Cognitive, Affective, and Relational Factors in Intimate Partner Violence Etiology and Intervention: Evidence vs. Ideology

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Abstract

In response to the high rates of intimate partner violence (IPV) prevalence and the serious physical and psychological consequences experienced by IPV victims, researchers have investigated perpetrator risk factors that may predict IPV onset and identify targets for IPV-focused interventions. Etiological models and intervention programs for abusive men assume that cognitive distortions play an important etiological role in IPV. However, evidence suggests that the ability of cognitive factors to discriminate between abusive and nonabusive individuals varies widely according to type of cognitive construct (e.g., implicit vs explicit cognitive processes) and the method of assessment approach used (e.g., endorsement vs production). In addition, influential ideologies of IPV etiology and intervention emphasizing gender-themed mechanisms have downplayed the role played by negative affect and couple communication factors in IPV perpetration. However, evidence suggests that these factors are actually substantive predictors of IPV onset and predictive of IPV intervention outcomes. In this presentation, I will review laboratory and clinical evidence evaluating the empirical status of the cognitive, affective, and relational factors that (a) differentiate abusive from nonabusive individuals, (b) are functionally related to IPV perpetration, and (c) are empirically valid targets of clinical intervention efforts. Disparities between this evidence and the prevailing ideologies in the field will be addressed.

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Expanded Outline

I. Intimate Partner Violence – <Overview>

The epidemiologic data clearly indicate the need to develop clear and testable models of IPV etiology and maintenance, and to translate these findings into applications that may directly address IPV risk factors and prevent future IPV victimization.

In the current paper, I will review three broad risk factors of relevance to etiology and intervention:

- Cognitive Processing
- Affect Regulation
- Couple Communication

I will review the status of each risk factor in terms of its role in etiologic models and treatment modalities in two ways. First, I will consider the status of the construct "in the field", i.e., how advocates, clinicians, and others on the front lines of direct service for IPV victims and perpetrators view the construct. Such individuals hold enormous power in terms of setting policy and practice guidelines at the local and national level, and also hold great sway over the way in which the public thinks about the causes of IPV. Second, I will consider the empirical status of each risk factor according to research from my own and others' research. As will be seen, there is a great divide between the empirical and the popular status of these risk factors as they relate to IPV etiology and intervention.

II. Risk for IPV – Cognition, Affect, and Communication

A. Cognitive Factors

Assumptions. The dominant perspective which currently guides policy and intervention guidelines regarding IPV is based on early profeminist theories of domestic violence (e.g., Dobash & Dobash, 1979), which posit that Western society is built upon patriarchy, defined as "a system of social organization that creates and maintains male domination over women" (Sugarman & Frankel, 1996; p. 14). Males are therefore socialized to hold attitudes that justify or support the patriarchal system. These attitudes and resulting behaviors, when combined with patriarchal practices in the legal system, religious institutions, and other social systems, result in the collective maintenance of male domination over women across social domains, including close relationships, marriage, and domestic life. Thus, this perspective sees abuse-related attitudes as being the result of long-term exposure to a patriarchal society/community, rather than as psychological processes per se, that have instilled a deeply held belief in male privilege and superiority that covertly and overtly sanction any means necessary to maintain this unequal power arrangement, including the use of coercion and aggressive force: "Men who batter not as abnormal members of society, but as men carrying out a role defined

for them by our own culture" (Pence, 1983; p. 252). Mental health providers and proponents of psychological and/or interactional models of IPV, in turn, have been criticized by feminist scholars and victims' advocates for ways in which their theories and interventions disempower women and blame victims for their experiences of abuse (Adams, 1988; Bograd, 1984; Gondolf, 2007).

An alternate starting point for establishing cognitive variables as risk factors for IPV emerged from the application of social learning theory to interpersonal violence, which focuses on process-level interactions of the individual with the broader social and interpersonal context (Bandura, 1973). The social learning approach predicts that aggressive behaviors are acquired through basic principles of learning (i.e., classical conditioning, operant conditioning, observational learning), and as a result of these direct and vicarious learning experiences, violent individuals' processing of social information is systematically biased toward negative assumptions of others' behavior and positive associations regarding the acceptability and value of aggressive behaviors (Dodge, 1991). Long-standing cognitive distortions further degrade the individual's ability to self-regulate their emotional responses to interpersonal conflict and impair the development of secure attachments with romantic partners (Dutton, Saunders, Starzomski, & Bartholomew, 1994). Together these deficits result in a deficient set of basic relationship skills that favor the use of controlling and abusive behaviors, including belligerent and coercive communication patterns (Jacobson et al., 1994). Thus, a central difference between the social learning and feminist accounts of how cognitive variables relate to IPV is that the social learning model addresses both cognitive content and cognitive processes presumed to be related to IPV, whereas the feminist account focuses almost entirely on biased cognitive content.

<insert intervention assumptions here>

… The Cognitive Behavioral Therapy (CBT) model emphasizes a social learning-based and optimistic hypothesis that even deeply ingrained attitudes and assumptions about the self and relationship partners can be altered in ways that are goal-promoting and therapeutic. With partner violent individuals, the cognitive focus is on challenging attitudes and beliefs that promote and maintain abusive behavior, such as negatively biased attributions of blame regarding partner behaviors and positive endorsement of aggression as a means of coping with relationship conflict. The client is involved in shaping the overall goals of treatment and in setting the priorities for each treatment session. The CBT counselor works with the client in reviewing self-monitoring situations, assessing thoughts and behaviors that occurred in conflict situations, and disputing and modifying dysfunctional patterns of cognition and action.

Evidence. While the feminist model and the intervention systems that it is has spawned (e.g., the Duluth Model; Pence & Paymar, 1993; Kivel, 1998) represent important starting points, the model's conceptualization of gender-focused cognitive/attitudinal disturbances as they relate to IPV is incomplete for a number of reasons. First, there is little evidence to support the notion that patriarchal attitudes and

power-related beliefs represent *specific proximal contributors* to the enactment of IPV (Malik & Lindahl, 1998; Sugarman & Frankel, 1996). Second, partner abuse is quite prevalent in lesbian and gay male relationships, a fact that is difficult to explain if abuse is a purely gender-based system of oppression (Burke & Follingstad, 1999). Third, recent literature reviews indicate that men in treatment for domestic abuse are not more likely than nonabusive men to endorse sexist beliefs in male privilege or regarding women's roles and rights, as indicated by over a dozen case control studies (Dutton & Corvo, 2006; Eckhardt & Dye, 2000; Sugarman & Frankel, 1996). Unfortunately, such beliefs are characteristic of a great many men across many societies; however, they do not appear to be unique or specific risk factors for IPV perpetration. Finally, the feminist model says little about the cognitive processes that lead to violence. While much attention is focused on specific types of attitudinal content that is indeed correlated with IPV (e.g., positive attitudes towards violence, needs for power), the model does not adequately specify the operations presumed to underlie a purely gendered analysis of IPV; in other words, while the model tells us <u>what</u> abusers are likely to think and provides a post hoc rationale for <u>why</u> they may think this way, it says little about <u>how</u> these thoughts come into consciousness and <u>how</u> they immediate cognitive activity may serve as predictors of acute episodes of IPV.

Over the last 20 years, researchers have refined the social learning approach in terms of understanding and assessing cognitive mechanisms that may be involved in IPV, again with an eye towards a broader understanding of both cognitive content and process that may translate into intervention advancements. Holtzworth-Munroe (1992) outlined a model of social skill deficits that outlines a sequence of social information processing stages that can result in marital aggression. During the first stage, *Decoding*, social stimuli are attended to, encoded, and interpreted. However, various cognitive deficits, including unrealistic expectations, faulty attributions, and irrational beliefs could result in the misconstrual of social stimuli," (Holtzworth-Munroe, 1992; p. 607). Thus, specific information processing distortions, such as Ellis' (1994) irrational beliefs, may distort the significance of incoming stimuli or result in other cognitive products, such as faulty attributions, that may otherwise disrupt accurate, goal-congruent processing of social stimuli. During the second *Decision Making* stage, the individual is confronted with the task of strategically constructing a number of potential responses to manage the demands of the specific situation. After the most appropriate response is selected, the individual decides if there is sufficient skill to enact that response as well as the response's likely positive and negative consequences. Finally, the third stage describes response *Enactment*, during which the selected response is put into action and its impact monitored.

Ample evidence supports this model. Briefly, relative to nonviolent males, IPV perpetrators exhibit (a) decoding, interpretation, and hostile attribution biases on questionnaire measures (Fincham et al., 1997) and during imagined conflict scenarios (Eckhardt, Barbour, & Davison, 1998; Eckhardt & Jamison, 2002; Holtzworth-Munroe & Hutchinson, 1993); (b) less competent decision making (i.e., greater generation of aggressive response options) on questionnaires (Field, Caetano, & Nelson, 2004; Sugarman & Frankel, 1996) and during conflict simulations (Anglin & Holtzworth-

Munroe, 1997; Barbour, Eckhardt, Davison, & Kassinove, 1998; Jacobson et al., 1994) ; and (c) positive evaluations of violence in close relationships (Kaufman-Kantor & Straus, 1990). A number of more detailed review papers that catalog the attitudes and cognitions that differentiate abusive from nonabusive individuals are available (Eckhardt & Dye, 2000; Holtzworth-Munroe, 2000; Murphy & Eckhardt, 2005; Stith, 2004).

<discuss some of these articles in more detail here>

Thus, the social learning and social information processing approaches make the prediction that IPV perpetrators will exhibit distortions in cognitive processing and biased cognitive content relative to nonabusive males. For the most part, the data support this assumption. However, there is relatively little direct evidence to suggest that cognitive distortions are functionally related to the onset of IPV. This remains a critical gap in this literature that is must be addressed in future research on cognitive factors and IPV.

Is there evidence that changing cognitions in partner violence interventions specifically predicts nonviolent outcomes? Surprisingly, the answer is no. To date, there is no published research that clearly demonstrates that cognitive change among IPV perpetrators during the course of an intervention independently predicts either nonviolent change or some other clinically meaningful outcome. That is a disappointing state of affairs. Given that practically all commonly implemented IPV intervention programs consider themselves CBT in orientation, it is alarming that we have no direct evidence that having clients make cognitive changes directly impacts abusive behavior separate from the influence of other components of the intervention or other factors associated with the sample. The available research on this topic involves single-sample pre-post designs, wherein a sample of men are given a paper-and-pencil measure of cognitive distortions early in the program and then at the end of the program. Many studies simply report whether men who successfully complete the program reported improvements in their attitudes and beliefs concerning women, relationships, and related factors (they do!) (e.g., Craig et al., 2006; Schmidt et al., 2007). In other reports, recidivists are compared

to nonrecidivists (or completers compared to dropouts) and the findings typically indicate that men who complete the program and remain nonviolent show fewer cognitive distortions than those who drop out of the program and/or reoffend against a partner (Gondolf, 2000; Tutty, Bidgood, Rothery, & Bidgood, 2001). Of course there are many problems with these studies, in that the single-sample/no control group design makes it impossible to rule out other extra-treatment reasons for cognitive change over the course of the intervention, and the lack of demonstration that cognitive change, rather than a myriad of other variables, actually mediated the relationship between the intervention and the outcome. Such a finding is best obtained when using suitable comparison groups (to address sample/selection effects), more careful assessment of cognition as it relates to program components, and specific mediation analyses which directly test the effects of a given intervention component relative to other factors on the outcomes of interest. Thus, while it would seem logical to target faulty attitudes and beliefs in interventions for abuse perpetrators, the jury is still out as to whether such changes indeed influence IPV-related

outcomes.

B. Regulation of Negative Emotions

Assumptions. While decades of theoretical (Ellis, 1962) and empirical (Haaga, 1991) work support the general proposition that cognitive disturbances intensify the experience of negative emotions and disrupt how these emotions are expressed interpersonally, much controversy exists within elements of the IPV field concerning the relevance of emotional variables in explaining and treating IPV. Indeed, while giving a recent talk to a group of battered women's advocates and intervention program workers about risk factors for male-to-female IPV, I was met with a chorus of boo's and rather nasty comments from the audience the moment I concluded that the data supported emotional problems and psychopathology as important risk factors for IPV. Why the negative reaction? Generally, there appears to be a general concern among many battered women's advocates and program staff that invoking internal constructs such as psychopathology or emotional problems will lead to a "medical model" approach to IPV that may lead to a focus away from what traditionally have been viewed as the root causes of violence (e.g., community supports which overtly or covertly condone abusive behavior and men's lack of accountability and responsibility). While it would indeed be counterproductive to see the causes of IPV as resting solely with the psychological disturbances of the male perpetrator, it seems similarly unproductive to blithely dismiss such factors when ample empirical evidence exists to substantiate these variables as legitimate risk factors.

In the context of IPV, the negative emotion that has garnered the most attention (favorable and not) is anger. The role of anger arousal in intimate partner violence (IPV) seems obvious, for it is often assumed that anger and aggression are "inextricably, biologically linked," (Tavris, 1989, p. 24), and one can easily imagine a scenario wherein an abusive male becomes intensely angry and assaults his female partner. There are few areas more controversial within areas of domestic violence research and advocacy areas than the issue of negative emotions, especially anger, and IPV. For example, Gondolf (2002; Gondolf & Russell, 1986) has steadfastly maintained that focusing on anger as a cause of IPV or as a legitimate target for batterer intervention programs at best misses the 'actual' causes of IPV, and at worst puts women at risk for future acts of aggression. Echoing these concerns, a number of state domestic violence coalitions have issues standards that explicitly outlaw anger control treatments or else strongly discourage their use (e.g., Austin & Dankwort, 1999).

Accordingly, there is very little enthusiasm within the IPV field in applying emotion regulation techniques for interventions directed towards IPV perpetrators. Part of this resistance reflects concerns about the extension of a 'medical model' approach into intervention programs and what this may imply about etiology. That is, if anger control interventions for work for IPV perpetrators, then this might suggest that anger-related factors may indeed be involved in the etiology of IPV; as noted above, such a conclusion is not exactly a popular one among a large sector of the grass-roots advocacy community. Echoing these suspicions, Gondolf (Gondolf, 2002; Gondolf & Russell, 1986) suggested

that ‘anger management’ interventions: 1) imply that the victim is to blame; 2) do not account for abuse meant to exert power and control; 3) perpetuate the batterer’s denial; 4) may put the female partner at further risk for violence; 5) give communities a reason to shun collective responsibility for IPV; and 6) give perpetrators new tools to coerce and control women. These sentiments are reflected by many advocates for battered women and state domestic violence coalitions (see Healey et al., 1998), who have lobbied effectively against the use of anger control treatments for men mandated to attend batterer intervention programs (BIPs). However, as noted by Maiuro, Hager, Lin, and Olson (2001), state standards governing BIP content typically lack any empirically justification, calling into question the basis for the ban on anger control interventions. Indeed, there is little cause for confidence at this point concerning what interventions should and should not be attempted with partner violent males, given the results of recent literature reviews showing high rates of attrition (Daly & Pelowski, 2000) and small preventive effects on future IPV (Babcock et al., 2004) among traditional batterer intervention programs.

The net result of these assumptions has not only been a resistance toward anger-based interventions, but a steadfast dismissal of anger as a potential risk factor for IPV. Ultimately, however, all of these concerns must be answered empirically rather than ideologically. So, is there a relationship between anger arousal and IPV?

Theory and Evidence.

The answer is yes, although the relationship is moderate in strength. From an empirical standpoint, recent quantitative reviews (Norlander & Eckhardt, 2005; Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001) have indicated that disturbances in anger experience and expression distinguish between partner violent and nonviolent men (effect size: $d = +.50$). Studies using self-report questionnaires consistently indicate that partner violent males show elevated trait anger, hostility, increased tendency to express anger outwardly, and decreased anger control (Eckhardt, Barbour, & Stuart, 1997; Norlander & Eckhardt, 2005). In addition, anger problems are directly related to more severe and frequent perpetration of IPV (Holtzworth et al., 2000). In observational research examining sequential patterns of couple interaction, violent couples demonstrate increased usage of ‘destructive’ forms of anger, involving expressions of contempt, disgust, and belligerence (e.g., Jacobson et al., 1994). Prior research on anger in subtypes of partner violent men suggests that some, although not all, partner abusive men exhibit symptoms of excessive and dysregulated anger (e.g., Chase, O'Leary, & Heyman, 2001; Dutton, 1988; Hershorn & Rosenbaum, 1991; Saunders, 1992; Holtzworth-Munroe & Stuart, 1994; Waltz, Babcock, Jacobson & Gottman, 2000). Most notably, Holtzworth-Munroe and colleagues (2000) found that the two most severe subtypes of partner violent men (labeled Generally Violent / Antisocial and Borderline / Emotionally Dysregulated) had significantly higher anger levels than less severe subtypes. Other research suggests that anger interacts with alcohol intoxication to increase the likelihood of IPV during relationship conflicts (Eckhardt, 2007). Finally, recent findings using forensic samples of IPV perpetrators suggest that approximately 20-25% of partner abusive men judicially mandated to attend batterer intervention programs have clinically significant problems with anger experience and expression (Eckhardt, Samper, & Murphy, 2008), and that

abusers with problematic anger are less likely to complete such programs and more likely to reassault female partners (Murphy, Taft, & Eckhardt, 2007).

But there are inconsistencies as well. Several studies using self-report questionnaires of anger and hostility have not found differences between partner violent and nonviolent males (see Norlander & Eckhardt, 2005). In addition, researchers using observational methods have typically found that direct statements of anger (e.g., "I'm really mad at you") do not reliably differentiate violent from nonviolent couples (Barbour et al., 1998; Gottman et al., 1995). Thus, while the accumulated data indicate that IPV perpetrators show dysfunctional levels of trait anger and anger control relative to nonviolent males, even after controlling for relationship distress, and that anger problems portend risk for treatment attrition and criminal recidivism, it is unlikely that partner violent males can be differentiated from their nonviolent counterparts *solely* on the basis of anger problems; indeed, batterers constitute a heterogeneous group of individuals (e.g., Holtzworth-Munroe & Stuart, 1994) who act abusively as a function of a diverse array of causes and situations (e.g., Babcock et al., 2004). Thus, rather than assuming that anger is 'always' or 'never' involved in IPV, it is more important to consider <u>whether</u> and <u>for whom</u> specific patterns of anger problems may be factors deserving of clinical attention (Murphy et al., 2007). From this perspective, the conclusions are straightforward: (1) anger problems differentiate abusive from nonabusive males and are linearly related to IPV severity; (2) a sizeable proportion of IPV perpetrators in the criminal justice system (approximately 1/3) present with severe anger problems, and (3) that perpetrators with anger problems present with a variety of clinical disturbances that will complicate the intervention process (Eckhardt et al., 2008; Murphy et al., 2007; Norlander & Eckhardt, 2005). These conclusions point to the relevance of a CBT approach in intervention programming for partner abusive males.

Is there evidence that changing negative emotions such as anger in partner violence interventions specifically predicts nonviolent outcomes? No. Overall, there have been relatively few controlled studies of CBT interventions for partner abuse perpetrators (for a review and commentary, see Wathen & MacMillan, 2004), and NO published research exists concerning whether anger/emotion focused techniques <u>specifically</u> reduce IPV risk. Again, this state of affairs is surprising and disappointing, especially in the context of the often vehement pronouncements against the usage of anger-focused interventions for IPV perpetrators (Adams, 1988; Gondolf, 2002), for one would assume that such negative evaluations would be based on actual evidence that would support such a position. Important research needs to be conducted to investigate whether interventions that have an emotion regulation component are more effective relative to standard interventions without such a component. In addition work needs to be done to examine whether there is a client-treatment matching effect with anger-focused interventions; perhaps CBT interventions with an anger focus become the intervention of choice for perpetrators with emotion regulation difficulties (Eckhardt et al., 2008; Murphy et al., 2007).

C. Interpersonal Skills: Assumptions

One of the hallmark assumptions of feminist informed models of CBT is that relationship disturbances of relevance to IPV are largely related to the male's malevolent use of relationship power and control tactics. As noted in a previous section, the central theme of these models is that the patriarchal society in which we live provides an enormously influential and reinforcing context for men to use power and control tactics to subjugate their female partners and promote male privilege. Thus, popular models of IPV suggest that aggressive manifestations of abuse are but one example of power and control tactics, as men may also utilize psychological/emotional abuse, economic coercion, and restriction of social contacts to intimidate, isolate, and control the partner. With this idea in mind, popular models of IPV tend to reject the notion that IPV can be the result of long-standing interactional problems and communication difficulties.

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Theory and Evidence. Research has not been consistently supportive of the specific links between relationship power and IPV (Malik & Lindahl, 1998). For example, Babcock et al. (1993) found no relationships between power bases (i.e., education, income, SES) and IPV, and only a modest relation among power-related outcomes (i.e., control over decision making) and IPV. However, violent husbands reported greater pursuit and demand tactics during conflict discussions while wives reported withdrawing or shutting down. This husband demand/wife withdraw communication pattern was also reported by Holtzworth-Munroe, Smutzler, and Stuart (1998). Thus, it may be the case that while the power-and-control model provides an important distal context from which to explore violence toward women, the motivations underlying partner violent acts are usually complex and multidetermined, rather than simple or straightforward expressions of dominance and control.

Prior reviews of risk factors for IPV have concluded that the context of IPV is indeed the relationship -- violent couples also tend to be very distressed and unhappy couples (Dobash & Dobash, 1979; Schumacher et al., 2001). But does relationship distress lead to IPV, or does violence in the relationship lead to other relationship problems? In a 4-year prospective study, Rogge and Bradbury (1999) reported that communication problems (but not violence) predicted relationship distress over the 4-year period; the presence of violence in the relationship uniquely predicted relationship dissolution. Thus, this and other studies (O'Leary et al., 1989) indicate that problematic couple communication patterns are strong determinants of relationship distress and that lower levels of relationship satisfaction differentiate violent from nonviolent couples. IPV tends to accompany relational distress and verbal arguments (O'Leary, 1999) and is itself a strong predictor of relationship termination. It follows, then, that the many existing strategies for the treatment of relationship dysfunction can be usefully applied to this population. In addition, the available evidence indicates that abusive behavior can play an important role in relationship stability, a fact that may prove crucial in motivating abusive clients to seek treatment, remain in treatment, and change their behavior.

Discussing the relationship context in which abuse occurs does not mean that victims of IPV are somehow to blame for their own victimization. But it seems reasonable to suggest that a complete understanding of IPV requires knowledge of the context in which it occurs, and that this context also includes the behavior of both partners (Jacobson, 1994; Murphy & Eckhardt, 2005). Research on the mutual nature of IPV further illustrates the importance of contextual factors in abusive behavior. When one partner has been physically aggressive in a relationship, it is highly likely that the other partner has been physically aggressive as well (Archer, 2000). Therefore, it becomes critical to understand the usual ways that couples with a violent male interact about matters both mundane and serious, and to integrate this information into effective clinical interventions. An important area of research in this regard is based the analysis of the sequential behavioral patterns associated with IPV. After discussing a typical topic of conflict for 15 minutes in the lab, researchers have found that relative to nonviolent couples, violent couples exhibit more offensive negative behaviors during conflict discussions as well as more reciprocal patterns of negative communication (Berns et al., 1999; Burman et al., 1993; Cordova et al., 1993; Jacobson et al., 1994; Margolin et al., 1988). In particular, violent couples seem to be locked in a pattern of reciprocated belligerence, contempt, disgust, and overt hostility, with both partners responding to the other's negative behavior with similarly negative reactions (Gottman, 1994). This back-and-forth, "negative reciprocity" sequence is longer lasting and involves more negative behaviors in violent couples than among nonviolent couples. While few differences have been observed on these variables between husbands and wives *within* violent couples, violent males tend not to stop this negative communication pattern even after their wives exhibit fear or try to terminate the conflict. In addition, alcohol appears to worsen this pattern of hostile communication and negative reciprocity (Leonard & Roberts, 1998). These data suggest what has long been observed in clinical settings: Among couples experiencing male-to-female IPV, both partners are likely to be negative, reactive, and locked in a competitive battle to defeat the other. This contextual reality neither absolves the male from his decision to act abusively, nor blames the victim for her victimization.

Is there evidence that modifying interpersonal and communication skills in partner violence interventions is associated with nonviolent change? Yes. Recent research indicates that interventions based upon improving couple communication and relationship skills are at least as effective at preventing new IPV episodes as standard intervention programs or other comparison interventions (for a more detailed review see Murphy & Eckhardt, 2005). For example, Dunford (2000) randomly assigned 861 men in the U.S. Navy stationed in San Diego to either a 26-week cognitive-behavioral group BIP, a 26-week couples therapy group, a rigorous monitoring group, or to a no-treatment control group. Follow-up reports from female partners of male participants gathered 6 and 12 months post-treatment indicated that individuals assigned to all treatments exhibited reductions in IPV, no differences in recidivism were found in male-to-female physical aggression across the four groups. In addition, using couples volunteering for treatment at a university marital distress clinic, O'Leary, Heyman and Neidig (1999)

found no difference between men assigned to either couples treatment versus a group Duluth Model intervention. Similar results using a court-referred sample were reported by Brannen and Rubin (1996). Thus, one can either conclude that treatment that is focused on improving relationship skills is unwarranted since it does no better than more traditional group treatments, or one can perhaps see couples treatment as a useful alternative for some violent couples (especially those who are clearly planning on staying together) since it appears to work just as well as traditional interventions. However, the clinician interested in implementing couples' treatment must take extreme care to make sure the couple is indeed appropriate for the intervention, and that the intervention does not exacerbate existing problems in ways that increase risks of future IPV victimization (for more, see LaTaillade, Epstein, & Werlinich, 2006; Murphy & Eckhardt, 2005).

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III. Conclusions

Substantial progress has been made in the development of etiologic models of IPV and interventions for individuals who assault their relationship partners. Over time, there has been a notable shift away from early ideologies that were solely focused on gender themes as being dominant model to understand the etiology and treatment of IPV (e.g., Adams, 1988), and towards an approach that attempts to broaden this point of view with less ideologically-based and more empirically-based findings concerning risk factors for IPV and how this understanding of risk relationships may translate into more focused interventions for perpetrators (Dutton & Corvo, 2006). Relative to non-perpetrators, partner violent individuals exhibit a variety of social information processing disturbances and show more favorable attitudes towards violence as an acceptable conflict resolution strategy. In terms of emotion regulation, the limited research available indicates that IPV perpetrators show more disturbances in anger experience and expression relative to nonviolent comparison samples, and that problems relating to anger control are linearly related to the severity and frequency of IPV perpetration. Laboratory studies indicate that relative to nonviolent males, IPV perpetrators induced to feel angry are more likely to respond to relationship conflict situations with expressions of verbal aggression, belligerence, and hostile conflict strategies. Data also clearly indicate the relational nature of violent conflict tactics: abusive behavior, while always the responsibility of the individual perpetrator, emerges in particular relationship contexts and follows a sometimes-predictable pattern of reciprocated and escalating interpersonal processes. Together, these findings make for a compelling framework around which to structure intervention programs for nonviolent change.

But, as noted by Stuart (2005), there is still quite a distance left to travel if we as a field are to make the paradigm shift towards an approach to addressing IPV that takes advantage of the most that social and behavioral science shave to offer. Unfortunately, it is still the case that large sectors of the abuser intervention community are devoted to an exclusive gender-themed ideology that leaves little room for dissenting voices or incompatible data (Dutton & Nichols, 2005; Stuart, 2005). Many have wondered if this approach extends into the therapeutic process; perhaps this "ideologically narrowed view

of domestic violence distorts and limits other approaches to behavioral and psychological change and generates an atmosphere in the client group that cannot be conducive to honest exchange, vulnerability, trust or disclosure" (Dutton & Corvo, 2006, p. 461).

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