The Evolution of Evidence-Based Treatment for Intimate Partner Violence Perpetrators

by

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Table of Contents

Paper 5: Hamel, J., Jones, D., Dutton, D., & Graham-Kevan, N. (2015). The CAT: A gender-inclusive measure of abusive and controlling tactics. *Violence and Victims,* 30 (4), 547-580.

Paper 6: Hamel, J. (2014). *Gender-Inclusive Treatment of Intimate Partner Abuse, 2nd Edition: Evidence-Based Approaches*. New York: Springer.

Paper 7: Cannon, C., Hamel, J., Buttell, F. P., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the U.S. and Canada: Findings and implications for policy intervention. *Partner Abuse*, 7 (3), 226-276.

Paper 8: Hamel, J. (2017). Understanding and intervening with partner abuse. In: J.L. Ireland, C.A. Ireland, N. Gredecki & M. Fisher (Eds.), *Routledge International Handbook of Forensic Psychology in Secure Settings* (pp. 362-373). Abingdon, UK: Taylor and Francis.

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I confirm that the thesis is my own work, and that all published or other sources of material consulted have been acknowledged in notes to the text or the bibliography. I confirm that the thesis has not been submitted for a comparable academic award.

Abstract

This commentary summarises the evolution of evidence-based treatment approaches for intimate partner violence (IPV) perpetrators from the point of view of a treatment provider who has sought to expand his knowledge of IPV through undertaking a number of research studies and academics reviews in order to broaden and deepen his clinical skills. Sub-themes include: the limited knowledge base possessed by mental health professionals, victim advocates and others involved in IPV policy and intervention; misunderstandings regarding the nature of what is "battering," and similarities and differences across gender, including those pertaining to motives for perpetration and rates of emotional abuse and non-physical forms of control; and how a more informed understanding of intimate partner violence characteristics, causes, consequences and current intervention approaches can increase future treatment outcomes. The focus of the thesis is on eight of the author's published works, beginning with the first edition of *Gender-Inclusive Treatment of Intimate Partner Abuse*, published in 2005, and ending with results of a national survey of perpetrator programs. Each is critiqued within the context of the extant IPV literature at the time of its publication, how well the work built upon that literature, and how it advanced evidence-based treatment overall. The commentary provides evidence of a bias among professionals working in the field of IPV to minimize violence by women, which accounts for the perseverance of the dominant "Duluth" treatment model, and proposes a model for evidence-based treatment based on known risk factors and outcome studies.

Summary

A critique of the dominant research and treatment paradigm in the field of intimate partner violence (IPV) is presented, based on a review of the research literature as well as findings from several of the author's original research studies. The commentary proposes a more promising evidence-based treatment approach from the unique perspective of a scholar-practitioner.

In Chapter 1, the author first describes the difficulties he faced when he first began working with IPV cases in the early 1990s, when he found that his clinical training had not prepared him to successfully treatment IPV perpetrators. A preliminary investigation of the empirical research literature indicated that his training had been based on the so-called "Duluth" model, one that overemphasized patriarchy and underemphasized other, more research-based risk factors such as aggressive personality, substance abuse, and relationship conflict, and emphasized an unproductive, confrontational style of working with clients. In Chapter 2, the author summarizes a new assessment and treatment model, as described in Paper 1 and Paper 2, based on evidence for the heterogeneity of IPV, its systemic nature, the greater symmetry than asymmetry across gender in the characteristics, causes, dynamics, motivation, and effects of IPV on victims, and the effectiveness of alternative treatment modalities to the dominant group format – e.g., couples counseling.

Chapter 3 suggests a general predilection among mental health professionals, victim advocates and Family Court personnel to minimize IPV perpetrated by women, one that explains the perseverance of the Duluth model despite its lack of empirical support, and the resistance the author found in some quarters to his new model. The evidence comes from a literature review as well as three original studies conducted by the author and various colleagues. In the first of these original studies, described in Paper 3, family court mediators, evaluators, judges and attorneys

scored only minimally better than first year university students on a ten-item quiz of general intimate partner violence knowledge, and incorrect responses were due more to gender bias than a general lack of knowledge. In the second study (Paper 4), three short vignettes depicting IPV scenarios (half featuring a male perpetrator, half featuring a female perpetrator) were presented to domestic violence treatment professionals, including victim advocates, and a comparison group of undergraduate university students. Respondents were asked to determine the extent to which the violence was perpetrated for expressive reasons (due to anger and escalated interpersonal conflict) or in an attempt to control the partner, a less benign motive that has been correlated with severe IPV. Male-perpetrated IPV was viewed as more coercive, and female-perpetrated IV was viewed as more expressive, by all respondents, and particularly by victim advocates who are the most likely group to evidence gender bias. This propensity to view female motives as more benign is contradicted by clinical and general population surveys finding men and women to self-report coercive and expressive motivations at comparable rates. It is also contradicted by the third study, described in Paper 5, which reports on results of a survey with court-mandated perpetrators finding no overall difference across gender in the use of emotional abuse and control against partners.

Based on findings from these three studies, and a more current, in-depth examination of the IPV literature, the author describes in Chapter 4 an updated treatment model, as summarized in Paper 6 and Paper 8, providing further support for the gender inclusive, systemic, multi-modal approach first described in Paper 1. A higher level of cooperation among IPV researchers and front-line treatment providers is recommended.

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Chapter 1: Introduction

Soon after securing my licensure as a Clinical Social Worker, I was given the opportunity to purchase from a colleague a part of his private practice in Northern California involving treatment of adults with anger management issues, including individuals who had been convicted of a intimate partner violence offense. Prior to purchasing this business, I had no prior specific experience in the field of intimate partner violence (IPV), a term that more broadly includes emotional and sexual abuse and attempts to control one's partner. I had not previously experienced family violence personally, neither with an intimate partner nor in my family of origin. Thus, I came to the field without any preconceptions, and no personal stake in the matter.

The initial training that I received was brief. In the first meeting, my colleague went over basic principles of anger management and conflict resolution, drawn from a popular manual intended for public consumption (Weisinger, 1985)and one of the first intimate partner violence treatment manuals for male perpetrators and their spouses within a multi-couples format (Neidig & Friedman, 1984). Subsequent meetings focused on basic intimate partner violence theory and intervention, conducted by someone connected to the local battered women's shelter. I learned later that this training drew almost exclusively from the so-called "Duluth" model (Pence & Paymar, 1993). According to this model, abuse between intimate partners – whether physical, emotional, or sexual – is perpetrated by men against their female partners. Men who abuse and dominate their partners – known as "batterers" – do so not because of mental health issues or personality, but rather to maintain their privileged status in a patriarchal society, which they believe is their right (e.g., Dobash & Dobash, 1979; Yllo, 1993).

Following this cursory training, I began to facilitate men's groups, which at the time met weekly for 90 minutes, over a period of 16 weeks. Most of the participants were Caucasian, and

referred by the criminal court. Each session consisted of an open-discussion section, and a didactic section consisting of brief lessons presented on a white erase board. Informational material was disseminated, and group members were required to complete written exercises and occasionally asked to engage in role plays.

Shortly thereafter, it became quite evident that my training had not adequately prepared me for the work I was doing. These men certainly had some misconceptions about women (e.g., as calculating, manipulative, and irrational) and struggled to understand and communicate with their female partners. However, few of the men evidenced outright misogyny or insisted on rigid adherence to gender roles, such as preventing the partner form securing a job outside the home. In fact, many voiced a frustration that their partners chose *not* to work, making it harder for them to provide for the family. Although the abuse perpetrated by these men was sometimes instrumental, out of a desire to exercise power and control, it was more often reactive, arising within the context of mutually escalated conflict. These conflicts seemed to arise less from the female partner's resistance to the man's attempts to maintain "male privilege" than from typical marital differences in such matters as parenting or what to spend their money on, and perceived inadequacies in the others' way of relating and communicating.

Over time, I observed that my clients were a heterogeneous group. A majority of these clients had engaged in occasional, minor types of physical aggression, leading to minimal or no injuries. Many were emotionally abusive, but this type of abuse mostly consisted of verbal abuse in contrast to the persistent pattern of isolating and threatening behaviors characteristic of batterers. Some showed no signs of psychopathology; the rest suffered from an anxiety or mood disorder, or evidenced signs of PTSD or Borderline Personality Disorder. Many had problems with drugs and alcohol. What most of these clients appeared to need was help with impulse

control, as well as more effective ways of communicating and resolving their relationship conflicts.

Aside from the usual complaints about the unfairness of the judicial justice system, a recurring complaint from these men was that their partners were as physically abusive and domineering as they were, but not being held accountable for their behavior. My initial training taught me to dismiss such allegations as examples of blame and denial, lest I unwittingly allow myself to "collude" with these manipulative clients. However, when court-mandated intimate partner violence perpetrator programs were expanded under California law to 52 weeks, I was afforded the opportunity to more reliably gauge their progress, as well as the validity of their various complaints. Some of these complaints were indeed examples of victim-blaming, but many appeared to be highly credible. My clinical impressions were supported from interview data obtained in family court cases, where both parents were mandated for evaluation. Although the man was nearly always the alleged perpetrator, approximately half of the female partners reported to have engaged in comparable, or higher, levels of physical and emotional abuse.

To resolve the discrepancies between my initial training and my clinical experience, and to enhance my therapeutic skills with this population, I began attending nearby IPV seminars and events. Unfortunately, the information and resources offered were overly simplistic, and steeped in feminist analyses of patriarchy. The sole therapeutic tools made available were the so-called Power and Control "Wheel," a visual depiction of the ways men abuse and control women (Pence & Paymar, 1993); and the 3-phase battering cycle first proposed by Walker (1983), consisting of a tension-building first phase, followed by an acute battering incident in the second phase, and a third phase of contrition during which the batterer professes contrition for his violence and seeks to remain in the relationship. The Wheel, however, did not address the types

of abuse and control tactics my clients alleged of their partners (e.g., withdrawing sex and affection, threatening to take the children). Furthermore, the violence perpetrated by many of my clients did not fit the Walker model. The Walker model, I later learned, depicts a pattern of unilateral abuse by someone with Borderline Personality Disorder (Dutton, 1998), but does not account for violence perpetrated by psychopaths and other instrumental batterers, which consists only of an acute battering event, without a build-up or contrition phase. It also does not account for the conflict-driven, mutual abuse cycles reported by many of my clients.

Evidence-Based Practice

According to the American Psychological Association (APA Presidential Task Force on Evidence-Based Practice, 2006), "evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Given the paucity of useful and reliable IPV treatment models at my disposal, it was necessary, in the beginning, to rely on my clinical experience. The men enrolled in my programs, I observed, exhibited greater motivation to change and take responsibility for their behavior when I maintained a safe and productive group environment and showed them respect. Using principles of established client-centered and non-judgmental therapies (e.g., Miller & Rollnick, 1991; Rogers, 1951), I sought to empower my clients to address their needs, rather than lecture them on their abusive and controlling behaviors (Maslow, 1970). But these approaches were not always sufficient in dealing with such a heterogeneous and challenging population. For my work to be truly evidence-based, I realised, it would need to draw upon research specific to IPV – its characteristics, causes and consequences. Thus I began an inquiry into the social science literature, to become acquainted with findings that would both validate some of my early clinical observations and challenge me to alter and expand

my program accordingly. This thesis summarises this evolution in my practice, as reflected in some of my published works.

Chapter 2: A New Treatment Model

The research I conducted prior to 2005 provided support for a gender-inclusive model of partner abuse, which recognises that males and females can be victims or perpetrators; evidence for the heterogeneous nature of the problem (as opposed to, for example, the assumption that all perpetrators are "batterers"); and evidence for its systemic nature, in contradistinction to rigid perpetrator/victim dichotomies and "top down" models of unilateral, male-perpetrated abuse. A summary of these initial findings can be found in my first book, *Gender-Inclusive Treatment of Intimate Partner Abuse* (Hamel, 2005) Paper 1, both in Chapter 1 and throughout the book, along with the treatment models they informed. These models include differential treatment options based on a careful assessment of client history and risk factors, as well as interventions in the modalities of individual and group, and couples and family therapy based on systemic models.

Many of the clinical manuals available at the time provided helpful treatment strategies, some better researched than others. The volume on ethnic minority populations edited by Carrillo and Tello (1998) was based primarily on the Duluth model, although a few chapters offered some type of combined feminist-CBT approach, intended for a broader treatment population. The Navy program by Neidig and Friedman (1984) targeted couples, and took into account systemic principles, but it was the men who were the identified perpetrators. Likewise, the volume edited by Caesar and Hamberger (1989) included chapters on family systems and psychoeducational couples groups, but regarded the men as the primary perpetrators. In their pioneering book, Stacey, Hazlewood and Schupe (1994) presented convincing evidence that the female partners of men arrested for intimate partner violence can be as violent and emotionally abusive; however, the book did not provide any detailed recommendations for treatment. *Treating the Abusive Partner* (Murphy & Eckhardt, 2005), one of the most thoroughly-

researched treatment manuals every written, focused on individual therapy with men. The otherwise excellent batterer intervention group manuals by Sonkin and Durphy (1997) and Wexler (2000), while based on solid research, were also written for male perpetrators, with an overemphasis on gender role ideology.

Evidence for a Gender-Inclusive Approach

According to the first major national surveys on IPV, The National Family Violence Surveys (NFVS), conducted in the United States during the 1970s and 1980s, about 6 million men and 6 million women were physically assaulted by their partner each year, and an equal number of men and women were verbally abused (Straus & Gelles, 1990). These findings were confirmed in a later meta-analysis by Archer (2000). These studies also found that the physical and emotional consequences of PV, including experienced physical injuries and symptoms of depression, anxiety and PTSD, were higher for female victims compared to males. Not surprisingly, the National Violence Against Women Survey (Tjaden & Thoennes, 1998), which measured PV within the context of personal safety, found somewhat higher rates of female victimisation.

The differential impact of PV based on gender does have clinical implications – e.g., the greater levels of fear generally experienced by women and how they affect abuse dynamics and the balance of power in relationships should always be taken into account. On the other hand, cultural norms allow for greater tolerance of female-perpetrated violence, and this, too, can be assumed to affect abuse dynamics. Together, these findings indicated that intimate partner violence should not be conceived as merely a gender problem, but rather as a human problem. The suggestion that female perpetration *and* male victimisation ought to be taken seriously has subsequently been addressed in my own research, which will be highlighted later.

Evidence for the Heterogeneity of Partner Abuse

Sugarman and Frankel's (1996) comprehensive meta-analysis of studies on patriarchy and partner violence found correlations between physical abuse and attitudes condoning such violence; however, traditional gender role attitudes – that the man, for example, should work outside the home and make the major family decisions himself – did not differentiate non-violent men from those who abuse their partners. Other risk factors were identified for male-perpetrated IPV: an aggressive temperament, lack of empathy, impulsivity, poor social skills, insecure attachment, and high dependency needs; having experienced abuse in one's family of origin; current high levels of stress (e.g., financial); substance abuse; and being in a high-conflict, unhappy relationship (Hamberger & Hastings, 1986; Hotaling & Sugarman, 1986; Straus, et al., 1990). The presence of such risk factors suggested a far more nuanced approach to treatment than simply "re-educating" sexist men into egalitarian gender roles.

Among the first to recognise that not all men arrested for IPV and mandated to a batterer intervention perpetrator program, or BIP, exhibit the same degree of aggression or pathology were Hamberger and Hastings (1986), who categorised this population on the basis of distinct personality characteristics. Subsequently, Dutton (1988; 1998) proposed a two-dimensional model: impulsive versus instrumental on one axis, and under-controlled versus over-controlled on the other. While research on these pioneering models is sometimes cited in the literature, the far more robust typology proposed by Holtzworth-Munroe and her colleagues (Holtzworth-Munroe & Stuart, 1994) has found much greater acceptance within the academic community, and among clinicians. Their meta-analytic review of the literature yielded a threefold typology of male batterers, organised according to eight dimensions and 12 separate variables. In contrast to men in the other two categories, *family-only* types, which the authors estimated to account for approximately 50% of male perpetrators, engage in the least severe kinds of abuse, and are the

least likely to have a personality disorder or to emotionally abuse and control their partners. Men in the *dysphoric/borderline* category differ from the *generally-violent/antisocial* men primarily in their absence of criminal activity and violence outside the home, as well as attachment style (preoccupied rather than dismissing) and other characteristics.

Partner violence is often bi-directional, as discussed in the next section. Taking this into account, Johnson proposed a typology that included rates of aggression by both partners, as well as the extent to which one or the other engaged in emotional abuse and coercive control (Johnson, 2000; Johnson & Leone, 2005). What he originally termed *intimate terrorism*, and later *controlling-coercive violence* (but more commonly known simply as "battering"), is the frequent use by one party of physical violence together with a pattern of emotional abuse and the use of demeaning, isolating, jealous, threatening and other control tactics. He used the term *mutually violent control* to describe intimate terrorism when perpetrated by both partners, and *violent resistance* for the use of violence by one party against a highly controlling intimate terrorist, generally in self-defense. Johnson's fourth category, *common couple violence* (later changed to *situational violence*) described the mutual use of lower-level physical violence in relationships characterised by high conflict and poor communication, and the absence of highly controlling behaviors. Johnson regarded this as the most common type of violence among intimate partners.

Johnson's claims that males account for 97% of intimate terrorists and women comprise the overwhelming proportion of violent resisters has been thoroughly debunked, as we will see in an upcoming chapter on measures of emotional abuse and control. His typology was based exclusively on research using samples of female victims, and the survey questions on control were derived from the Duluth Model, and focused on male tactics. Notwithstanding these

limitations, the model more accurately reflects the more common ways that intimate partner violence is manifested and can be helpful in generating more informed treatment plans. For example, as I will discuss in greater detail later, the modality of couples therapy is not appropriate until the violent partner has begun to control his or her violence, and especially when there is pathology as with generally-violent/antisocial and dysphoric/borderline individuals.

Evidence for the Systemic Nature of Partner Abuse

Traditional models of IPV, as mentioned earlier, conceptualise IPV as a unilateral phenomenon, something that males perpetrate upon female victims. However, evidence began to emerge indicating a much greater bi-directionality than previously assumed. According to the National Family Violence Surveys (Straus, 1993), in at least 50% of abusive relationships both partners are violent. This finding did not readily fit with Walker's (1983; 1989) three-phase model, unless one assumes that all of the bi-directional violence involved women defending themselves against aggressive male partners, an implausible assumption given that when violence is unilateral the woman is as likely as the man to be the aggressor (Straus, 1993).

The characteristics of abusive relationships were explored by various researchers in a number of well-designed laboratory studies with high conflict couples in the 1990s (e.g., Burman, John & Margolin, 1992). Although recruitment efforts for most of these studies initially targeted couples where the man was identified as the aggressor, careful observations of the participating couples, along with extensive interviews and questionnaires, identified a variety of abusive relational dynamics in which *both* partners negatively contributed. Violence would typically result from mutually-escalating conflicts driven by factors including poor impulse control, mutual dependency, insecure attachment and poor communication skills. Specific abuse cycles were identified, such as approach-avoid and attack-defend, involving various degrees of

negative reciprocity (when aggression or negative communication is met with aggression or negative communication by the partner, rather than attempts to defuse, redirect, or end the conflict.) Because violence can emerge from interactive processes involving contributions from both partners, rather than driven solely by the actions of one pathological individual, these findings suggest that treatment for violent couples requires interventions that target relationship dynamics in addition to individual personality factors.

Aside from the impact that intimate partner violence has on the couple, it also has an impact on their children who witness or hear such violence (especially younger children), in the form of both internalising symptoms (e.g., anxiety, depression) and externalising symptoms (aggression, poor school performance). Many of the men enrolled in my perpetrator groups voiced concerns about the ramifications for the children not only of their own violence, but also violence by the mother. The emphasis within the intimate partner violence treatment community on the former reflected the prevailing IPV paradigm, supported by a limited and misleading body of research. Indeed, studies published prior to 2005 reported almost exclusively on the experiences of victimised women who had sought refuge in a battered women's shelter, and rarely asked about the women's own perpetration, against their partners or their children (e.g., Holden, 1998). The ones that did found that child witnesses evidence internalising and externalising symptoms regardless of the parent's sex (e.g., English, Marshall, & Stewart, 2003; Johnston & Roseby, 1997), and are as likely to subsequently perpetrate PV in their own adult relationships (Straus, 1992).

These and other findings, including significant correlations between rates of child abuse and inter-parental violence, provided support for a model of partner violence as a systemic and family problem. Factors such as generational differences, the multitude of tasks to be carried

out, and competing needs and interests result in high levels of stress for all families (e.g., Salzinger, Feldman, Ing-mak, Mojica, Stockhammer, & Rosario, 2002).

Evidence for Alternative Treatment Modalities

My research also led me to a small, but convincing body of evidence for alternative treatment options to the standard psychoeducational group model; in particular, evidence for the viability of couples therapy. This evidence is presented in my first book (Hamel, 2005) Paper 1, and expanded upon in my second book, *Family Interventions in Domestic Violence* (Hamel & Nicholls, 2007).

The first intimate partner violence models based on systems theory were initially proposed by Giles-Sims (1983), who focused on the experiences of battered women and the homeostatic mechanisms operating in a closed system; and Lane and Russell (1989), who elucidated the ways that such mechanisms maintain both unilateral and bi-directional violence. Among the first clinicians to draw on such models were Deschner (1984), whose treatment program featured same –sex groups for each partner, followed by join participation in a multi-couples relationship skills-building group; and Neidig, who offered short-term psychoeducational groups, also in the multi-couples format, for men serving in the United States Navy (Neidig & Friedman, 1984). While the men were in nearly every case the designated perpetrators, the program explored the role of both psychological and patriarchal factors and, more importantly, targeted the types of mutual abuse dynamics previously discussed. According to the authors, the widely-held belief that men are the sole perpetrators of IPV, and that the violence is essentially a product of social factors, may have unintended consequences, such as reducing their guilt and sense of responsibility while adding to their feelings of helplessness.

The authors were concerned about the rigid "victim" and "perpetrator" roles implied in such belief:

> Victims may assume that they can legitimately seek retribution or punishment, which can in turn lead to additional violent attempts to settle the score. Second, if the violence sequence is punctuated too narrowly, if either party only views the incident from his own perspective, and if interactional variables are not attended to, the violence may appear as if it erupted spontaneously and is beyond the influence of both parties. This perception is a therapeutic dead end. Third, when positive relationship factors and the contribution of both spouses to the conflict escalation process are ignored, women tend to be viewed as helpless, childlike victims, thus perpetuating conditions that may contribute to additional violence. (Neidig & Friedman, 1984, pp. 3–4).

The use of family therapy has never been empirically tested for IPV cases, although this modality has been found to be the most effective in the treatment of substance abusers, an acting-out population that shares many characteristics with partner-violent individuals (Stanton & Shadish, 1997). However, empirical support has been found for couples therapy in partner abuse cases involving common couple violence, from research utilising either RAC or quasi-experimental designs. One outcome study found lower recidivism rates for that format compared to a traditional, Duluth-model batterer intervention group (Brannen & Rubin,1996), and another (O'Leary, Heyman & Neidig, 1999) found couples therapy and a same-sex CBT group to be equally effective in reducing perpetration rates. Stith, Rosen, and McCollum (2004) also reported successful outcomes for couples therapy, with the lowest recidivism rates among participants in the multi-couples format. Despite its demonstrated efficacy, and its endorsement by a number of feminist theorists and clinicians (e.g., Goldner, 1998; Greenspun, 2000), couples

therapy continues to be prohibited in a majority of states for individuals mandated to batterer intervention (Babcock, et al., 2016).

Treatment Implications

(Hamel, 2005) Paper 1 was the first comprehensive IPV treatment text in which women were not viewed primarily as victims. Following is a summary of the book's contents, which demonstrate the contribution of my research.

Assessment. Chapter 1 of my book reviews the empirical research literature, previously described, and is followed by a section that examines some of the more salient issues related to intimate partner violence assessments. One important consideration, especially in cases involving mutual combat, is the extent to which one partner may initiate the abuse and the other react in either self-defense or in retaliation. Identifying *the dominant aggressor*, when there is one, can be part of a systemic intervention approach in which all parties are held responsible for their actions, and can also help in the allocation of clinical resources – e.g., both partners commence with couples counseling after the dominant aggressor has taken steps to curtail his or her controlling tendencies (Hamel, 2011) . Another consideration is whether the abuse is perpetrated primarily for instrumental, purposes (that is, to dominate and control), or expressively (that is, due to poor impulse control or lack of communication and conflict resolution skills) (Hamel, Desmarais & Nicholls, 2007) Paper 4. The recommended assessment procedure presented in Chapter 3[1] consists of an oral interview, conducted in the vein of Motivational Interviewing (Miller & Rollnick, 2002), necessary for overcoming resistance and

[1] In (Hamel, 2007) Paper 2, I present additional assessment strategies when assessing the family system, with suggestions on exploring relationship dynamics, dominant aggressor issues, the function of each person's behavior within the system, family beliefs about violence, family structure, boundaries and hierarchies, and the family's adaptability and accessibility to outside influences.

developing a strong client-therapist alliance, and the administration of various questionnaires suggested by my literature review: Conflict Tactics Scales (Straus, 1979), to measure rates of verbal and physical abuse; the Controlling and Abusive Tactics Questionnaire, useful in measuring emotional abuse and control (discussed in greater depth in a later section); and the Experiences in Close Relationships Questionnaire (Fraley, Waller, & Brennan, 2000), focused on a client's attachment style and dependency needs. Chapter four expounds on how clinicians can best consider the needs of ethnic minority and LGBT clients, personality-disordered perpetrators, and individuals with a history of substance abuse.

Treatment. The intervention approaches in this section draw from the research evidence already presented. Chapter 5 presents the core elements of perpetrator treatment, to be included regardless of the modality in which services are delivered: overcome stress, challenge irrational and pro-violent beliefs, identify unhealthy and abusive interaction patterns, acquire pro-social interpersonal skills, and overcome emotional/mental disorders and childhood trauma . In Chapter 6, I outline my recommendations for fashioning a workable treatment plan. The chapter begins with an extended discussion on how to maintain the physical and emotional safety of victims when conducting treatment within the modalities of couples or family therapy (Geffner, Barrett, & Rossman, 1995; Goldner, 1998; Greenspun, 2000). I acknowledge the objections of feminist writers – e.g., Bograd (1984), who argues that simply meeting in the same room "gives the subtle message that both parties are responsible for the abuse" (Hamel, 2005, p.80) Paper 1. In response, I suggest the following:

> The key to responsible treatment is careful assessment, an evaluation based on all the facts of the case. Systems formulations have their drawbacks, but are useful when properly applied. The neutral descriptions, for instance, are indeed only functional

> descriptions and not moral assessments of accountability. But that is also the systems approach value and strength. The astute clinician can be objective about processes, and yet hold the perpetrator accountable for his or her actions. (Hamel, 2005, p. 80).

In the next part of the chapter, I present my three-phase approach, which focuses on safety, trust-building, and basic emotion management and behavior change in the first phase; and proceeds to the teaching of pro-social communication and conflict resolution skills, with practice exercises initially limited to minor conflicts, then followed by an exploration of core issues and the freer expression of affect (Ronan, Dreer, Dollard & Ronan, 2004). Additional suggestions are presented for how to choose the right modality. Recommendations are then made for case management (e.g., referrals to substance abuse treatment, mental health resources). The chapter ends with a discussion of how to help the client establish personal goals, and orienting that client to the course of treatment, which includes instructions on how to use the CBT progress logs.

Chapter 7 presents the curriculum for a 26-52 session IPV perpetrator group program, including guidelines for facilitators, and the client workbook exercises.

The educational topics were selected based largely on what research indicates are the most significant risk factors for IPV (Capaldi et al., 2012). The sessions on anger management, for example, target aggressive impulses, and the communication and conflict resolution sections address the needs of clients in high-conflict relationships. In the final chapter of the book, I outline the various treatment options available to clinicians working with members of the family unit, while alerting readers to the way systems tend to resist change, and how to best address this problem. Given that changes in one part of the system affects other parts of the system, the full range of modalities must be considered (Lane & Russell, 1989; Neidig & Friedman, 1984).

Special attention is paid to insecure attachment dynamics, and how they can lead to violence (Sonkin & Dutton (2003).

After its publication, Hamel (2005) Paper 1 was cited in the most authoritative work on male intimate partner violence victims (Cook, 2009). In particular, the author praised its discussion of the many reliable and validated gender-inclusive assessment instruments, with which to more thoroughly assess abuse by both male and female partners. The introductory chapter to my second book (Hamel, 2007) Paper 2, which summarises the gender-inclusive conception of IPV and the research upon which it is based, has been viewed favorably by several authors. Linda Mills (2008) cites it in her book on couples counseling and restorative justice, to support her recommendations a less gendered, more inclusive and community-oriented approach to intimate partner violence intervention. Potter-Efron (2015) enumerates the core postulates of a gender-inclusive theory of treatment from Hamel (2007) Paper 2 in his popular *Handbook of Anger Management and Domestic Violence Offender Treatment,* including the importance of a thorough assessment, openness to using all treatment modalities, willingness to consider men and women as victims or perpetrators, recognizing the systemic nature of abuse, etc. Potter-Efron also recommends Hamel (2005) Paper 1 for its assessment protocol and instrument. In his chapter contribution to the volume, *Strengths-Based Batterer Intervention*, Lehmann (2009) calls for a radical change in IPV treatment, away from confrontational models such as Duluth, towards a more client-centered one, and directs his readers to Hamel (2007) Paper 2 for a review of the literature supporting "paradigm shift."

Chapter 3: The Pervasiveness of Misinformation

Aside from the Potter-Efron (2005) anger management book, Hamel (2005) Paper 1 remains to this day the only comprehensive treatment book to embrace a truly gender-inclusive model of domestic violence. Clearly, policy and treatment have lagged behind the research, which has continued to document in studies with various populations the heterogeneous, systemic and gender-inclusive nature of intimate partner abuse. A good sign, from my own observations, has been the greater frequency at national conferences on intimate partner violence of presentations on female perpetrators, male victims, and the benefits of couples counseling and non-traditional approaches such as Motivational Interviewing.

Unfortunately, this information has for the most part been unavailable to frontline treatment providers. The perseverance of the dominant policy and treatment model, what Don Dutton of the University of British Columbia calls the *gender paradigm* (Dutton, 2010; Dutton & Corvo, 2006; Dutton, Corvo & Hamel, 2009; Dutton & Nicholls, 2005), has been explained according to cultural and historical factors, such as the appropriation of the shelter movement by ideological feminists, and the unwillingness of policy makers to challenge a worthwhile social movement despite its flaws (Corvo & Johnson, 2012; Dixon, Archer, & Graham-Kevan, 2012; Dutton, 2010; Straus, 2010). It has also been explained as the failure of clinicians to properly identify and overcome cognitive errors such as confirmation bias (Nicholls, Desmarais, Douglas, & Kropp, 2006). Additionally, Murray Straus (2010) points out that outside the home, men are more aggressive than women, and female IPV victims suffer the greater share of serious injuries (which media reports typically focus on).

In this chapter, I summarise the results of three original research studies I conducted on the pervasiveness of the gender paradigm. The first reports on the results of a study determining

basic intimate partner violence knowledge. In the second, gendered assumptions about perpetrator motivation are explored, and the third study reports on the power and control tactics used by males and females. These original research projects were undertaken for the purpose of exposing the deficiencies in the gender paradigm and thus overcome some of the resistance to evidence-based, gender-inclusive intervention and policy.

Results of an Intimate Partner Violence Knowledge Assessment

Over the years, a significant number of clients referred to one of my batterer intervention programs in the San Francisco Bay Area have been referred by the family court, following allegations of IPV by the other parent in a disputed custody dispute. As indicated in the introductory chapter, although fathers accounted for most of these referrals, the mothers often admitted, in separate interviews, of having perpetrated intimate partner abuse at levels comparable to, or higher, than the fathers. When I brought up these findings at various county-wide family violence community meetings, or at professional meetings with family court professionals, I was greeted with indifference or outright resistance. My guess was that this resistance was not simply due to political reasons, because among those professionals were attorneys whose loyalties were for their clients rather than feminist advocacy groups, and that perhaps the resistance was at least partly due to a lack of accurate information.

I therefore constructed a 10-item assessment of basic IPV knowledge (see appendix A), and with colleagues at Boston University and the University of British Columbia, administered it via the internet and at two professional conferences to child custody mediators, evaluators, therapists, attorneys and judges throughout the United States, as well as to victim advocates and a comparison group of undergraduate university students (Hamel, Desmarais, Nicholls, Malley-Morrison & Aaronson, 2009) Paper 3. The correct answers (in bold) were based on the review I

conducted of the extant social science literature, supplemented by a formal PsycINFO search using relevant key words for each of the 10 knowledge items (e.g., "male victims," "bi-directional IPV"). Incorrect answers were meant to be consistent with the patriarchal paradigm. We hypothesised that the family court professionals would answer less than 50% of the items correctly. Given the focus of victim advocates on battered women, we hypothesised that this group would have the lowest scores. The university students, we thought, would score better than the advocates and not significantly worse than the family court professionals. Of the 410 respondents who completed the knowledge assessment, about a quarter (24%) identified themselves as child custody mediators or evaluators, 15% as family law attorneys, 3% as family law judges, 4% as victim advocates or shelter workers, and 32% as university students. The remaining 22% indicated they were health professionals, court administrators, or researchers.

Rates of correct responding were very low overall. On average, respondents answered well below 50%, only 2.80 out of 10 items correctly. Chi-square analyses revealed that, with the exception of items four, nine and ten, respondents answered incorrectly significantly more often than correctly. Furthermore, response rates for each item were highly consistent with the gender paradigm (the man is usually the perpetrator), as the contrary answer (that the woman is usually the perpetrator) was never selected by a majority of respondents. It is notable that the "I don't know" option was infrequently selected, on average about 20% of the time, indicating that incorrect answers were due to prevailing beliefs (the paradigm) rather than lack of knowledge per se.

Results supported our other predictions as well. Family court professionals scored significantly better than did shelter workers and victim advocates. As hypothesised, the student group scored higher on average than did the shelter/victim advocacy group, and not significantly

lower than the family court professionals, including judges and attorneys. This was a remarkable finding, given the students' far lesser amount of education and training.

Results from this study then informed a paper I co-authored(Dutton, Hamel, & Aaronson, 2010), which challenged prevailing assumptions among family court researchers and professionals, in particular regarding the relative distribution of controlling-coercive violence across gender. In the Hamel et al. (2009) Paper 3 study, 44% of the knowledge assessment respondents wrongly assumed that verbal and emotional abuse and controlling behaviors are perpetrated almost always by the man and sometimes by the woman; and 39% indicated, incorrectly, that the percentage of battering perpetrated by men is 80-95% of the total. Dutton, Hamel and Aaronson (2010) was then cited by Austin and Drozd (2012), which put forward a scientific model for conducting child custody assessments; and by Ackerman and Gould (2015) as evidence for the complex nature of partner abuse in their chapter on assessment issues in custody evaluations, included in the most current edition of the APA *Handbook of Forensic Psychology (2015)*.

Perceptions of Motives

Since the publication of the Archer meta-analysis in 2000 (Archer, 2000), there has been a notable increase in the intimate partner violence research literature of studies finding equal rates of physical abuse perpetration across gender (Desmarais, Reeves, Nicholls, Telford & Fiebert, 2012). Today, scholars who identify as "feminist" are likely to acknowledge these findings; however, there remains continued resistance to the possibility that comparable numbers of men and women use intimate partner violence in order to dominate and control their partners (e.g., Johnson, 2008; Stark, 2007). Because the motive to dominate and control has traditionally been associated with patriarchal structures, and these conditions benefit men, female-perpetrated

violence is presumed to be driven by other motives, mostly self-defense, and expressive rather than instrumental in nature: a failure to manage one's anger during mutually-escalating conflicts (e.g., Dragiewicz, 2008; Swan, Gambone, Caldwell, Sullivan, & Snow, 2008).

In fact, male and female perpetrators assault intimate partners for essentially the same reasons. Survey respondents enumerate a variety of motives: to express anger, to control, in self-defense, in retaliation, or simply in an attempt to communicate (Langhinrichsen-Rohling & McCullars, 2012). Many of these studies were published in the 1990s, such as the large U.K. population survey by Carrado and colleagues (Carrado, George, Loxam, Jones & Templar, 1996), and the dating study by Diana Follingstad and her colleagues in California (Follingstad, Wright, Lloyd & Sebastian, 1991). Why, then, were these studies generally ignored, and why are some of the gender paradigm-consistent conclusions reached in the DV motivation literature unsupported even by the researchers' own data (Feder & Henning, 2005; Kernsmith, 2005)?

I set out to answer these questions in a study I conducted with colleagues at Simon Fraser University, Canada (Hamel, Desmarais & Nicholls, 2007) Paper 4. In the literature review, I cite results from national and community surveys finding significantly greater acceptance of female-perpetrated partner violence than male-perpetrated violence in the broader society (Simon et al, 2001; Sorenson & Taylor, 2005; Straus, Kaufman-Kantor & Moore, 1997) and specifically among mental health professionals. For example, in a study involving case vignettes, male and female psychologists judged emotional abuse as more severe when perpetrated by men (Follingstad, DeHart & Green, 2004); and in several other studies the potential danger posed by violent female psychiatric patients was grossly underestimated, especially by female clinicians (Coontz, Lidz & Mulvey, 1994; Elbogen, Williams, Kim, Tojkins, & Scalora, 2001; Skeem et

al., 1995). From these findings, I theorised that mental health professionals would be more likely to ascribe expressive motives to female abusers and coercive motives to male abusers.

I constructed three short vignettes of intimate partner aggression, from which expressive and coercive motives could reasonably be assumed on the basis of the behaviors depicted, with the lowest degree of coercion in vignette number one, somewhat higher in vignette number two, and the highest in vignette number three (Appendix B). They were included in two questionnaires, which we made available online and at a national IPV conference to 128 male and 273 female respondents. Half of the respondents were family violence professionals, including therapists and victim advocates, and 42% undergraduate university students. In one questionnaire, the perpetrators depicted in the three vignettes were male; in the other, they were female. The respondents were asked to provide demographic information, and to indicate on a 5-point Likert scale the extent to which they thought the abuse depicted was primarily expressive, primarily coercive, or somewhere in between. Given their connections with shelters, who tend to represent the most gendered views of IPV (Hines, 2014), and their familiarity with mostly female victims, we hypothesised that, as a group, the victim advocates would be the most likely to ascribe expressive motives in the vignettes involving female-perpetrated aggression and coercive motives in those depicting male aggression. Based on previous research **(**Coontz et al., 1994; Elbogen et al., 2001), we expected similar responses from the female respondents.

Overall, respondents' understood the vignettes as we constructed them – intended to depict increasing degrees of coercion. The aggression was deemed to be the most expressive, by a majority of respondents, in vignette number one and most coercive in vignette number three. Ratings of vignette two fell between these two. Respondents were not confused about the motives for the behaviors depicted, which strengthens the following findings.

A significant main effect of perpetrator gender on ratings was found for vignettes number 1 and 2, with male-perpetrated aggression rated as significantly more coercive than female-perpetrated aggression. We did not find a significant main effect of perpetrator gender on ratings for vignette number three. We also did not find a main effect for respondent gender for vignettes one and three, but did observe a significant main effect of respondent gender on ratings in vignette number two, with ratings of female-perpetrated aggression by male respondents significantly higher than those of female respondents. Finally, results supported our hypothesis that victim advocates would ascribe the most coercive intentions to men, and the most expressive intentions to women. Across the three vignettes, those respondents who identified themselves as victim advocates (including shelter workers) ascribed significantly higher ratings for male-perpetrated aggression than female-perpetrated aggression. On the basis of these findings, we concluded:

> The argument that the focus on male-perpetrated IPV is warranted because of significant differences between genders was negated by this study's design, which presented hypothetical scenarios involving identical behaviors by male and female perpetrators. That is, given the same set of facts, domestic violence professionals rated male-perpetrated violence as more coercive and intentional and female-perpetrated violence as more expressive. To the extent that expressive motives are supposed to indicate a lesser threat, female-perpetrated IPV is therefore assumed to be less serious than male-perpetrated IPV (p. 571).

This study is cited by Spitzberg (2011) in his book, The Dark Side of Relationships, and mentioned in the conclusions and recommendations section of the literature review on psychological abuse by Carney and Barner (2012) as evidence for research based reforms in IPV

arrest policies. In her review paper on gender and IPV, Langhinrichsen-Rohling (2010) includes the Hamel et al. (2007) Paper 4 study to buttress her view that motivations for relationship violence are similar across gender. Using case vignettes to measure attitudes about IPV with a general population of adults in Australia, Dennison and Thompson (2011) found participants to be "more likely to identify the behavior of a male perpetrator as illegal and recommend more severe penalties" (p. 358), thus adding to the Hamel et al. (2007) Paper 4 findings. Findings of gender bias in this line of research was challenged by Hamby & Jackson (2010), whose sample of undergraduate college students rated vignettes featuring a male perpetrator as more frightening than those depicting a female abuser. The authors concluded that because men are usually bigger and stronger, gendered perceptions are based in actual gender differences and not simply stereotypes. It should be noted, however, that the study did not measure perceptions of motives, as did Hamel et al. (2007) Paper 4, nor perceptions of psychological abuse, but rather the impact of physical violence, which is undeniably greater on female victims. In New Zealand, Robertson and Murachver (2011) investigated the relationship between coercive control and IPV with a mixed sample of university students, incarcerated inmates, and adults in the general population, and cite Hamel et al. (2007) Paper 4 in their literature review among the studies showing that *"pervasive gendered beliefs that tend to associate male violence with control are reflected in the media and social policy"* (p. 209). A correlation between IPV and coercive control was found for male and female perpetrators alike, and coercive control tended to be reciprocal in nature. In sum, Hamel et al.(2007) Paper 4 has been cited by numerous scholars, and has made a notable contribution to the field of IPV. Its findings of gender bias and the minimization of female-perpetrated IPV have shed light on complex issues of motivation and

gender roles in intimate partner violence dynamics, and with implications for evidence-based assessment and intervention policies.

Gender and Emotional Abuse and Control

The belief that women's violence is expressive rather than coercive underlies much of current intimate partner violence policies, which are disproportionately responsive to the needs of female victims, and it extends beyond motives for physical violence perpetration, to perpetration involving nonphysical abuse. For example, an examination I completed (Hamel, 2011) of the California law enforcement officers' manual on IPV arrest procedures found no mention and no case vignettes of a female "dominant aggressor" in the section on mutual abuse cases, a finding that is not surprising given that among the main criterion for determining the dominant aggressor is which partner has a history of power and control behaviors, This study was cited by Leisring (2011) to support her contention that female-perpetrated violence is minimised by law enforcement.

However, aside from sexual abuse, the empirical evidence refutes the notion that men are significantly more likely than women to engage in those so-called "power and control" behaviors discussed earlier, which also include stalking, threats, and attempts to restrict a partner's movement or diminish their self-esteem, (e.g., Maiuro, 2001; Pence & Paymar, 1993). In intimate relationships, men have consistently been found to physically stalk and sexually abuse partners at significantly higher rates than women. However, verbal abuse, threats, possessive behaviors, and attempts to degrade and control one's partner are perpetrated, overall, far more often than physical assault, stalking, or sexual abuse (Black et al., 2011; Carney & Barner, 2012; Williams, Ghandour, & Kub, 2008); and there is convincing evidence from dating as well as large population surveys that these other power and control behaviors are perpetrated at

comparable rates across gender (Black et al., 2011; Carney & Barner, 2012; Coker et al., 2002; Coker, Sanderson, Cantu, Huerta, & Fadden, 2008; Felson & Outlaw, 2007; Follingstad & Rogers, 2014; Harned, 2001; Kasian & Painter, 1992; Laroche, 2005; Sears, Byers, & Price, 2007). Furthermore, research indicates that these forms of abuse predict physical abuse perpetration (Cano, Avery-Leaf, Cascardi, & O'Leary, 1998; Kasian & Painter, 1992; Murphy & O'Leary, 1989; Simonelli & Ingram, 1998; Stets, 1991; White, Merrill, & Koss, 2001). Indeed, based on Johnson's (2008) definition of intimate terrorism as the combination of physical and emotional abuse and control, the reanalysis of data from the National Violence Against Women Survey by Jana Jasinski and colleagues (Jasinski, Blumenstein, & Morgan, 2014) found rates of intimate terrorism to be comparable across gender.[2]

Aware that few studies have addressed these issues with individuals court-mandated to a batterer intervention program (Feder & Henning, 2005), I decided to conduct research into such programs in California, using what would become to be known as the Controlling and Abusive Tactics Questionnaire (CAT), both to measure rates of emotional abuse and control across gender and to create a reliable, validated instrument for assessing this particular population in clinical practice (Paper 5 – Hamel, Jones, Dutton, & Graham-Kevan, 2015). Most previous measures of non-physical types of abuse had been based on samples of male perpetrators and/or female victims (Follingstad, Hause, & Ruledge, 1992; Rodenburg & Fantuzzo, 1993), with Tolman's (1989, 1999) 58-item Psychological Maltreatment of Women Inventory (PMWI) the most widely-known and utilised. Reviews of these instruments can be found in papers by O'Leary (2001) and Graham-Kevan (2007). Citing emerging research finding high rates of emotional abuse and control by women, Kasian and Painter (1992) created a gender-inclusive,

[2] As I explain in a previous book chapter (Hamel & Russell, 2013), Johnson's definition doesn't exactly fit the type of rare but extreme violence that the term "intimate terrorism" suggests. When fear and life-threatening injuries are factored into the definition, women are clearly the predominant victims.

modified version of Tolman's PMWI, which they administered to a university student dating population. Tested with a more diverse sample, Graham-Kevan and Archer's (2003) Controlling Behaviors Scale nonetheless drew heavily on reports from battered women and male-oriented power and control items from the Duluth treatment model (Pence & Paymar, 1993).

Subsequently, Murphy and Hoover (2001) developed an instrument (the Multidimensional Measure of Emotional Abuse), that added a subscale for hostile withdrawal to the traditional ones for denigration, isolation, and domination/intimidation, and drew on a previous gender-inclusive measure (Murphy & Cascardi, 1999). Most recently, Follingstad (2011) reported on the MPAB, a 14-factor instrument based on a large representative sample of 649 men and women. The MPAB organises emotional abuse and control in degree of severity as well as the malicious intent behind the behavior. None of these previous instruments were field tested with male both male and female offenders in perpetrator programs. However, previous research with court-mandated male offenders found high rates of emotional abuse and control by their non-adjudicated female partners, who were legally regarded as the "victims" in the relationship (Capaldi et al., 2009; Stacey, Hazelwood, & Shupe, 1994).

The items used in my CAT research were derived from these instruments and supplemented with clinical observations. To make the instrument truly gender-inclusive, additional items were derived from reports by male victims (Cook, 1997; Hines, Brown, & Dunning, 2007) and a treatment manual for female batterers (Koonin, Cabarcas, & Geffner, 2003), yielding behaviors normally associated with females – e.g., "makes fun of partner's sexual performance," "excludes partner from child rearing decisions." Altogether, the original CAT instrument featured sixty-two items with high face value, arranged in the following ten categories: threats and intimidation, isolation and jealousy, economic abuse, diminishment of

self-esteem, general control, obsessive relational intrusion (e.g., stalking), passive-aggressiveness and withdrawal, using children, legal system abuse, and sexual coercion. The instrument, which asked about behaviors perpetrated as well as received, was administered in person to 240 male and 188 female court-mandated batterer intervention program participants in 15 urban and rural California counties.

Items that were not sufficiently endorsed were dropped. An initial factor analysis was then conducted. For abuse perpetrated, no significant differences were found across gender for 47 items. Women reported significantly more perpetration for nine items (e.g., "searches partner's purse/wallet/cell phone calls," "withholds affection or sex," "calls, pages, or text messages constantly"); men reported significantly more perpetration for six items (e.g., "tries to restrict partner's movements," "controls the money and excludes partner from financial decisions," "pressures partner to have sex when he/she doesn't want to"). As part of our overall study (Hamel et al., 2015) Paper 5, we subsequently conducted a confirmatory factor analysis online with 177 men and 200 women. This yielded four distinct categories for men (derogation and control, jealous hypervigilance, threats/control of space, sexual derogation) and four for women (derogation and control, jealous hypervigilance, threats, control of space). The two sets of categories differ slightly, but with only a couple of exceptions nearly all of the items are scored, for men and for women (see Appendix C). For the sake of simplicity when working with clinical populations, I have created a combined version, the CAT-2 (C).

We then administered the CAT-2 to another online sample of adults, so we could compare the CAT items to those on the Follingstad (2011) questionnaire, and we correlated its items to the Buss-Perry Aggression Scale (Buss & Perry, 1992) as well as to an assessment of malevolent personalities, known as the Dark Triad (Paulhus & Williams, 2002). The CAT-2 was

significantly and positively correlated with the Follingstad measure, the Buss-Perry measure , and, as predicted, the psychopathy and narcissism subscales of the Dark Triad measure. The CAT-2 therefore has been shown to have good construct and convergent validity. We concluded:

> Having drawn from a large pool of items, including behaviors perpetrated by both male and female perpetrators enrolled in batterer intervention programs, and subjected to factor and confirmatory analyses with general population samples, the resulting CAT-2 is highly generalizable, available for research and clinical purposes (Hamel et al., 2015, pp. 566-567).

Since its creation, the CAT has been administered to hundreds of court-mandated intimate partner violence perpetrators in the author's clinical practice. While Hamel et al. (2015) Paper 5 has not yet been cited in any peer-reviewed studies, it was cited in the clinical manual by Potter-Efron 2015), and I have conducted numerous trainings in its clinical use to numerous mental health professionals and batterer intervention treatment providers throughout the United States.

Chapter Four: Toward Evidence-Based Practice

The second edition of *Gender-Inclusive Treatment of Intimate Partner Violence* (Hamel, 2014) Paper 6 builds on the gender-inclusive and systemic model of treatment introduced in the first edition, with additional research evidence from sources such as the *Partner Abuse State of Knowledge Project* (PASK), published in five special issues of the peer reviewed journal, Partner Abuse between 2012-2013 (Hamel, Langhinrichsen-Rohling, & Hines, 2012; Hamel & Russell, 2013), as well as from my own original research projects and literature reviews, previously discussed.

Chapter three, on conducting partner abuse assessments, retains the essential elements from the original interview protocol, plus two added instruments. The first is the Safe at Home Questionnaire – Revised, based on the Transtheoretical Stages of Change theory, which measures a client's likelihood of taking responsibility for their abuse. I administer the instrument to both males and females, because my recent research field tested with court-mandated perpetrators of both sexes found comparable motivation levels for men and women (Sielski, Begun, & Hamel, 2015). The second is the Reasons for My Violence Scale, which gauges motivation. I also use this with clients of both sexes, based on a further study I conducted with colleagues examining with 177 male and female clients enrolled in batterer intervention programs showing similar motivations across gender (Elmquist, Hamel, Shorey, Labrecque, Ninnemann, & Stuart, 2014). This study was later cited in a paper by Cannon & Buttell (2015) on heteronormative bias towards IPV perpetrators in the LGBT community. The version of the CAT in the second edition reflects the final changes as reported in Hamel et al. (2005) Paper 1, with slightly differing versions for males and females.

Given the disturbing amount of misinformation prevalent among family court professionals, discussed previously, I added a new chapter (chapter ten), to focus on partner abuse in disputed child custody cases, to include my research showing how parents are motivated to minimise, distort and lie, in order to maintain custody of their children (Dutton, Corvo & Hamel, 2009; Dutton, Hamel & Aaronson., 2010). Some allege IPV or child abuse by the other parent; others, who have minimal visitation rights, charge that the custodial parent (the one with primary custody) has been deliberately trying to alienate that child. Both sets of allegations can be true, and should therefore be taken seriously (Ackerman & Gould, 2015; Austin & Drozd, 2012). The impact of IPV on children is well-known, but alienation is a form of emotional child abuse, with serious lifetime consequences (Baker, 2007). The real possibility, however, of false or exaggerated charges renders the assessment process difficult at best. Echoing concerns raised by my colleagues and I in Hamel et al. (2009) Paper 3 and Dutton, Hamel & Aaronson, (2010), and by others (e.g. Salem and Dunford-Jackson, 2008). I caution family court mediators and evaluators about *"the perceived notion from the family court side that advocates believe research supporting the overwhelming prevalence of males as perpetrators in classic battering should be considered probative"* (Hamel, 2014, p. 446) Paper 6. To avoid the predisposition to automatically view the father as the dominant aggressor and, therefore, not fit to have custody of the children, therapists are advised to consider assessment protocols that helps to substantiate abuse, and to differentiate between true alienation of a child and his/her estrangement due to the effects of the abuse, or due to poor parenting or other reasons.

Shortly after its publication, Hamel (2014) Paper 6 was cited by Cannon and Buttell (2015) several times in their paper on the failure of the gender paradigm to account for same-sex violence; and heavily cited in Potter-Efron's (2015) book, *Handbook of Anger Management and*

Domestic Violence Offender Treatment. Notably, Potter-Efron cites the book's assessment protocol, and updated instruments, among them the Reasons for My Violence Scale and findings from my field studies conducted on that instrument showing comparable motivations for DV perpetration across gender. The author also cites sections from Hamel (2014) Paper 6 on the similarities and differences between male and female perpetrators, with implications for practice, and recommends the chapters on couples and family interventions.

The Alternative Behavior Choices Perpetrator Program

The chapter on group interventions in Hamel (2014) Paper 6 takes into account most of the up-to-date research available, but the most current version of my group intervention program for perpetrators, *Alternative Behavior Choices*, can be found in Hamel (2017) Paper 8, and reflects findings from the PASK literature reviews, including the review of risk factor research by Capaldi, Knoble, Shortt, and Kim (2012), as well as recent research I conducted with numerous colleagues on evidence-based perpetrator program standards (Babcock et al., 2016). According to this research, an MI interviewing style and a strong client-facilitator alliance are among the most robust predictors of successful treatment outcomes. Accordingly, I have retained my program's non-confrontational, client-centered approach. The program curriculum for female offenders continues to remain the same as for the men, given the similarities across gender for this population, as noted earlier and further discussed in Babcock et al. (2016), and we have kept the client progress logs in light of BIP outcome research finding homework compliance to predict diminished levels of psychological abuse (Gondolf & Werniks, 2009; Taft, Murphy, King, Musser, & DeDeyn, 2003).

Based on feedback from clients and from my group facilitators, and in accordance with the research literature, including the Babcock et al. (2016) report and qualitative findings from a

national survey of perpetrator programs that I conducted with colleagues at Tulane University (Cannon, Hamel, Buttell, & Ferreira, 2016) Paper 7, I have simplified the original psychoeducational curriculum. Alternative Behavior Choices now consists of 16 core lessons, divided into three sections, (see appendix D). Overall, the curriculum emphasises emotion management and relationship-building skills. In Hamel (in press) Paper 8, I identify these risk factors and where in the curriculum they are addressed, and cite supporting studies. All clients are exposed to the same educational material, adapted to meet the particular needs of each client through a careful assessment, personal client goals, group discussions, and, when necessary, referrals to outside agencies.

Research I conducted with Cannon and colleagues (Cannon et al., 2016) Paper 7indicates that nearly a third of individuals currently enrolled in BIPs (perpetrator programs) are unemployed, and the programs found to be the most successful in reducing rates of recidivism include a stress reduction component in their curriculum (Babcock et al., 2016). Lesson nine therefore includes relaxation and meditation exercises. Poor impulse control is targeted in several lessons, given research finding lowered rates of relationship violence by men who have learned to lower their anger levels (e.g., Hamberger & Hastings, 1988; Saunders & Hanusa, 1986). In lessons four and five, we teach participants about the function of emotions, including the positive functions of anger. Relevant neuropsychological findings are outlined in lesson six, and essential anger management strategies are then explained in lesson seven. Interventions that specifically target emotional dependency and insecure attachment styles have yet to be empirically tested; however, their role in intimate partner abuse dynamics has been well-documented (Sonkin, Ferreira, Buttell, Hamel, & Frias, in press; Stewart, Flight, & Slavin-

Stewart, 2013). Accordingly, lesson eleven discusses the various ways that insecure attachment can lead to escalated conflict and violence.

Given that pro-violent attitudes and a need to dominate predict the use of physical partner abuse, and that successful IPV interventions based on CBT models target cognitive distortions and irrational beliefs, the intervention helps clients examine their irrational, sexist and anti-social attitudes in session eight. Jealousy, a major motive for interpersonal aggression (Langhinrichesen-Rohling & McCullar, 2012) is the focus of lesson four, and one of its primary antidotes, empathy, is discussed in lesson twelve. The first three lessons address the various causes of intimate partner violence, with exercises devoted to exploring the role that developmental and family of origin factors have on one's current personality and behavior. Within a primarily psychoeducational approach, we provide the group structure, support , acceptance and skills found to be highly effective with Dysphoric-Borderline types (Fruzzetti & Levensky, 2000). In lesson 14, we also teach the positive parenting practices needed to understand the consequences of their behaviors on their children, and how they perpetuate the intergenerational cycle of abuse.

The final factor, being in a high conflict relationship, is addressed in lessons ten through sixteen and the exercises on communication, conflict containment and conflict resolution. Participants review the abuse dynamics outlined in chapters ten and eleven (involving negative reciprocity and insecure attachment, fear, retribution, and mind reading and self-fulfilling prophesies), and are helped to understand how these contribute to relationship conflict and violence. According to Babcock et al. (2016), improved communication skills have been shown to reduce relationship violence by men and among couples, and lower recidivism rates have been reported for CBT programs that incorporate communication and conflict resolution skills.

Reflections

There are limitations to this thesis. Among the original research projects discussed, only Hamel et al. (2007) Paper 4 has had a demonstrated impact on the scholarly literature, and the extent to which they may have impacted attitudes on a policy or intervention level would be difficult to ascertain. In her review of fact sheets available on websites administered by the National Coalition Against Domestic Violence in the United States, Hines (2011) found numerous false facts, including some that had been disputed by Hamel et al. (2009) Paper 3.

Additionally, the ABC group program, as well as my general intervention approach to working with families affected by intimate partner violence, is informed by an incomplete body of research. While there is evidence that programs using a primarily CBT approach are somewhat more effective than those operating from a gender-based philosophy, such as Duluth, and the effectiveness of any intervention is increased when they utilize a Motivational Interviewing component, few well-designed outcome studies have been conducted on batterer intervention programs overall (Babcock, Green & Robie, 2004; Eckhardt, Murphy, Whitaker, Sprunger, Dykstra, & Woodard, 2013). Almost no studies using a true random-assignment-to-conditions (RAC) design have been conducted on differential treatment, to determine what type of intervention would work best for women, same-sex couples or ethnic minority populations, or for various sub-groups according to level of offending, psychopathology, or motivation. The ABC program (Hamel, 2017) Paper 8 has been well-received at professional conferences where I have presented. It draws on the best available research, and its educational components take into account known risk factors, but its efficacy has not been empirically demonstrated.

Future Directions

To move forward, evidence-based practice will need to further separate from the gender paradigm, as argued in this thesis. To do so, scholars will need to replicate the findings of Hamel et al. (2007) Paper 4, Hamel et al. (2009) Paper 3, and Hamel et al. (2015) Paper 5, and investigate additional ways that the gender paradigm unduly influences intimate partner violence intervention policies (e.g., along the lines of Hines' 2011 internet study). A preponderance of scholarly journal articles report on rates of IPV risk factors, but far less on contextual factors, and the data base upon which evidence-based practice depends will need to grow substantially, to include findings from well-designed experimental outcome studies. Additionally, most IPV research has been conducted in the United States, the U.K., and Canada, and the findings presented in this thesis may not all meet the treatment needs of perpetrators who reside elsewhere. Very little has been published about IPV relationship dynamics in highly patriarchal countries, where gender roles are a greater risk factor than in the West (Esquivel-Santovena, Lambert & Hamel, 2013). How gender interacts with personality, stress, relationship conflict, substance abuse and other factors should provide valuable insights in maximizing treatment efficacy. Already, many agencies throughout Africa and South America combine feminist theory with CBT and other psychological approaches (Esquivel-Santovena & da Silva, 2016; McCloskey, Boonzaier, Steinbrenner, & Hunter, 2016)

Most clinicians do not have access to peer-reviewed journal articles, and as previously noted "fact sheets" on IPV are notoriously unreliable (Hines, 2011). Still, results from 238 batterer intervention program directors who completed the North American Domestic Violence Intervention Program Survey (Buttell et al., 2016) Paper 7 are noteworthy. Only about a third of all programs continue to identify primarily as Duluth, down from the 53% reported in a previous national survey by Price and Rosenbaum (2009). Group facilitators are on the whole well-

trained, with a majority of agencies requiring a Master's degree or higher and the average facilitator having eight years of clinical experience and 30 hours of annual training. The large majority of programs, including many ostensibly identified as Duluth, teach the emotion management and communication and conflict resolution skills found to be effective in reducing rates of recidivism. Although most programs approve of their state standards, two-thirds at least "sometimes" supplement them. Assessments appear to be very thorough (average intake is 90-120 minutes), and 63.9% reported to adapting their program to meet client needs.

Ultimately, there will need to be a great deal more communication and cooperation among research scholars and clinicians. Currently, treatment providers can access the Partner Abuse State of Knowledge manuscripts for free, by going to www.domesticviolenceresearch.org. They may also contact the Association of Domestic Violence Intervention Programs (ADVIP; www.domesticviolenceintervention.net), a web-based organization that brings together intervention provider and research scholars from around the world, providing them with up-to-date research and recommendations for evidence-based standards (Babcock et al., 2016) and online forums with which to exchange intimate partner violence-related news and information. As of this writing, ADVIP membership had approached 200 individuals, many of whom identified as *both* scholars and practitioners. This is a promising trend, indeed.

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Appendix A. Domestic violence knowledge assessment

1. In the general population, men perpetrate approximately what percentage of intimate partner violence, or IPV (defined as any physical assault) per year?
   a. 45-65%
   b. 65-85%
   c. 850-95%
   d. I don't know
2. Female victims of IPV incur greater injuries than male victims, at approximately what rate?
   a. 2:1
   b. 5:1
   c. 7:1
   d. I don't know
3. Sometimes IPV is bidirectional. When both partners hit each other, who tends to strike the first blow?
   a. Almost always the man
   b. Mostly the man, but often the woman
   c. Mostly the woman, but often the man
   d. I don't know
4. Verbal and emotional abuse and controlling behaviors are perpetrated:
   a. Almost always by the man, but sometimes by the woman
   b. Almost always by the woman, but sometimes by the man
   c. By either the man or the woman, at approximately equal rates

d. I don't know

5. Battering (defined as the use of physical and emotional abuse and controlling behaviors, or defined as abuse leading to physical injuries as well as fear and help seeking on the part of the victim) is perpetrate by men in what percentage of cases?

   a. 80-95%

   b. 65-80%

   c. 50-65%

   d. I don't know

6. Data from the 1998 National Violence Against Women Survey indicates that the mental/physical health effects from having been a victim of intimate partner violence are:

   a. Significantly greater for men

   b. Significantly greater for women

   c. Not significantly different for men or women overall

   d. I don't know

7. In violent families, the highest rates of physical assaults are perpetrated by:

   a. Parents on each other

   b. Parents on the children

   c. No significant difference in parent-on-parent and parent-on-child rates

   d. I don' know

8. When children are maltreated (including neglect, sexual abuse, physical abuse, or psychological maltreatment) by a parent, the perpetrator is likely to be:

   a. Equally the father or the mother

   b. The mother

c. The father

d. I don't know

9. Children who witness IPV between their parent are at greatest risk for later perpetrating IPV themselves if they had witnessed violence by:

   a. The father

   b. The mother

   c. Either the father or the mother

   d. I don't know

10. A parent who hits the other parent is likely to also hit the children. This is most often the case when the perpetrating parent is:

    a. The father

    b. The mother

    c. Either the father or the mother

    d. I don't know

Appendix B. Vignettes depicting intimate partner violence perpetrated by men or women.

Vignette 1

Jeff and Susan are sitting at the kitchen table, going over the bills that need to be paid. Jeff (Susan) wants Susan (Jeff) to spend less and insists she (he) pay the bills, but Susan (Jeff) thinks they need to make more money. Susan (Jeff) begins to scream at Jeff (Susan). He (She) suggests a "time out." She (He) calls him a "piece of sh-t." Jeff (Susan) picks up the bundle of bills and tosses them at Susan (Jeff). What is Jeff's (Susan's) motivation for his (her) aggression?

Vignette 2

Don and Erica are arguing about their 15-year-old son, Steve, who has been caught for the second time using marijuana. Don (Erica) wants to send Steve to an intensive, 30-day inpatient treatment program. Erica (Don) explains at length why they should give Steve another chance, raising her (his) voice, and not letting Don (Erica) have an opportunity to respond. Don (Erica) yells at Erica (Don) to "shut up" and grabs her (him) by the arm. What is Don's (Erica's) motivation for his (her) aggression?

Vignette 3

Elizabeth (Rod) is watching television. Rod (Elizabeth) tells her (him) that he (she) wants to talk to her (him) about something and asks that she (he) turn it off. After asking three times and not getting any response, Rod (Elizabeth) slaps Elizabeth (Rod) on the side of the head. What is Rod's (Elizabeth's) motivation for his (her) aggression?

Appendix C. Controlling and Abusive Tactics Questionnaire for Males and Females - CAT-2

MALE VERSION:

Indicate how often you engage or have engaged in the behaviors listed below toward your current or most recent ex-partner, using the following scale.

0 = Never; 1 = Rare; 2 = Occasional; 3 = Common; 4 = Frequent

Derogation and Control

1. Refuses to work or contribute financially 0 1 2 3 4

2. Calls partner names (e.g., Bitch, Loser) 0 1 2 3 4

3. Ridicules partner 0 1 2 3 4

4. Treats partner like he/she is stupid 0 1 2 3 4

5. Tells partner he/she is incompetent and helpless 0 1 2 3 4

6. Tells others partner is crazy 0 1 2 3 4

7. Blames partner for all the problems in the relationships 0 1 2 3 4

8. Orders partner around 0 1 2 3 4

9. Expects partner to "hop to it" 0 1 2 3 4

10. Nags 0 1 2 3 4

11. Refuses to accept "No" for an answer 0 1 2 3 4

12. Criticizes partner's every move 0 1 2 3 4

13. Deliberately ignores partner 0 1 2 3 4

14. Withholds affection or sex 0 1 2 3 4

15. Locks partner out of bedroom or residence when angry 0 1 2 3 4

16. Refuses to cooperate 0 1 2 3 4

Jealous Hypervigilance

17. Attempts to control who partner spends time with 0 1 2 3 4

18. Accuses partner of being unfaithful or flirting with others 0 1 2 3 4

19. Secretly records partner 0 1 2 3 4

20. Searches partner's purse/wallet/cell phone calls 0 1 2 3 4

21. Interrogates partner as to where he/she has been, who he/she has seen 0 1 2 3 4

22. Follows partner around 0 1 2 3 4

23. Calls, pages, or text messages constantly 0 1 2 3 4

24. Leaves numerous unwanted messages on partner's voice mail/computer 0 1 2 3 4

Threats/Control of Space

25. Controls the money and excludes partner from financial decisions 0 1 2 3 4

26. Verbally threatens to hurt partner 0 1 2 3 4

27. Threatens with gestures (e.g., staring) 0 1 2 3 4

28. Harms or threatens to harm someone partner cares about 0 1 2 3 4

29. Tries to restrict partner's movements 0 1 2 3 4

30. Keeps partner from leaving (e.g., stand in front of doorway) 0 1 2 3 4

31. Withholds car keys, disables vehicle 0 1 2 3 4

Sexual Derogation

32. Tells partner he/she is unattractive 0 1 2 3 4

33. Flirts with others to make partner jealous 0 1 2 3 4

34. Makes fun of partner's sexual performance 0 1 2 3 4

35. Humiliates in front of others 0 1 2 3 4

36. Spreads false rumors about partner 0 1 2 3 4

FEMALE VERSION:

Indicate how often you engage or have engaged in the behaviors listed below toward your current or most recent ex-partner, using the following scale.

0 = Never; 1 = Rare; 2 = Occasional; 3=5 Common; 4 = Frequent

Derogation and Control/Threats

1. Verbally threatens to hurt partner 0 1 2 3 4

2. Threatens with gestures (e.g., staring) 0 1 2 3 4

3. Controls the money and excludes partner from financial decisions 0 1 2 3 4

4. Refuses to work or contribute financially 0 1 2 3 4

5. Tells partner he/she is unattractive 0 1 2 3 4

6. Flirts with others to make partner jealous 0 1 2 3 4

7. Calls partner names (e.g., Bitch, Loser) 0 1 2 3 4

8. Makes fun of partner's sexual performance 0 1 2 3 4

9. Humiliates in front of others 0 1 2 3 4

10. Ridicules partner 0 1 2 3 4

11. Treats partner like he/she is stupid 0 1 2 3 4

12. Tells partner he/she is incompetent and helpless 0 1 2 3 4

13. Tells partner what he/she cares about is unimportant 0 1 2 3 4

14. Spreads false rumors about partner 0 1 2 3 4

15. Tells others partner is crazy 0 1 2 3 4

16. Blames partner for all the problems in the relationship 0 1 2 3 4

17. Orders partner around 0 1 2 3 4

18. Expects partner to "hop to it" 0 1 2 3 4

19. Nags 0 1 2 3 4

20. Refuses to accept “No” for an answer 0 1 2 3 4

21. Criticizes partner’s every move 0 1 2 3 4

22. Follows partner around 0 1 2 3 4

23. Deliberately ignores partner 0 1 2 3 4

24. Locks partner out of bedroom or residence when angry 0 1 2 3 4

25. Withholds affection or sex 0 1 2 3 4

Jealous Hypervigilance

26. Harms or threatens to harm someone partner cares about 0 1 2 3 4

27. Accuses partner of being unfaithful or flirting with others 0 1 2 3 4

28. Searches partner’s purse/wallet/cell phone calls 0 1 2 3 4

29. Interrogates partners as to where he/she has been, who he/she has seen 0 1 2 3 4

30. Calls, pages, or text messages constantly 0 1 2 3 4

31. Leaves numerous unwanted messages on partner’s voice mail or computer 0 1 2 3 4

Control of Space

32. Attempts to control who partner spends time with 0 1 2 3 4

33. Tries to restrict partner’s movements 0 1 2 3 4

34. Keeps partner from leaving (e.g., stand in front of doorway) 0 1 2 3 4

35. Withholds car keys, disables vehicle 0 1 2 3 4

Appendix D. Alternative Behavior Choices group curriculum

Lesson	**Class Exercises**
1. Characteristics / Causes, Part 1	When is Violence Justified?/Defenses Against Accountability
2. Causes, Part 2	Socialisation/Gender Roles/Impact of Gender Role Socialisation
3. Consequences	Consequences of Abuse/Impact of Domestic Violence on Children
4. Emotions	Identifying Emotions in Oneself/Jealousy
5. Understanding anger	Positive and Negative Functions of Anger/ Myth of the Pressure Cooker
6. Aggression and the brain	
7. Anger and stress management, Part 1	Warning Signs of Anger/Time-Outs
8. Anger and stress management, Part 2	Overcoming Irrational Self-Talk/Challenging Irrational Beliefs/Review Sample Progress Log
9. Anger and stress management, Part 3	Grounding Meditation/Progressive Relaxation/ Meditation and Visualisation
10. Abuse dynamics, Part 1	Who is the Dominant Aggressor?
11. Abuse dynamics, Part 2	Identifying Abuse Dynamics
12. Listening skills/empathy	Paraphrasing/Developing Empathy
13. Speaking skills/ assertiveness	Assertiveness Versus Aggressiveness/ Dealing with “Blocking Maneuvers”
14. Positive communication/parenting	The Relationship Bank Account/Good Parenting
15. Conflict resolution, Part 1	Importance of Meta-Communication
16. Conflict resolution, Part 2	Problem Solving