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# Intimate partner violence: treating abuser and abused

Alison M. Heru

**Abstract** Intimate partner violence is associated with significant psychiatric comorbidity. Treatment has focused on male perpetrators but recent studies indicate that this is of limited success in reducing male violence. This article reviews the current available treatments from three perspectives: that of the victim, the perpetrator, and the couple who wish to remain together. It also provides guidelines to assist the general psychiatrist in determining what treatment to offer patients who present with intimate partner violence. Guidelines emphasise the need for assessment of risk factors that indicate a potentially lethal relationship and the importance of the diagnosis and treatment of comorbidity, especially alcohol misuse and dependence.

The term 'wife beating' was first used in the 1856 campaign for divorce reform in the UK, and its successor, 'domestic violence' has been conceptualised to be a problem of male perpetrators and female victims. The more recent term 'intimate partner violence' is used to differentiate violence between two people who are involved in a romantic relationship from other types of domestic violence such as child abuse and elderly abuse.

Intimate partner violence is identified in multiple settings, from the general practitioner's office (Porcerelli *et al*, 2003) to in-patient psychiatric units (Heru *et al*, 2006). Patients agree that physicians should ask about such violence and believe that they can be helpful in dealing with it (Burge *et al*, 2005). Indeed, compared with 5 years ago, family physicians are asking more frequently about intimate partner violence, resulting in improved patient mental health and acceptance of treatment (Glowa *et al*, 2003). One significant hindrance to physicians asking about intimate partner violence is their lack of knowledge about the behaviour, how to refer patients and what treatments are effective. This article will increase the general psychiatrist's understanding of this type of violence and how to assess what treatment options are best for their patients.

## Gender distribution

It is important to recognise that intimate partner violence is no longer considered just as a situation

involving a male perpetrator and a female victim, although women remain more likely to be injured by partner violence than men (Whitaker *et al*, 2007). Since many community and clinical studies have found that intimate partner violence is often bidirectional, where each partner is both an aggressor and a victim, a broader definition is now considered more applicable. The US National Comorbidity Survey revealed rates of victimisation using severe physical aggression of 6.5% against women and 5.5% against men (Kessler *et al*, 2001). A meta-analysis of 82 studies including both community and clinical samples found that more women than men reported physical aggression in their relationships (Archer, 2000). In an out-patient sample of couples seeking marital therapy, 64% of wives and 61% of husbands were classified as aggressive (Langhinrichsen-Rohling & Vivian, 1994). In 272 engaged couples, 44% of women and 31% of men reported physical violence towards their partners (O'Leary *et al*, 1989). Thus, there is a range of intimate partner violence from the classic male perpetrator and female victim, to the couple who engage in mutual violence through to the less common female aggressor and male victim.

## Marital dysfunction

Without intervention, physical aggression in relationships continues. One study found that individuals who were physically aggressive before marriage remained physically aggressive 30 months after they

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had married (O'Leary *et al*, 1989). Another showed that nearly 50% of couples with severe physical aggression remained severely aggressive after 24 months (Jacobson *et al*, 1996). It seems that the more severe or chronic the physical aggression is in newly-wed couples, the more likely it is to continue (Quigley & Leonard, 1996). Verbal and physical aggression before marriage predicts physical aggression 24 months after the ceremony (Schumacher & Leonard, 2005). Another longitudinal study found that marital dysfunction was more common among aggressive than non-aggressive couples (70 *v.* 38%) especially in severely aggressive compared with moderately aggressive couples (93 *v.* 46%) (Lawrence & Bradbury, 2001).

## Associated psychopathology

In addition to marital dysfunction, intimate partner violence is associated with individual psychopathology, with rates of 54–68% for major depressive disorders and 50–75% for post-traumatic stress disorder in female victims (Nixon *et al*, 2004).

### Box 1 Safety planning

- Memorise important phone numbers of people to call in emergency
- If your children are old enough, teach them important phone numbers, including when to dial 999
- Keep information about domestic violence in a safe place, where your abuser won't find it, but where you can get it when you need to review it
- Keep change for pay phones with you at all times
- If you can, open your own bank account
- Stay in touch with friends. Get to know your neighbours. Don't cut yourself off from people, even if you feel like you want to be alone
- Rehearse your escape plan until you know it by heart
- Leave a set of car keys, extra money, change of clothes and copies of important documents with a trusted friend or relative: your own and your children's birth certificates, children's school and medical records, bank books, welfare identification, passport/green card, immigration papers, social security card, lease agreements or mortgage payment books, insurance papers, important addresses and telephone numbers

Excessive alcohol use is associated with intimate partner violence: with rates of 45% for men and 20% for women (Roizen, 1993). Female victims and female perpetrators report excessive alcohol use (Stuart *et al*, 2004). Women arrested for intimate partner violence have high rates of post-traumatic stress disorder, depression, generalised anxiety disorder, panic disorder, substance use disorders, borderline personality disorder and antisocial personality disorder (Stuart *et al*, 2006a). None of these studies comments on whether the violence causes or is a result of the psychopathology. We do know, however, that witnessing or being a victim of intimate partner violence as a child is associated with perpetrating violence as an adult (Ernst *et al*, 2006).

Regardless of the aetiology, when intimate partner violence is treated, there is a reduction in depressive symptoms (Kernic *et al*, 2003). Successful treatment of alcohol misuse and dependence with couples therapy also reduces such violence (O'Farrell *et al*, 2004). No studies have examined whether intimate partner violence is reduced as a consequence of treating comorbid psychiatric illnesses such as depressive disorders or post-traumatic stress disorder, although one study suggests that an integrated approach to the treatment of trauma and comorbid disorders may be helpful for women victims (Morrissey *et al*, 2005).

## Research into treatment options

### Victims

Studies that target victims of intimate partner violence usually have separation of the (female) victim from the (male) abuser as their goal. Simply assessing for intimate partner violence and offering a referral can interrupt the violence and its associated trauma (McFarlane *et al*, 2006). In McFarlane *et al*'s study, 360 abused women recruited from US urban public primary care clinics were compared on two interventions: a referral card and a 20 min session with a nurse following a case management protocol. After 2 years, both treatment groups reported significantly fewer threats of abuse, assaults, risks for homicide and events of work harassment. Compared with baseline, both groups adopted significantly more safety-promoting behaviours. Therefore simple disclosure of abuse in primary care clinics is associated with the same reduction in violence and increase in safety behaviours (safety planning such as that outlined in Box 1) as a 20 min case management intervention.

Brief telephone intervention with victims of intimate partner violence – six phone calls for an overall total time of 60 min over 8 weeks – increases safety-promoting behaviours (McFarlane *et al*,

2004). This study randomly assigned 150 women who sought civil protection orders to the telephone intervention or to a control group. Analysis showed that the women in the intervention group ( $n=75$ ) practised significantly ( $P<0.01$ ) more safety-promoting behaviours than women in the control group at each assessment, and results were sustained at 18 months.

Wathen & MacMillan (2003) reviewed articles that focused on treatment of female victims from a primary care perspective. They found no high-quality evidence to evaluate the effectiveness of shelter stays in reducing violence. Among women who had spent at least 1 night in a shelter, they found fair evidence that those who received a specific programme of advocacy and counselling services reported a decreased rate of re-abuse and an improved quality of life. The benefits of several other intervention strategies were found to be unclear, primarily because of a lack of adequately designed research.

More specific interventions are also effective in reducing intimate partner violence. Pregnant women attending an antenatal clinic in a public hospital in Hong Kong reported less intimate partner violence after receiving a 6-week empowerment intervention, compared with a control group receiving standard care for abused women. Six weeks after childbirth, the experimental group reported higher physical functioning, less psychological (but not sexual) abuse, minor (but not severe) physical violence and had significantly lower postnatal depression scores (Tiwari *et al*, 2005). This study, however, followed participants for 6 only weeks.

It is important to identify as broad a range of outcomes as possible when assessing the effect of an intervention. Women recruited from shelters who received a 10-week intervention using trained advocates were twice as likely to be free of violence as a control group at 2 years follow-up. However, after 3 years, the advocacy programme's effect did not continue. Nevertheless, the women who received the intervention had an improved quality of life and more social support (Bybee & Sullivan, 2005).

Another approach to treatment is to match interventions to the woman's stage of change, i.e. pre-contemplative, contemplative, preparation, action and maintenance. An in-depth study examining 23 female victims of intimate partner violence suggests that women in the early or precontemplative stage benefit most from receiving information about what constitutes abuse (Burke *et al*, 2004). Interventions tailored to the other stages of change would likewise be stage-specific and possibly more likely to be effective, although this study did not test these assumptions.

### Box 2 Effective treatments for victims

- Assess and offer a referral
- Brief telephone intervention
- Increase social support
- 6-week empowerment intervention
- Provision of information about abuse

In summary, simple interventions for female victims of domestic abuse or intimate partner violence (Box 2) are quite successful in the short-term. Even long-term effects are apparent on outcomes other than reports of violence. These studies certainly support the helpfulness of the simple action of identifying abuse. We found no studies that discussed treatment of male victims.

### Perpetrators

Treatment for perpetrators of intimate partner violence is usually in gender-specific (i.e. all male) groups, and focused on educating the perpetrators about different ways to express anger and reduce interpersonal controlling behaviour. Treatment for male perpetrators is usually court-ordered and therefore not voluntary.

A meta-analysis of 22 studies of gender-specific treatment for male perpetrators indicates that treatment effect sizes are small (Babcock *et al*, 2004). The treatments evaluated were similar in orientation, all being based on the Duluth model. According to this model, the primary cause of male domestic violence is patriarchal ideology and societal sanctioning of men's use of power and control over women. These programmes are not considered to be therapy. Rather, group facilitators lead consciousness-raising exercises to challenge the man's perceived right to control or dominate his partner. A fundamental tool of the Duluth model is the 'power and control wheel,' which illustrates that violence is part of a pattern of behaviour including intimidation, male privilege, isolation, emotional and economic abuse, rather than isolated incidents of abuse or cyclical explosions of pent-up anger or painful feelings. The treatment goals of the Duluth model are to help men change from using the behaviours on the power and control wheel, which result in authoritarian and destructive relationships, to using the behaviours on the 'equality wheel,' which form the basis for egalitarian relationships (Pence & Paymar, 1993).

The meta-analysis included only studies in which treatment results could be compared with a control group or where those who dropped out of treatment were included in the analysis. Forty-eight studies

were excluded because of weak methodological designs. For the remaining studies, there was no difference in effect size by treatment type. Of concern is the report that men-only treatment groups lead some men to support negative attitudes and aggressive behaviours towards women.

### Conjoint treatment

Owing to the popularity of the Duluth model, conjoint (couples) treatment for intimate partner violence has been considered inadvisable. Three main reasons are given, all relating to the female partner: women will be inhibited from expressing themselves fully because of fears of reprisal from their husbands; women may come to feel partly responsible for their husband's aggression; and comments made by the women in the joint session may place them at risk of further violence. However, in a study that measured rates of fear in women who participated in group conjoint treatment, no higher rates of fear of the partner or increased rates of violence during or after treatment occurred (O'Leary *et al*, 1999).

Conjoint treatment for male perpetrators has been pioneered in several states in the USA. In California, a comparison study of 49 court-referred perpetrators found that gender-specific treatment and conjoint couples treatment were equally successful in reducing intimate partner violence (Brannen & Rubin, 1996).

### A conjoint treatment model

In Virginia, a model of conjoint treatment used when the male partner has perpetrated mild-to-moderate violence and both partners want to remain together is successful (Stith *et al*, 2004). The screening process in Stith *et al*'s study excluded severe violence and substance misuse. The model consists of two steps: the men and women first attend gender-specific groups and then participate in conjoint treatment, either in individual couples therapy or in multi-couple group therapy. The stages of treatment in the multi-couple group therapy are outlined in Box 3. No escalation in violence occurred when risk assessment screening and experienced therapists were used.

Effective strategies for minimising risk include the use of a 'no violence contract' and a time-out tool (Rosen *et al*, 2003). Six months after treatment, male violence recidivism rates were significantly lower for the multi-couple group (25%) than for either the individual couple condition (43%) or the comparison group (66%). Marital aggression and the acceptance of wife battering decreased significantly among men who participated in multi-couple group therapy, but not among those who participated in individual couples therapy or the comparison group.

#### Box 3 The stages of multi-couple group therapy

- Stage 1 engages the participants in the therapy process and develops a vision of a violence-free relationship
- Stage 2 focuses on enhancing the non-violent marital relationship and couples are taught new skills in communication, negotiation and so on
- Stage 3 focuses on solidifying change, anticipating problems and determining whether further treatment is necessary
- Stage 4 is the termination stage, which focuses on affirmation of progress and change

(Stith *et al*, 2004)

### Does treatment work?

The San Diego Navy Experiment is frequently discussed as an example of the ineffectiveness of treatment for male perpetrators of intimate partner violence. In this study 861 Naval personnel who had assaulted their wives were assigned to one of three treatment conditions or to a control condition. The three treatment conditions were: a gender-specific (men's) group treatment; a conjoint (couples) group treatment; or 'rigorous monitoring', i.e. individual counselling, periodic record searches and ongoing interviews with spouses. In the control condition the only service provided was brief stabilisation and safety planning (Box 1) for the wives (Dunford, 2000). The men's group used a cognitive-behavioural model of change, and met weekly for 6 months and then monthly for 6 months for a total of 26 sessions. The didactic portion of the sessions addressed perpetrator attitudes and values regarding women and the men were taught skills such as cognitive restructuring, empathy enhancement, communication skills, anger modification and management of jealousy. The conjoint group also had 26 sessions and was organised in a similar way to the men's group, with didactic and process components. In the rigorous monitoring group, the men were seen monthly for 12 months for individual counselling, and their wives were called monthly and asked about new instances of abuse. Progress reports were sent monthly to the men's commanding officers. The men in the control group did not receive any treatment.

Dunford demonstrated significant reductions in violence across all three interventions, with no significant outcome differences between treatment formats and no difference noted compared with the control group formats. According to their wives,

**Box 4 Research results**

- Meta-analysis of 22 gender-specific treatment studies yield a small treatment effect size
- California conjoint treatment equal to gender-specific treatment
- Virginia conjoint treatment shows significant results for multi-couple groups
- San Diego Navy study indicates no difference for three treatments over control group

83% of the men did not injure them again during the 1-year follow-up.

**Summary**

Rigorous studies using control groups have shown that male perpetrators do not respond to the traditional gender-specific Duluth model (Box 4). Multi-couple group therapy has been shown to be effective in select studies involving court-referred perpetrators. Aggressors who are mandated into treatment will require programmes that are sanctioned by the court. Both male and female perpetrators of violence who seek help voluntarily are likely to be more motivated and treatment more successful.

**Treatment for couples in the community**

Few practitioners are trained in or support the use of couples therapy where intimate partner violence exists. Nevertheless, several studies have been conducted involving couples who have entered treatment voluntarily (rather than through victim protection or the legal system). These treatments are summarised in Box 5.

**Box 5 Effective treatment for couples in the community**

- Gender-specific treatment and group conjoint treatment
- Treatment of alcoholism with a sobriety contract, behavioural assignments and relapse prevention

O'Leary *et al* (1999) compared gender-specific treatment with 14-week conjoint group treatment in a community sample of 75 couples who were recruited via advertisements offering treatment for repeated acts of husband-to-wife physical aggression. Inclusion criteria were at least two acts of physical aggression in the past year. Both treatment groups followed a cognitive-behavioural programme focusing on psychoeducation, anger control techniques and communication skills. Both groups reported a reduction of physical violence at the end of the treatment and at 1 year follow-up, although only 25% of husbands remained violence free. The only difference found between groups was that husbands in conjoint treatment reported improved marital satisfaction. Thus, gender-specific treatment and group conjoint treatment had equivalent outcomes for husband-to-wife violence in the community.

Successful treatment of alcoholism can significantly reduce intimate partner violence (Stuart *et al*, 2006b). O'Farrell *et al* (2004) enrolled 303 male married alcoholics into couples treatment. Greater treatment involvement was related to greater reduction in violence. The treatment consisted of a sobriety contract (Box 6), behavioural assignments and relapse prevention. The behavioural assignments were aimed at increasing positive feelings, shared activities and constructive criticism. At the end of treatment, each couple completed a continued recovery plan to be reviewed quarterly for 2 years. The reduction in violence was mediated by reduced problem drinking and enhanced relationship functioning.

A small number of practitioners have well-established programmes for the treatment of intimate partner violence in couples, but these approaches have not been subjected to empirical study. Goldner (2004) at the Ackerman Institute for Family Therapy in New York states that 'conjoint abuse work can create a transitional space between public and private – a space in which these couples can tell these horrible stories and retell and rework them from multiple perspectives' (p. 371). The role

**Box 6 The sobriety contract**

- The patient states their intention not to drink
- The spouse expresses support for their efforts to stay abstinent and records the daily performance of the contract on a calendar.
- Both partners agree not to discuss past drinking or fears

of the therapist is to 'help clients develop a rich psychological understanding of the abuse' (p. 349) without blame or shame and without letting the perpetrators avoid responsibility for their actions. Goldner uses attachment theory and feminist theory (especially the work of Jessica Benjamin) and views the work of the family therapist as inserting a moral perspective. Goldner highlights clinical multiplicity, with abuse and coercion coexisting alongside intense love and genuine friendship, making it hard for friends and family as well as clinicians to maintain empathic objectivity for the couple. Goldner believes that the mutative factor in any therapy includes bearing witness and helping abusers accept responsibility for their actions.

Jory & Anderson (2000) practice couples therapy based on accountability and a theory of intimate justice. In this model, the therapist teaches the aggressor to be accountable for the aggression. This usually results in psychological distress, which the authors believe represents positive change in the aggressor. The victim then describes the 'anguish of abuse'. Therapists simultaneously engage both the victim and the abuser by creating two therapeutic environments, one that affirms the victim and one that challenges the abuser.

A third approach is solution-focused treatment for perpetrators of intimate partner violence. This offers a 'strengths perspective', holding individuals accountable for finding solutions, rather than focusing on the problems (Lee *et al*, 2004).

## Conclusions

Interventions for intimate partner violence range from simply asking about it and offering a referral to victims, to highly structured intensive couples treatment. The reported success of interventions is dependent on the population studied and the goal of the intervention. Most studies have involved female victims who have come to the attention of the authorities or male perpetrators mandated to treatment by the courts. In community studies, couples must be highly motivated to enter treatment for a condition that is socially stigmatised. The success of treating comorbidity such as alcoholism suggests the potential of including intimate partner violence within treatments for depressive disorders and post-traumatic stress disorders.

### *A guide for the clinician*

Several conclusions can be drawn that are of help to the clinician faced with a patient who describes intimate partner violence. The following steps can guide the clinician.

#### **Box 7 Risk factors for lethality**

- Uncontrolled continuous use of alcohol or drugs
- Fear of serious injury from their partner
- Severe violence that has resulted in the victim requiring medical attention
- Conviction for a violent crime or violation of a restraining order
- Prior use of a weapon against the partner, prior threat to kill the partner
- Stalking or other partner-focused obsession-al behaviour
- Bizarre forms of violence such as sadistic violence

- 1 Ask patients about relationship violence. They may prefer to discuss 'aggression' in their relationships, because of the stigma associated with the words violence or domestic violence and the fear that they or their partner may be reported to the police. Patients may prefer to differentiate between psychological, sexual and physical aggression. Patients are more likely to report violence on a questionnaire than during direct questioning.
- 2 If intimate partner violence is present, determine its severity and ask about fear of partner. Provide safety planning. The American Medical Woman's Association maintains a CPD programme on its website that provides a basic understanding of domestic violence (the Domestic Violence Health Care Provider Education Project at <https://secure.amwadoc.org/index.cfm?objectId=72F327C5-D567-0B25-52A723F34B87FFCD>).
- 3 Identify risk factors (Box 7) that indicate a potentially lethal relationship that would preclude couples treatment (Bogard & Mederos, 1999).
- 4 If substance misuse is present, recommend abstinence and if possible refer for treatment, for example to Alcoholics Anonymous.
- 5 Ask the couple whether they wish to stay together and want to resolve the violence. If so, conjoint treatment can be recommended. The key components to conjoint treatment are the signing of a no violence contract, the use of negotiated time-out and strategies to manage anger. A family therapist specialising in managing intimate partner violence should provide this treatment.
- 6 Treatment of psychiatric comorbidity is important and both partners should be

### Box 8 Guidelines for assessing intimate partner violence

- Ask about relationship violence. Consider use of questionnaire
- If present, determine severity and ask about fear of partner
- Identify risk factors for potentially lethal relationship
- If substance misuse present, recommend abstinence and refer for treatment
- If the couple wishes to stay together and to resolve the intimate partner violence refer for conjoint treatment with a specialised family therapist
- Assess and treat common comorbidities: depressive disorder and post-traumatic stress disorder

assessed for depressive disorder and post-traumatic stress disorder.

- 7 If the perpetrator is subject to court-ordered treatment, then the treatment programme must meet court approval. In this case, gender-specific group treatment is the most likely treatment available. Women who have been arrested for perpetration of intimate partner violence may not have access to appropriate treatment (Finn & Bettis, 2006).

Research into the aetiology and treatment of intimate partner violence is in its infancy because society has traditionally sought a legal solution to the problem, by punishing the perpetrator and rescuing the victim. As discussed above, intimate partner violence is commonly bidirectional and a legal solution will not help in such cases. Using couples therapy with couples who wish to stay together has been considered 'off limits' for many years because of fears that are often unfounded. Couples that themselves seek treatment to reduce intimate partner violence have different treatment needs compared with couples that enter treatment by court referral. Self-referred couples may be interested in improving many aspects of their relationship, are more motivated and have been able to identify a problem and seek out a solution.

The guidelines offered in this article provide steps for assessment (Box 8) and recommendations for treatment of couples that present to the clinician with intimate partner violence.

### Declaration of interest

None.

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## MCQs

### 1 Intimate partner violence:

- a is frequently bidirectional
- b is openly acknowledged by victims
- c is always assessed in healthcare settings
- d is not associated with alcohol misuse
- e usually results in incarceration.

### 2 Court-ordered treatment of male perpetrators usually takes the form of:

- a gender-specific group treatment
- b community service
- c individual psychotherapy
- d jail sentence
- e couples therapy.

### 3 Risk factors indicating a lethal relationship include:

- a stalking or sadistic behaviour
- b alcohol misuse
- c fear or history of serious injury
- d violation of previous restraining order
- e all of the above.

### 4 Randomised controlled trials of intimate partner violence treatment have found that:

- a gender-specific treatment is the most effective intervention for male perpetrators
- b assessing and offering a referral for victims is effective
- c couples therapy is always contraindicated
- d psychiatric comorbidity is not relevant
- e intimate partner violence cannot be treated.

### 5 The following are ineffective in couples therapy:

- a a no violence contract
- b anger management strategies
- c communication skills training
- d acceptance of responsibility for violence
- e encouragement of expression of anger.

### MCQ answers

1	2	3	4	5
a T	a T	a F	a F	a F
b F	b F	b F	b T	b F
c F	c F	c F	c F	c F
d F	d F	d F	d F	d F
e F	e F	e T	e F	e T

Review

## Substance abuse and intimate partner violence: treatment considerations

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### Abstract

Given the increased use of marital- and family-based treatments as part of treatment for alcoholism and other drug disorders, providers are increasingly faced with the challenge of addressing intimate partner violence among their patients and their intimate partners. Yet, effective options for clinicians who confront this issue are extremely limited. While the typical response of providers is to refer these cases to some form of batterers' treatment, three fundamental concerns make this strategy problematic: (1) most of the agencies that provide batterers' treatment only accept individuals who are legally mandated to complete their programs; (2) among programs that do accept nonmandated patients, most substance-abusing patients do not accept such referrals or drop out early in the treatment process; and (3) available evidence suggests these programs may not be effective in reducing intimate partner violence. Given these very significant concerns with the current referral approach, coupled with the high incidence of IPV among individuals entering substance abuse treatment, providers need to develop strategies for addressing IPV that can be incorporated and integrated into their base intervention packages.

### Substance abuse and intimate partner violence: treatment considerations

While historically considered a private family matter, intimate partner violence (IPV) has more recently been conceptualized as a widespread public health concern, requiring the attention of both the treatment community and criminal justice system. In fact, representative surveys of couples, which include less severe instances of aggression, such as single occurrences of pushing or slapping one's partner, suggest rates of 15% to 20% annually for any husband-to-wife violence [1,2]. Yet, these estimates are dwarfed in comparison to those observed among married or cohabiting substance-abusing patients entering substance abuse treatment. More specifically, studies conducted over the last decade have consistently revealed that

roughly 60% of substance-abusing men with intimate partners report at least one instance of IPV during the year prior to program entry. Given the increased use of family-involved assessments and interventions in substance abuse treatment programs, providers are increasingly faced with the challenge of addressing this complex clinical issue.

Unfortunately, effective treatment options for providers who must deal with this issue are limited. To date, the typical answer has been for providers to refer these cases to agencies specializing in batterers' treatment. However, there are three fundamental problems with this strategy. *First*, many batterers' treatment programs will only accept individuals who are specifically mandated by the legal

community to participate in IPV treatment. Yet, most patients in substance abuse treatment settings are not required to attend a batterers' program; in fact, a large majority of substance-abusing patients are not identified as having engaged in IPV or are only so identified after lengthy or careful assessment while receiving treatment for substance abuse. *Second*, in those instances in which batterers' programs will accept referrals of nonmandated substance-abusing patients, the vast majority of these patients typically either do not attend the batterers' intervention or drop out early in the treatment process. *Third*, and perhaps most important, results of a recent meta-analytic review indicate that batterers' intervention programs are largely ineffective in reducing partner aggression. Given these very significant problems with the current referral approach, substance abuse treatment programs need to develop strategies for addressing IPV that can be incorporated into their intervention packages.

Thus, the purpose of this article is to explore what is known about IPV, with an emphasis on the association between substance abuse and IPV. Current strategies for addressing IPV in substance abuse treatment settings will also be reviewed. Finally, recommendations for treatment directions to treat IPV among alcoholic and drug-abusing patients and their partners are provided.

### **Defining IPV**

A number of theories have been proposed to explain the factors that cause and contribute to IPV. From a feminist perspective, IPV is viewed as a matter of control and has roots in the historical traditions of male dominance in intimate relationships (e.g., marriage) [3,4]. Family violence theory views IPV as a matter of conflict, produced from the daily stresses of life that often result in conflict. These conflicts, in turn, have the potential to escalate into violence [5].

IPV encompasses a wide range of physically aggressive behaviors between partners that vary greatly along such dimensions as (a) type and severity of aggression (e.g., a push versus an injury-inducing beating), (b) frequency (e.g., a single shove versus repeated shoving over an extended time frame), and (c) emotional and physical impact (i.e., aggression that induces fear) [6]. Along these lines, Johnson [7] developed a model of IPV based on the control context within the relationship. More specifically, Johnson describes three types of IPV that appear to be conceptually and etiologically distinct. The first, *Intimate Terrorism*, is distinguished by severe male-to-female physical aggression (e.g., punching, threatening with weapons), with less severe female-to-male violence occurring during these episodes as a manner of self-defense (i.e., *Violent Resistance*). For the female partner, this severe type of violence is usually accompanied by an increased

likelihood of physical injury and increased fear of the male partner. In instances of *Intimate Terrorism*, the aggression serves the purpose of dominating and controlling the partner, which is typically displayed through a wide range of power and control tactics, including violence [8]. As noted above, the second type, *Violent Resistance*, is characterized by violence that occurs in response to a partner's violent and controlling behavior (e.g., *Intimate Terrorism*). In these cases, the resistor is violent, but not controlling. The last type, *Situational Couple Violence*, is characterized by bidirectional partner aggression (i.e., violence that may be initiated by either partner), which is mild to moderate in severity, and typically occurs as a reaction as a conflict escalates. In general, *Situational Couple Violence* is not used as a form of control and is also less likely to cause fear in or endanger the female partner. In general, *Situational Couple Violence* is likely to be akin to violence reported in the general population surveys, whereas *Intimate Terrorism* more closely resembles the violence typically found in clinical samples. The primary distinctions among these three types of violence are related to patterns of power and control.

Much of the debate about IPV is focused on *Intimate Terrorism*, despite the fact that most partners who report and enter treatment for IPV engage in violence that more closely resembles *Situational Couple Violence*. This seems to be the case for violent couples in which a partner enters substance abuse treatment; the vast majority of these couples (i.e., over 95%) report episodes of partner aggression that are similar to descriptions of common couple violence than patriarchal terrorism [9].

### **Prevalence of IPV**

Depending on the definition of violence used, as well as the context in which it is examined, estimates of physical aggression between partners may vary widely. The Department of Justice estimates that roughly 1,500 instances of homicide and manslaughter between intimate partners occur annually, with more than 1,200 of these involving women as victims [10]. In addition, approximately 250,000 emergency room visits in the U.S. each year involve a victim of IPV. Moreover, the National Crime Victim Survey [11] reports that nearly 1 million women are victims of IPV annually. Findings of numerous studies indicate one out of every eight husbands engages in some form of physical aggressive behavior, including less severe episodes of aggression (e.g., single episodes of pushing or slapping) against his intimate partner [1,2]. Interestingly, it appears that women perpetrate physical aggression in their intimate relationships at similar or slightly higher rates than men [12]; however, the consequences of male-to-female physical aggression appear to be significantly greater on the female partners [13].

However, it is worth acknowledging that there is much debate around the incidence and prevalence of men's and women's IPV. In fact, there has been much disagreement among researchers about definitions, methods used, and the results concerning the direction and impact of violence between men and women in intimate relationships [14]. More specifically, several authors [14-18] have argued that quantitative act-based measures (including the Conflict Tactics Scale; CTS) undercount men's perpetration of IPV, and thus, do not provide an accurate reflection of true levels of IPV. These researchers argue that the use of a narrow, act-based approach to defining and measuring violence is more likely to find symmetry between men and women in their reports of violence.

#### **Substance use, intoxication, and IPV: the debate**

The occurrence of violence between intimate partners is thought to be the result of multiple interacting factors (e.g., contextual, social, biological, psychological, and personality), which exert their influence at different times, under different circumstances, acting in a probabilistic fashion [19]. Of the various components that have been identified in conceptual and predictive models of IPV, alcohol use is among the most controversial and widely debated. While there is agreement that those who engage in IPV often drink and that intoxication often accompanies violence, there is considerable debate as to whether or not alcohol use simply covaries with partner violence, is inherently facilitative or a contributing cause of IPV, or is simply an "excuse" for aggression. Thus, this debate has important treatment implications. More precisely, if intoxication is causally linked to IPV, it would follow that interventions that are successful in reducing drinking could reduce the occurrence of partner violence.

#### **Treatment options for IPV among substance-abusing patients**

Unfortunately, there is a lack of agreement about the best treatments for IPV among patients entering substance abuse treatment. Comprehensive evaluations of different types of interventions for IPV are only now beginning to emerge. In the following, I describe some of the typical responses to IPV by substance abuse treatment programs, as well as less commonly used approaches, and highlight the evidence for their respective effectiveness.

##### *Treatment-As-Usual (TAU): standard substance abuse treatment*

Given the increase in prevalence of IPV among men seeking substance abuse treatment, it seems substance abuse treatment programs may represent a critical point of entry for addressing IPV. Yet, surveys of substance abuse treatment agencies reveal that referral to domestic violence intervention programs is rare [20,21]. In fact, individuals entering alcoholism treatment are typically not assessed

for IPV or, if they are, the assessments themselves are inadequate [9].

Nonetheless, if alcohol use is causally linked to IPV, standard treatment for substance abuse might be an effective intervention for IPV; results of recent studies provide support for this contention. For example, O'Farrell et al. [22] conducted a study examining IPV among alcoholic men ( $N = 301$ ) entering a typical outpatient substance abuse treatment program, in which IPV was not the focus of treatment. In the year before treatment, 56% of the alcoholic patients perpetrated violence toward their female partners, compared with a rate of 14% in a demographically matched nonalcoholic comparison sample. In the year after treatment, IPV decreased to 25% among all treated patients, but was only 15% among remitted alcoholics and 32% among relapsed patients.

While there is a paucity of research in this area with female alcoholic clients, available results are similar to those obtained with male alcoholic patients. For example, Stuart et al. [23] examined the effect of intensive alcoholism outpatient treatment on IPV perpetration and victimization among female patients. Results indicated a decrease in both the prevalence and frequency of partner violence after treatment. Moreover, women who relapsed during the 1-year posttreatment follow-up period were more likely to perpetrate IPV than those women who had not relapsed.

Interestingly, IPV does appear to decrease as a result of standard alcoholism treatment, particularly among patients who did not relapse in the posttreatment period. These findings support the notion that clients who have problems with alcohol should receive substance abuse treatment as a component of an overall intervention for IPV. However, the major drawback to this approach in addressing IPV is that the violence reductions appear to rely on alcohol abstinence. Other factors (e.g., conflict resolution skills, partner responses to patients' relapses, etc.) that may contribute to IPV are typically ignored or not addressed as part of the standard substance abuse treatment. Given the relapse rates typically reported for patients after substance abuse treatment, plus the manyfold increase in the likelihood of IPV on days of alcohol use after treatment completion, standard substance abuse treatment may best be viewed as a necessary, but not sufficient, intervention for patients seeking help for alcoholism who have also engaged in IPV.

##### *Referral to domestic violence intervention programs*

As previously noted, it could be argued that a reasonable approach would be to train substance abuse treatment programs to assess and accurately identify incoming patients who have engaged in IPV and then refer those

patients to domestic violence intervention programs. However, two critical issues make the referral strategy approach more problematic than it may appear. First, many domestic violence interventions are considered most appropriate for perpetrators of IPV mandated by the criminal justice system in which a swift and certain court response to violations is implemented [24,25]. Thus, the potential for legal ramifications serves as a powerful motivator for clients to participate in these programs. In contrast, patients entering substance abuse treatment who perpetrate IPV are rarely mandated by the criminal justice system to also participate in some form of domestic violence intervention programs as part of their overall treatment plan. A review of records across multiple community-based substance abuse treatment programs revealed that less than 2% of patients were mandated to also participate in a domestic violence intervention program. Although most domestic violence programs admit nonmandated patients, available evidence suggests that few alcohol-dependent patients accept a referral to these programs, or those that do typically drop out very early in the course of the intervention [26]. Simply stated, this very low level of engagement and participation is likely due to the fact that very few alcohol-dependent patients are coerced by the criminal justice system to participate in these batterer intervention programs. Additionally, linkages between domestic violence and substance abuse treatment programs are usually very poor, and thus, little effort is made to monitor and coordinate, effectively, the referral process.

### **IPV treatment options**

The most common model for treating IPV in community settings is referred to as Gender Specific Treatment (GST) [27]. This model was originally developed as part of the Duluth Domestic Abuse Intervention Project in Minnesota and is also known as the Duluth Model. These programs emphasize two interrelated themes about IPV: (a) it is a purposeful and systematic behavior by men to exert power and control over their partners, and (b) it results from the patriarchal structure of society. According to the Duluth Model, male partners must: (1) take full responsibility for occurrences of IPV and for stopping such abuse, (2) acknowledge and recognize their need for power and control at the familial and societal level, and (3) accept that their abusive beliefs about power and control perpetuate aggression in the home. The treatment delivery format is typically male-only groups, which are used to emphasize men's sole responsibility for episodes of IPV [28]. In general, these domestic violence intervention programs emphasize accountability and safety for the partner. Additionally, in many programs, accountability is seen as possible only when there is certainty that the criminal justice system will impose swift, consistent, and meaningful sanctions [25].

Yet, the evidence for the effectiveness of domestic violence intervention programs in reducing or eliminating IPV has been mixed. Results of a recent meta-analytic review revealed little or no effects for these programs [29], a conclusion that has been supported by other recently completed experimental studies. Gondolf [24], however, noted several limitations of these studies, and based on the results of a multisite evaluation of batterer treatment programs, he concluded these programs have moderate treatment effects. Despite the questionable effectiveness of these programs, it could be argued that it is better to provide some form of focused intervention, than to do nothing. This view assumes the intervention, even an ineffective one, would at least do no harm. However, there are serious implications to this perspective. As an example, suppose a violent male completes a domestic violence program. If the patient's partner incorrectly believes the program has been effective in treating her partner (i.e., reduced or eliminated the likelihood of IPV), she may behave differently based on this assumption (e.g., she may return home if she has left, she may engage in an emotionally-charged argument that she might otherwise have avoided). Along these lines, if there has been no attempt to address alcohol use, any of the "lessons learned" may be negated during episodes of drinking. Thus, in this case, participation in an ineffective domestic violence program or even one that is marginally effective, but has not addressed the role of alcohol use, may actually *increase* the likelihood of potential harm. Results of a study by Gondolf [30] are consistent with this contention. In that study, more than 6,000 women leaving battered women's shelters were queried as to whether they intended to return to their abusive partners or leave them. The strongest predictor of women's decisions was whether or not their partners participated in some form of domestic violence treatment. More specifically, if the male partners were involved in domestic violence treatment, 53% of the wives planned to return to them; if the male partners were not participating in domestic violence treatment, only 19% of the women planned to return.

### **Conjoint therapy**

Partner-involved therapies are among the most controversial and widely debated treatment approaches for IPV. In much of the IPV literature, marital and family therapies for IPV are typically viewed as inappropriate, ineffective, ethically questionable, and potentially dangerous [25]. The controversy is based on the following assumptions: (a) conjoint therapy models highlight participants' shared responsibility for the behavior, with the victim assuming she is at least partially responsible for her partner's violence, and thus, the abuser is able to conclude he is not fully responsible for his own aggressive behavior; and (b) conjoint counseling encourages honest and open disclosure, which could facilitate conflict in therapy sessions

that could escalate to violence outside of therapy. Consequently, most states have implemented standards and guidelines that discourage the use of or prohibit funding to programs that offer couples or family therapy as an intervention for IPV [31,32].

Alternatively, some researchers have recognized the potential advantages that partner-involved treatments may have for couples who engage in IPV [33]. First, a more comprehensive evaluation of the level and severity of IPV can be obtained because both partners are providing information on situations in which reports and descriptions of IPV are often discrepant [1]. Conjoint therapy also provides a safer environment for partners to discuss high conflict and emotionally-charged topics; these discussions can also be delayed until the partners meet with the therapist, which can help them avoid such topics at home until they have the skills necessary to discuss such issues constructively. Based on previous research that partner aggression most often occurs in the context of arguments between partners [34] and is often mutual and bidirectional [35], addressing the interactional nature of the partner aggression may reduce its frequency by altering the interaction patterns that precede it. Since relationship distress is a powerful predictor of partner aggression [36], improvements in a couple's functioning (a primary goal of conjoint treatment) should reduce the likelihood of IPV.

Interestingly, in the three studies that compared gender-specific group therapy approaches to conjoint treatment with partner-aggressive men and their partners, both types of treatment led to IPV reductions, but no group differences in levels of IPV were found [37-39]. Couples participating in these studies were interested in remaining together and were willing to engage in conjoint therapy; as such, these dyads may be dissimilar from couples in which partners are entering domestic violence programs. However, it's worth noting that these couples may not be so different in important respects from couples in which a partner is entering substance abuse treatment.

#### **Behavioral Couples Therapy (BCT) for alcoholism and substance abuse: effects on IPV**

A couples-based treatment for substance abuse that has extensive empirical support for its clinical and cost effectiveness is BCT [40]. BCT is a partner-involved treatment for substance abuse which teaches skills that promote partner support for abstinence and emphasizes the resolution of common relationship problems. For a review, see Klostermann, Fals-Stewart, et al., 2005 [41].

In regard to IPV, nonsubstance-abusing partners are taught coping skills to increase safety when faced with a situation where the likelihood of IPV is heightened. More

specifically, behaviors that reduce the likelihood of aggression when a partner is intoxicated (e.g., leaving the situation, avoiding conflictual and emotionally-laden discussion topics with an intoxicated partner) are emphasized. Thus, BCT is designed to reduce partner violence in these couples even when relapse occurs. In contrast to traditional individual treatment for substance abuse, BCT does not rely exclusively on abstinence as the mechanism of action for nonviolence.

A number of studies have examined the effects of BCT on IPV prevalence and frequency of IPV among substance-abusing men and their nonsubstance-abusing female partners. In these investigations, the type of violence reported by couples typically resembled Situational Couple Violence. O'Farrell, Murphy, Stephan, Fals-Stewart, and Murphy [42] replicated, with a large heterogeneous intent-to-treat sample, initial study findings of dramatically reduced male partner physical violence associated with abstinence after BCT [43]. In this study, IPV was examined pre and post BCT for 303 married or cohabiting male alcoholic patients; the study also included a demographically matched non-alcoholic comparison sample. Findings showed in the year prior to BCT, 60% of alcoholic patients had been violent toward their female partners, which was five times the comparison sample rate of 12%. In turn, in the year after BCT, violence decreased to 24% in the BCT group, but remained higher than the comparison group. Among remitted alcoholics after BCT, the rates of violence were reduced to 12%, identical to the comparison sample and less than half the rate among relapsed patients (30%). Results at the 24-month post BCT point revealed similar findings. Interestingly, Chase and colleagues [44] reported similar findings with a sample of married or cohabiting alcoholic women and their nonsubstance-abusing male partners who engaged in BCT.

Fals-Stewart, Kashdan, O'Farrell, and Birchler [45] examined changes in IPV among 80 married or cohabiting drug-abusing patients and their nonsubstance-abusing female partners randomly assigned to receive either BCT or individual treatment. While almost half of the couples in each condition reported male-to-female IPV during the year before treatment, the number reporting violence in the year after treatment was significantly lower for the BCT group (17%) compared to the individual treatment for the male partner only group (42%). Mediation analyses indicated BCT led to greater reductions in IPV because participation in BCT reduced drug use, drinking, and relationship problems to a greater extent than individual treatment.

Importantly, BCT is designed to reduce partner violence in these couples even when relapse occurs. In contrast to tra-

ditional individual treatment for substance abuse, BCT does not rely exclusively on abstinence as the primary mechanism of action for nonviolence.

Fals-Stewart [46] randomly assigned couples with an alcoholic male partner and recent history of IPV to one of three treatment conditions: (a) BCT, (b) individual-based alcoholism treatment for the male partner only, and (c) a psychoeducational attention control treatment for couples. During the year after treatment, the likelihoods of IPV on days of substance use for couples in the three conditions were compared. All of the treatments were equally effective in reducing male-to-female physical aggression on days in which the male partner did not drink. However, on days of male partner drinking, the likelihood of male-to-female physical aggression was significantly reduced (i.e., 51% lower on average) for couples who received BCT compared to the couples in the other conditions.

While these results are indeed impressive, there are two primary limitations of these investigations that make drawing more definitive conclusions difficult. First, the Chase et al. [44] and O'Farrell et al. [42] investigations were essentially pre-post designs (with the concomitant threats to validity) and used act-based measures. Second, the Fals-Stewart et al. [45] investigation did not recruit couples who engaged in IPV; these results were culled from a larger study of BCT for drug abuse that happened to include a proportion of couples who reported IPV in the year prior to study entry. Thus, the sizeable clinical effects observed for BCT, in terms of levels of IPV, coupled with the study design limitations noted, reveal the need for further study in this area.

### Conclusion

Given the increased attention to IPV and the public's growing demand for action on the part of the legal and treatment communities to address this problem, it is unfortunate that results of studies examining the effectiveness of interventions for IPV have been mixed. While some studies indicate that batterer treatment programs are moderately effective [24], the findings of a recently completed meta-analytic review reveals little or no effects for these programs [29], a conclusion that is consistent with several recently completed experimental studies [47]. These findings raise important questions about the usual response to IPV by clinicians and members of the criminal justice system of mandating perpetrators to traditional domestic violence treatment. While it appears that treating alcohol use is an effective approach to reducing IPV, this is not a common strategy. In fact, there is limited clinical research describing approaches for addressing IPV and alcohol use, and the few approaches that have been recommended lack empirical support [48].

Despite the controversy surrounding conjoint treatments for IPV, carefully conceptualized and delivered couples treatment appears to be at least as effective as traditional treatment for IPV [49]. A conjoint treatment for alcoholism that has received extensive empirical support for its effectiveness is BCT. A series of studies have demonstrated the effects of BCT on reducing the prevalence and frequency of IPV among substance-abusing men and their nonsubstance-abusing female partners who have experienced low levels of violence [43,45,46]. Future investigations might assess the effectiveness of BCT in reducing alcohol use, relationship distress, and levels of IPV among a sample of men specifically identified as having substance abuse problems and who've perpetrated low levels of violence in their relationship. If BCT is not only effective at reducing alcohol use and relationship distress, but also levels of IPV, it would result in a research-supported integrated treatment manual that could easily be disseminated to community providers.

Given the mixed empirical support of current treatments, coupled with our ideas on improving existing treatments, it is now our responsibility to apply what we know about this complex problem to improve and develop new treatments [50]. The consequences of treatment failure are very salient in IPV research. Although well-intentioned, it is important to recognize that doing what we have been doing in most substance abuse treatment programs (e.g., standard substance abuse treatment without attention to IPV, referral to domestic violence programs with very high dropout rates and mixed IPV outcomes) is also potentially placing patients and their families at risk. Future studies may wish to further develop or examine new integrated IPV and substance abuse treatment models, including conjoint approaches. The evidence from studies of at least one conjoint therapy (BCT), where an IPV focus is combined with an abstinence focus, suggests there are some conditions where conjoint therapies can be a substantial improvement over conventional choices. Given the current direction of the field toward a "coordinated community response," substance abuse treatment programs may also wish to develop a strategic plan to address IPV, in terms of strengthening referral linkages to other providers or developing requisite expertise among program staff to treat partner violence. Finally, given the debate of sexual symmetry in IPV rates, we need a better understanding of IPV by female partners in their relationships, how much of it is defensive responding, how much of it is unidirectional versus interactional, and what is the best way to measure this phenomenon. Thus, there is a need for research focused on understanding and synthesizing the factors that have been identified as contributing to IPV and alcohol use and on treatments designed to address these contributing factors [48].

## Competing interests

The author declares that he has no competing interests.

## Authors' contributions

The author declares that he is the sole author of the article.

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