV.	• Predicts that a specific treatment intervention will be helpful in reducing IPV.	• Help therapists implement a particular intervention.
MTP (Brooks-Harris, 2008)	• Ideas that a particular focal dimension contributes to psychological distress. For example, maladaptive core-beliefs contributing to depressive symptoms.	• Key strategies connected to specific focal dimensions that are predicted to be useful for treating a particular mental health concern.	• How to implement that key strategy. • What that key strategy looks like.
Example from A Unified Framework for Addressing Sexual Minority Stress in	• The second distal proposition is that some LGBT community values related to body size, effeminacy, physical attractiveness, age, race,	• Utilize cognitive restructuring techniques to address concerns regarding gender non-conforming appearance and behaviors	• Identify and challenge problematic attitudes regarding physical attractiveness, and body size (Proujanski & Pachankis, 2014).

Psychotherapy (Gargurevich, 2017)	and other values, may lead to social rejection within LGBT persons' own community (Proujanski & Pachankis, 2014). For example, gay men have historically valued physical attractiveness, thinness and fitness, which leads sexual minority men to expect social rejection unless they meet these ideals (Foster-Gimbel & Engeln, 2016).	(Proujanski & Pachankis, 2014).	• Teach LGBT gender non-conforming individuals coping strategies to deal with negative responses to their gender expression/identity (Lehavot & Simoni, 2011; Plöderl & Fartacek, 2009; Sandfort et al., 2007).

Researcher Background and Biases

It is customary in qualitative research methods for authors to disclose their background and identified biases, so that readers can decipher, for themselves, the extent to which these factors may have impacted the results of the study (Morrow, 2005). As a self-identified feminist researcher, the author of this dissertation also notes that it is customary in feminist research to disclose one's biases for similar reasons as mentioned above (Morrow, 2005). It is important to know the contexts, social locations and lenses that impact how an author might view and interpret qualitative data.

The author of this dissertation identifies as a 30-year-old, White, able-bodied, heterosexual, cisgender man, holding values consistent with a social justice and feminist perspective. The author of this dissertation also identifies as being brought up in a Catholic family, but has identified as Agnostic and Atheist for over a decade. Additionally, the author also identifies coming from a middle-class family and having a privileged education status as a doctoral student.

As noted before, the author of this dissertation also identifies as a feminist and was trained at a feminist, multicultural, and social justice oriented doctoral program in counseling psychology. A foundational component of feminist theory is the importance of advocacy and involvement in social justice (Brown, 2010). As a feminist researcher, advocate, and practitioner in training, the author of this dissertation values research as an avenue towards social change. It is hoped that information gathered within this dissertation may aid in developing effective treatments for RVM, as well as, be used as a teaching tool to expand access of appropriate interventions to BIP facilitators. Finally, the

author of this dissertation has been involved in several research projects within the field of psychology since an undergraduate student and has taken various courses in research design, statistics, and qualitative research methods both as an undergraduate and as a graduate student.

The author of this dissertation holds similar biases as feminist critics about the use of couples interventions for IPV, especially regarding the safety of couples therapy for IPV (Adams, 1988; Mederos, 2002). However, the author of this dissertation believes that ideas from couples interventions, such as communication training, could be taught or utilized within an RVM's group or in an individual format with RVM. Therefore, interventions and theoretical propositions originally proposed by couples theorists are included within this dissertation, but under the assumption that they will be applied within an RVM's group or individual setting. The author of this dissertation included literature on the controversy of utilizing a couples format within the couples section of the literature review so that readers may come to their own conclusions about the use of couples therapy for IPV.

Finally, the author of this dissertation has previous experience working as a BIP co-facilitator and has been engaged in previous research experiences (e.g., thesis and research team) related to developing battering interventions. As part of the author's first practicum training experience he helped co-facilitate a BIP group at an IPV focused community mental health agency for approximately one year. During that time the author worked with both adult perpetrators and survivors of IPV, as well as children and adolescent survivors. The BIP program that the author previously co-facilitated/trained at

identified primarily as Duluth, though utilized interventions from other perspectives as well. As a psychotherapist-in-training, the author of this dissertation also identifies as an integrationist and displays an openness to a variety of theoretical orientations, interventions and perspectives. Finally, the author of this dissertation has been involved with previous research regarding MTP and developing a unified approach towards treating RVM.

Inclusionary and Exclusionary Criteria for Sources

For the purposes of this dissertation, given the context that men perpetrate a vast majority of IPV (Breiding et al., 2014; Katz, 2006, 2012), treatment hypotheses targeting men were included in the analysis. Additionally, since gender-nonspecific treatment hypotheses can be applied to RVM, such non-specific interventions were also be included in the analyses of this dissertation. Treatment hypotheses that uniquely target women or those within the Lesbian, Gay, Bisexual, Queer or Questioning, Intersex, and Asexual (LGBTQIA+) community were not included in this dissertation. The reasoning for excluding these specific treatment hypotheses is (a) there are unique characteristics to women and LGBTQIA+ individuals that deserve their own attention and/or may not be applicable to men, (b) these populations account for a smaller percentage of IPV perpetration and (c) the gender nonspecific treatment hypotheses described in this dissertation could potentially be applied to these populations if need be. While some BIP treatment hypotheses are designed to work with any perpetrator of violence, other treatment interventions, such as those from the feminist/Duluth model (Miller, 2010) specifically target men, and usually within the context of heterosexual relationships. IPV

within same-sex relationships can have significant differences from IPV within heterosexual relationships. For example, a lesbian batterer may use homophobic control or threaten to *out* her partner as a method of psychological abuse (West, 2002). Additionally, the causes of IPV within sexual minority relationships may have different causes than within heterosexual relationships. For example, one theory suggests that internalized homophobia may play a role in IPV within lesbian relationships (West, 2002). This is in contrast to the predominant theory of IPV within heterosexual relationships, which suggests that IPV results from patriarchy (Mederos, 2002; Miller, 2010). Though patriarchy may have connections to heterosexism and homophobia by putting heterosexual relationships at the center and same-sex relationships at the margins, it is assumed by the author of this dissertation that these are differing forms of oppression that will require differing theories of IPV and different interventions. For the sake of limiting the scope of this dissertation and honoring the complexity of IPV within same-sex relationships or within LGBTQIA+ relationships the author of this dissertation decided to exclude interventions that specifically targeted these populations. Similarly, though historically there has been debate regarding women's perpetration of violence (Winstok, 2011), many sources suggest that women have lower rates of perpetrating IPV (Breiding et al., 2014; Katz, 2006; Seamans et al., 2007) and suggest that women's violence is often used in self-defense from men's violence (Seamans et al., 2007; Winstok, 2011).

The author of this dissertation notes that examining and developing a wholistic view of IPV interventions for these populations may be interesting future areas for

research. It is likely that two separate dissertations could be written regarding interventions for relationally violent women and for IPV within the LGBTQIA+ community. Finally, as mentioned above several gender non-specific interventions within this dissertation might potentially be applicable to these populations. For example, Seamans et al. (2007) suggest that anger management techniques may be useful for working with relationally violent women, which are also techniques used in many RVM's groups (Babcock et al., 2004; Edleson, 1984; Novaco, 1978; Rosenbaum & Leisring, 2001). At the same time, Seamans et al. (2007) advocate against applying interventions originally designed for RVM towards women and suggest that specialized considerations and interventions are needed for this population.

Sequence of Analysis

Selecting Sources

The first step in deriving a unified theoretical model of IPV treatment is to cull relevant sources of treatment constructs. Table 2 lists primary sources addressing IPV perpetration. Some of the key terms used to search for sources included: IPV, battering intervention, battering intervention programs, relationally violent men, IPV perpetrators, and domestic violence intervention. Having researched this topic in the past, the author of this dissertation was already aware of certain articles and sources that pertained to the scope of this dissertation. The author of this dissertation also consulted peers and his dissertation committee for additional relevant articles. Primary sources were included in this dissertation if they specifically focused on treatment interventions for RVM. More specifically, treatment related sources met one of the following criteria: (a) included

hypotheses about treatment approaches for RVM/battering/IPV perpetration, and/or (b) included operational definitions of potential treatment interventions addressing RVM/battering/IPV perpetration. Additionally, treatment hypotheses had to be either specifically applicable to the treatment of RVM or be gender non-specific in terms of the target population. Treatment hypotheses specific to relationally violent women or those within the LGTBQIA+ community were not included within the scope of this dissertation. Finally, interventions had to be implemented either within an individual or group format. Interventions that can only be implemented within a couples therapy setting were not included within the scope of this dissertation due to concerns about the safety of couples therapy within the context of IPV (Adams, 1988; Mederos, 2002). With that said, however, interventions that were described originally within the context of couples literature that could potentially be applied or are applied in either a group or individual format (e.g., communication training) were included in this dissertation. Since many couples oriented IPV programs contain groups with multiple couples (e.g., CHRP; Bradley et al., 2011; Bradley & Gottman, 2012), it is assumed that interventions from these programs could easily be adapted to fit within a RVM's group format. However, couples' programs often rely on having the couple practice these skills, it could easily be adjusted to where men pair up in a RVM's group to practice these skills, similar to what is done in the RWV groups (Bierman & Cheston, 1996). The sources selected for this investigation are listed in Table 2.

Table 2

List of Primary Sources

Number	Author (s) and Year of Publication	Title
1	Adams (1988)	Treatment models of men who batter: A pro-feminist analysis.
2	Adams (2012)	Interventions with men who are violent to their partners: Strategies for early engagement.
3	Adams & Cayouette (2002)	Emerge – A group education model for abusers.
4	Almeida & Hudak (2002)	The cultural context model.
5	Armenti & Babcock (2016)	Conjoint treatment for intimate partner violence: A systematic review and implications.
6	Babcock et al. (2005)	Applying the transtheoretical model to female and male perpetrators of intimate partner violence: Gender differences in stages and processes of change.
7	Babcock et al. (2004)	Does batters' treatment work? A meta-analytic review of domestic violence treatment.
8	Barner & Carney (2011)	Interventions for intimate partner violence: A historical review.
9	Bernardi & Day (2015)	Intimate partner violence perpetrator subtypes and their developmental origins: Implications for prevention and intervention.
10	Bierman & Cheston (1996)	Relating without violence: A manual for a treatment program for domestically abusive men.
11	Bradley et al. (2014)	Treating couples who mutually exhibit violence or aggression: Reducing behaviors that show a susceptibility for violence.
12	Bradley et al. (2011)	Supporting healthy relationships in low-income, violent couples: Reducing conflict and strengthening relationship skills and satisfaction.
13	Bradley & Gottman (2012)	Reducing situational violence in low-income couples by fostering healthy relationships.
14	Brown (2004)	Shame and domestic violence: Treatment perspectives for perpetrators from self psychology and affect theory.
15	Crane & Easton (2017)	Integrated treatment options for male perpetrators of intimate partner violence.

16	Crockett et al. (2015)	Breaking the mold: Evaluating a non-punitive domestic violence intervention program.
17	Donnelly et al. (2002)	The batterer education program for incarcerated African-American men, 1997-2000.
18	Eckhardt et al. (2004)	Partner assaultive men and the stages and processes of change.
19	Edleson (1984)	Working with men who batter.
20	Geffner & Rosenbaum (2001)	Domestic violence offenders: Treatment and intervention standards.
21	Gondolf (2007)	Theoretical and research support for the Duluth model: A reply to Dutton and Corvo.
22	Gondolf (2011)	The weak evidence for batterer program alternatives.
23	Hamberger (2002)	The men's group program – a community-based, cognitive-behavioral, pro-feminist intervention program.
24	Hancock & Siu (2009)	A culturally sensitive intervention with domestically violent Latino immigrant men.
25	Herman et al. (2014)	Outcomes from a Duluth model batterer intervention program at completion and long term follow-up.
26	Hernández (2002)	CECEVIM – Stopping male violence in the Latino home.
27	Lawson et al. (2012)	Integrated cognitive-behavioral and psychodynamic psychotherapy for intimate partner violent men.
28	Lee et al. (2003)	Solution-focused treatment of domestic violence offenders.
29	Mederos (2002)	Changing our visions of intervention- The evolution of programs for physically abusive men.
30	Miller (2010)	Discussing the Duluth curriculum: Creating a process of change for men who batter.
31	Palmstierna et al. (2012)	Cognitive-behaviour group therapy for men voluntary seeking help for intimate partner violence.
32	Pascual-Leone et al. (2011)	Emotion-focused therapy for incarcerated offenders of intimate partner violence: A 3-year outcome using a new whole-sample matching method.
33	Pence (2002)	The Duluth domestic abuse intervention project.
34	Perilla & Pérez, (2002)	A program for immigrant Latino men who batter within the context of a comprehensive family intervention.
35	Ronel & Claridge (2003)	The powerlessness of control: A unifying model for the treatment of male battering and substance addiction.

36	Rosen et al. (2003)	Negotiated time-out: A de-escalation tool for couples.
37	Rosenbaum & Leisring (2001)	Group interventions programs for batterers.
38	Scott & Straus (2007)	Denial, minimization, partner blaming, and intimate aggression in dating partners.
39	Sonkin & Dutton (2003)	Treating assaultive men from an attachment perspective.
40	Stover et al. (2009)	Interventions for intimate partner violence: Review and implications for evidence-based practice.
41	Stuart et al. (2007)	Improving batterer intervention programs through theory-based research.
42	Tollefson & Phillips (2015)	A mind-body bridging treatment program for domestic violence offenders: Program overview and evaluation results.
43	Vetere (2011)	Family violence and family safety: An approach to safe practices in our mental health services.
44	Waltz (2003)	Dialectical behavior therapy in the treatment of abusive behavior.
45	Zarling et al. (2015)	A randomized controlled trial of acceptance and commitment therapy for aggressive behavior.

Note: (n = 45)

It should be noted that while reviewing primary sources, a few articles that were originally identified were excluded due to the following reasons: (a) some sources were exclusively focused on the causes of IPV and did not include interventions (n = 2), (b) some were geared towards prevention or systemic interventions and not psychotherapy interventions (n = 2), or (c) the author of this dissertation could not obtain access to the primary source (n = 1). In total five sources were excluded due to these reasons. However, the author of this dissertation identified several substitutions and additional sources. Despite the excluded sources, the final number of coded sources exceeded the original 40 sources that was estimated. In total 45 primary sources were coded. These sources are listed in Table 2.

Coding Process

For the first round of qualitative coding, the author of this dissertation reviewed primary sources identified within the literature on IPV perpetration and identified segments of text that seemed to include propositions of cause, treatment hypotheses, and/or operational definitions of interventions. These segments of direct quotes were compiled into one document with the corresponding page number, primary source authors and treatment model (if one was identified). For the second round of coding these direct quotes where coded for focal dimensions, propositions of causes of IPV, hypotheses related to treatment, and operational definition of treatment intervention strategies.

Theory Construction

Initially, treatment hypotheses and corresponding operational definitions were organized by the propositions that they appeared to follow. Several of these groupings, however, did not fit neatly into the MTP framework, which divides treatment hypotheses by focal dimensions. The author of this dissertation consulted with his committee and rearranged the treatment hypotheses and operational definitions into the MTP focal dimension framework.

Areas for Consideration During Analysis

One of the more challenging aspects of coding revolved around identifying focal dimensions. Several treatment hypothesis constructs either lacked a clearly defined focal dimension or potentially fit multiple focal dimensions. As an example, the treatment hypothesis regarding accountability was nearly a universal intervention cited in nearly

every primary source. Accountability was mentioned by programs of various theoretical modalities, which additionally made it difficult to pinpoint a focal dimension. Other treatment hypotheses were also nearly universal across BIPs including a cluster of interventions often labeled as anger management techniques. These anger management interventions often include, for example, de-escalation and time-out strategies, exploration of escalation cues that precede anger and violence, and exploration of the consequences of violence.

When there was uncertainty regarding a construct's corresponding focal dimension the author reviewed the literature and consulted with his dissertation committee to find an appropriate fit. For example, the author consulted with committee members regarding the treatment hypothesis related to accountability and it was determined by experts on the committee that this fit the behavioral focal dimension. This same process was conducted for any construct that contained ambiguity regarding its focal dimension or fit within the unified framework until all constructs had been appropriately fitted. This process resulted in the following unified theory which will be described later in Chapter IV results.

As with accountability, the cluster of anger management treatment hypotheses also appeared to lack a clearly defined focal dimension. Initially the author wondered if the anger management cluster should be integrated with the other treatment hypotheses in the *feelings* focal dimension since this cluster targeted anger reduction. However, many of the anger management treatment hypotheses did not appear to deal with emotion, making the feelings focal dimension seem like an uncertain fit. The author of this

dissertation consulted with one of his committee members to discuss best fit for this cluster of anger management treatment hypotheses. The following decisions were made: (a) exploring consequences and illuminating the costs of aggression and violence was moved to the *actions* focal dimension since this is similar to looking at consequences in behavior therapy's ABC model (Antony & Roemer, 2011; Spiegler & Guevremont, 2003); (b) exploring escalation cues that precede anger and violence was placed with the feelings focal dimension; (c) anger as secondary emotion/exploring feelings under anger was placed in the feelings focal dimension since it clearly focuses on emotions; (d) relaxation training was moved to the actions focal dimension since relaxation interventions are commonly included in behavior therapy models (Antony & Roemer, 2011; Spiegler & Guevremont, 2003); and (e) the time-out and de-escalation strategies were moved to the actions focal dimension as well due to the time-out being thought of as an action or behavior.

Another issue that emerged during the theory construction process revolved around treatment hypotheses that appeared to overlap. For example, communication skills training and assertiveness were considered to be very similar constructs. In an effort to condense some of the treatment hypotheses that contained overlap in the constructs that they were describing, some treatment hypotheses were merged together. This occurred for the following treatment hypotheses: (a) communication and assertiveness training, (b) cognitive restructuring and challenging sexist belief systems, (c) role plays and practicing new skills, (d) focusing and self-experiencing, (e) building the therapeutic relationship and developing safety and support among group members, and (f) consciousness raising

and providing psychoeducation. Each of these constructs were initially coded with separate codes, but combined in the final theory to form these six treatment hypotheses. The author of this dissertation consulted with his committee regarding some of these merges, such as the communication and assertiveness training treatment hypothesis. In other cases, the author of this dissertation made executive decisions to combine codes into single treatment hypotheses. The overall finished theory was reviewed with committee members.

Another similar issue that arose during data analysis included the issue that some codes appeared to fit within a particular treatment hypothesis. Some of these constructs were placed in the operational definitions of treatment hypotheses. For example, the use of control logs and vignettes were placed in the operational definition for the treatment hypothesis consciousness raising and providing psychoeducation. This occurred for other codes as well. For example, mindfulness was included as an operation definition for relaxation training. Likewise, a description of RVM nurturing their inner child was included as an operational definition for the treatment hypothesis working though family of origin trauma.

CHAPTER IV

RESULTS

The coding process and theory-building approach described previously in Chapter III was utilized to organize propositions of cause, treatment hypotheses and operational definitions of interventions. This resulted in the following: (a) a total of 12 propositions of cause divided among five focal dimensions, (b) a total of 43 treatment hypotheses, and (c) the identification of corresponding operational definitions of treatment interventions. Additionally, during the theory construction process one of the original focal dimensions described in MTP was altered for the creation of an integrated interpersonal and trauma-informed focal dimension which will be discussed later on. Each proposition of cause will be described next. See Table 3 below for a full list of propositions of cause. A full list of propositions, treatment hypotheses and corresponding operational definitions can be found in Appendix A.

Table 3

Propositions of Cause by Focal Dimension

	A.	**Thoughts**
1		Cognitive Errors
2		Cognitive Beliefs
	B.	**Actions**
3		Social Learning
4		Substance Abuse
	C.	**Feelings**
5		Lack of Emotional Awareness and Regulation
6		Emotional Blocks from Past Trauma
	D.	**Interpersonal Relationships and Trauma Informed**
7		Family of Origin Trauma/ Intergenerational Violence
8		Psychopathology/ Personality Disorder
9		Attachment
10		Communication Skills Deficits and Situational Couple's Violence
	E.	**Culture**
11		Patriarchy
12		Oppression

Propositions by Focal Dimension

Description of Cognitive Propositions

Two propositions of cause related to the cognitive focal dimension *thoughts* were depicted in the literature and noted in Table 3. The first cognitive proposition proposes that partner violence is caused by RVM's errors in thinking (Barner & Carney, 2011). Common cognitive distortions such as all-or-nothing thinking, making overgeneralizations, and jumping to conclusions, for example, may contribute to IPV under this proposition. As an example, Rosenbaum and Leisring (2001) discuss how

RVM tend to negatively interpret their partner's behaviors. They give the example of a group member jumping to the conclusion that his partner is cheating on him when she does not return his call.

The second cognitive proposition proposes that partner violence is caused, reinforced, and justified by RVM's beliefs. This proposition is often described in conjunction with the patriarchy proposition, which will be described in the cultural propositions. Patriarchal belief systems including beliefs about gender roles and men's dominance over women, for example, often contribute to men's violence towards women.

Description of Behavioral Propositions

Two propositions of cause related to the behavioral focal dimension actions were depicted in the IPV literature and noted in Table 3. The first behavioral proposition proposes that partner violence is a learned behavior via modeling and positive reinforcement. Adams and Cayouette (2002) describe this proposition in the following quote:

> Battering is a learned behavior. According to social learning theory, behavior is learned in two ways, through modeling and through positive reinforcement. Men's behavior, attitudes, and expectations concerning women are most often originally influenced by how their fathers (or other male caretakers) treated their mothers. These behaviors and attitudes are additionally shaped by male peer pressure and societal messages concerning gender roles and the legitimacy of violence as a means of resolving differences. Violence can also be "positively reinforced" when it enables a person to establish control and dominance in his

> intimate relationships. While violence also leads to negative outcomes, such as loss of closeness, some men come to prioritize control over closeness. (p. 3)

This proposition is often discussed in conjunction with the patriarchy proposition, which will be discussed later on. The synergy between these two propositions likely reflects the overlap in pro-feminist and CBT programs that several authors have noted previously (Babcock et al., 2004; Gondolf, 2007; Rosenbaum & Leisring, 2001; Stuart et al., 2007).

The second behavioral proposition of cause suggests that substance abuse may exacerbate partner violence (Crane & Easton, 2017). Proponents of this proposition often point out that IPV perpetration tends to decrease following substance abuse intervention even in the absence of BIP treatment (Crane & Easton, 2017). Substance abuse was included within the actions focal dimension, since addiction treatment often involves behavioral interventions, such as looking at triggers or the antecedents to addictive behaviors, as well as, the consequences of addictive behaviors (Crane & Easton, 2017). This is very similar to the ABC model in behavior therapy (Spiegler & Guevremont, 2003). Future directions, however, may aim to determine whether this proposition might fit better under another focal dimension, such as the biological focal dimension. Again, the biological focal dimension was not a focus of this study due to the fact that this study targeted psychotherapy treatment hypotheses.

Description of Affective Propositions

Two propositions of cause related to the affective focal dimension feelings were depicted in the literature and noted in Table 3. The first affective proposition proposes

that IPV is caused by RVM having a lack of emotional awareness and difficulty regulating their emotions (Pascual-Leone et al., 2011). Some authors note the role men's socialization plays in this proposition. For example, societal messages often encourage men to suppress all emotions other than anger and thus anger and aggression is often seen as the only socially acceptable way for men to express their emotions (Rosenbaum & Leisring, 2001).

The second affective proposition of cause suggests that RVM have developed emotional blocks as a result of past trauma (Bierman & Cheston, 1996). Bierman and Cheston (1996) describe this proposition in more detail here:

> Male domestic violence is rooted in emotional wounds that have been buried and festering since childhood. As these boys have grown into men, the emotional pain, fear and shame from their childhood wounds have led them to develop societally supported personality characteristics for males, such as control and aggression, to create emotional distance from others as a form of psychological self-protection. In unconscious attempts to protect themselves from further emotional pain, and to lash out from their childhood wounds, these men develop controlling and abusive relationships with their adult partners. (p. 43)

Again, as with the previous proposition, consideration of men's socialization to avoid vulnerability and repress feelings is evident within this proposition. While at the same time, the need for psychological self-protection is exacerbated for these men due to childhood trauma.

Description of Interpersonal and Trauma Informed Propositions

A total of four propositions of cause related to the interpersonal and trauma-informed focal dimension were identified in the literature and presented in Table 3. The first interpersonal and trauma-informed proposition proposes that partner violent behaviors are often passed on from one generation to the next (Bierman & Cheston, 1996; Pascual-Leone et al., 2011). Under this proposition, family of origin or intergenerational trauma is thought to contribute to IPV. This proposition in particular has several intersections with other propositions including the social learning and emotional blocks propositions.

The second interpersonal and trauma-informed proposition proposes that underlying personality characteristics and psychopathology fuel RVM's violence towards their partners. Scott and Straus (2007) describe this proposition as follows:

> Psychoanalytic writings also offer theory that directly links a negative inner sense of self to denial, minimization, blaming, and to abusive behaviors. First, it is proposed that controlling behavior serves a similar defensive function to denial and blaming. Specifically, such behaviors prevent an intimate partner from providing negative feedback, thereby preserving the abuser's fragile and often falsely positive sense of self. (p. 854)

The third interpersonal and trauma-informed proposition proposes that RVM's insecure attachments contribute to partner violence (Sonkin & Dutton, 2003). This proposition in particular is often discussed in relation to the intergenerational violence

proposition as insecure attachment styles are thought to develop from negative and often traumatic experiences with parental figures.

Finally, the fourth interpersonal and trauma-informed proposition proposes that violence arises from communication deficits and dysfunctional communication patterns among couples. This proposition is often described as skills deficits or situational couple's violence in the research literature. Advocates of the situational couple's violence proposition often recommend a couple's intervention format since the couple's communication patterns as a whole are considered part of the problem (Armenti & Babcock, 2016). A lack of communication and conflict resolutions skills is seen as the main contributor to situational couple's violence. Other authors view this proposition from a gender asymmetrical lens. For example, Rosenbaum and Leisring (2001) discuss how RVM may resort to violence as a conflict resolution strategy due to underlying deficits in communication.

Description of Cultural Propositions

A total of two propositions of cause emerged related to the cultural focal dimension and are noted in Table 3. The first cultural proposition asserts that IPV arises from societal power inequalities between men and women which are reinforced by patriarchal culture (Mederos, 2002; Miller, 2010). Scott and Straus (2007) describe this proposition as follows:

> Feminist theories are rooted in the idea that abuse of women by their intimate partners is the inevitable result of a patriarchal society that directly and indirectly allows men to dominate and control their partners. In other words, a man abuses a

> woman because cultural norms support his belief that violence is an acceptable and effective method of solving interpersonal conflicts, because he is entitled and expected to control his wife, and because his use of violence receives no social penalty. (p. 853)

It should be noted that this proposition was frequently tied to the social learning proposition from the actions focal dimension.

The second cultural proposition recognizes patriarchy and violence against women as one of many forms of societal oppression (Almeida & Hudak, 2002). This proposition also recognizes the commonalities across these various forms of oppression. Almeida and Hudak (2002) describe this proposition as follow:

> Therapeutic conversations begin at the sociopolitical level, where domestic violence is viewed in a larger context as but one form of social control and oppression. Other examples of such abuses of power include racism, genocide, homophobia, class entrapment, anti-Semitism, and imperialism. The major objective of this approach is to create a collective experience that changes systems as well as individuals within those systems. (p. 3)

Treatment Hypotheses and Operational Definitions of Interventions

The next section details treatment hypotheses and corresponding operational definitions of interventions for each of the five focal dimensions. A total of 43 treatment hypotheses emerged from the BIP literature. These included five cognitive treatment hypotheses, 12 behavioral, 6 affective, 13 interpersonal and trauma-informed, and 7

cultural treatment hypotheses. Treatment hypotheses and operational definitions for each focal dimension will be described next.

Cognitive Treatment Hypotheses and Operational Definitions of Interventions

Five treatment hypotheses were identified for the cognitive focal dimension *thoughts*. These included: (a) exploring thoughts and beliefs that support violence, (b) cognitive restructuring and challenging sexist belief systems, (c) exploring and clarifying values, (d) confronting denial, minimization and blame, and (e) increasing motivation to change. Cognitive treatment hypotheses and corresponding operational definitions are shown in Table 4 below. Treatment hypotheses appear on the left side of the table and operational definitions appear on the right side. Operational definitions are depicted in direct quotes from the primary source in which they were extracted.

Table 4

Treatment Hypotheses and Operational Definitions for Cognitive Focal Dimension Thoughts

Treatment Hypotheses	Operational Definitions of Interventions Examples
Exploring Thoughts and Beliefs that Support Violence	• …we look at the kinds of beliefs that support our actions… I am really interested in hearing about the experiences men had – in their childhoods, their churches, their hockey and baseball teams, their schools, and their neighborhood groups that they hung around with – that led them to see the world the way they do…. We have to go even deeper. You could ask, what is your justification? We are trying to see what justifies abusive behavior in our heads and our hearts… if we unmask how they were constructed, we will see that they can be taken apart, and that something else can replace them. Once the men identify specific experiences that led to how they thing about women, then we ask, who benefits from these beliefs? … we have to establish that these belief "systems" operate for the benefit of men, at the expense of women (Pence, 2002, p. 36-37). • Opening up all these issues of pride, authority, money, and decision-making power in families. Any one issue you raise now could be very, very important to explore. It all links back to how those kinds of concepts and belief systems contribute to the use of violence against women (Miller 2010, p. 1017).
Cognitive Restructuring and Challenging Sexist Belief Systems	• Questioning the beliefs that support violence (Adams, 2012, p. 460).

	• This category includes beliefs learned about gender roles (example response: "Guys, we've talked about a number of situations with your wives and partners that lead to violence. One of the thinking themes we've identified is that 'she has no right to criticize me— ever.' Let's talk about how that belief can lead to more anger and even violence") (Lawson et al., 2012, p. 193-194). • Batterers may be taught to identify this pattern and to replace the inflammatory cognitions with more calming ones (Rosenbaum & Leisring, 2001, p. 63). • You have to challenge his belief that he gets to make her do what he wants, control what she wants, and tell her how she thinks and feels. If you don't do that first, then teaching him to talk about his feelings will just put more pressure and danger on a woman…. We want them to understand how their feelings – the ones they think cause abusive behavior – are rooted in their belief systems (Pence, 2002, p. 41).
Exploring and Clarifying Values	• Self-reevaluation (how one feels and thinks about the self in the context of the problem, value clarification); (Eckhardt et al., 2004, p. 82).
Confronting Denial, Minimization and Blame	• Men learn to confront one another's denial and victim blaming (Babcock et al., 2004, p. 1027). • We help people with defensiveness by talking to them in role, for example, we may say, "John, as a father"… Or, we use future questions, such as, "John, as a father, what do you want your children to learn from you about how men and women treat each other in intimate relationships?" "How do you want your

	children to learn to keep themselves safe in their adult intimate relationships", and so on. Future questions enable people to talk aspirationally about the futures of their children, and then we work backwards to the present day (Vetere, 2011, p. 253-254). • That made me realize that challenging a man when he minimizes, denies, and blames is not simply having him identify how he does it. We must question why does it, what he gets out of it, and whether he could possibly change without being totally honest about what he has done (Pence, 2002, p. 42).
Increasing Motivation to Change	• At the process level, the goal is to enhance change talk (as opposed to sustain talk) and commitment to behavior change. Standard MI responses are used including reflective listening to client verbalizations, double-sided reflection of ambivalence about change, amplified reflection, reframing resistance language, summarizing change-relevant content, using open-end questions to evoke client concerns and goals, and affirmation of autonomy (Lawson et al., 2012, p. 195). • Establishing a safe, non-confrontational, non-judgmental therapeutic environment in which clients may feel comfortable resolving naturally occurring ambivalence and committing to the change process (Crane & Easton, 2017, p. 29). • There are five main strategies to motivational interviewing: (a) express empathy, (b) develop discrepancies, (c) avoid argumentation, (d) roll with

	resistance, and (e) support self-efficacy (Stover et al., 2009, p. 231). • A collaborative approach that respects participants' expertise and knowledge about themselves and their strengths helps to enhance their motivation to accomplish positive changes through treatment (Lee et al., 2003, p. 14). • Motivational interviewing strives to meet clients at their current state of readiness and uses nonconfrontational strategies to assist individuals in eliciting their own reasons for change. It is assumed that developing a supportive working relationship with clients will reduce defensiveness and increase willingness to explore the need for change over more confrontational approaches (Stuart et al., 2007, p. 561). • DBT includes a variety of strategies used for increasing the client's level of commitment, which would be used at this point in the therapy process. For example, the therapist may have the client explore the pros and cons of stopping abusive behavior versus continuing to be abusive. The therapist may explore any areas of the client's life that he does want to change and then link those goals to reducing abusive behavior (i.e., stopping violence in the service of having a more satisfying relationship with one's partner) (Waltz, 2003, p. 87-88). • When the therapist offers a question that describes their violent behaviour as having been "screwing up" their lives, it is clearly the behaviour that is identified

	as unacceptable, and not the person. This allows the client to begin seeing his violent and controlling behaviours as aspects of himself to change, as opposed to seeing them as inseparable from himself as a person. It also expresses from the therapists, a recognition of the violence as an unwanted characteristic of a valued person that can be addressed in therapy (Bierman & Cheston, 1996, p. 5).

Behavioral Treatment Hypotheses and Operational Definitions of Interventions

A total of 12 treatment hypotheses related to the behavioral focal dimension actions emerged from the BIP literature. These included: (a) de-escalation and time-out strategies, (b) behavioral and safety contracts, (c) role plays and practicing skills, (d) providing homework to reinforce new skills, (e) modeling nonviolent behaviors, (f) identifying and teaching nonviolent alternative behaviors, (g) reinforcing positive behavior changes, (h) exploring consequences and illuminating the costs of aggression and violence, (i) relaxation training, (j) parenting skills, (k) substance abuse and relapse prevention skills and intervention, and (l) increasing accountability for one's violence. Behavioral treatment hypotheses and corresponding operational definitions are shown in Table 5 below. Again, treatment hypotheses appear on the left side of the table and operational definitions appear on the right side. Operational definitions are depicted in direct quotes from the primary source in which they were extracted.

Table 5

Treatment Hypotheses and Operational Definitions for Behavioral Focal Dimension Actions

Treatment Hypotheses	Operational Definitions of Interventions Examples
De-escalation and Time-Out Strategies	• Time out: Most programs teach some variation of the time-out procedure. Batterers are encouraged to identify cues that their anger is building and remove themselves (physically) from the argument until they have calmed down sufficiently to continue the interaction. The combination of identifying cues and using time-out are the foundations of anger management (Rosenbaum & Leisring, 2001, p. 62). • Very often, family members elect to use 'time out' as a short term strategy, but again it is important to get partners' agreement, for example, as calling 'time out' and leaving an interactional space can be seen as abandonment (Vetere, 2011, p. 251).
Behavioral and Safety Contracts	• Providers reinforce behavioural contracts during each session (e.g. "no angry touching, no yelling/screaming, reduce substance use, and get out of the situation if you are under the influence or have the urge to lose control." Crane & Easton, 2017, p. 27). • Lethality assessment (Geffner & Rosenbaum, 2001, p. 6). • As part of these safety plans they must refrain from engaging in any type of abuse. They must also refrain from using drugs or alcohol 24 hours before or after sessions, they must comply with court orders, they must respect their partners' limits, and they must

	cease attempts to isolate their partners from others. Clients are expected to report any violations of their safety plans to the program and must accept the consequences for their actions (Rosenbaum & Leisring, 2001, p. 67). • We hold regular meetings to review the safety plan, to adjust it as necessary, and always seek feedback from our minimum of the three perspectives: our view, that of our clients, and that of the stable third. When it looks as though the safety plan is working, and the violence has stopped, we may then move on to help family members deal with other relationship issues. If the no-violence contract is broken, we hold a meeting to review our work with our clients and the stable third, and make decisions about how best to proceed, for example, we may work individually with people if couples and family work is deemed unsafe, or group work might be more appropriate. We do not abandon people, and always attempt to signpost them to other services if we cannot immediately help, and sometimes only a legal response is appropriate. In our experience a minimum of six meetings, either weekly or fortnightly, is needed to establish a safety plan (Vetere, 2011, p. 252). • The stable third position to help us corroborate what families are saying about the cessation of violence and to help us with safety planning. Clearly when violence is known about from the outset, the stable third can be invited to initial safety assessment meetings, and to subsequent safety review meetings,

	where progress is considered and treatment plans developed (Vetere, 2011, p. 249).
Role Plays and Practicing Skills	• Role plays. Some clients may be asked to re-enact one example of abusive or controlling behavior toward their partner by doing a role play in the group. Usually, one of the group leaders plays the part of the victim… Role plays often bring out important aspects of a client's abuse not identified when he simply described his behavior. They reveal tone of voice, choice of words, facial expressions, body posture, and sequence of behavior… group members are asked to identify each element of abuse and control that they observed and to discuss its likely impact on the victim. The abuser is then asked to replay the incident with the goal of not repeating his abusive or controlling behavior, using non-abusive language and behavior instead (Adams & Cayouette, 2002, p. 14).
Providing Homework to Reinforce New Skills	• RVM are required to complete intersession homework to further hone new skills (Crane & Easton, 2017, p. 27). • Clients complete weekly cognitive restructuring homework exercises, monitor and record instances of aversive arousal (typically anger or annoyance) and record a brief description of the situation (Hamberger, 2002, p. 28-29).
Modeling Nonviolent Behaviors	• Model constructive male-female communication for participants. It is important that at least one female and one male therapist co-lead RWV groups. This provides an important modelling opportunity of the male and female co-leaders communicating with

	equality and mutual respect (Bierman & Chester, 1996, p. 1-2). • Group members view videotapes of man-woman couples dialoguing (Bierman & Chester, 1996, p. 29). • Group members observe the co-leaders communicating empathically and authentically. When group leaders guide a participant through a Shared Self-Experiencing process in the group, other group members learn how to do this in their mutual helping dyads (Bierman & Chester, 1996, p. 29). • Veteran members serve as positive role models and supporters, a role comparable to veteran members in self-help 12-step groups who serve as mentors in the sub-culture of recovery (Ronel & Claridge, 2003, p. 61).
Identifying and Teaching Nonviolent Alternative Behaviors	• Most programs also discuss alternatives to power and control strategies, for example, Geffner and Mantooth (2000) include these behaviors on an "equality wheel" which was adapted from the Duluth program (Rosenbaum & Leisring, 2001, p. 61). • Treatment focuses on identifying exceptions and solution behaviors, which are then amplified, supported, and reinforced through a systematic solution building process (Lee et al., 2003, p. 10). • An acceptable goal is defined as new, different behavior that is helpful and that can be done with enough regularity that participants can make reports regarding their goal work at each group session. The goal is interpersonal, that is, it must have an impact on other people (Lee et al., 2003, p. 56).

	• Exception questions. In the process of developing useful goals, it is helpful to ask questions that lead participants to consider alternatives to their current behavior or questions that ask them to search for times when things were better. These are called exception questions because they ask participants to look for an exception to the problem (Lee et al., 2003, p. 142).
Reinforcing Positive Behavior Changes	• We perceive compliments as a powerful way to reinforce participants' goal efforts. They validate effort and instill hope (Lee et al., 2003, p. 117). • Develop connection between participants' actions and positive outcomes (Lee et al., 2003, p. 112). • Another goal was to identify support systems that would encourage and sustain new behaviors, such as attending a batterer intervention program on release; attending church, sober bars, and aftercare groups; using community resources and programs; making new friends; and practicing violence/alcohol/drug sobriety (Donnelly et al., 2002, p. 9).
Exploring Consequences and Illuminating the Costs of Aggression and Violence	• Costs of aggression: Focusing on the many costs of aggression including, financial costs, effects on their own and partner's health, effects on children, effects on career, damage to the relationship, loss of intimacy, loss of freedom, and loss of status in the community increases the likelihood that batterers will learn that the negative consequences of using aggression outweigh any benefits. Discussing the effects on children can be particularly powerful, since

	many batterers witnessed violence in their own families and have negative feelings about their fathers (Rosenbaum & Leisring, 2001, p. 62).
Relaxation Training	• Programs may take a problem-solving approach to reducing stress, teaching batterers to identify specific stressors, generate possible solutions, evaluate pros and cons of each, select the most reasonable alternative, and try it out. Relaxation protocols (deep muscular relaxation, breathing exercises, mental imagery) may be used to provide the men with skills they can use to reduce tension and/or anger (Rosenbaum & Leisring, 2001, p. 63). • Progressive relaxation teaches a person to relax by alternating tensing and relaxing muscles in various parts of his or her body. By contrasting tension with a relaxed state, a person learns to identify tension in different parts of the body and to dissolve that tension quickly. … when a relaxed state can be achieved at will, it allows a client to perform more easily in stress inducing situations (Edleson, 1984, p. 239). • Mindfulness (Tollefson & Phillips, 2015, p. 785). • Mindfulness that promotes somatic awareness. Somatic awareness is defined as the ability to perceive, interpret, and act on the basis of one's own internal bodily sensations that can be a powerful tool in regulating emotion, maintaining health and facilitating recovery from illness and dysfunction (Tollefson & Phillips, 2015, p. 785). • A mindfulness tradition informs a number of important concepts that are part of the treatment,

	including the notion of being "non-judgmental." … Clients are taught to identify judgments and to notice the impact of judgmental thinking (Waltz, 2003, p. 86-87). • We teach regular, rhythmic breathing to reduce arousal… the client is guided to construct his own imagery of a "quiet place." … tension checks are scheduled to occur at naturally predictable times throughout the day (Hamberger, 2002, p. 25-26).
Parenting Skills	• Batterers may be taught how to empathize with the child, the importance of developing a positive parent-child relationship, and the value of non-physical means of child management, such as the "other time out," the use of consistent consequences and positive reinforcement (Rosenbaum & Leisring, 2001, p. 63-64).
Substance Abuse and Relapse Prevention Skills and Intervention	• Alcohol and substance abuse: Alcohol and aggression are inextricably linked, and although as Kantor and Straus (1990) noted, alcohol is neither necessary nor sufficient for the occurrence of relationship aggression, it is a common accompaniment. Programs differ in their handling of these issues. Some require group members to be in alcohol or substance abuse treatment prior to or during batterers' treatment. Others include a module in which they discuss the relationship between alcohol and aggression, raise consciousness about the problems associated with alcohol and substance use, and provide information and referral (Rosenbaum & Leisring, 2001, p. 62). • Develop a sobriety contract and recovery plan.

	• Relapse prevention (e.g., "What are some example thoughts or behaviors that would let you know your sliding back toward the violence/abuse behavior?") (Lawson et al., 2012, p. 196).
Increasing Accountability for One's Violence	• Letter writing as we use it encompasses many different therapeutic tasks. It is used foremost as a document of accountability; this document is written in the culture circle, over time, with feedback from sponsors and community members (Almeida & Hudak, 2002, p. 18). • Men… are connected with men sponsors from their community who support nonviolence. This linking offers a network of accountability (Almeida & Hudak, 2002, p. 4). • A solution focused approach holds domestic violence offenders accountable for building solutions rather than focusing on their problems and deficits (Lee et al., 2003, p. 10). • The effectiveness of any approach that promotes personal responsibility and accountability depends on group members giving detailed reports of their continuing interactions with partners and children. It also depends on their receiving meaningful and constructive feedback about this behavior from fellow participants. Both of these things have to be actively promoted in groups, since abusive men often do not give helpful self-reports or feedback (Adams & Cayouette, 2002, p. 7). • Monitoring the use of pronouns. As explored earlier, pronouns can play a significant role in disguised

	claims of overriding and appropriating authority over a women's perspective. Practitioners need to watch for ambiguities in the abuser's use of pronouns and, when spotted, invite men to convert suggestions of universality into statements of personal preference. For example, when a man claims, ''Men find it difficult to share feelings,'' the practitioner might ask, ''You find it difficult to share your feelings?'' or when he states ''We (i.e., me and my partner) need to communicate better,'' the response could be, ''Do you wish to communicate better?'' (Adams, 2012, p. 465).

Affective Treatment Hypotheses and Operational Definitions of Interventions

A total of six treatment hypotheses related to the affective focal dimension feelings emerged from the BIP literature. These included: (a) promoting awareness of emotions, (b) anger as secondary emotion and exploring feelings under anger, (c) developing empathy, (d) focusing and self-experiencing, (e) working through unfinished business, and (f) exploring escalation cues that precede anger and violence. Affective treatment hypotheses and corresponding operational definitions are shown in Table 6 below. Again, treatment hypotheses appear on the left side of the table and operational definitions appear on the right side. Operational definitions are depicted in direct quotes from the primary source in which they were extracted.

Table 6

Treatment Hypotheses and Operational Definitions for Affective Focal Dimension Feelings

Treatment Hypotheses	Operational Definitions of Interventions Examples
Promoting Awareness of Emotions	• ACT focuses on reducing experiential avoidance by developing mindful awareness of emotions and thoughts and making behavior changes in line with personal values (Zarling et al., 2015, p. 201). • Because many clients have limited feeling word vocabularies, we provide them with a "feeling word dictionary" to help them identify words that capture a wide range of feelings. The men not only learn to express feelings accurately, they learn that doing so allows their partners more fully into their lives, shows trust in themselves and their partners to handle their feelings, and invites greater mutual sharing of feelings (Hamberger, 2002, p. 35).
Anger as Secondary Emotion and Exploring Feelings Under Anger	• Feelings underlying anger–the anger funnel: Although some have argued that battering is not about anger, anger management seems to be a feature of many batterer treatment programs. The anger funnel is a metaphor for the idea that men are socialized to suppress all emotions except anger and thus anger becomes the only acceptable way to express feelings. As such, anger becomes a proxy for hurt, fear, sadness, shame, and other painful emotions. Helping batterers get in touch with the actual emotions can be therapeutic in and of itself, but can also be used to get the men to address the emotions they are feeling. For example, telling a partner that they are hurt is

	potentially more productive than disguising it as anger and gives the partner a chance to respond to the true feeling (Rosenbaum & Leisring, 2001, p. 62). • Anger and frustration can sometimes be a secondary response to sadness and fear. These perceptions and emotions intersect with issues of power and control, for example, it is often when a person feels at their most powerless that they hit out, and ironically this is when they are felt as most powerful (Vetere, 2011, p. 250). • One of the most difficult feelings for perpetrators to identify and acknowledge is shame, since it is such an immobilizing and passive emotion, striking at the core of masculinity. As it frequently seems to underlie anger, it is an important step for these men to identify it, and tolerate it in the presence of another (Brown, 2004, p. 52-53).
Developing Empathy	• Participants learn to empathize as helpers, and to share self-experiencing as helpees. These processes are practiced in weekly mutual helping dyads of pairs of residents, and in group sessions with the group leaders. This practicing involves the group members in helping relationships in which they function both as helpers and as helpees. As helpers they empathize while facilitating their partners' processing of emotional pain, and as helpees, they self-experience and share their feelings from their own emotional wounds (Bierman & Cheston, 1996, p. 25). • Increasing their abilities to empathize is central to these men being able to overcome some of their

	masculine constraints to feeling, to enhance their appreciation of the emotional pain of their victims and themselves, and to prepare them for relating to intimate partners in caring and respectful ways. They are given instructions to "tune in" so that they are not trying to figure out the other person, but are able to feel with him. They learn to resist feeling sorry for their partner, but rather they learn to step in his shoes and feel a touch of what he is going through, so that in dyad work each helpee knows his partner is there with him. They learn to really be there inside for the person, and how this is very different from sitting there and telling a person what to do. Their improved empathy skills are important tools that allow them new possibilities in terms of relating to others (Bierman & Cheston, 1996, p. 27).
Focusing and Self-Experiencing	• Shared Self-Experiencing is the process by which the men access and work through their own emotional blocks. It is a process, adapted from the "focusing" work of Dr. Eugene Gendlin (Gendlin, 1981), in which a person is guided to become aware of, and to explore, his sources of childhood emotional pain. The buried emotional pain is accessed by having a client clear his mind and bring his attention inside the center of his body, to attend, at a very low level of abstraction, to the bodily felt sense of a problem, filling his awareness only with physical sensations he is feeling in his stomach or chest. By bringing the client "out of his head", to a state of attending to what is being felt inside, a connection with his emotional self is accomplished. The client is then guided

	through a series of steps to encourage interaction of the felt sense with symbolic awareness (Bierman & Cheston, 1996, p. 26).
Working Through Unfinished Business	• We are then able to guide the client into a "self-experiencing" state in which he immerses himself in the felt sense, flashes to images of when he felt this sensation as a boy, re-experiences the trauma, and resolves some aspect of it, or completes some "unfinished business". This process begins to modify the dysfunctional emotion scheme, or block, that had kept the person stuck with personality patterns such as rage to mask his shame, power assertion or other defensiveness that had served to maintain emotional distance from others, and had also been part of his pattern of domestic violence (Bierman & Cheston, 1996, p. 26). • When a core issue concerns the person's childhood relationship with his parent(s), we utilize an Imaginary Parent Dialogue. To do this, the facilitator of the self-experiencing suggests that the helpee talk to the facilitator "as if" the facilitator is the person's parent. The client is thereby able to express feelings, reactions and requests to the parent that he might not have been able to express as a child, and has consequently held in for years (Bierman & Cheston, 1996, p. 102).
Exploring Escalation Cues that Precede Anger and Violence	• Helping them to identify physical, behavioral, and psychological cues earlier in the anger trajectory increases the likelihood that they can preempt the buildup and choose a more reasonable alternative.

	Situational cues are also presented. Batterers are taught to identify "hot topics" and to avoid replicating trouble spots (Rosenbaum & Leisring, 2001, p. 61-62). • Seeing the arousal process as a series of discreet phase that occur over time (Hamberger, 2002, p. 29). • Skills can be learned for managing arousal at each phase of escalation (Hamberger, 2002, p. 29). • Breaking the arousal process into such discreet "chunks," arousal is no longer viewed by clients as an "all or none" process (Hamberger, 2002, p. 29). • Search for triggers for violent interaction. Under what circumstances might conflict escalate into violence, for example? Often the triggers are attachment related, such as fears of rejection or abandonment, fears of loss and jealous responses (Vetere, 2011, p. 250). • Similarly other more distal factors might contribute to a violent escalation, such as money worries, conflict with neighbors or in-laws, work related problems, oppression, and so on. All these factors need to be explored and understood in their own right, as part of how we are helpful to families, but here they may be the context or part of the triggering process into unhelpful arousal and problems with affect regulation and self-management (Vetere, 2011, p. 250).

Interpersonal and Trauma-Informed Treatment Hypotheses and Operational Definitions

A total of 13 treatment hypotheses related to the interpersonal and trauma-informed focal dimension emerged from the BIP literature. These included: (a) working through transference issues, (b) working through family of origin trauma, (c) exploring relational patterns, (d) exploring and working through attachment difficulties, (e) providing a corrective emotional experience, (f) addressing collusion, (g) building the therapeutic relationship and developing safety and support among group members, (h) promoting collaborative and egalitarian relationships, (i) providing interpersonal feedback, (j) group check-ins, (k) communication and assertiveness training, (l) relationship enhancement skills, and (m) conflict resolution skills. Interpersonal and trauma-informed treatment hypotheses and corresponding operational definitions are shown in Table 7 below. Again, treatment hypotheses appear on the left side of the table and operational definitions appear on the right side. Operational definitions are depicted in direct quotes from the primary source in which they were extracted.

Given this interpersonal focal dimension included several propositions of cause and treatment hypotheses related to intergenerational violence and trauma, it was recommended by the author's committee to include a trauma-informed lens within this focal dimension. This discussion led to the integration of this focal dimension, which is now called the interpersonal and trauma-informed focal dimension. It should be noted that this focal dimension is looking through a trauma-informed lens from the side of perpetrators and from an interpersonal or family violence perspective. This does not

necessarily include other forms of trauma, such as racial trauma, for example, which is included in the cultural focal dimension. It should also be noted that all treatment models addressing RVM should also be trauma-informed from the perspective of survivors, that is the partners of RVM, including this unified model (Adams, 1988; Mederos, 2002). The safety of survivors of IPV should always be at the forefront when implementing an intervention or treatment model (Adams, 1988; Mederos, 2002).

While a full review of trauma-informed perspectives is outside the scope of this dissertation, the author recommends taking into consideration trauma-informed perspectives such as Herman's (1992) *Trauma and Recovery*, and Briere and Scott's (2014) *Principles of Trauma Therapy*. From Herman's (1992) model a trauma-informed lens includes taking into consideration the stages of trauma recovery. These stages include: (a) establishing safety, (b) reconstructing the trauma story, and (c) restoring connection between survivors and their communities (Herman, 1992). Briere and Scott's (2014) model contains similar recommendations for treatment and more concrete strategies for assessing symptoms and facilitating trauma recovery. Another important facet of having a trauma-informed lens includes having an understanding of the socio-cultural power dynamics which have greatly impacted IPV. It is recommended that therapists working with survivors of interpersonal trauma have an understanding of the social, political and historical contexts which have often severed to silence survivors' experiences (Herman, 1992). Much of this context and history is discussed at the beginning of Herman's (1992) *Trauma Recovery*. Finally, any trauma-informed

perspective should have a conception of what constitutes trauma. Herman (1992) describes trauma in the following:

> traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe. According to the Comprehensive Textbook of Psychiatry, the common denominator of psychological trauma is a feeling of "intense fear, helplessness, loss of control, and threat of annihilation." (p. 24)

Experiences of intergenerational interpersonal violence and family violence growing up would fall within this conception of trauma, which many RVM have experienced in their family of origin.

Table 7

Treatment Hypotheses and Operational Definitions for Interpersonal and Trauma-Informed Focal Dimension

Treatment Hypotheses	Operational Definitions of Interventions Examples
Working Through Transference Issues	• It is also necessary, at times, for participants to have both a female and a male therapist to whom they can express both "mother" and "father" transference issues during the therapeutic processes of RWV. Transference is a therapeutic process in which a client expresses feelings towards a therapist, which are actually feelings the client has about someone else, such as a parent figure (Bierman & Chester, 1996, p. 1-2).
Working Through Family of Origin Trauma	• Process experiences of violence in family of origin (Crockett et al., 2015, p. 495). • Process emotion related to traumatic life experiences (i.e., of parental shaming, physical/sexual abuse, or abandonment); (Pascual-Leone et al., 2011, p. 333-334). • The objectives of RWV Therapy that follow from this perspective of domestic violence are as follows: for participants to access and re-experience painful feelings of fear and shame which are associated with their childhood traumatic experiences, for participants to process the previously buried painful emotions in a supportive therapeutic setting in which the avoided, overwhelming feelings can be accepted as tolerable aspects of themselves; for participants to access and mobilize their personal healing resources to begin meeting their unmet needs that were stifled by

	traumatic childhood experiences; (Bierman & Cheston, 1996, p. 23-24). • Nurturing inner child. The person is guided to get an image of his own inner child. It is then suggested that he imagine his adult self approaching his wounded inner child, and then imagine his adult self taking his inner child to a safe place, away from the place he has re-experienced his childhood pain. Once the person is imagining himself with his wounded child in a safe place, a dialogue is encouraged between the adult self and his wounded child which leads to the person identifying his unmet childhood needs and ways that his adult self can now begin to self-nurture himself to start meeting those unmet needs (Bierman & Cheston, 1996, p. 111-112).
Exploring Relational Patterns	• Relationship history. Within two to three sessions of a man's entry into the second stage he is asked to share his relationship history in the group… group leaders ask the person and other group members if they see any patterns to this history. Common patterns emerged from relationship histories include jealousy or possessiveness, difficulty accepting the ending of relationships, a preference for younger partners, sexual coercion, numerous relationships, frequent infidelity, and relationships revolving around alcohol or drugs. Once these patterns have been discussed, the person who has done the relationship history is asked to think about the goals he would like to establish for the remainder of his time in the program. (Adams & Cayouette, 2002, p. 13-14).

	• A final interactional pattern of importance is the clinician's awareness of countertransference to the client as a guide and window into the client's predominate maladaptive pattern of interaction… Even though being drawn into a reenactment of a man's maladaptive interpersonal pattern is often frustrating for a clinician, it allows for an in vivo experience of how a man's interpersonal style affects others (Lawson et al., 2012, p. 197).
Exploring and Working Through Attachment Difficulties	• Bowlby explicitly saw the therapist as a surrogate mother who encouraged the client to explore the world from a secure base he or she creates. In the context of therapeutic work with individuals, Bowlby (1988) defined five tasks: 1. Create a safe place, or Secure Base, for client to explore thoughts, feelings and experiences regarding self and attachment figures; 2. Explore current relationships with attachment figures; 3. Explore relationship with psychotherapist as an attachment figure; 4. Explore the relationship between early childhood attachment experiences and current relationships; and 5. Find new ways of regulating attachment anxiety (i.e., emotional regulation) when the attachment behavioral system is activated (Sonkin & Dutton, 2003, p. 111).
Providing a Corrective Emotional Experience	• Providing a corrective emotional experience (example response: "I noticed you got very angry when the rest of the group didn't agree with you on the time out issue. Could you help me better understand what you're feeling and thinking right now? What's it like

	sharing it out loud with me?") (Lawson et al., 2012, p. 194). • In the case of psychotherapy, the clinician is the caretaking figure who likewise provides a secure base so that the client's attachment system is sufficiently deactivated and the client is free to explore and play. In therapy, however, the exploration is the inner world of feelings, thoughts, and experiences, and the play is, for example, trying on new identities and responses to stress and conflict (Sonkin & Dutton, 2003, p. 113).
Addressing Collusion	• Collusion. New men need to make an agreement not to collude and to accept being confronted when doing so. If someone is not willing to stop colluding in the class, other participants will ask him to leave and take a hard look at his unwillingness to take responsibility for his violence (Hernández, 2002, p. 21). • To avoid reinforcing irresponsible attitudes, facilitators need to be well prepared to be able to identify collusion and also to stop it. To know an irresponsible attitude when he sees it, a facilitator must call on abilities grounded in self-reflection and self-criticism and take responsibility for his own controlling and dominating behaviors and attitudes (Hernández, 2002, p. 27).
Building the Therapeutic Relationship and Developing Safety and Support Among Group Members	• It is essential for an effective BIP to create a safe environment that invites honest disclosure (Crockett et al., 2015, p. 490). • The men receive support in becoming actively involved in each other's change process. This is a

	powerful tool in dismantling some of the more rigid norms of masculinity (Almeida & Hudak, 2002, p. 14).
Promoting Collaborative and Egalitarian Relationships	• When clients were treated as equals in the therapeutic process, participants did take significantly more accountability for their violent actions by the conclusion of the treatment program (Crockett et al., 2015, p. 495). • It's the process that is important. It's important that we avoid doing in a men's group what they do at home to their wives, which is always telling them what to think and how to think. I think it's very important that we don't impose our opinions on the men. It's important the men see that though we are teachers, and people in positions of power, that doesn't require us to impose our own beliefs and ideas on another person (Miller 2010, p. 1012).
Providing Interpersonal Feedback	• Another way that group leaders promote constructive interaction is by giving instruction and feedback about positive group participation. This is accomplished in two ways – (1) educating the group as a whole about the value and elements of giving good feedback and (2) giving specific feedback to each member about the quality of his feedback to others, as well as his overall participation in the group (Adams & Cayouette, 2002, p. 17).
Group Check-Ins	• Check ins. The check-in involved the facilitator's going around the room and having each man describe the positive and negative ways in which he handled

	anger and/or conflict during the week. (Donnelly et al., 2002, p. 10-11).
Communication and Assertiveness Training	• This might involve encouraging the men to listen, ask questions, use "I" language, and paraphrase. It also may involve teaching batterers about the different elements of communication, such as tone, posture, facial expression, volume, gestures, content, and the fact that they may send mixed messages, for example, if the tone and content are discrepant (Rosenbaum & Leisring, 2001, p. 62-63). • Promoting more constructive, straightforward communications and interactions around each others' needs and vulnerabilities. This often involves supporting partners in seeking solace and comfort with each other, supporting each other practically and socially and challenging long held adverse beliefs about their own self-worth (Vetere, 2011, p. 251-252). • Assertiveness: Batterers are often saddled with traditional male attitudes that they must be strong and self-reliant. In addition to some of the negative consequences that this has for their partner, it also puts a great deal of pressure on the men, themselves. They may be unable to ask for help from their partners. They may also have difficulty admitting they are wrong, giving and receiving compliments, refusing requests by others (Rosenbaum & Leisring, 2001, p. 64-65). • The goals of assertive communication is not go "get what you want," but to provide the receiver with

	direct, honest communication of ideas within a framework of respect for the equal right of the other person to express his or her ideas, including those that differ or disagree and including when the other refuses to grant a request (Hamberger, 2002, p. 31-32). • Men learn that if they hope for someone to provide them with something, they have a responsibility to assertively ask for it rather than expect the person simply to "know" what they want. The men also learn that just as they have a right to refuse requests they deem unreasonable, others, including their partners, have a right to judge their requests as unreasonable and refuse them as well (Hamberger, 2002, p. 33-34).
Relationship Enhancement Skills	• Creating emotional intimacy, and fostering friendships, a culture of appreciation, fondness, and respect (Bradley et al., 2011, p. 103). • Establishing emotional connections in the family with partners and children; maintaining intimacy; creating shared meaning (Bradley et al., 2011, p. 103).
Conflict Resolution Skills	• Facilitate conflict management (e.g., helping couples identify and manage perpetual vs. solvable problems) (Bradley et al., 2011, p. 189). • Approaches to expressing and resolving conflict are presented which emphasize getting to the emotional issues which underlie surface conflict triggers in relationships. Starting with ways to clearly hear and empathize with what the expressing person describes as the behaviors he or she objects to, clients are guided to appreciate and to communicate the feelings

	associated with the conflictual behaviors. They are then guided to help their partner become aware of, and to express the childhood wounds which underlie the surface issue (Bierman & Cheston, 1996, p. 27-28). • Central to nonviolent conflict resolution: The ability to clearly identify and state parameters of a problem situation, to identify and express his own feelings about what is happening, to be able to identify and state his partner's point of view, to offer solutions from which he and his partner may benefit and to negotiate a final compromise (Adams, 1988, p. 188-189).

Cultural Treatment Hypotheses and Operational Definitions of Interventions

A total of seven treatment hypotheses related to the cultural dimension emerged from the BIP literature. These included: (a) consciousness raising and providing psychoeducation, (b) exploring culture and cultural values, (c) expanding conceptions of masculinity, (d) exploring systems of oppression to help men understand oppression of women, (e) taking into consideration historical context of oppression, (f) encouraging relationally violent men to become activists and advocates, and (g) exploring intersectionality with masculinity. Cultural treatment hypotheses and corresponding operational definitions are shown in Table 8 below. Again, treatment hypotheses appear on the left side of the table and operational definitions appear on the right side. Operational definitions are depicted in direct quotes from the primary source in which they were extracted. This focal dimension is considered very important when working with RVM. It is this author's recommendation that any therapists or BIP facilitators hoping to utilize this model have an understanding of systemic and institutionalized forms of oppression, especially an in-depth knowledge of patriarchal systems. Having this awareness is key for implementing treatment hypotheses from focal dimensions that fall within the cultural dimension as well. MTP notes that the cultural focal dimension greatly impacts focal dimensions that lie within its boundaries and all focal dimensions can have a bi-directional relationship impacting one another (Brooks-Harris, 2008). For this reason along with the recommendation of other researchers, it is recommended that treatment hypotheses be implemented from a lens that takes into consideration patriarchal

systems, as well as, other systems of oppression (Almeida & Hudak, 2002; Hancock & Siu, 2009).

As noted previously in the interpersonal and trauma-informed focal dimension, it is important for therapists and BIP facilitators to have an understanding of trauma from these systemic forms of oppression. Many of the treatment hypotheses in this section require therapists to have an understanding of systemic trauma, such as racial trauma (Mental Health America, 2020).

Table 8

Treatment Hypotheses and Operational Definitions for Cultural Focal Dimension

Treatment Hypotheses	Operational Definitions of Interventions Examples
Consciousness Raising and Providing Psychoeducation	• Challenge perpetrators' beliefs about power, control, and dominance over their spouses (Barner & Carney, 2011, p. 237). • Use the Power and Control Wheel to illustrate how men use intimidation, male privilege, isolation, emotional and economic abuse, and violence to control women (Stover et al., 2009, p. 224). • Present RVM with the many forms of aggression and types of control and encourage them to consider the way they use these strategies in their intimate relationships. Much of this is consciousness raising, as batterers are often aware of the wrongness of hitting, but do not consider restricting activities, monitoring behavior, restricting access to money, or treating their partners as servants as abusive (Rosenbaum & Leisring, 2001, p. 61). • Helping RVM understand definitions of violence (Crockett et al., 2015, p. 490). • Reeducation about power differentials between men and women, male privilege, and the patriarchal structure of society, with the goal of shifting beliefs and behaviors toward a more egalitarian orientation with women (Lawson et al., 2012, p. 190). • Vignettes and Control Logs: The important thing is that men start to make connections between their behaviors and their intent…Why do you think the guy

	in the video did what he did? Why do you think he used that behavior instead of another behavior? What did he intend when he got close to her?... this control log helps the men to decode the vignette through that personal and collective analysis (Pence, 2002, p. 19).
Exploring Culture and Cultural Values	• A culturally sensitive approach incorporates into treatment the knowledge of the male batterer's cultural context including his language, traditions, customs, values and rituals (Hancock & Siu, 2009, p. 125). • The intervention also had to be grounded in the pre-migration, migratory and acculturation experiences (Hancock & Siu, 2009, p. 125). • A major intention of the intervention was to engage the men, even though they were court ordered, in a genuine commitment to change by appealing to positive aspects of their cultural values and traditions, especially the central importance of family in their lives (Hancock & Siu, 2009, p. 125). • Group leaders ask men to discuss what their particular culture (however they want to define this) taught them about being a man and how this has influenced their expectations toward women. This exercise enables men to overcome preconceptions or misconceptions about particular cultures, and to see their own cultural background in a broader perspective. This exercise also serves to create trust among men from different ethnic and racial differences as well as underlying similarities (Adams & Cayouette, 2002, p. 21).

	• We need to keep our cultures to maintain a sense of identity. We, however, need to be self-critical and recognize that oppression and repression of women has to end regardless of where we are… We have to acquire enough tools to change the parts of the culture that are destructive, keep the ones that are constructive for all people in the culture, and know the difference (Hernandez, 2002, p. 28).
Expanding Conceptions of Masculinity	• Traditional norms of patriarchy can be challenged and transformed into expanded ways of being male (Almeida & Hudak, 2002, p. 11). • Sponsors model an expanded notion of masculinity that includes vulnerability, nurturing, gentleness, empathy, and an understanding of others. They also model respect for women, children, people of color, sexual minorities, and others who are different than them (Almeida & Hudak, 2002, p. 11).
Exploring Systems of Oppression to Help Men Understand Oppression of Women	• They understand their own oppression and they need to generalize it to realize that they themselves are women's oppressors (Hernández, 2002, p. 5). • Another exercise that helps abusers discuss differences in cultural perspectives is the Historical Perspective – Attitudes About Women exercise. It begins with a presentation of a brief history concerning voting and property rights for women and people of color in the United States. Following this, group members are asked to brainstorm the following: What are the effects on the woman/person of color being devalued? What are the effects on the person who is devaluing others? What effect does this

	thinking have on the relationship between the person being devalued and the person who is devalued? … a common result of this exercise is that men who have experienced oppression because of their racial, economic, or religious background are more able to empathize with women whom they have oppressed through their abuse and control (Adams & Cayouette, 2002, p. 21). • The facilitators stressed the connections between violence and oppression experienced and violence and oppression done to others. A second thread was that all types of oppression have something in common. This unit encouraged men to recognize commonalities between the oppressions associated with race, gender, income, and sexual orientation (Donnelly et al., 2002, p. 9).
Taking into Consideration Historical Context of Oppression	• Considering history of colonization (Pence, 2002, p. 10-11). • Considering history of slavery, Jim Crow laws, segregation, and mass incarceration. • Such an approach usually takes into account the oppression and internalized oppression that men of color experience in their daily lives and the difficulty they may have trusting and relating to the therapeutic encounter (Hancock & Siu, 2009, p. 125). • Required that the men address feelings of anger, frustration, and sadness associated with devaluation and dehumanization in environments outside the home, and the loss of personal and cultural identity in

	the immigration process (Hancock & Siu, 2009, p. 126).
Encouraging Relationally Violent Men to Become Activists and Advocates	• To become a peer educator for men in the program and in the community at large and create a new society and culture (Hernández, 2002, p. 26-27). • To replicate the program in one's own community by learning to become a class facilitator (Hernández, 2002, p. 26-27). • We also train men in public speaking in churches, radio, television, and schools and support them as they prepare to participate in annual marches against domestic violence and similar activities (Hernández, 2002, p. 26-27).
Exploring Intersectionality with Masculinity	• The connection between race/ethnicity, class, life context issues, manhood, and domestic violence (Mederos, 2002, p. 21-22). • In a session on the cultural expectations around black manhood, courage, and violence, we asked participants to identify negative and positive elements associated with being black and to come up with new definitions of manhood that were nonviolent (Donnelly et al., 2002, p. 11).

CHAPTER V

DISCUSSION

The literature review for this dissertation illuminated several findings that support the need for better approaches for treating RVM, such as a more wholistic and unified approach. This dissertation sought to review the available BIP literature in order to develop a more comprehensive, unified approach to treating RVM. In Chapter IV the results of this content analysis were described, including the propositions, treatment hypotheses, and operational definitions used to construct a unified theory for treating RVM. This chapter will detail a summary of significant insights from data analysis, applications for this unified model, discuss its strengths and limitations, and provide ideas for future research directions.

Summary of Significant Insights from Data Analysis

Given the tension that has existed between various theoretical camps (see Dutton & Corvo, 2007; Gondolf, 2011; Winstok, 2011), the author of this dissertation was surprised by the amount of overlap in treatment hypotheses across varied treatment models. During the analysis, for example, the author of this dissertation noted that nearly all sources encouraged accountability to some degree. Even solution-focused models, which de-emphasize looking at the problem, had some version of accountability that held men answerable for finding solutions (Lee et al., 2003). Additionally, the author of this dissertation noted that a cluster of treatment hypotheses often referred to as anger management were common across most treatment models. These include treatment

hypotheses such as de-escalation and time-out strategies, exploring escalation cues that precede anger and violence, exploring the consequences and costs associated with partner violence, and viewing anger as secondary emotion often covering more vulnerable primary emotions such as shame or fear (Rosenbaum & Leisring, 2001). Additionally, this author noted that communication training, increasing motivation for change, addressing collusion and building group safety and the therapeutic alliance were also common across varied theoretical models. Given these treatment hypotheses' commonality across theoretical models, this also made it somewhat difficult to identify corresponding focal dimensions for these treatment hypotheses. Initially the cluster of anger management treatment hypotheses and a cluster of other treatment hypotheses lacking a focal dimension were grouped separate from the working unified model, which included the MTP focal dimensions (e.g., thoughts, actions, feelings, interpersonal relationships, and cultural systems). The author of this dissertation contemplated forming a new focal dimension that dealt with group dynamics for several of these treatment hypotheses including, building group safety and the therapeutic relationship, addressing collusion, increasing motivation for change and check-ins. However, after consultation with one of his dissertation committee members, it was determined that a majority, if not all, treatment hypotheses identified in the literature could be adapted to either a group or individual format. Therefore, the idea for a group dynamics focal dimension was discarded and the treatment hypotheses in this cluster were moved to fit with existing focal dimensions. The same was done for the cluster of anger management treatment hypotheses, until all treatment hypotheses fit into one of the five identified focal

dimensions, thoughts, actions, feelings, interpersonal and trauma-informed, and cultural systems originally described in the MTP model (Brooks-Harris, 2008).

Discussion regarding the inclusion of a group dynamics focal dimension did spark ideas for future research in determining which treatment hypotheses might be best implemented in a group, individual or even possibly in a couples format. Couples intervention might be applicable after RVM have completed either individual and/or group and have demonstrated their commitment to non-violence by remaining non-violent for a significant amount of time. As echoed by many of the pro-feminist theorists, this author believes that the safety of survivors should be at the forefront when selecting a treatment format (Adams, 1988; Miller, 2010). Couples intervention should only be considered once nonviolence has been achieved. At the same time, once nonviolence has been achieved, a couples format may be an optimal format for the relationship enhancement treatment hypothesis often covered in the CHRP (Bradley & Gottman, 2012; Bradley et al., 2011).

Another important insight from data analysis was the inclusion and integration of a trauma-informed lens within the interpersonal focal dimension. Several of the treatment hypotheses and propositions of cause in the interpersonal focal dimension contained content related to the men's own trauma from their family of origin. Therefore, it felt important to include this within the interpersonal focal dimension. While all treatment models should be trauma-informed in terms of prioritizing the safety of RVM's partners (Adams, 1988; Miller, 2010), this focal dimension is unique in taking into consideration RVM's own victimization from childhood. Additionally, it should be noted that this new

focal dimension is specific to looking at interpersonal violence from RVM's own childhood. Other forms of cultural trauma, such as experiences of racial trauma are included within the cultural focal dimension. Several treatment hypotheses and one proposition of cause within the cultural focal dimension address RVM's own experiences of oppression.

Application of a Unified Model for Relationally Violent Men

One major application of this unified approach for treating RVM is that it can be used to help with conceptualization and treatment planning, especially within an individual therapy format. MTP's five-step treatment planning protocol could be adapted to this model to aid in this process. MTP treatment planning protocol includes the following five steps: (a) watching for multidimensional focus makers, (b) conducting a multidimensional survey, (c) establishing an interactive focus on two or more dimensions, (d) formulation of a multitheoretical conceptualization, and (e) selecting interventions from a catalog of key strategies corresponding to identified focal dimensions (Brooks-Harris, 2008). For the purposes of this dissertation and this unified approach, Steps One and Two might involve interviewing clients for content based on the identified propositions of cause and looking for focal dimension makers. An example of this for the interpersonal and trauma-informed focal dimension, might include assessing for intergenerational violence, communication patterns, and relationship with attachment figures. For the cultural focal dimension, this might include exploring experiences of oppression, attitudes towards women and conceptions of masculinity or what it means to be a man. For the cognitive focal dimension, this might include exploring thoughts and

beliefs about gender-roles, or beliefs supportive of violence. For the affective focal dimension, this might include exploring attitudes towards certain emotions, expression of emotions, emotional vocabulary and ability to regulate emotions. For the behavioral focal dimension, this might include assessing for addictions, substance use and attitudes and social experiences that may have supported partner violence. Following the multidimensional interview, the clinician can collaboratively work with the client to identify focal dimensions for which a treatment focus may be beneficial. The final step involves choosing treatment hypotheses that correspond to focal dimensions or relevant propositions and adapting operational definitions of interventions that correspond to the selected treatment hypotheses. Table 9 presents the full unified treatment model for working with RVM, which may aid in treatment planning. Focal dimensions and propositions of cause are depicted with their corresponding treatment hypotheses.

Table 9

Full Unified Treatment Model for Treatment Planning

FOCAL DIMENSION	PROPOSITIONS	TREATMENT HYPOTHESES
Thoughts	Cognitive Errors	• Confronting Denial, Minimization and Blame
	Cognitive Beliefs	• Exploring Thoughts and Beliefs that Support Violence • Cognitive Restructuring and Challenging Sexist Belief Systems • Exploring and Clarifying Values • Increasing Motivation for Change
Actions	Social Learning	• De-escalation and Time-out Strategies • Behavioral and Safety Contracts • Role Plays and Practicing Skills • Providing Homework to Reinforce New Skills • Modeling Nonviolent Behaviors • Identifying and Teaching Nonviolent Alternative Behaviors • Reinforcing Positive Behavior Changes • Exploring Consequences and Illuminating the Costs of Aggression and Violence • Relaxation Training • Parenting Skills • Increasing Accountability
	Substance Abuse	• Substance Abuse and Relapse Prevention Skills and Intervention
Feelings	Lack of Emotional Awareness and Regulation	• Promoting Awareness of Emotions • Anger as Secondary Emotion and Exploring Feelings Under Anger • Exploring Escalation Cues that Precede Anger and Violence
	Emotional Blocks	• Developing Empathy

		• Focusing and Self-Experiencing • Working Through Unfinished Business
Interpersonal & Trauma-Informed	Family of Origin Trauma & Intergenerational Violence	• Working Through Family of Origin Trauma • Exploring Relational Patterns • Building the Therapeutic Relationship and Developing Safety and Support Among Group Members
	Psychopathology & Personality Disorder	• Addressing Collusion • Providing Interpersonal Feedback
	Attachment	• Working Through Transference Issues • Exploring and Working Through Attachment Difficulties • Providing a Corrective Emotional Experience
	Communication Skills Deficits & Situational Couples Violence	• Promoting Collaborative and Egalitarian Relationships • Communication and Assertiveness Training • Relationship Enhancement Skills • Conflict Resolution Skills
Culture	Patriarchy	• Consciousness Raising and Providing Psychoeducation • Expanding Conceptions of Masculinity • Encouraging Relationally Violent Men to Become Activists and Advocates • Exploring Intersectionality with Masculinity
	Oppression	• Exploring Culture and Cultural Values • Exploring Systems of Oppression to Help Men Understand Oppression of Women • Taking into Consideration Historical Context of Oppression

Implementing this unified approach in a group setting might look a little bit different. Group facilitators may decide to focus on one focal dimension during each week's meeting. For example, a group might spend 2 to 3 weeks on one focal dimension before moving on to the next, cycling through all five focal dimensions. The author of this dissertation recommends that certain focal dimensions and treatment hypotheses may be helpful earlier in group treatment compared to others. For example, the cognitive treatment hypotheses related to increasing motivation for change and confronting denial, minimization and blame may be helpful towards the beginning of group treatment, whereas interpersonal and trauma-informed treatment hypotheses related to working through past traumatic experiences might be more effective after group safety and cohesion have had time to develop. Future research may be helpful in determining the best timing or circumstances in which to utilize a particular treatment hypothesis. At the same time, this model does encourage flexibility and allowing group facilitators to use their clinical judgement when selecting treatment hypotheses and corresponding interventions. This approach allows for flexibility in responding to group content that arises spontaneously.

One major challenge for the implementation and acceptance of a unified model for treating RVM by the BIP community includes the historical tension that has existed between various theoretical camps (see Dutton & Corvo, 2007; Gondolf, 2011; Winstok, 2011). This tension often appears to exist regarding the propositions of cause of IPV. As an example, there has historically been significant conflict between pro-feminist theorists and advocates of couples intervention who often have differing views regarding the

perpetration of partner violence being primarily by men or equal across genders. While the propositions of what causes IPV are often debated, less tension may exist among treatment hypotheses and operational definitions of interventions across treatment modalities. As an example, while pro-feminist theorists argue that partner violence is not about anger (Adams, 1988), most programs still utilize some form of traditional anger management techniques (Rosenbaum & Leisring, 2001). Additionally, this author noted during the data analysis that nearly all programs emphasized increasing RVM's accountability. This author also observed that it was common for programs to utilize communication and assertiveness training, role plays, rehearsal of new skills, and anger management interventions. BIPs across various theoretical modalities may share more in common than they sometimes realize. This point has also been reflected in the literature, as several theorists point out the overlap among various theoretical modalities (Babcock et al., 2004; Gondolf, 2007; Rosenbaum & Leisring, 2001; Stuart et al., 2007).

While historically significant debate has existed regarding the causes of IPV (Adams, 1988; Armenti & Babcock, 2016; Winstok, 2011), this unified model seeks to respond flexibly to each relationally violent man's unique context and recognizes the possibility of multiple causes of IPV. In this unified model of treating RVM, propositions of cause are not necessarily considered to be mutually exclusive. In fact, many of the propositions are thought to overlap and are often described from an integrative perspective in the BIP literature. As an example, here is quote from Pascual-Leone et al.'s (2011) *Relating Without Violence* program that integrates several theoretical propositions:

> It is known that traumatic early life experiences in which parents have been abusive, cruel, and coercive in attempts to control a child are a frequent part of the personal histories of many abusive adults (Dutton, 1995; Lewis, 1992) …. A corpus of research from several empirical lines of inquiry has shown that a history of this kind, of complex relational trauma, is related to deficits in facets of emotional intelligence such as the awareness, regulation, and processing of feelings (Paivio & Pascual-Leone, 2010). Consistent with this, research has shown a link between the personality psychopathologies that describe batterers and an array of dynamic emotional characteristics, such as avoidance, jealousy, attachment-related anxiety, and compulsive care seeking (Waltz, Babcock, Jacobson, & Gottman, 2000). (p. 332)

This quote gives an example of how several propositions can overlap across multiple focal dimensions. The interpersonal propositions related to intergenerational violence, attachment, and personality disorders are integrated with the affective proposition related to emotional dysregulation and lack of emotional awareness.

Apart from treatment planning and responding more flexibly to RVM in treatment, this unified model may also serve to provide some convergent validity with Harris et al.'s (2016) unified model for treating RVM. Several of the treatment hypotheses from this investigation line up with those described in Harris et al.'s (2016) unified model, while also providing some additional treatment hypotheses that could expand Harris et al.'s (2016) model. For example, some of the following treatment

hypotheses were not included in Harris et al.'s (2016) model and would expand this model: (a) increasing motivation for change, (b) addressing collusion, (c) building group safety and the therapeutic relationship, and (d) encouraging RVM to become activists and advocates. At the same time, several interventions described in Harris et al.'s (2016) model were not reflected in this content analysis. For example, the Emotion-Focused key strategy - creating dialogue between the aggressive part of a client and the part that wants to heal, was not reflected in the content analysis in this dissertation. Some of Harris et al.'s (2016) interventions may have been adapted from non-BIP related sources or from sources that were simply not within the scope of this dissertation. The combination of both Harris et al.'s (2016) model and this dissertation's model may provide the most comprehensive list of treatment hypotheses for treating RVM.

Limitations

One limitation of this dissertation includes the fact that all propositions, treatment hypotheses, and operational definitions in the BIP literature reviewed were considered without discrimination in regards to their empirical support. Some treatment modalities, such as Duluth and CBT programs have been studied extensively (Babcock et al., 2004), whereas other treatment models have very limited empirical support or have yet to be empirically tested. For example, the only known study evaluating the RWV program includes Pascual-Leone et al.'s (2011) study. This may be problematic for the affective focal dimension since many of the treatment hypotheses in this focal dimension were extracted from the RWV program. Treatment hypotheses that are potentially ineffective or questionable in terms of their efficacy could weaken the overall effectiveness of a

unified approach for treating RVM. Given one of the most recent and widely cited meta-analyses on BIP intervention in the literature was conducted in 2004 (Babcock et al., 2004), future directions may aim to update and replicate this meta-analysis with the same level of rigor. Additionally, newer and less empirically supported approaches such as the RWV program (Pascual-Leone et al., 2011), ACT (Zarling et al., 2015), and attachment-based interpersonal approaches (Sonkin & Dutton, 2003) should be evaluated more rigorously to determine their efficacy in reducing violence. While some of these treatment models may have more extensive empirical support for treating other concerns, it would be important to establish whether they actually help reduce partner violent behavior. Having an updated review of the efficacy of various approaches may help to inform which treatment hypotheses should be retained in a unified approach and help determine if there are any that should be excluded.

Another limitation of this dissertation is that it is somewhat assumed that a unified approach will be better than any treatment modality alone. This is where future research would be needed to empirically test how this unified approach to treating RVM compares to treatment as usual (most likely CBT or Duluth) in terms of reducing recidivism and drop out. Future directions such as these will be discussed in the next section.

One final limitation relates to potential researcher bias. As discussed in the methods chapter, the author of this dissertation identifies as a feminist man and holds certain beliefs consistent with other feminist researchers on the topic of IPV intervention. For example, the author of this dissertation holds similar biases as feminist critics about the use of couples therapy for IPV, especially in regards to the safety of RVM's partners

(Adams, 1988; Mederos, 2002). Knowing, for instance, that IPV is greatly underreported by both RVM and their partners for various reasons (Babcock et al., 2004; Gondolf, 2004; Gondolf, 2007; Rosenfeld, 1992; Sartin et al., 2006; Stover et al., 2009), this author admits being somewhat skeptical of the accuracy of assessment procedures used in couples therapy addressing IPV (Armenti & Babcock, 2016). However, at the same time, after having completed this dissertation project the author admits being slightly more open to couples therapy as a mode of intervention for RVM following the completion of either individual therapy or a group BIP. This author also recognizes the utility of using treatment hypotheses often used in couples therapy, such as communication and assertiveness training, which have often historically been a part of many BIPs' curriculum (Rosenbaum & Leisring, 2001). Similarly, the author of this dissertation generally agrees with feminist critics who assert that anger is not the primary cause of IPV (Adams, 1988; Miller, 2010). While this author agrees that anger is not the root cause of IPV, the author does believe that discussion of anger can be important for intervention with RVM. For example, discussion of men's socialization to cover other emotions with anger (e.g., the treatment hypothesis addressing anger as a secondary emotion) and exploring beliefs that may contribute to RVM becoming angry and violent are useful treatment hypotheses often discussed in the BIP literature (Miller, 2010; Rosenbaum & Leisring, 2001). This potential researcher bias may show in the particular language selected to describe certain treatment hypotheses. For example, the author of this dissertation was intentional about adding the word *violence* to the treatment hypothesis dealing with escalation cues to anger. Adding the word violence to this

treatment hypothesis emphasizes that violence is the behavior that is ultimately trying to be eliminated.

Future Directions

The next foreseeable step following this dissertation may include determining whether a unified approach for treating RVM is feasible. One of the primary limitations of more wholistic approaches is that they can take longer for therapists to learn because they contain many more skills than any one modality alone (Boswell et al., 2010). Therefore, determining the best way to teach this model may be an important next step. On the other hand, there are a few factors that may make this more feasible. Given many BIPs have significant overlap and may be integrative to an extend already, it may not be unreasonable to suggest that a unified approach could be taught. Many BIP facilitators are likely familiar with at least a portion of these treatment hypotheses. However, the development of a training manual could aid in feasibility and adherence to this model.

As mentioned earlier, one potential barrier to the adherence and acceptance of a unified approach to treating RVM includes the historical conflict that has existed between various theoretical camps (Dutton & Corvo, 2007; Gondolf, 2011; Winstok, 2011). In promoting unity, it could be emphasized that many programs already overlap significantly in the interventions that they utilize. While there is significant debate regarding the causes of IPV, it was interesting to observe the amount of overlap across BIPs of various treatment modalities. Future directions aimed at teaching this model should emphasize these points including the idea that these varying theoretical perspectives do not necessarily need to be mutually exclusive.

Future research may aim to empirically test which treatment hypotheses or interventions work best under which circumstances. This may be a challenging undertaking given many programs are already fairly integrative and utilize multiple treatment interventions. For example, many sources have noted the overlap in self-identified CBT and pro-feminist/Duluth programs, noting that these programs tend to be "one-in-the-same [*sic*]" (Gondolf, 2007, p. 652; Stuart et al., 2007). Additionally, this author observed during the coding process that some clusters of interventions, such as traditionally identified anger management interventions, as well as, skills training interventions, and accountability were common across most programs, if not universally employed interventions. While it is seen as an advantage that most programs are integrative and employing multiple treatment hypotheses, this may make it more difficult to separate and empirically examine each treatment hypothesis individually. Some integrative BIPs have begun to experiment with employing various treatment hypotheses at different points in treatment. For example, Lawson et al.'s (2012) integrative cognitive-behavioral and psychodynamic approach to treating RVM utilized motivational interviewing and CBT treatment hypotheses early on in therapy, while reserving psychodynamic focused interventions after group safety and trust had been developed later on in the second half of treatment. Similarly, other treatment models noted the utility of using certain treatment hypotheses at certain points in treatment. For example, Bierman and Cheston's (1996) RWV program recommends that denial, minimization, and blame be confronted and that the men make a commitment to nonviolence before moving on to their emotion-focused and relational treatment hypotheses.

While the biology focal dimension was not a focus within this study, it may be worth exploring potential biological treatment hypotheses in the future. One such intervention may look to utilize biofeedback techniques to assist RVM in learning relaxation skills and to recognize their physiological escalation cues. Likewise, biofeedback may be a helpful supplement to the focusing and self-experiencing techniques discussed in Relating Without Violence program (Bierman & Cheston, 1996) and helping RVM gain more awareness of the physiological aspects of their emotions. In this unified model, it is presumed that an intervention targeting one focal dimension can impact other focal dimensions. Focal dimensions are thought to have a bi-directional and reciprocal relationship with other focal dimensions (Brooks-Harris, 2008). Therefore, it is presumed that the treatment hypotheses for treating RVM described in this dissertation will also have an impact on RVM's biology. As an example, cognitive restructuring will likely result in physiological changes to one's biology where new neural connections are formed.

Another focal dimension and treatment format that may be interesting to explore more in the future is the use of family therapy and the family systems focal dimension from MTP (Brooks-Harris, 2008). Some of the propositions of cause and treatment hypotheses related to intergenerational violence, for example, could potentially be moved to a family systems focal dimension in the future. The author of this dissertation decided to include intergenerational violence within the interpersonal and trauma-informed focal dimension given some interpersonally-focused perspectives are greatly integrated with family systems perspectives. For example, Teyber's (2006) *Interpersonal Process in*

Therapy: An Integrative Approach, integrates interpersonal and family systems perspectives. However, future directions may explore the potential benefit of separating out these focal dimensions and developing a more clearly defined family systems focal dimension with its own unique treatment hypotheses. Additionally, future directions may also aim to explore the benefit of using a family therapy format for intervening with RVM. The results of this study's content analysis did not find any sources that clearly utilized a family therapy mode of intervention. One program in the analysis called Reading Safer Families (Vetere, 2011) did describe itself as having a family systems lens. However, it was not clear what treatment formats (e.g., individual, group etc.) were used in the Reading Safter Families program and they were unclear regarding specific family systems treatment hypotheses. Most of the treatment hypotheses they discussed resembled the anger management techniques common across most BIPs (Rosenbaum & Leisring, 2001). The Reading Safer Families program did utilize what they called a stable third, a person outside the family that helps relay more accurate information to the BIP facilitators (Vetere, 2011). However, this intervention was not considered a family systems treatment hypothesis by the author of this dissertation due to two reasons. These include: (a) the stable third's purpose seemed to relate to promoting accountability, an existing treatment hypothesis, and (b) the stable third appeared to be more of an intervention aimed at the program's structure and not a psychotherapy intervention per se. Additionally, while this program provides services to all family members, it was not clear if any therapy is conducted with the family as a whole in this program. Future directions may aim to examine whether family therapy, or having a clearly defined family

systems focal dimension, could have utility in treating RVM. As with couples therapy, it is presumed that any form of family therapy would be best only after RVM have completed either individual or group therapy, and have made a commitment to staying non-violent. Again, the safety of RVM's partners and children should be prioritized when considering a treatment format (Adams, 1988; Mederos, 2002).

As discussed earlier, future directions may also aim to examine partner violence within the LGBTQIA+ community or among relationally violent women. It is presumed that the causes and treatment hypotheses regarding IPV for these groups may differ significantly from RVM. Therefore, separate unified treatment models would likely be needed for each of these groups in order to address these specific causes. As noted previously, much of women's violence is in self-defense from their partners' violence (Seamans et al., 2007). Therefore, future unified models addressing women's violence would want to take this into consideration and would likely apply treatment hypotheses geared towards working with survivors of IPV (Trabold et al., 2018). Similarly, models addressing violence within the LGBTQIA+ community would want to take into consideration the role heterosexism plays in controlling behaviors among this community (West, 2002).

Conclusion and Contributions

In conclusion, the development of interventions for men's violence have often been overlooked in the research literature regarding IPV. This dissertation sought to develop one of the first comprehensive and unified treatment models targeting men's violence. It is this author's hope that this model may be a stepping stone towards

developing more efficacious interventions for RVM. This proposed model may serve to provide a more wholistic and flexible approach to treating men's violence that has the potential to decrease recidivism and drop out. Future directions may aim to empirically examine this unified model, address challenges to adherence, and potentially expand focal dimensions and treatment hypotheses within this unified framework for treating RVM.

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APPENDIX A

A Unified Framework for Treating Relationally Violent Men

Appendix A: Unified Framework for Treating Relationally Violent Men

Focal Dimension: Thoughts

Cognitive Errors Proposition:

1) Direct quote from text: Viewing violent acts as a result of errors in thinking. (Barner & Carney, 2011, p. 238)

Cognitive Beliefs Proposition:

1) Direct quote from text: Problematic behavior may be influenced or maintained by clients' beliefs or cognitions. If the behavioral analysis suggests that the client's beliefs or thoughts play a role in maintaining the behavior, cognitive-based interventions may be useful. (Waltz, 2003, p. 96)

Treatment Hypotheses	Operational Definitions of Interventions Examples
Exploring Thoughts and Beliefs that Support Violence	• …we look at the kinds of beliefs that support our actions… I am really interested in hearing about the experiences men had – in their childhoods, their churches, their hockey and baseball teams, their schools, and their neighborhood groups that they hung around with – that led them to see the world the way they do…. We have to go even deeper. You could ask, what is your justification? We are trying to see what justifies abusive behavior in our heads and our hearts… if we unmask how they were constructed, we will see that they can be taken apart, and that something else can replace them. Once the men identify specific experiences that led to how they thing about women, then we ask, who benefits from these beliefs? … we have to establish that these belief "systems" operate for the benefit of men, at the expense of women (Pence, 2002, p. 36-37).

	• Opening up all these issues of pride, authority, money, and decision-making power in families. Any one issue you raise now could be very, very important to explore. It all links back to how those kinds of concepts and belief systems contribute to the use of violence against women (Miller 2010, p. 1017).
Cognitive Restructuring and Challenging Sexist Belief Systems	• Questioning the beliefs that support violence (Adams, 2012, p. 460). • This category includes beliefs learned about gender roles (example response: "Guys, we've talked about a number of situations with your wives and partners that lead to violence. One of the thinking themes we've identified is that 'she has no right to criticize me— ever.' Let's talk about how that belief can lead to more anger and even violence") (Lawson et al., 2012, p. 193-194). • Batterers may be taught to identify this pattern and to replace the inflammatory cognitions with more calming ones (Rosenbaum & Leisring, 2001, p. 63). • You have to challenge his belief that he gets to make her do what he wants, control what she wants, and tell her how she thinks and feels. If you don't do that first, then teaching him to talk about his feelings will just put more pressure and danger on a woman…. We want them to understand how their feelings – the ones they think cause abusive behavior – are rooted in their belief systems (Pence, 2002, p. 41).
Exploring and Clarifying Values	• Self-reevaluation (how one feels and thinks about the self in the context of the problem, value clarification); (Eckhardt et al., 2004, p. 82).
Confronting Denial, Minimization and Blame	• Men learn to confront one another's denial and victim blaming (Babcock et al., 2004, p. 1027). • We help people with defensiveness by talking to them in role, for example, we may say, "John, as a father"… Or,

	we use future questions, such as, “John, as a father, what do you want your children to learn from you about how men and women treat each other in intimate relationships?” “How do you want your children to learn to keep themselves safe in their adult intimate relationships”, and so on. Future questions enable people to talk aspirationally about the futures of their children, and then we work backwards to the present day (Vetere, 2011, p. 253-254). • That made me realize that challenging a man when he minimizes, denies, and blames is not simply having him identify how he does it. We must question why does it, what he gets out of it, and whether he could possibly change without being totally honest about what he has done (Pence, 2002, 42).
Increasing Motivation to Change	• At the process level, the goal is to enhance change talk (as opposed to sustain talk) and commitment to behavior change. Standard MI responses are used including reflective listening to client verbalizations, double-sided reflection of ambivalence about change, amplified reflection, reframing resistance language, summarizing change-relevant content, using open-end questions to evoke client concerns and goals, and affirmation of autonomy (Lawson et al., 2012, p. 195). • Establishing a safe, non-confrontational, non-judgmental therapeutic environment in which clients may feel comfortable resolving naturally occurring ambivalence and committing to the change process (Crane & Easton, 2017, p. 29). • There are five main strategies to motivational interviewing: (a) express empathy, (b) develop discrepancies, (c) avoid argumentation, (d) roll with

	resistance, and (e) support self-efficacy (Stover et al., 2009, p. 231). • A collaborative approach that respects participants' expertise and knowledge about themselves and their strengths helps to enhance their motivation to accomplish positive changes through treatment (Lee et al., 2003, p. 14). • Motivational interviewing strives to meet clients at their current state of readiness and uses nonconfrontational strategies to assist individuals in eliciting their own reasons for change. It is assumed that developing a supportive working relationship with clients will reduce defensiveness and increase willingness to explore the need for change over more confrontational approaches (Stuart et al., 2007, p. 561). • DBT includes a variety of strategies used for increasing the client's level of commitment, which would be used at this point in the therapy process. For example, the therapist may have the client explore the pros and cons of stopping abusive behavior versus continuing to be abusive. The therapist may explore any areas of the client's life that he does want to change and then link those goals to reducing abusive behavior (i.e., stopping violence in the service of having a more satisfying relationship with one's partner) (Waltz, 2003, p. 87-88). • When the therapist offers a question that describes their violent behaviour as having been "screwing up" their lives, it is clearly the behaviour that is identified as unacceptable, and not the person. This allows the client to begin seeing his violent and controlling behaviours as aspects of himself to change, as opposed to seeing them as inseparable from himself as a person. It also expresses from the therapists, a recognition of the violence as an

	unwanted characteristic of a valued person that can be addressed in therapy (Bierman & Cheston, 1996, p. 5).

Focal Dimension: Actions

Social Learning Proposition:

1) Direct quote from text: Violence is a learned behavior, nonviolence can similarly be learned according to the cognitive behavioral model. Violence continues because it is functional for the user, reducing bodily tension, achieving victim compliance, putting a temporary end to an uncomfortable situation, and giving the abuser a sense of power and control. (Babcock et al., 2004, p. 1026)

2) Direct quote from text: Battering is a learned behavior. According to social learning theory, behavior is learned in two ways, through modeling and through positive reinforcement. Men's behavior, attitudes, and expectations concerning women are most often originally influenced by how their fathers (or other male caretakers) treated their mothers. These behaviors and attitudes are additionally shaped by male peer pressure and societal messages concerning gender roles and the legitimacy of violence as a means of resolving differences. Violence can also be "positively reinforced" when it enables a person to establish control and dominance in his intimate relationships. While violence also leads to negative outcomes, such as loss of closeness, some men come to prioritize control over closeness. (Adams & Cayouette, 2002, p. 3)

Substance Abuse Proposition:

1) Direct quote from text: Likely due to the proximal psychopharmacological effects of acute substance use, reductions in alcohol and drug use resulting from substance abuse treatment involvement, even in the absence of partner violence content, have been shown to reduce the perpetration of IPV. (Crane & Easton, 2017, p. 26)

Treatment Hypotheses	Operational Definitions of Interventions Examples
De-escalation and Time-Out Strategies	• Time out: Most programs teach some variation of the time-out procedure. Batterers are encouraged to identify cues that their anger is building and remove themselves (physically) from the argument until they have calmed down sufficiently to continue the interaction. The combination of identifying cues and using time-out are the foundations of anger management (Rosenbaum & Leisring, 2001, p. 62). • Very often, family members elect to use 'time out' as a short term strategy, but again it is important to get partners' agreement, for example, as calling 'time out' and leaving an interactional space can be seen as abandonment (Vetere, 2011, p. 251).
Behavioral and Safety Contracts	• Providers reinforce behavioural contracts during each session (e.g. "no angry touching, no yelling/screaming, reduce substance use, and get out of the situation if you are under the influence or have the urge to lose control." Crane & Easton, 2017, p. 27). • Lethality assessment (Geffner & Rosenbaum, 2001, p. 6). • As part of these safety plans they must refrain from engaging in any type of abuse. They must also refrain from using drugs or alcohol 24 hours before or after sessions, they must comply with court orders, they must respect their partners' limits, and they must cease attempts to isolate their partners from others. Clients are expected to report any violations of their safety plans to the program and must accept the consequences for their actions (Rosenbaum & Leisring, 2001, p. 67). • We hold regular meetings to review the safety plan, to adjust it as necessary, and always seek feedback from our minimum of the three perspectives: our view, that of our clients, and that of the stable third. When it looks as

	though the safety plan is working, and the violence has stopped, we may then move on to help family members deal with other relationship issues. If the no-violence contract is broken, we hold a meeting to review our work with our clients and the stable third, and make decisions about how best to proceed, for example, we may work individually with people if couples and family work is deemed unsafe, or group work might be more appropriate. We do not abandon people, and always attempt to signpost them to other services if we cannot immediately help, and sometimes only a legal response is appropriate. In our experience a minimum of six meetings, either weekly or fortnightly, is needed to establish a safety plan (Vetere, 2011, p. 252). • The stable third position to help us corroborate what families are saying about the cessation of violence and to help us with safety planning. Clearly when violence is known about from the outset, the stable third can be invited to initial safety assessment meetings, and to subsequent safety review meetings, where progress is considered and treatment plans developed (Vetere, 2011, p. 249).
Role Plays and Practicing New Skills	• Role plays. Some clients may be asked to re-enact one example of abusive or controlling behavior toward their partner by doing a role play in the group. Usually, one of the group leaders plays the part of the victim… Role plays often bring out important aspects of a client's abuse not identified when he simply described his behavior. They reveal tone of voice, choice of words, facial expressions, body posture, and sequence of behavior… group members are asked to identify each element of abuse and control that they observed and to discuss its likely impact on the victim. The abuser is then asked to

	replay the incident with the goal of not repeating his abusive or controlling behavior, using non-abusive language and behavior instead (Adams & Cayouette, 2002, p. 14).
Providing Homework to Reinforce New Skills	• RVM are required to complete intersession homework to further hone new skills (Crane & Easton, 2017, p. 27). • Clients complete weekly cognitive restructuring homework exercises, monitor and record instances of aversive arousal (typically anger or annoyance) and record a brief description of the situation (Hamberger, 2002, p. 28-29).
Modeling Nonviolent Behaviors	• Model constructive male-female communication for participants. It is important that at least one female and one male therapist co-lead RWV groups. This provides an important modelling opportunity of the male and female co-leaders communicating with equality and mutual respect (Bierman & Chester, 1996, p. 1-2). • Group members view videotapes of man-woman couples dialoguing (Bierman & Chester, 1996, p. 29). • Group members observe the co-leaders communicating empathically and authentically. When group leaders guide a participant through a Shared Self-Experiencing process in the group, other group members learn how to do this in their mutual helping dyads (Bierman & Chester, 1996, p. 29). • Veteran members serve as positive role models and supporters, a role comparable to veteran members in self-help 12-step groups who serve as mentors in the sub-culture of recovery (Ronel & Claridge, 2003, p. 61).
Identifying and Teaching Nonviolent Alternative Behaviors	• Most programs also discuss alternatives to power and control strategies, for example, Geffner and Mantooth (2000) include these behaviors on an “equality wheel”

	which was adapted from the Duluth program (Rosenbaum & Leisring, 2001, p. 61). • Treatment focuses on identifying exceptions and solution behaviors, which are then amplified, supported, and reinforced through a systematic solution building process (Lee et al., 2003, p. 10). • An acceptable goal is defined as new, different behavior that is helpful and that can be done with enough regularity that participants can make reports regarding their goal work at each group session. The goal is interpersonal, that is, it must have an impact on other people (Lee et al., 2003, p. 56). • Exception questions. In the process of developing useful goals, it is helpful to ask questions that lead participants to consider alternatives to their current behavior or questions that ask them to search for times when things were better. These are called exception questions because they ask participants to look for an exception to the problem (Lee et al., 2003, p. 142).
Reinforcing Positive Behavior Changes	• We perceive compliments as a powerful way to reinforce participants' goal efforts. They validate effort and instill hope (Lee et al., 2003, p. 117). • Develop connection between participants' actions and positive outcomes (Lee et al., 2003, p. 112). • Another goal was to identify support systems that would encourage and sustain new behaviors, such as attending a batterer intervention program on release; attending church, sober bars, and aftercare groups; using community resources and programs; making new friends; and practicing violence/alcohol/drug sobriety (Donnelly et al., 2002, 9).

Exploring Consequences/ Illuminating the Costs of Aggression and Violence.	• Costs of aggression: Focusing on the many costs of aggression including, financial costs, effects on their own and partner's health, effects on children, effects on career, damage to the relationship, loss of intimacy, loss of freedom, and loss of status in the community increases the likelihood that batterers will learn that the negative consequences of using aggression outweigh any benefits. Discussing the effects on children can be particularly powerful, since many batterers witnessed violence in their own families and have negative feelings about their fathers (Rosenbaum & Leisring, 2001, p. 62).
Relaxation Training	• Programs may take a problem-solving approach to reducing stress, teaching batterers to identify specific stressors, generate possible solutions, evaluate pros and cons of each, select the most reasonable alternative, and try it out. Relaxation protocols (deep muscular relaxation, breathing exercises, mental imagery) may be used to provide the men with skills they can use to reduce tension and/or anger (Rosenbaum & Leisring, 2001, p. 63). • Progressive relaxation teaches a person to relax by alternating tensing and relaxing muscles in various parts of his or her body. By contrasting tension with a relaxed state, a person learns to identify tension in different parts of the body and to dissolve that tension quickly. … when a relaxed state can be achieved at will, it allows a client to perform more easily in stress inducing situations (Edleson, 1984, p. 239). • Mindfulness (Tollefson & Phillips, 2015, p. 785). • Mindfulness that promotes somatic awareness. Somatic awareness is defined as the ability to perceive, interpret, and act on the basis of one's own internal bodily sensations that can be a powerful tool in regulating

	emotion, maintaining health and facilitating recovery from illness and dysfunction (Tollefson & Phillips, 2015, p. 785). • A mindfulness tradition informs a number of important concepts that are part of the treatment, including the notion of being "non-judgmental." … Clients are taught to identify judgments and to notice the impact of judgmental thinking (Waltz, 2003, p. 86-87). • We teach regular, rhythmic breathing to reduce arousal… the client is guided to construct his own imagery of a "quiet place." … tension checks are scheduled to occur at naturally predictable times throughout the day (Hamberger, 2002, p. 25-26).
Parenting Skills	• Batterers may be taught how to empathize with the child, the importance of developing a positive parent-child relationship, and the value of non-physical means of child management, such as the "other time out," the use of consistent consequences and positive reinforcement (Rosenbaum & Leisring, 2001, p. 63-64).
Substance Abuse and Relapse Prevention Skills/ Intervention	• Alcohol and substance abuse: Alcohol and aggression are inextricably linked, and although as Kantor and Straus (1990) noted, alcohol is neither necessary nor sufficient for the occurrence of relationship aggression, it is a common accompaniment. Programs differ in their handling of these issues. Some require group members to be in alcohol or substance abuse treatment prior to or during batterers' treatment. Others include a module in which they discuss the relationship between alcohol and aggression, raise consciousness about the problems associated with alcohol and substance use, and provide information and referral (Rosenbaum & Leisring, 2001, p. 62). • Develop a sobriety contract and recovery plan.

	• Relapse prevention (e.g., "What are some example thoughts or behaviors that would let you know your sliding back toward the violence/abuse behavior?") (Lawson et al., 2012, p. 196).
Increasing Accountability for One's Violence	• Letter writing as we use it encompasses many different therapeutic tasks. It is used foremost as a document of accountability; this document is written in the culture circle, over time, with feedback from sponsors and community members (Almeida & Hudak, 2002, p. 18). • Men… are connected with men sponsors from their community who support nonviolence. This linking offers a network of accountability (Almeida & Hudak, 2002, p. 4). • A solution focused approach holds domestic violence offenders accountable for building solutions rather than focusing on their problems and deficits (Lee et al., 2003, p. 10). • The effectiveness of any approach that promotes personal responsibility and accountability depends on group members giving detailed reports of their continuing interactions with partners and children. It also depends on their receiving meaningful and constructive feedback about this behavior from fellow participants. Both of these things have to be actively promoted in groups, since abusive men often do not give helpful self-reports or feedback (Adams & Cayouette, 2002, p. 7). • Monitoring the use of pronouns. As explored earlier, pronouns can play a significant role in disguised claims of overriding and appropriating authority over a women's perspective. Practitioners need to watch for ambiguities in the abuser's use of pronouns and, when spotted, invite men to convert suggestions of universality into statements of personal preference. For example, when a

	man claims, ‘‘Men find it difficult to share feelings,’’ the practitioner might ask, ‘‘You find it difficult to share your feelings?’’ or when he states ‘‘We (i.e., me and my partner) need to communicate better,’’ the response could be, ‘‘Do you wish to communicate better?’’ (Adams, 2012, p. 465).

Focal Dimension: Feelings

Lack of Emotional Awareness and Regulation Proposition:

1) Direct quote from text: This third perspective conceptualizes IPV as also being related to problems in emotional functioning; the abuser has poor emotional awareness coupled with inadequate and maladaptive attempts at regulating emotional distress. (Pascual-Leone et al., 2011, p. 332)

Emotional Blocks from Past Trauma Proposition:

1) Direct quote from text: Male domestic violence is rooted in emotional wounds that have been buried and festering since childhood. As these boys have grown into men, the emotional pain, fear and shame from their childhood wounds have led them to develop societally supported personality characteristics for males, such as control and aggression, to create emotional distance from others as a form of psychological self-protection. In unconscious attempts to protect themselves from further emotional pain, and to lash out from their childhood wounds, these men develop controlling and abusive relationships with their adult partners. (Bierman & Cheston, 1996, p. 43)

Treatment Hypotheses	Operational Definitions of Interventions Examples
Promoting Awareness of Emotions	• ACT focuses on reducing experiential avoidance by developing mindful awareness of emotions and thoughts and making behavior changes in line with personal values (Zarling et al., 2015, p. 201). • Because many clients have limited feeling word vocabularies, we provide them with a "feeling word dictionary" to help them identify words that capture a wide range of feelings. The men not only learn to express feelings accurately, they learn that doing so allows their partners more fully into their lives, shows trust in themselves and their partners to handle their feelings, and invites greater mutual sharing of feelings (Hamberger, 2002, p. 35).
Anger as Secondary Emotion and Exploring Feelings Under Anger	• Feelings underlying anger–the anger funnel: Although some have argued that battering is not about anger, anger management seems to be a feature of many batterer treatment programs. The anger funnel is a metaphor for the idea that men are socialized to suppress all emotions except anger and thus anger becomes the only acceptable way to express feelings. As such, anger becomes a proxy for hurt, fear, sadness, shame, and other painful emotions. Helping batterers get in touch with the actual emotions can be therapeutic in and of itself, but can also be used to get the men to address the emotions they are feeling. For example, telling a partner that they are hurt is potentially more productive than disguising it as anger and gives the partner a chance to respond to the true feeling (Rosenbaum & Leisring, 2001, p. 62). • Anger and frustration can sometimes be a secondary response to sadness and fear. These perceptions and emotions intersect with issues of power and control, for example, it is often when a person feels at their most

	powerless that they hit out, and ironically this is when they are felt as most powerful (Vetere, 2011, p. 250). • One of the most difficult feelings for perpetrators to identify and acknowledge is shame, since it is such an immobilizing and passive emotion, striking at the core of masculinity. As it frequently seems to underlie anger, it is an important step for these men to identify it, and tolerate it in the presence of another (Brown, 2004, 52-53).
Developing Empathy	• Participants learn to empathize as helpers, and to share self-experiencing as helpees. These processes are practiced in weekly mutual helping dyads of pairs of residents, and in group sessions with the group leaders. This practicing involves the group members in helping relationships in which they function both as helpers and as helpees. As helpers they empathize while facilitating their partners' processing of emotional pain, and as helpees, they self-experience and share their feelings from their own emotional wounds (Bierman & Cheston, 1996, p. 25). • Increasing their abilities to empathize is central to these men being able to overcome some of their masculine constraints to feeling, to enhance their appreciation of the emotional pain of their victims and themselves, and to prepare them for relating to intimate partners in caring and respectful ways. They are given instructions to "tune in" so that they are not trying to figure out the other person, but are able to feel with him. They learn to resist feeling sorry for their partner, but rather they learn to step in his shoes and feel a touch of what he is going through, so that in dyad work each helpee knows his partner is there with him. They learn to really be there inside for the person, and how this is very different from

	sitting there and telling a person what to do. Their improved empathy skills are important tools that allow them new possibilities in terms of relating to others (Bierman & Cheston, 1996, p. 27).
Focusing and Self-Experiencing	• Shared Self-Experiencing is the process by which the men access and work through their own emotional blocks. It is a process, adapted from the "focusing" work of Dr. Eugene Gendlin (Gendlin, 1981), in which a person is guided to become aware of, and to explore, his sources of childhood emotional pain. The buried emotional pain is accessed by having a client clear his mind and bring his attention inside the center of his body, to attend, at a very low level of abstraction, to the bodily felt sense of a problem, filling his awareness only with physical sensations he is feeling in his stomach or chest. By bringing the client "out of his head", to a state of attending to what is being felt inside, a connection with his emotional self is accomplished. The client is then guided through a series of steps to encourage interaction of the felt sense with symbolic awareness (Bierman & Cheston, 1996, p. 26).
Working Through Unfinished Business	• We are then able to guide the client into a "self-experiencing" state in which he immerses himself in the felt sense, flashes to images of when he felt this sensation as a boy, re-experiences the trauma, and resolves some aspect of it, or completes some "unfinished business". This process begins to modify the dysfunctional emotion scheme, or block, that had kept the person stuck with personality patterns such as rage to mask his shame, power assertion or other defensiveness that had served to maintain emotional distance from others, and had also been part of his pattern of domestic violence (Bierman & Cheston, 1996, p. 26).

	• When a core issue concerns the person's childhood relationship with his parent(s), we utilize an Imaginary Parent Dialogue. To do this, the facilitator of the self-experiencing suggests that the helpee talk to the facilitator "as if" the facilitator is the person's parent. The client is thereby able to express feelings, reactions and requests to the parent that he might not have been able to express as a child, and has consequently held in for years (Bierman & Cheston, 1996, p. 102).
Exploring Escalation Cues that Precede Anger and Violence	• Helping them to identify physical, behavioral, and psychological cues earlier in the anger trajectory increases the likelihood that they can preempt the buildup and choose a more reasonable alternative. Situational cues are also presented. Batterers are taught to identify “hot topics” and to avoid replicating trouble spots (Rosenbaum & Leisring, 2001, p. 61-62). • Seeing the arousal process as a series of discreet phase that occur over time (Hamberger, 2002, p. 29). • Skills can be learned for managing arousal at each phase of escalation (Hamberger, 2002, p. 29). • Breaking the arousal process into such discreet “chunks,” arousal is no longer viewed by clients as an “all or none” process (Hamberger, 2002, p. 29). • Search for triggers for violent interaction. Under what circumstances might conflict escalate into violence, for example? Often the triggers are attachment related, such as fears of rejection or abandonment, fears of loss and jealous responses (Vetere, 2011, p. 250). • Similarly other more distal factors might contribute to a violent escalation, such as money worries, conflict with neighbors or in-laws, work related problems, oppression, and so on. All these factors need to be explored and understood in their own right, as part of how we are

	helpful to families, but here they may be the context or part of the triggering process into unhelpful arousal and problems with affect regulation and self-management (Vetere, 2011, p. 250).

Focal Dimension: Interpersonal and Trauma-Informed

Family of Origin Trauma/ Intergenerational Violence Proposition:

1) Direct quote from text: It is known that traumatic early life experiences in which parents have been abusive, cruel, and coercive in attempts to control a child are a frequent part of the personal histories of many abusive adults. (Pascual-Leone et al., 2011, p. 332)

Psychopathology/ Personality Disorder Proposition:

1) Direct quote from text: Psychoanalytic writings also offer theory that directly links a negative inner sense of self to denial, minimization, blaming, and to abusive behaviors. First, it is proposed that controlling behavior serves a similar defensive function to denial and blaming. Specifically, such behaviors prevent an intimate partner from providing negative feedback, thereby preserving the abuser's fragile and often falsely positive sense of self. (Scott & Straus, 2007, p. 854)

Attachment Proposition:

1) Direct quote from text: Research in domestic violence suggests that male batterers represent all three insecure attachment classes: avoidant, pre-occupied, and disorganized or fearful. Each form of insecure attachment has particular defense mechanisms as a method of coping with attachment anxiety. (Sonkin & Dutton, 2003, p. 114)

Communication Skills Deficits and Situational Couple's Violence Proposition:

1) Direct quote from text: Situational violence is tied to poor communication skills, problem-solving techniques, and entrenched patterns of conflict between two people. (Armenti & Babcock, 2016, p. 120)

2) Direct quote from text: Batterers may have poor communication skills and typically are not good listeners. They tend to be defensive in discussions and magnify the importance of winning the argument by tying their sense of self-worth to being right and having their way. Because they lack good communication skills and may be less articulate than their partners, they sometimes resort to violence as a conflict resolution strategy. (Rosenbaum & Leisring, 2001, p. 62-63)

Treatment Hypotheses	Operational Definitions of Interventions Examples
Working Through Transference Issues	• It is also necessary, at times, for participants to have both a female and a male therapist to whom they can express both "mother" and "father" transference issues during the therapeutic processes of RWV. Transference is a therapeutic process in which a client expresses feelings towards a therapist, which are actually feelings the client has about someone else, such as a parent figure (Bierman & Chester, 1996, p. 1-2).
Working Through Family of Origin Trauma	• Process experiences of violence in family of origin (Crockett et al., 2015, p. 495). • Process emotion related to traumatic life experiences (i.e., of parental shaming, physical/ sexual abuse, or abandonment); (Pascual-Leone et al., 2011, p. 333-334). • The objectives of RWV Therapy that follow from this perspective of domestic violence are as follows: for participants to access and re-experience painful feelings of fear and shame which are associated with their childhood traumatic experiences, for participants to process the previously buried painful emotions in a supportive therapeutic setting in which the avoided, overwhelming feelings can be accepted as tolerable aspects of themselves; for participants to access and mobilize their personal healing resources to begin meeting their unmet needs that were stifled by traumatic childhood experiences; (Bierman & Cheston, 1996, p. 23-24). • Nurturing inner child. The person is guided to get an image of his own inner child. It is then suggested that he imagine his adult self approaching his wounded inner child, and then imagine his adult self taking his inner child to a safe place, away from the place he has re-experienced his childhood pain. Once the person is

	imagining himself with his wounded child in a safe place, a dialogue is encouraged between the adult self and his wounded child which leads to the person identifying his unmet childhood needs and ways that his adult self can now begin to self-nurture himself to start meeting those unmet needs (Bierman & Cheston, 1996, p. 111-112).
Exploring Relational Patterns	• Relationship history. Within two to three sessions of a man's entry into the second stage he is asked to share his relationship history in the group… group leaders ask the person and other group members if they see any patterns to this history. Common patterns emerged from relationship histories include jealousy or possessiveness, difficulty accepting the ending of relationships, a preference for younger partners, sexual coercion, numerous relationships, frequent infidelity, and relationships revolving around alcohol or drugs. Once these patterns have been discussed, the person who has done the relationship history is asked to think about the goals he would like to establish for the remainder of his time in the program (Adams & Cayouette, 2002, p. 13-14). • A final interactional pattern of importance is the clinician's awareness of countertransference to the client as a guide and window into the client's predominate maladaptive pattern of interaction… Even though being drawn into a reenactment of a man's maladaptive interpersonal pattern is often frustrating for a clinician, it allows for an in vivo experience of how a man's interpersonal style affects others (Lawson et al., 2012, p. 197).
Exploring and Working Through Attachment Difficulties	• Bowlby explicitly saw the therapist as a surrogate mother who encouraged the client to explore the world from a

	secure base he or she creates. In the context of therapeutic work with individuals, Bowlby (1988) defined five tasks: 1. Create a safe place, or Secure Base, for client to explore thoughts, feelings and experiences regarding self and attachment figures; 2. Explore current relationships with attachment figures; 3. Explore relationship with psychotherapist as an attachment figure; 4. Explore the relationship between early childhood attachment experiences and current relationships; and 5. Find new ways of regulating attachment anxiety (i.e., emotional regulation) when the attachment behavioral system is activated (Sonkin & Dutton, 2003, p. 111).
Providing a Corrective Emotional Experience	• Providing a corrective emotional experience (example response: "I noticed you got very angry when the rest of the group didn't agree with you on the time out issue. Could you help me better understand what you're feeling and thinking right now? What's it like sharing it out loud with me?") (Lawson et al., 2012, p. 194). • In the case of psychotherapy, the clinician is the caretaking figure who likewise provides a secure base so that the client's attachment system is sufficiently deactivated and the client is free to explore and play. In therapy, however, the exploration is the inner world of feelings, thoughts, and experiences, and the play is, for example, trying on new identities and responses to stress and conflict (Sonkin & Dutton, 2003, p. 113).
Addressing Collusion	• Collusion. New men need to make an agreement not to collude and to accept being confronted when doing so. If someone is not willing to stop colluding in the class, other participants will ask him to leave and take a hard look at his unwillingness to take responsibility for his violence (Hernández, 2002, p. 21).

	• To avoid reinforcing irresponsible attitudes, facilitators need to be well prepared to be able to identify collusion and also to stop it. To know an irresponsible attitude when he sees it, a facilitator must call on abilities grounded in self-reflection and self-criticism and take responsibility for his own controlling and dominating behaviors and attitudes (Hernández, 2002, p. 27).
Building the Therapeutic Relationship and Developing Safety and Support Among Group Members	• It is essential for an effective BIP to create a safe environment that invites honest disclosure (Crockett et al., 2015, p. 490). • The men receive support in becoming actively involved in each other's change process. This is a powerful tool in dismantling some of the more rigid norms of masculinity (Almeida & Hudak, 2002, p. 14).
Promoting Collaborative and Egalitarian Relationships	• When clients were treated as equals in the therapeutic process, participants did take significantly more accountability for their violent actions by the conclusion of the treatment program (Crockett et al., 2015, p. 495). • It's the process that is important. It's important that we avoid doing in a men's group what they do at home to their wives, which is always telling them what to think and how to think. I think it's very important that we don't impose our opinions on the men. It's important the men see that though we are teachers, and people in positions of power, that doesn't require us to impose our own beliefs and ideas on another person (Miller, 2010, p. 1012).
Providing Interpersonal Feedback	• Another way that group leaders promote constructive interaction is by giving instruction and feedback about positive group participation. This is accomplished in two ways – (1) educating the group as a whole about the value and elements of giving good feedback and (2) giving specific feedback to each member about the

	quality of his feedback to others, as well as his overall participation in the group (Adams & Cayouette, 2002, p. 17).
Group Check-Ins	• Check ins. The check-in involved the facilitator's going around the room and having each man describe the positive and negative ways in which he handled anger and/or conflict during the week (Donnelly et al., 2002, p. 10-11).
Communication and Assertiveness Training	• This might involve encouraging the men to listen, ask questions, use "I" language, and paraphrase. It also may involve teaching batterers about the different elements of communication, such as tone, posture, facial expression, volume, gestures, content, and the fact that they may send mixed messages, for example, if the tone and content are discrepant (Rosenbaum & Leisring, 2001, p. 62-63). • Promoting more constructive, straightforward communications and interactions around each others' needs and vulnerabilities. This often involves supporting partners in seeking solace and comfort with each other, supporting each other practically and socially and challenging long held adverse beliefs about their own self-worth (Vetere, 2011, p. 251-252). • Assertiveness: Batterers are often saddled with traditional male attitudes that they must be strong and self-reliant. In addition to some of the negative consequences that this has for their partner, it also puts a great deal of pressure on the men, themselves. They may be unable to ask for help from their partners. They may also have difficulty admitting they are wrong, giving and receiving compliments, refusing requests by others (Rosenbaum & Leisring, 2001, p. 64-65).

	• The goals of assertive communication is not go "get what you want," but to provide the receiver with direct, honest communication of ideas within a framework of respect for the equal right of the other person to express his or her ideas, including those that differ or disagree and including when the other refuses to grant a request (Hamberger, 2002, p. 31-32). • Men learn that if they hope for someone to provide them with something, they have a responsibility to assertively ask for it rather than expect the person simply to "know" what they want. The men also learn that just as they have a right to refuse requests they deem unreasonable, others, including their partners, have a right to judge their requests as unreasonable and refuse them as well (Hamberger, 2002, p. 33-34).
Relationship Enhancement Skills	• Creating emotional intimacy, and fostering friendships, a culture of appreciation, fondness, and respect (Bradley et al., 2011, p. 103). • Establishing emotional connections in the family with partners and children; maintaining intimacy; creating shared meaning (Bradley et al., 2011, p. 103).
Conflict Resolution Skills	• Facilitate conflict management (e.g., helping couples identify and manage perpetual vs. solvable problems) (Bradley et al., 2011, p. 189). • Approaches to expressing and resolving conflict are presented which emphasize getting to the emotional issues which underlie surface conflict triggers in relationships. Starting with ways to clearly hear and empathize with what the expressing person describes as the behaviors he or she objects to, clients are guided to appreciate and to communicate the feelings associated with the conflictual behaviors. They are then guided to help their partner become aware of, and to express the

	childhood wounds which underlie the surface issue (Bierman & Cheston, 1996, p. 27-28). • Central to nonviolent conflict resolution: The ability to clearly identify and state parameters of a problem situation, to identify and express his own feelings about what is happening, to be able to identify and state his partner's point of view, to offer solutions from which he and his partner may benefit and to negotiate a final compromise (Adams, 1988, p. 188-189).

Focal Dimension: Culture

Patriarchy Proposition:

1) Direct quote: Feminist theories are rooted in the idea that abuse of women by their intimate partners is the inevitable result of a patriarchal society that directly and indirectly allows men to dominate and control their partners. In other words, a man abuses a woman because cultural norms support his belief that violence is an acceptable and effective method of solving interpersonal conflicts, because he is entitled and expected to control his wife, and because his use of violence receives no social penalty. (Scott & Straus, 2007, p. 853)

Oppression Proposition:

1) Direct quote: Therapeutic conversations begin at the sociopolitical level, where domestic violence is viewed in a larger context as but one form of social control and oppression. Other examples of such abuses of power include racism, genocide, homophobia, class entrapment, anti-Semitism, and imperialism. The major objective of this approach is to create a collective experience that changes systems as well as individuals within those systems. (Almeida & Hudak, 2002, p. 3)

Treatment Hypotheses	Operational Definitions of Interventions Examples
Consciousness Raising and Providing Psychoeducation	• Challenge perpetrators' beliefs about power, control, and dominance over their spouses (Barner & Carney, 2011, p. 237). • Use the Power and Control Wheel to illustrate how men use intimidation, male privilege, isolation, emotional and economic abuse, and violence to control women (Stover et al., 2009, p. 224). • Present RVM with the many forms of aggression and types of control and encourage them to consider the way they use these strategies in their intimate relationships. Much of this is consciousness raising, as batterers are often aware of the wrongness of hitting, but do not consider restricting activities, monitoring behavior, restricting access to money, or treating their partners as servants as abusive (Rosenbaum & Leisring, 2001, p. 61). • Helping RVM understand definitions of violence (Crockett, Keneski, Yeager, & Loving, 2015, p. 490). • Reeducation about power differentials between men and women, male privilege, and the patriarchal structure of society, with the goal of shifting beliefs and behaviors toward a more egalitarian orientation with women (Lawson et al., 2012, p. 190). • Vignettes and Control Logs: The important thing is that men start to make connections between their behaviors and their intent…Why do you think the guy in the video did what he did? Why do you think he used that behavior instead of another behavior? What did he intend when he got close to her?... this control log helps the men to decode the vignette through that personal and collective analysis (Pence, 2002, p. 19).

Exploring Culture and Cultural Values	• A culturally sensitive approach incorporates into treatment the knowledge of the male batterer's cultural context including his language, traditions, customs, values and rituals (Hancock & Siu, 2009, p. 125). • The intervention also had to be grounded in the pre-migration, migratory and acculturation experiences (Hancock & Siu, 2009, p. 125). • A major intention of the intervention was to engage the men, even though they were court ordered, in a genuine commitment to change by appealing to positive aspects of their cultural values and traditions, especially the central importance of family in their lives (Hancock & Siu, 2009, p. 125). • Group leaders ask men to discuss what their particular culture (however they want to define this) taught them about being a man and how this has influenced their expectations toward women. This exercise enables men to overcome preconceptions or misconceptions about particular cultures, and to see their own cultural background in a broader perspective. This exercise also serves to create trust among men from different ethnic and racial differences as well as underlying similarities (Adams & Cayouette, 2002, p. 21). • We need to keep our cultures to maintain a sense of identity. We, however, need to be self-critical and recognize that oppression and repression of women has to end regardless of where we are… We have to acquire enough tools to change the parts of the culture that are destructive, keep the ones that are constructive for all people in the culture, and know the difference (Hernandez, 2002, p. 28).

Expanding Conceptions of Masculinity	• Traditional norms of patriarchy can be challenged and transformed into expanded ways of being male (Almeida & Hudak, 2002, p. 11). • Sponsors model an expanded notion of masculinity that includes vulnerability, nurturing, gentleness, empathy, and an understanding of others. They also model respect for women, children, people of color, sexual minorities, and others who are different than them (Almeida & Hudak, 2002, p. 11).
Exploring Systems of Oppression to Help Men Understand Oppression of Women	• They understand their own oppression and they need to generalize it to realize that they themselves are women's oppressors (Hernández, 2002, p. 5). • Another exercise that helps abusers discuss differences in cultural perspectives is the Historical Perspective – Attitudes About Women exercise. It begins with a presentation of a brief history concerning voting and property rights for women and people of color in the United States. Following this, group members are asked to brainstorm the following: What are the effects on the woman/person of color being devalued? What are the effects on the person who is devaluing others? What effect does this thinking have on the relationship between the person being devalued and the person who is devalued? … a common result of this exercise is that men who have experienced oppression because of their racial, economic, or religious background are more able to empathize with women whom they have oppressed through their abuse and control (Adams & Cayouette, 2002, p. 21). • The facilitators stressed the connections between violence and oppression experienced and violence and oppression done to others. A second thread was that all types of oppression have something in common. This

	unit encouraged men to recognize commonalities between the oppressions associated with race, gender, income, and sexual orientation (Donnelly et al., 2002, p. 9).
Taking into Consideration Historical Context of Oppression	• Considering history of colonization (Pence, 2002, p. 10-11). • Considering history of slavery, Jim Crow laws, segregation, and mass incarceration. • Such an approach usually takes into account the oppression and internalized oppression that men of color experience in their daily lives and the difficulty they may have trusting and relating to the therapeutic encounter (Hancock & Siu, 2009, p. 125). • Required that the men address feelings of anger, frustration, and sadness associated with devaluation and dehumanization in environments outside the home, and the loss of personal and cultural identity in the immigration process (Hancock & Siu, 2009, p. 126).
Encouraging Relationally Violent Men to Become Activists and Advocates	• To become a peer educator for men in the program and in the community at large and create a new society and culture (Hernández, 2002, p. 26-27). • To replicate the program in one's own community by learning to become a class facilitator (Hernández, 2002, p. 26-27). • We also train men in public speaking in churches, radio, television, and schools and support them as they prepare to participate in annual marches against domestic violence and similar activities (Hernández, 2002, p. 26-27).
Exploring Intersectionality with Masculinity	• The connection between race/ethnicity, class, life context issues, manhood, and domestic violence (Mederos, 2002, p. 21-22).

	• In a session on the cultural expectations around black manhood, courage, and violence, we asked participants to identify negative and positive elements associated with being black and to come up with new definitions of manhood that were nonviolent (Donnelly et al., 2002, p. 11).