2019

Approved Victim Contact and Treatment Outcomes Among Domestic Violence Offenders

Brian Timothy Longworth
Walden University

Walden University

College of Social and Behavioral Sciences

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Brian Longworth

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Review Committee
Dr. Stephen Hampe, Committee Chairperson, Psychology Faculty
Dr. Donna Heretick, Committee Member, Psychology Faculty
Dr. Lisa Scharff, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

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M.A., Northwest Christian College, 2004

B.A., Boise Bible College, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

May 2019

Abstract

Batterer intervention programs (BIPs) were developed to address high recidivism rates and low treatment completion rates in domestic violence offenders. Segregation between these offenders and their victims has been traditional in BIPs, but there has been no research exploring if this separation is related to treatment outcome. This research explored the relation between offender contact with their children or victims and outcomes including recidivism and treatment completion. Cognitive behavioral theory was used to predict that contact with families would allow for more positive outcomes. This was a quasi-experimental study using archived data including 213 individuals who participated in a BIP in the Northwester United States between 2010 and 2012. Nonparametric analyses were used to investigate the relations between categorical variables. There were no significant associations between victim-partner contact and/or child contact and treatment outcomes. There was also no statistically significant association between victim-partner and/or child contact and the treatment outcomes of general recidivism, person-on-person recidivism, or treatment completion. The null hypothesis was retained for all of the research questions, as there was no apparent relation between victim family contact and any of the dependent variables. The findings may be used to guide social change in that they may help inspire future research on the topic and may also be used to help BIPs re-examine policies of segregating domestic violence perpetrators from their victim families.

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Dedication

This dissertation is dedicated to my parents, Glen and Diane Longworth, for their support throughout my education; to Marla Moreno, my good friend who helped me through the process of writing my dissertation; and to Irene Longworth, who has been supportive in giving me time to finish my dissertation process.

Acknowledgments

I would like to acknowledge the help from my chair, Dr. Stephen Hampe, and Dr. Heretick, my committee member.

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Chapter 1: Introduction to the Study

Introduction

The purpose of this study was to evaluate the relationship between including victim-partners and/or their children in the treatment of domestic violence offenders and those offenders' rates of treatment completion and recidivism. The inclusion occurred after having a no-contact order lifted with treatment-approved victim-partner contact and/or having their child approved to be in the home with them after the offense. My aim was to compare the intervention outcomes of completion, general recidivism, and person-on-person recidivism for domestic violence offenders who had approved victim-partner contact during their treatment to the intervention outcomes for offenders who participated in domestic violence intervention treatment without victim-partner contact. Another purpose was to compare the same treatment outcomes for those offenders who had minor children and were approved to have them in their homes and for those who had minor children but were not approved to have them in their homes. The analyses were based on archival data gathered from a domestic violence intervention program in the Northwestern United States.

In this study, I evaluated the relationship that treatment-approved victim-partner contact has with domestic violence intervention treatment attrition, person-on-person recidivism, and recidivism for any crime. I also evaluated the relationship between treatment-approved child contact (i.e., having their children approved to be in their home during the intervention) and treatment attrition, general recidivism, and person-on-person recidivism. In chapter, I presented the background, problem statement, purpose

statement, research questions, nature of the study, definitions, assumptions, limitations, and significance of this research.

Background

The most comprehensive study to date concerning treating domestic violence while involving treatment-approved victim-partner contact was a qualitative study by Todahl, Linville, Shamblin, and Ball (2012). They interviewed partners who participated in groups targeted at couples who had experienced domestic violence in their relationships. Todahl et al. queried participants about their perceptions of safety in the program, and participants reported that they perceived they were safe. The participants understood the inherent risks, but they felt that the program had reasonably addressed concerns, and they perceived that learning from other couples in the groups was helpful (Todahl et al., 2012). Participants reported positive attitude changes, greater awareness of their partner's needs, and that they gained valuable tools, such as communication skills and stress management (Todahl et al., 2012). The qualitative interviews revealed the value in addressing domestic violence within the family. Following up with a quantitative study that takes place over a longer time period could provide further evidence of the efficacy of employing couple groups to treat domestic violence.

A quantitative approach would demonstrate whether statistical evidence supports what the participants reported in Todahl et al.'s study. This also enabled me to address the study's potential limitation that the participants were trying to report their improvements in a positive light in order to achieve the desired outcome of reunification. High recidivism rates are a focus of most domestic violence intervention programs

(Coulter & VandeWeerd, 2009). The completion of a quantitative study on this population may demonstrate the relationship between recidivism and the intervention of having treatment-approved victim-partner contact.

This study explored the treatment outcomes of treatment approved contact with children. Children are often involved in domestic violence as bystanders. Obadina (2013) indicated that children with guardians who are violent or aggressive can develop disorganized attachments. Howarth et al. (2015) reported that children who witness violence in the home often demonstrate symptoms of posttraumatic stress disorder (PTSD). Emery and Buehler (2009) demonstrated the negative impact that witnessing domestic violence has on children. They reported behavioral and psychological problems among children who remained in homes where there was continued exposure to violence. In homes where the violent behavior was reported to have stopped, the negative symptoms of the children decreased (Emery & Buehler, 2009). Litrownik, Newton, Mitchell, and Richardson (2003) compared children who had been permanently separated from their parents before the age of 6 years with those who had been reunited with their parents. Those who were reunited with their families demonstrated aggressive tendencies, but among those who were placed in new homes, their expressed behaviors were dependent on the homes they were placed in (Litrownik et al., 2003). Stanley, Graham-Kevan, and Borthwick (2012) indicated that fathers view contact with their children as a motive for positive change. These authors concluded that children are resilient when there is positive change, and they can also serve as a motivation for positive change;

however, continued exposure to violence can lead to trauma and future aggressive behavior (Obadina, 2013; Stanley et al., 2012).

Problem Statement

High recidivism rates and low completion rates are problems that current domestic violence intervention programs aim to address (Coulter & VandeWeerd, 2009). Recent researchers evaluating recidivism have not distinguished between program outcomes and the type of intervention or curriculum the program used (Richards, Jennings, Tomsich, & Gover, 2014). The purpose of this study was to determine whether structuring domestic violence intervention to allow victim-partner contact has a relationship with recidivism and program completion rates. I also explored the relationship that treatment-approved minor children contact in the home has on those same treatment outcomes. I compared the areas of general recidivism, person-on-person crime recidivism, and treatment completion between those offenders who had victim-partner contact and/or their minor child approved to be in their home during their treatment and those offenders who did not. The data came from the archival files of 678 individuals who participated in domestic violence intervention in the Northwestern United States, between 2010 and 2012.

Practitioners who develop domestic violence offender interventions primarily aim to decrease recidivism rates (Olver, Stockdale, & Wormith, 2011). Frantzen, Miguel, and Kwak (2011) completed a large study on the recidivism rates of domestic violence offenders, reporting that 22% of domestic violence perpetrators were charged with additional domestic violence charges after their initial charge. A lack of treatment

compliance and high dropout rates are pervasive problems for domestic violence offender treatment programs. For example, Gover, Jennings, Davis, Tomsich, and Tewksbury (2011) reported that the low rate of treatment completion was one of the most problematic issues related to domestic violence intervention and also contributed to high recidivism rates.

Historically, domestic violence interventions have separated the perpetrator from the victim-partner with the intended goal of securing the victim's safety (Olver et al., 2011). In a meta-analysis on recidivism, Olver et al. (2011) reported that the rate in programs that isolate and treat the domestic violence offender had a recidivism rate of 37.8%. According to the Domestic Violence Research Foundation, current recidivism rates for those who are convicted of domestic violence offenses range from 30% to 40%, regardless of the interventions used. The California Partnership to End Domestic Violence (2015) reported that such programs in California did little to impact recidivism rates. Individual characteristics such as desire to change were more of a predictor of whether a person recidivated than whether they completed any type of treatment (California Partnership to End Domestic Violence, 2015).

Donovan and Griffiths (2013) completed a longitudinal study over a 3-year period on both perpetrators and victims of domestic violence who were referred to social services in the United Kingdom. They demonstrated that only 24% of male domestic violence perpetrators initially referred for treatment completed that treatment (Donovan & Griffiths, 2013). The reasons given for the low completion rates were that the perpetrators were not engaged with the family unit and female social work practitioners

were often biased due to their fear of the perpetrators. These findings matched those of previous studies by revealing high treatment attrition rates.

Gover et al. (2011) completed a study in Colorado exploring the variety of dynamics related to domestic violence interventions in relation to treatment completion. One of the conditions the researchers assessed was the relationship between treatment completion and having the perpetrator living with their victim-partner at the time of discharge from treatment (Gover et al., 2011). This study included 4,000 male participants, and the results demonstrated that those who were living with their victim-partner at the time of discharge were 106% more likely to complete treatment than those who were not living with their partners at the time of discharge. The findings were limited, however, because the researchers did not explore recidivism after discharge, making it difficult to determine the relationship between living together and recidivism.

Mills, Barocas, and Ariel (2013) completed a study exploring the outcomes of 155 cases of domestic violence. The researchers performed this study in Arizona to measure the effectiveness of The Circle of Peace curriculum compared to typical batterer intervention treatment (Mills et al., 2013). While there was no significant difference between those who participated in the Circle of Peace curriculum compared to other traditional curricula, the researchers discovered that of the 155 perpetrators, 46% received the intended treatment from the two treatment groups combined. Those in the traditional batterer intervention programs had a recidivism for violent crimes of 21% and crimes in general of 44% (Mills et al., 2013). While these researchers did not address treatment-approved victim-partner contact, their findings demonstrated low completion

rates and high recidivism rates over a 2-year period after conviction for those who participated in domestic violence intervention.

Olver et al. (2011) completed a meta-analysis that included 34 studies over 8,232 domestic violence offenders and demonstrated an attrition rate of 37.8%. Their findings indicated that violent recidivism was 10% higher and general recidivism was 20% higher for those domestic violent offenders who did not complete the programs. The limitations of this study included that the researchers did not indicate the length of interventions the participants were referred for, nor did they reveal the percentage of domestic violence offenders who never began treatment after being referred.

Missing in the research is a quantitative study that explores the relationship of having partner approved contact between domestic violence offenders and their victim-partners. In a qualitative study, Todahl et al. (2012) explored the relationship of having victim-partner participation in treatment. These researchers evaluated whether victim-partners were safe by looking at the relationship between victim-partner contact and recidivism. Spjeldnes et al. (2012) explored the relationship between family and social contact with recidivism among all types of offenders. These scholars explored the relationship of family support—in the form of approved victim-partner contact—to treatment completion, general recidivism, and recidivism involving person-on-person crimes among domestic violence offenders. The purpose was to explore whether their findings would uncover a similar relationship with domestic violence offenders in relationship to approved victim contact. Gover et al. (2011) reported that domestic violence offenders who were living with their victim-partners were 106% more likely to

complete the domestic violence intervention they were referred to than those who were not living with their victim-partners. Gover et al. did not indicate whether there was treatment-approved contact during treatment and did not explore recidivism rates, as I did in the current study.

Researchers, such as Howarth et al. (2015) and Obadina (2013), have reported the negative psychological impact of exposure to violence on children; such impacts include aggressive tendencies and/or PTSD symptoms. Emery and Buehler (2009) and Litrownik et al. (2003) indicated the resiliency of children after the elimination of violence from their environment. Stanley et al. (2012) completed a qualitative study in which fathers reported that their children were a motivation for positive change. Through this study, I aimed to bridge a gap in the literature concerning the relationship of having contact with children during domestic violence intervention with positive treatment outcomes.

Purpose of the Study

This was a quantitative study in which I aimed to explore the relationship between person-on-person crime recidivism, general recidivism, and treatment completion rates to interventions that include approved victim-partner contact during treatment compared to those offenders who had no-contact orders with their victim-partners while they participated in domestic violence intervention. I also intended to explore the relationship between treatment outcomes of recidivism, general recidivism, and treatment attrition for those who had their children approved to be in their home compared to those offenders who did not have their children in their home while they participated in domestic violence intervention. The overall purpose was to compare the relationship to outcomes

for those who had treatment-approved contact with their victim-families and those who did not have contact with their victim-family while participating in domestic violence intervention treatment. Recidivism is defined as being charged with a new crime in the 5 years after treatment. Recidivism for a violent crime means being charged with any person-on-person crime during the 5 years after treatment; in the Northwestern United States, where the research was conducted, domestic violence crimes are not separated from general assault charges. Treatment completion was defined as completing all components of state required batterer intervention curriculum, completing at least 36 weeks of treatment, and being deemed complete by both the treatment provider and the referral agent. I analyzed coded archival data in the form of a file review of a domestic violence intervention program in the Northwestern United States.

Variables

The population included those who were convicted of a domestic violence crime and were referred for and participated in domestic violence intervention treatment that followed the Northwestern United States Revised Standards for batterer intervention programs (BIP). The independent variables are those offenders who had children and were allowed to have them in their home while participating in treatment and those who had children and were not allowed to have them in their homes while in treatment; those offenders who had treatment-approved victim-partner contact while participating in treatment and those who were not allowed to have victim-partner contact while in treatment. The dependent variables were treatment completion, general recidivism within 5 years after intake into treatment, and person-on-person crime recidivism within 5 years

after intake. I analyzed victim-partner contact and having a minor in the home to determine whether these factors predict completion from treatment, general recidivism, and person-on-person crime recidivism.

Treatment Completion

The sample included offenders charged with a domestic violence crime and mandated to complete domestic violence intervention. The intervention met Northwestern United States Standards concerning length and substance. Completion required completing all components of the intervention such that both the treatment provider and the referral agent considered it complete. The population did not include those offenders who did not complete or who attended at least five sessions and stopped treatment for any reason before they were considered complete by the treatment program and/or the referral agent.

Recidivism

For this study, I defined recidivism as being convicted of any crime within 5 years after participation in an Northwestern United States certified domestic violence intervention program. The relationship with the independent variables was measured by either yes, they were convicted with a new crime within 5 years of their participation in treatment, or no, they were not charged with a new crime within 5 years of their participation in treatment. It was measured over a 5-year period after their treatment so that all offenders in this study were uniform in the amount of time they had to recidivate.

Person-on-Person Crime Recidivism

There are no distinct domestic violence charges in the state of Oregon, so person-on-person crime recidivism was defined as being charged with any new person-on-person crime within 5 years of being referred to a Northwestern United State certified domestic violence intervention program for intake and participation in treatment. The relationship with the independent variables was measured by either yes, they were convicted with a new violent crime within 5 years of treatment, or no, they were not charged with a new violent crime within 5 years of treatment.

Research Questions and Hypotheses

Based on the theoretical framework for this study, the research questions were as follows:

RQ1. Is there a statistically significant difference in the recidivism rates for any crime during the period of 5 years following BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families during BIP treatment and those who did not?

$H1_0$: There is no statistically significant difference in the recidivism rates for convictions of any new crimes between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H1_A$: There is a statistically significant difference in the recidivism rates for convictions of any new crime between domestic violence offenders who had treatment-

approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact.

RQ2. Is there a statistically significant difference in the recidivism rates for the 5-year period following BIP treatment for convictions of new person-on-person specific crimes, as defined by the Oregon Revised Statutes, between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact?

$H2_0$: There is no statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H2_A$: There is a statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

RQ3. Is there a statistically significant difference in completion rates of domestic violence offenders who attended at least five sessions of BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not?

$H3_0$: There is no statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H3_A$: There is a statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

Theoretical Framework

Most domestic violence interventions are psychoeducational in nature (Barner & Carney, 2011). These programs are often based on the cognitive behavioral theory (CBT) premise that if an individual's thinking process can be changed, a change in actions can result (Barner & Carney, 2011). According to Lawson, Kellam, Quinn, and Malnar (2012), most BIPs are based on a combination of CBT and/or feminist theory. The two theories are similar in practice because both attempted to change belief systems in order to change behavior (Lawson et al., 2012). The difference is that feminist theory focuses on reducing power differences between men and women, which are brought on by a patriarchal-based society and lead to male privilege or men using their power to abuse women. In contrast, CBT focuses on anger management, stress management, and basic relationship-building skills (Lawson et al., 2012). Most current BIPs integrate both CBT and feminist theory, rather than relying on one (Lawson et al., 2012). Bograd (1999) reported that many domestic violence treatments utilize *he*, *the offender* and *she, the victim* language. Historically, practitioners have developed domestic violence interventions on the premise that men are the perpetrators of domestic violence, while women are the oppressed victims (Bograd, 1999).

Oregon's statutes allow for freedom of curriculum and interventions if state standards are met. The Duluth Domestic Abuse Intervention Project (Duluth Model) and

Skills, Techniques, Options, and Plans (STOP) Program curricula have psychodynamic elements to them, which address the Oregon Revised Standards (Barner & Carney, 2011; Robinson, 2008). The Duluth Model has been the standard since the early 1990s, and many states have used it when developing their domestic violence interventions statutes. Some programs are transitioning to the STOP Program as an alternative to the Duluth Model. The domestic violence intervention program in the Northwestern United States, uses much of the Duluth Model curriculum but integrates it with the type of skill-building approach that STOP promotes. This hybrid program attempts to take the strengths from both approaches, with the awareness component of the Duluth Model and the application component of STOP, which in turn integrates CBT and feminist theory.

The psycho-educational approach of the Duluth Model originated in 1981. It is a multi-institutional team contribution of emergency responders (i.e., 911 operators), police departments, prosecutors, courts, several existing women's shelters, and human service agencies (Pence & Paymar, 1993). The approach focuses on the power and control men use against women to raise domestic violence offenders' awareness concerning abusive actions. The implication is that if men are more aware of their controlling behaviors, they will refrain from controlling and abusing their partners.

The Duluth Model focuses on the diverse types of abuse that men inflict on women through controlling behavior. It uses power and control wheel illustrations as a teaching tool to help perpetrators identify diverse types of controlling behavior, as well as the alternatives to such behaviors (Pence & Paymar, 1993). These wheels have eight spokes, with each spoke representing a type of control used, which is identified at the

hub. There is a separate wheel that uses its spokes to represent healthy noncontrolling alternative behaviors for every unhealthy spoke on the control wheel. A punitive aspect of the Duluth Model focused solely on the power and control aspect of a patriarchal-dominated society and had little focus on family constellation issues or cognitive triggers (Barner & Carney, 2011). The Duluth Model does not explore dynamics beyond male dominance in the family. While it may not address all the aspects of domestic abuse in the home, many offenders fit the offense dynamic the Duluth Model addresses. It soon became the foundation of an active government lobbying force and became written into law in most states. Duluth, Minnesota, was the first place to implement the Duluth Model as a part of written legislation. By the early 1990s, all 50 states had applied the Duluth Model into state law on some level (Pence & Paymar, 1993). The application of the model is still written into law in most states, but it has undergone criticism (Pence & Paymar, 1993).

Although the Duluth Model has been credited with raising the awareness of abuse for those who participate, some scholars have questioned its effectiveness in lowering re-offense rates among domestic violence offenders (Day, Chung, O'Leary, & Carson, 2009). While many issues make it difficult to track domestic violence re-offense rates—such as domestic violence charges not being categorized separately from other general assault charges—most researchers have indicated that both the Duluth Model and CBT approaches, which are used in most treatment programs, are not effective at lowering recidivism (Langlands, Ward, & Gilchrist, 2009). Researchers have presented evidence demonstrating that when perpetrators participate in a Duluth Model type of intervention

and when the victims attend an advocacy group, re-offense rates are not significantly improved compared with groups receiving no treatment (Stover, Meadows, & Kaufman, 2009). Some treatment providers have begun to explore alternatives to the Duluth Model in order to improve the effectiveness of domestic violence interventions.

The STOP Program, the second treatment model reviewed in this study, includes concerns from a feminist perspective, but has a client-centered focus and integrated approach in addition to addressing feminist concerns of power and control. Dr. David Wexler developed the program in 2000 after researching domestic violence (Robinson, 2008). The STOP Program focuses on areas of power and control as well as exercises aimed at developing empathy for women (Robinson, 2008). The emphasis on identifying client deficit and assisting them in gaining skills to address the needs is unique to the STOP Program's approach.

The STOP Program focuses on clients' learned behaviors to assist them in identifying learned social deficits to focus on when acquiring new skills. This program takes a social learning approach by helping clients explore how their developmental experiences shaped how they meet their needs in their current lives. STOP assists clients in learning new skills to address the dysfunctional social skills that have not been working for them (Robinson, 2008). The program relies on clients' strengths to regulate and manage the acquired skills (Langhinrichsen-Rohling & Friend, 2008). An advantage of STOP is its focus on clients' needs and the creation of an atmosphere conducive to motivating clients to accept change. The focus on universal experiences and needs has

contributed to STOP being adaptable to other populations, such as domestic violence among same-gender partnerships.

The STOP Program was developed as an intervention for men who committed domestic violence against women, but it has been used successfully with other populations (Robinson, 2008). The program's materials use masculine terms for the offender and feminine terms for the victim, but the experiences and needs addressed are universal regardless of gender (Robinson, 2008). STOP also promotes the idea of different subtypes of domestic violence offenders, rather than viewing all offenders as fitting the traditional power and control model (Langhinrichsen-Rohling & Friend, 2008). The adaptability of the program makes it easy to integrate with groups that include victim-partners. The focus on communication skills is unique to STOP, making it especially effective when adapting to work with couples (Langhinrichsen-Rohling & Friend, 2008). Follow-up research is needed on the effectiveness of this approach. I'll discuss the other approaches to domestic violence intervention further in Chapter 2. The relationship between family contact during domestic violence intervention and treatment outcomes is what this study intends to address.

Nature of the Study

The study was a quantitative study to explore the relationship that victim-partner contact and/or children in the home during domestic violence intervention has on treatment completion and recidivism. Previous qualitative researchers have explored the impact of contact with children and victim-partners during domestic violence intervention (Stanley et al., 2012; Todahl et al., 2012). In this study, I attempted to build on such

studies and approach the issue from a quantitative approach to determine whether a statistical relationship to treatment outcomes exists. I collected data in the forms of coded data sets, which are the result of a file review.

Definition of Terms

Domestic violence: I used the United Nations' definition for domestic violence, which has become a standard definition: Domestic violence against women is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (World Health Organization, 2016, p. 89). Domestic violence includes "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors" (World Health Organization, 2016, p. 89). According to the Oregon Revised Statute 135.230 (2015), abuse within the household includes:

> (a) Attempting to cause or intentionally, knowingly or recklessly causing physical injury; (b) Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury; or (c) Committing sexual abuse in any degree as defined in ORS 163.415 (Sexual abuse in the third degree), 163.425 (Sexual abuse in the second degree) and 163.427 (Sexual abuse in the first degree).

Domestic violence intervention programs: These programs provide a curriculum that teaches perpetrators to become aware of all forms of abuse and to take personal accountability for their actions. They typically teach skills such as anger management,

empathy, relaxation techniques, and timeouts **(**Rosenbaum & Leisring, 2001).

> Most commonly, batterers are treated in gender specific groups of determinant lengths. That is, the groups include only males, and are time limited…. Although there are groups that are open-ended, they primarily serve self-referred participants and are more like standard therapy groups. Groups serving court-mandated batterers are, of necessity, time limited, as judges could not be expected to sentence batterers to programs of indeterminate length. (p. 59)

Domestic violence victims: These include victims who have experienced physical violence (e.g., beating, kicking, strangling, destroying household equipment, poking, pushing over, severe battering), psychological violence (e.g., humiliating, offending, insulting, ridiculing, threatening, blackmailing, verbally abusing), sexual violence (e.g., rape or being forced to perform sexual acts), or economic violence (e.g., full financial/residential dependence) (Front-Dziurkowska, 2016).

Recidivism: This refers to being charged with a new crime. It does not refer to being rearrested on a parole violation because that could result in artificially high recidivism rates depending on the time remaining on criminal supervision after being referred for treatment. Defining recidivism as being charged with a new crime resulted in lower recidivism rates across the study but provided more consistency (Ostermann, Salerno, & Hyatt, 2015). According to Ostermann et al., defining recidivism by arrest rates alone becomes problematic when individuals are on criminal supervision because the arrest may be due to a simple parole violation. “The use of arrest data has the

advantage that information is available on every case, considering that many victims either do not report or underreport levels of abuse" (Frantzen et al., 2011, p. 397).

Person-on-person crime recidivism: For this study, this was defined as "any offence against a person that included homicide offences, (sexual) assault, robbery, kidnapping, threats of violence, and use of weapons" (O'Brien & Daffern, 2016, p. 783). Violent recidivism rates do not distinguish between domestic violence and violence from other crimes (Langlands et al., 2009).

Assumptions

I assumed that the domestic violence intervention program in the Northwestern United STates, provided the treatment they reported and that they provided treatment criteria that met the guidelines of county and s. I further assumed that the treatment methods they documented using were accurate and used in the manner they stated. The data were based on archival information from client records. I assumed that the data were fair, accurate, and had not been tainted. I also assumed that the databases that track recidivism were accurate.

I assumed that *treatment completion* means that participants completed all completion criteria and received a certificate of completion from the program and that the program complied with state requirements. I assumed that *victim-partner contact* refers to treatment-approved contact between domestic violence offenders and their victim-partners. I assumed that because of the process they had to go through to acquire victim-partner contact, the contact was more than occasional incidental contact, which might be expected and would not require treatment-approval. Victim-partner contact may mean,

but does require, that the perpetrator move back into the home with the victim-partner. Many times, partners remain separated but have contact for the purposes of co-parenting.

Scope and Delimitations

The scope of the study was measuring risk for domestic violence offenders who were referred for domestic violence intervention in Lane County between 2010 and 2011. The offenders were referred by parole and probation, the courts, or the Department of Human Services to comply with State Certified Domestic Violence Treatment. The treatment model used was the Duluth Model enhanced with interventions from other models such as the STOP Program.

The purpose of the intervention program was to enhance domestic violence offenders' awareness of what constituted domestic violence, help them gain a better understanding of the impact of their actions, and help them to implement healthy alternative actions. Most treatment was facilitated in group settings with a few individual sessions interspersed during treatment for assessment and to help them complete their individual assignments. When victim contact was approved, it was done under supervision in a manner that allowed for assessment and review as contact increased. I did not account for those who may have had unapproved victim-partner contact.

The offenders were required to complete individual assignments that consisted of at least a victim empathy letter, an offense impact assignment, and an action plan for safe living. Domestic violence offenders who had victim contact were required to complete safety plans that assessed and minimized potential risks of violence with their victim-partners. I compared the outcomes between those who participated in treatment-

facilitated victim-partner contact and those who participated in traditional domestic violence intervention treatment without victim-partner contact.

The group I used for comparison did not include those deemed a higher risk to re-offend because they are either repeat offenders or demonstrated a higher level of violence due to the nature of their crime. Data from those who are higher risk were not explored because they would not typically be referred to reunification; including their data would add an additional independent variable, thereby making the study less reliable. Domestic violence offenders who are female, or have same-gender victims, or are transgender were not included in the scope of this study due to the small sample size of individuals in those categories.

Limitations

The participants were from the Northwester United States, which has an overwhelmingly Caucasian population; therefore, it should not be assumed the results would be the same over a wider demographic of domestic violence offenders. The focus was on recidivism rates between 2010 and 2012 in the Northwestern United States; therefore, it should not be assumed the results would be the same in another geographical location, with different demographics, or if the study was projected over a longer period. The treatment mode relied heavily on the Duluth Model in a group treatment setting; therefore, it should not be assumed that the results would be similar using a different curriculum or in different modes, such as individual or family system based treatment.

A limitation in the study was that the archival data only told whether they had treatment-approved contact with their victim-partner. There was no information regarding

whether the offender and victim were living together at the time of the intervention or not. While many offenders with approved contact likely did cohabitate with their victim-partner, it is not an aspect of victim-approved contact that could have been explored in this study.

The archival data included whether offenders had treatment-approved overnight contact with their minor children but does not give the ages of the children or any details concerning the children or the nature of the relationship between the offenders and their children. There are many demographics related to risk factors that were either not included or not consistently recorded in the data. It would be helpful to include risk factors, such as socioeconomic status and mental health diagnosis, but they were not included in the archival data used here.

The results were impacted by the therapist who implemented the intervention. The therapists' skill level in delivering the intervention could have a direct impact on the results. I assumed that both treatment groups—those with treatment-approved contact and those without—would be impacted at a similar level, but it is not a guarantee. While Oregon provided clear standards concerning what should be included in domestic violence intervention, there is also freedom for a provider to add other interventions as they deem necessary. The treatment standards and curriculum were based on Oregon standards. It cannot be assumed that the results would be similar in another state that has different standards for how domestic violence intervention should be implemented or for what constitutes domestic violence.

Another limitation concerned approved victim-partner contact. The data only contained information about whether no-contact orders were lifted and contact was approved. There is no information provided explaining the amount of contact between the domestic violence offender and the victim-partner after approved contact was given. The recidivism rates did not differentiate between recidivism for domestic violence and recidivism for other crimes. While this still gave a measure of comparison, it was limited because it did not explore recidivism for domestic violence specifically (Langlands et al., 2009).

Significance

Domestic violence is a problem that affects many individuals in the United States. Exact domestic violence statistics are often difficult to determine because domestic violence charges are often grouped together with other forms of violence. In a recent study, Frantzen et al. (2011) demonstrated that 22% of the domestic violence offenders in the study were arrested on another domestic violence charge within 2 years. According to the State of Oregon (2012), the recidivism rate for all convicted felons released from prison to probation after 2 years was 15.3% for any crime, including probation violations. The recidivism for sexual offenders by comparison was 13.4% for any crime, not just new sexual offenses (State of Oregon, 2012). Frantzen et al. (2011) compared diverse types of deterrents used against domestic violence offenders and found no significant difference among different forms of legal deterrents. Frantzen et al. further concluded that no-contact orders were not effective. If treatment-facilitated reunification of those couples who are already reunifying can make a positive impact, then such reunification

has the potential to improve the recidivism rates of domestic violence offenders (Frantzen et al., 2011).

Over half of the couples who separate because of domestic violence ultimately reunite (Griffing et al., 2002). More than half of the couples who seek marriage counseling have been involved in domestic violence, yet have received limited treatment (Schacht, Dimidjian, George, & Berns, 2009). The individuals who are vulnerable to domestic violence are those who have already been involved in it (Bischoff, 2006). An exploration of the relationship between treatment-approved victim-partner contact and recidivism could not only optimize the measurement of the risk level of this intervention with those who have committed documented offenses, but it could aid marriage therapists in determining the approach to take when working with couples who admit to domestic violence in their relationships.

Summary

The purpose of this study was to explore the relationship between treatment-facilitated victim-partner contact with treatment attrition, general recidivism, and recidivism for person-on-person crimes. Todahl et al. (2012) demonstrated in a qualitative study that participants—both perpetrators and victim-partners—perceived the benefits of victim participation in domestic violence intervention treatment. Through this quantitative study, I intended to measure the relationship between treatment-approved victim-partner contact during domestic violence intervention and outcomes, including general and person-on-person crime recidivism, as well as treatment attrition.

Chapter 2: Literature Review

Introduction

The purpose of this study was to evaluate the relationship between including victim-partners in domestic violence intervention and treatment outcomes of domestic violence offenders. To do this, I compared the outcomes of completion rates, general recidivism, and person-on-person crime recidivism for domestic violence offenders who had approved victim-partner contact during their treatment and those who participated in domestic violence intervention treatment without their victim-partners' involvement. The interventions included those participants who had treatment-approved victim-partner contact and those who did not have their victim-partner participate in treatment. The data were from a file review gathered from the domestic violence intervention program in the Northwestern United States.

Literature Search Strategy

I sourced the literature in this review through keyword searches in the Thoreau multi-database search tool and Google Scholar. I used keywords such as *domestic violence intervention*, *recidivism*, *attrition*, *children and domestic violence*, and *risk levels* in the search. I used the reference lists in key articles to find additional articles. The keywords were developed based on the general variables I initially intended to focus my study on.

A review of existing literature focusing on current studies that have been published in professional journals is significant to providing information about the topic under review. This section includes a review of scholarly research from literature sources

exploring recidivism and treatment attrition rates among domestic violence offenders. In this section, I also reviewed scholarly research related to victim-partner contact and the potential impacts on the family. This included a review of recidivism and what the rates of recidivism are for domestic violence offenders are as well as how interventions have impacted recidivism, treatment attrition the relation to risk of recidivism, and a review of family reunification in other contexts. I provided a review of the literature concerning the psychological impact of domestic violence against adults and children.

Domestic Violence Recidivism

Recidivism is the key marker that I explored in this study in order to determine the efficacy of treatment-facilitated contact between domestic violence offenders and their victims. Researchers have used recidivism rates to explore the rate that offenders commit acts of violence or commit new crimes in general (Frantzen et al., 2011). The prevalence of high recidivism rates, however, has demonstrated the need to develop more creative intervention strategies (Frantzen et al., 2011).

Walters and Cohen (2016) explored the correlation between criminal thought process and recidivism. These researchers used 1-year changes on the General Criminal Thinking (GCT) score of the Psychological Inventory of Criminal Thinking Styles (PICTS) to measure criminal thinking on 35,147 male and 5,254 female federal probationers on supervised releases (Walters & Cohen 2016). They discovered a correlation between high scores on the PICTS and recidivism. Walters and Cohen also explored whether cognitive based treatment programs that helped to lower PICTS scores would correlate to lower recidivism, and they found a significant correlation. In the

context of domestic violence offenders, these findings suggest that if domestic violence intervention programs could lower perpetrators' criminal thinking, lower recidivism rates would result.

Swogger et al. (2015) competed a quantitative study measuring the relationship between recidivism and whether a violent crime was premeditated or impulsive in nature. They recruited and evaluated 91 individuals on federal pretrial supervision, concluding that premeditation correlated significantly with higher recidivism rates and was a valid predictor for future acts of violence. Llor-Esteban, García-Jiménez, Ruiz-Hernández, and Godoy-Fernández (2016) reported, "Intimate partner violence (IPV) is one of the most common types of aggression suffered by women, and worldwide, 38% of homicides of women and 42% of physical and/or sexual aggressions were perpetrated by their partners or ex-partner" (p. 40). Llor-Esteban et al. explored recidivism using the Spousal Assault Risk Assessment (SARA) Guide. They studied 90 men who were on supervision for IPV crimes and used the assessment to put them into high-, moderate-, and low-risk groups (Llor-Esteban et al., 2016). The offenders in the high-risk group had serious comorbid mental health issues, those in the moderate-risk group had antisocial features with no comorbid mental health diagnosis, and those in the low-risk group had no serious mental health issues and were characterized mainly by a lack of healthy conflict resolution skills (Llor-Esteban et al., 2016).

Several types of punitive intervention appear to have benefits. Doing nothing from a punitive perspective concerning domestic violence can be worse than doing something that initially appears to be ineffective. According to Frantzen et al. (2011),

individuals who are charged with—but not convicted of—domestic violence offenses are seven times more likely to be charged with a future domestic violence offense than those who are charged and convicted. Frantzen et al. demonstrated that perpetrators who had previously been charged with domestic violence were 58% more likely to be convicted rather than dismissed when receiving an additional charge compared to those individuals receiving their first charge. These authors evaluated 458 individuals charged with domestic violence offenses in Texas, ranging from assault to protection order violations compared to those convicted of assault (Frantzen et al., 2011). They identified that the most important indicator of recidivism among domestic violence offenders is previous domestic violence history; specifically, the more severe the injury was during the assault, the more likely the perpetrator was to recidivate (Frantzen et al., 2011). Frantzen et al. ultimately concluded that little can be done to prevent the reoccurrence of domestic violence; however, it is important to identify those who are engaging in a repeating cycle of violent behavior. The long-term nature of some individuals' domestic assault cycles could influence the results of studies completed over a shorter period.

Many studies concerning domestic violence and recidivism do not consider the long-term cyclical nature of domestic violence. Jones and Gondolf (2002) reported that most scholars have used follow-up research statistics 6 to 12 months after completion of intervention programs. When attempting to apply evidence-based treatment standards, determining the desired treatment outcomes has often been difficult due to the long-term nature of domestic violence abuse cycles (Jones & Gondolf, 2002). Many abusers can demonstrate control of their behaviors for short periods of time; therefore, follow-ups that

take place after less than 2 years may not be a long enough period to identify whether a perpetrator is going to remain abstinent from their violent behaviors (Jones & Gondolf, 2002). The patterns revealed that after individuals spend a significant amount of time in the emotional abuse category, they are highly likely to commit physical violence. If someone committed physical violence, they are unlikely to move back to the lowest stage of violence (Jones & Gondolf, 2002). Those who spent a considerable time in the third stage were unlikely to reach the physical violent stage (Jones & Gondolf, 2002). An exploration of the longer-term patterns of couples who have had domestic violence in their relationship would provide insights into which couples would be successful and which couples who would be at the greatest risk.

Clark (2011) completed a literature review exploring whether factors such as age, race, and type of crime correlated with recidivism rates. Clark stated that "almost 70 percent of homicide offenders were between the ages of 21 and 40 when released indicating they were in teens to early twenties when they committed their crimes" (p. 11). The likelihood of committing a crime in general peaks when a person is approximately 18 years old, and then declines. According to Clark, the younger someone is when they commit their first crime, the more likely they are to commit a second crime and thus viewed age as one of the leading predictors of recidivism. Clark also indicated that substance abuse was especially correlated with recidivism for violent crimes. The type of violent crime also correlated to recidivism (Clark, 2011). If the crime was an accident or an isolated event, the recidivism rate was lower than if it was premeditated or part of a pattern (Clark, 2011).

High recidivism rates are an issue that domestic violence intervention providers still seek to address. Factors such as education, employment, and marital status appear to have the most significant relationship with recidivism. Treatment attrition is another factor with a significant relationship to recidivism (Gover et al., 2011).

Treatment Attrition

Gover et al. (2011) completed a study on domestic violence intervention treatment completion, concluding that couples often decide to remain together after the perpetrator begins treatment, but the victim is three times more likely to be re-assaulted if the perpetrator does not complete treatment. Gover et al. suggested that perpetrators' capacity to complete treatment should be carefully examined when assessing the safety of their victim-partner. Remaining with their partner, employment status, and abstinence from alcohol appeared to be the most key factors to treatment completion (Gover et al., 2011). In addition, first-time offenders were much more likely than repeat offenders to complete domestic violence intervention treatment (Gover et al., 2011).

Domestic violence offenders who participate in and complete treatment have been identified as having a higher level of positive outcomes compared to those who have not participated in treatment. Feder and Wilson (2005) found a correlation between treatment completion and lowered recidivism. When those results were further explored using victim reports, outcomes for those who participated in domestic violence interventions and did not complete them were not significantly different from those offenders who had not participated in domestic violence intervention (Feder & Wilson, 2005). Feder and Wilson demonstrated the need to foster dialogue with victims in order to receive a true

indication of treatment progress. Treatment could teach perpetrators to avoid law enforcement while still engaging in abusive behaviors.

According to Olver et al. (2011), when focusing on domestic violence intervention, treatment attrition rates need to be considered. Domestic violence offenders have the highest attrition from treatment rates of any type of criminal offender (Olver et al., 2011). Olver et al. demonstrated that over 50% of those who were referred to domestic violence intervention did not complete it, compared to 27% of other types of criminal offenders. Domestic violence programs with a cognitive behavioral focus had the lowest attrition rates at 27%, but the most violent offenders still had an attrition rate of 57% (Olver et al., 2011). Olver et al. reported that the three main reasons for attrition were economic, education, and ethnic barriers. Ethnic barriers referred to the differences across cultures of what constitutes family structure and what is considered domestic violence (Olver et al., 2011). Identifying those who began treatment and dropped out was helpful in identifying the types of domestic violence offenders who were most likely to not complete domestic violence intervention treatment.

Olver et al. (2011) reported that those who were referred to domestic violence treatment and did not complete had a significantly higher rate of recidivism than those who were referred to and completed treatment. Those who were referred to and dropped out of domestic violence intervention were more likely to recidivate than were those never referred to domestic violence intervention, leading some researchers to hypothesize that having a client begin domestic violence intervention treatment and not complete can worsen the behavior (Olver et al., 2011). Olver et al. completed a meta-analysis exploring

the relationship between treatment completion and recidivism. Their review covered 114 studies representing 41,438 offenders from both domestic violence and sexual offender treatment programs. The attrition rate for domestic violence offenders was 37.8%, compared to 27.6% for sexual offenders (Olver et al., 2011). The data from both offender programs demonstrated those who did not complete treatment were 10% more likely to recidivate with a violent crime and 27% more likely to recidivate in general (Olver et al., 2011). These researchers also labeled those least likely to complete treatment as high-risk and high-need clients (Olver et al., 2011).

Petrucci (2010) completed a study that was substantial in sample size and length on the efficacy of 52-week domestic violence intervention programs in California at lowering recidivism. California and Oregon require longer domestic violence intervention than most states do (Petrucci, 2010). Petrucci reported on a 4-year follow-up completed in California on men who had been arrested for misdemeanor domestic violence. The men were referred to 52-week domestic violence intervention programs. The rearrest rates after 4 years for those who completed the programs were significantly lower than those who failed to complete them (Petrucci, 2010, p. 143). Petrucci hypothesized that treatment requirements for abstinence from illicit drugs over an extended period contributed to the lower rearrest rates because many rearrests are substance abuse related. Petrucci hypothesized that longer programs may be more effective at both treating domestic violence and identifying those who are most likely to be successful at sustaining abstinence from violence. The punitive aspect of domestic violence intervention is typically present due to the programs' coordination with law enforcement agencies.

Gover et al. (2011) explored the factors relating to treatment completion. They discovered that white women were most likely to complete treatment, and those living with their partner—regardless of gender—were significantly more likely to complete treatment (Gover et al., 2011). The findings indicated that many of the other factors which they explored in relationship to treatment completion had mixed results.

Buttell and Pike (2002) completed a similar study exploring the dynamics associated with treatment attrition and treatment completion. They looked at the Domestic Violence Inventory (DVI) scores of 91 men, 66 of whom completed treatment and 25 of whom did not complete treatment. The findings were inconclusive concerning the relationship between psychological factors and treatment completion. But Buttell and Pike concluded that educational attainment, employment status, self-reported alcohol use, and marital status had significant relationships with treatment completion.

Other researchers, such as Spjeldnes, Jung, Maguire, and Yamatani (2012), have suggested that for criminal offenders in general, family support and involvement reduces recidivism. Spjeldnes et al. reported that family support was correlated with lower recidivism and higher levels of self-esteem. Exploring whether positive family support would have the same relationship for those who are on supervision for domestic violence offenses may have value. Although there are no quantitative studies considering the efficacy of treatment-approved victim contact by domestic violence intervention programs, scholars have demonstrated that criminal offenders in general benefit from being integrated into the family, so they have family support (Spjeldnes et al., 2012). There is a lack of quantitative information, however, concerning the association between

approved victim-partner contact during domestic violence intervention treatment and outcomes such as treatment completion, general recidivism and person-on-person crime recidivism.

Spjeldnes et al. (2012) suggested that family support reduces recidivism for criminal offenders in general. It would be valuable to determine whether positive family support has the same impact for those who are on supervision for domestic violence offenses. Anderson et al. (2013) reported a significant benefit for couples involved in anger management groups together. Future explorations of these behavior variables with longer-term follow-up intervals may provide additional information to expand these findings. It might be helpful to study couple treatment groups where the couples admitted to physical violence in the relationship, but there had been no legal involvement. When approaching treatment intervention for those individuals who have committed acts of physical aggression, the safety of all individuals involved must be considered.

VanMeter, Laux, Piazza, Ritchie, Tucker-Gail (2015) studied the relationship between substance abuse screening results and recidivism and treatment attrition for domestic violence offenders. The purpose of the study was to determine whether substance abuse screening results could be used as a predictor for recidivism and treatment attrition. VanMeter et al. reported high recidivism rates and treatment attrition rates, ranging between 40% and 60%, as motivation for the study. They found no significant relationship between substance abuse screening results and either recidivism or treatment attrition rates (VanMeter et al., 2015).

Brodeur, Rondeau, Brochu, Lindsay, and Phelps (2008) explored whether the trans-theoretical model could accurately predict treatment attrition for domestic violence offenders. They measured the four constructs of stages of change, decisional balance, self-efficacy, and processes of change to explore whether those factors served as predictive factors for treatment attrition (Brodeur et al., 2008). The sample group consisted of 302 French-speaking Canadian men in five different domestic violence intervention programs. Brodeur et al. failed to demonstrate a significant relationship between their dynamic factors and treatment attrition, but they did demonstrate that sociodemographic variables such as age, education, income, marital status, criminal history, and drug/alcohol consumption have significant correlations to treatment completion.

Jones and Gondolf (2002) argued that treatment interventions are more effective at identifying domestic violence offenders who would typically be successful regardless of treatment than they are at treating those most likely to reoffend. Jones and Gondolf indicated that perpetrators who are psychologically healthy when beginning treatment are more likely to complete a domestic violence intervention program. The healthy individuals who complete such programs influence the results of typical treatment outcome studies (Jones & Gondolf, 2002). The likely bias of those who are most likely to be successful at completing treatment needs to be considered when exploring the results of intervention outcome studies concerning domestic violence.

Family Reunification

State welfare systems often address issues of family violence where law enforcement has not become involved and have provided valuable information concerning the process Jones and Finnegan (2003). The child welfare system engages in family reunification by returning children to homes after the issues that could be detrimental to the child have been addressed. Jones and Finnegan explored the family reunification process in Oregon after children were removed from the home. The purpose of this process was to bring all support people into collaboration to participate in the intervention process (Jones & Finnegan, 2003). The researchers revealed that families that were more engaged in the process were typically matriarchal with fathers absent from the process. Jones and Finnegan hypothesized that fathers often were often excluded from this processes due to biases on the part of social workers. They concluded that the participation of support people such as friends and extended family in the intervention increased the participation of both parents (Jones & Finnegan, 2003). Cole and Caron (2010), who completed a qualitative study on successful family reunification cases involving domestic violence, indicated that the primary element in common was the parental involvement with provider services. Those who were successful typically had a good working relationship with their social worker and other support staff (Cole & Caron, 2010). Family reunification appeared to be most effective when all parties were involved, yet biases may have led fathers to become disenfranchised from the process. It may be beneficial to focus on what social workers have found to be successful, such as exploring ways to build working relationships with families.

An exploration of the factors that contribute to successful reunification within the social work context may facilitate effective applications within the domestic violence intervention context. Cole and Caron (2010) interviewed social workers concerning the dynamics between successful family reunification involving children compared to family reunification, which was unsuccessful. The researchers concluded that the level of success depended on the level of accountability of both parents involved (Cole & Caron, 2010). The mothers were likely to be successful in having their children returned to their home if they acknowledged the partner violence and held themselves accountable for any of their own participation in violent behaviors (Cole & Caron, 2010). Fathers were more likely to be successful at becoming reunified with their families when they were willing to take full accountability of their abusive actions and address them in treatment (Cole & Caron, 2010). Cole and Caron's study was qualitative, so the authors did not analyze data from a large sample size. The findings of Cole and Caron, in comparison to those of Jones and Finnegan (2003), demonstrated that fathers can be safely integrated back into families if they are willing to be accountable for their abusive behaviors. Both sets of researchers demonstrated the need for accountability of all parties within family reunification to be fundamental to success.

When addressing violence in the home, the traditional mode of conflict resolution has been separation of the partners involved. Recently, some scholars have begun to challenge the separation approach from a treatment standpoint. Anderson et al. (2013) completed a 2-year study using curriculum with the purpose of enhancing anger management and other relationship skills. Anderson et al. reported that most of the

couples involved in their study did not report being at risk at the start of the study. The couples generally reported significantly higher levels of marital satisfaction after 6 months in the couples' groups (Anderson et al., 2013). While these authors did not directly address domestic violence, they demonstrated the efficacy of treating anger management in couples groups. They recommended further research integrating additional behavior variables and implementing longer-term follow-up intervals. When approaching treatment intervention for those individuals who have committed acts of physical aggression, it is important to consider the safety of all individuals involved.

The safety of the female victims of domestic violence is a core goal of domestic violence interventions. Practitioners have previously assumed that it is ideal to separate the domestic violence perpetrator from his or her victim (Schneider, 2008). Several researchers, however, have explored whether such separation is ideal in every situation. Bischoff (2006) completed a meta-study, reporting that widely-accepted treatments are those that emphasize work with domestic violence offenders segregated from their families. Bischoff indicated that most practitioners view the treatment of couples within domestic violence intervention as harmful and putting women at risk of further abuse. Bischoff reported that many researchers have attempted to understand the partner dynamics in domestic violence, and have recommended holding offenders accountable and not supporting offenders in shifting the blame for their own actions to the victim (Bischoff, 2006). Additional research may be useful in aiding therapists who work with couples in providing treatment to hold domestic violence offenders responsible and not blaming the victim. The results of these studies may be helpful when working with

offenders with histories of domestic violence, but who are not currently violent (Bischoff, 2006). Bischoff's emphasis on accountability matches that of Cole and Caron (2010), who emphasized the importance of accountability when exploring the elements that contribute to successful family reunification. When offenders are willing to take personal accountability for their actions, the prognosis for successfully treating them within the couple dynamic improves. If addressing domestic violence within the family unit is an effective intervention for domestic violence, the types of interventions used may need to be explored.

Exploring how domestic violence intervention programs can screen offenders and facilitate treatment-approved contact and reunification is important. The most comprehensive study to date concerning treating domestic violence within the couple unit was a qualitative study by Todahl et al. (2012), who completed interviews with couples who participated in couple's groups as part of domestic violence intervention. When it came to perception of safety, none of the participants reported perceiving themselves as unsafe during the process. The participants stated that they understood that such a program could increase risk but felt that the format of the program adequately addressed safety considerations (Todahl et al., 2012). The participants indicated the benefits from participating in the program. The participants reported learning from other couples and viewing how other couples addressed problems that were like their own. They indicated attitude changes were associated with a greater awareness of their own needs, the needs of their partner, and how their behavior impacted them both. Participants reported having learned valuable tools such as communication skills and stress management (Todahl et

al., 2012). The results of the qualitative interviews revealed that there can be much value in addressing domestic violence within the family. This study needs further follow-up with a study qualitative in nature that takes place over a longer interval of time thus providing further evidence to the efficacy of domestic violence providers employing couple of groups to treat domestic violence.

Researchers who explored the issue of domestic violence in the family the impact of assisting the family within the family unit have demonstrated there are some treatment dynamics, such as accountability of the offender, that contribute to safe family reunification. There are other researchers who have either explored anger management curriculum or performed studies which were qualitative. There is a lack of quantitative data that directly addresses the issue of domestic violent treatment providers facilitating contact between domestic violence offenders and their victims.

Domestic Violence Intervention Strategies

Treatment-facilitated contact between domestic violence offenders and those they victimized should be explored in the context of other types of interventions used with domestic violence offenders. It may be helpful to understand the history concerning the development of domestic violence intervention to understand interventions that are currently used.

History

The women's shelter movement, which began in the 1970s, has impacted the concept of domestic violence intervention. It did so by addressing the need to protect women, without addressing the need to treat domestic violence offenders (Barner &

Carney, 2011). The Duluth Model was the first standardized treatment for domestic violence abusers; this model grew out of the women's movement. It was created as a tool to help abusers identify the diverse ways in which they used power and control to abuse women (Barner & Carney 2011). The need for domestic violence intervention became part of public awareness after the Tracy Thurman 1984 case in Connecticut, in which the victim was nearly killed in a domestic incident (*Thurman v. City of Torrington*, 1985). The victim won a lawsuit against local police for failure to protect. The situation helped to move public sentiment, gaining national attention for the issue and helping transition domestic violence from a family court issue to offender-based court management (Barner & Carney, 2011). The first reaction to the Thurman case was an increased emphasis on the women's shelter movement, which segregated female victims from their abusive partners in order to protect them (Barner & Carney, 2011). Corvo, Dutton, and Chen (2008) cited that historically, domestic violence offenders have been isolated, thereby limiting their access to social supports. The historical context domestic violence intervention was developed in had an important impact on the Duluth Model becoming part of state statutes (Olver et al., 2011). The goal of such domestic violence interventions is to lower violence recidivism and to keep women safe.

Treatment Responsivity

Researchers have identified a relationship between treatment completion and lowered recidivism. Frantzen et al. (2011) concluded that the treatment outcomes between those who participated in and completed domestic violence interventions and those who did not complete were not significantly different. Maiuro and Eberle (2008)

suggested that the outcomes of domestic violence intervention are effective when using the appropriate strategies. Olver et al. (2011) indicated that domestic violence interventions require a risk-needs-responsivity approach to treatment. Gondolf (2009) recommended more varied approaches to domestic violence intervention in order to address the individual needs of those being treated.

Matching appropriate treatment models to therapeutic needs is a significant element in general in mental health treatment. Domestic violence treatment strategies that have demonstrated the most effectiveness have followed the model of risk, needs, and responsivity (Olver et al., 2011). Risk refers to matching the treatment to risk level of the client (Olver et al., 2011). Need refers to identifying the clients' felt and demonstrated needs and providing healthy alternatives to help them meet those needs (Olver et al., 2011). Responsivity refers to a program which is cognitive behavioral in nature and which engages the clients in a manner that motivates them and appeals to their learning styles. Day et al. (2009) indicated that clients' needs may change during treatment as they move through stages of change. It is necessary to respond to the needs of domestic violence offenders for treatment to be effective.

There are patterns in domestic violence intervention programs that have been demonstrated to contribute to positive treatment outcomes. Maiuro and Eberle (2008) completed a study exploring the efficacy of interventions used with domestic violence offenders. The interventions that were more collaborative in nature provided treatment providers with increased freedoms—within standards—to explore new methods of

treatment and have more individual treatment plans (Maiuro & Eberle, 2008). These authors also provided recommendations, including:

> …procedures for regular updates, review committees with members who are familiar with the latest research, improved standardized risk assessments, improved screening for substance abuse and mental illness, evolve from a 'one size fits all' model to a client centered evidence based approaches, and victim safety protocols which include innovative need based approaches, treatment program evaluation procedures and standards, and procedures for evaluating specialty populations such as minorities, homosexuals, military, and women. (Maiuro & Eberle, 2008, p. 149)

It is essential for programs to address needs, meet standards for internal evaluation, and evolve with research and cultural changes. Part of addressing individual needs is addressing mental health needs in addition to the initial domestic violence referral.

Abuse perpetrators often receive additional diagnoses; therefore, addressing the needs of these individuals often means addressing dual-diagnosis mental health needs. Gondolf (2009) examined the relationship between participants referred to domestic violence intervention who had mental health assessments and subsequent mental health treatment compared to those who only received domestic violence intervention. Perpetrators who had completed mental health evaluations were six times more likely to complete domestic violence intervention (Gondolf, 2009). The male perpetrators who complied with mental health treatment were one third less likely to commit another assault during the 15-month evaluation period (Gondolf, 2009). Addressing domestic

violence may mean addressing underlying mental health issues to be successful. When considering the correlation of recidivism between those who fail to complete domestic violence intervention, those who have needs addressed in a way that contributed to treatment completion appeared to benefit on multiple levels. The language used by treatment providers can help support clients in becoming more invested in their treatment.

Language can facilitate a therapeutic alliance with clients, but it must be used in a way that enables clients to take personal accountability for their violent behaviors. According to Adams (2012), when domestic violence treatment providers view domestic violence as a premeditated plan a with a goal of power and privilege, they often have difficulty engaging men who view themselves as disempowered by their circumstances, which may include separation from their family, loss of their children, legal problems, substance abuse, and their own history of being abused (Adams, 2012). Practitioners use intervention approaches to attempt to address the dichotomy between how men domestic violence offenders view themselves and how others view them (Adams, 2012). It is important to recognize how disempowered clients may perceive themselves, while still holding them accountable for their abusive actions. Practitioners use different approaches to bridge the gap between therapeutic empathy and accountability.

Feminist Approach

There are benefits to treatments that explore domestic violence from a feminist approach. The individual approach explorers the origin of the behavior, while the feminist approach de-emphasizes the origins and focuses on the social utility of the

violence (Adams, 2012). The pro-feminist approach focuses on how the domestic violence abuser uses violence to gain power and control (Adams, 2012). The interventions focus on assisting men with taking responsibility for their behavior and the safety of those with which they engage (Adams, 2012). The dilemma of focusing solely on the ways that men use power and control against women is that they often perceive themselves as powerless for the following reasons: "(a) prior experiences of being abused; (b) issues with alcohol and other drug use; (c) poor expression of emotional needs; (d) insecurity in relationships; (e) involvement in legal proceedings; (f) social isolation" (Adams, 2012, p. 461). The pro-feminist approach is helpful in assisting domestic violence offenders in exploring the motivation and methods of their violence. The Duluth Model was originally based on a pro-feminist model.

Duluth Model

The Duluth Model was the original standard for domestic violence intervention. This model was a community-based program intended to facilitate interventions in domestic violence cases (Bilby & Hatcher, 2004), with the goal of coordinating treatment provider interventions with other agencies such as the criminal justice system (Bilby & Hatcher, 2004). The original program consisted of a 24-week non-violence curriculum that the creators designed to lower the likelihood court mandated domestic violence offenders would re-offend (Bilby & Hatcher, 2004). The focus of the curriculum was to challenge the attitudes and beliefs that contribute to domestic violence, while enhancing the perpetrators' social skills and victim empathy (Bilby & Hatcher, 2004). The Duluth

Model effectively raises perpetrators' awareness concerning how they abuse and control women.

The Duluth Model remains the most commonly used domestic violence intervention, despite many researchers demonstrating its ineffectiveness at reducing violent behavior (Corvo & Dutton, 2009). When strictly applied, some researchers have criticized the Duluth Model for ignoring serious the mental health issues and substance abuse that often influence domestic violence offenders (Corvo & Dutton, 2009). Several scholars have questioned the efficacy of current domestic violence intervention programs (Corvo & Dutton, 2009). Many researchers have demonstrated that mandating male offenders to traditional domestic violence intervention has no significant impact on recidivism (Corvo & Dutton, 2009). In many cases, the Duluth Model has become part of state law, and is therefore not subject to the same level of appraisal and review that other programs receive (Corvo & Dutton 2009). When used without other interventions, the Duluth Model appears to raise awareness concerning how men abuse and control women, but does not seem to assist offenders in the development of alternative behaviors to prevent recidivism.

Day et al. (2009) explored some of the reasons why rehabilitation programs for male perpetrators of domestic violence appear to be less effective in reducing recidivism than programs for other offender groups. Despite the strength of the Duluth Model in raising awareness of abuse and in developing an approach integrating domestic violence with the criminal justice system, scholars have debated over providing the range of treatment required for effective domestic violence offender treatment (Day et al., 2009).

Although the Duluth Model provides increased awareness of abuse against women, it does not adequately provide a model for change (Day et al. 2009). The Duluth Model highlights a need for change but does not provide sufficient direction for the change to occur (Day et al., 2009). The family system approach provides an intervention approach to help perpetrators address domestic violence within the family context.

Family System Approach

The family system approach is the most recent development in domestic violence intervention. Oka and Whiting (2011) explored the efficacy of treating violence within the family system. They performed a meta-analysis to explore the diverse types of treatment methods used within the family system (Oka & Whiting, 2011). Narrative therapy was reported to be an effective therapy when both members of the couple are engaged in treatment, desiring change, and willing to be accountable for their contributions to the violence (Oka & Whiting, 2011). There is a lack of data demonstrating an adequate level of safety for victims of violence when using this method (Oka & Whiting, 2011). Researchers have demonstrated collaborative therapy—where couples are engaged in the process, develop safety plans, and are actively engaged in the process—to be the most effective of the Family System models for working with families where domestic violence has taken place at reducing incidents of violence (Oka & Whiting, 2011). More studies on the collaborative approach are needed concerning long-term effectiveness in reducing violence (Oka & Whiting, 2011).

Solution-Focused Brief Therapy

Solution-focused brief therapy focuses on the immediate need but does not give a foundation for treatment or require accountability. Solution-focused brief therapy has had the most criticism because it does not set clear boundaries at the onset typically needed to facilitate safety for all parties after violence has taken place (Oka & Whiting, 2011). Interventions which focus on problem solving may be helpful when combined with other interventions that set boundaries and call for accountability. Emotionally focused therapy is another type of family system therapy which has received criticism yet may have benefits when used in the correct context.

Emotionally Focused Therapy

Emotionally focused therapy has received much criticism when addressing the needs of families who have a repeating pattern of violence (Oka & Whiting, 2011). Scholars have suggested that this therapy can open the vulnerable partner to further abuse (Oka & Whiting, 2011). Emotionally focused therapy can be an effective method for addressing situational violence, but further study is needed, and the participants would need to be thoroughly screened to differentiate between situational violence and a long-term pattern of violence (Oka & Whiting, 2011). The safety of all involved parties should be carefully examined when using any theory to address violence at a family system level (Oka & Whiting, 2011). Family system approaches appear to have efficacy as domestic violence interventions when they are used in the proper context and address identified needs. Family system approaches should only be used after screening has taken place to determine the appropriate intervention.

Social Learning Theory

Social learning theory has been used to explore and address the bi-generational nature of domestic violence. According to Cochran, Sellers, Wiesbrock, and Palacios (2011), intergenerational transmission theory (IGT) is the main social learning theory that practitioners use in domestic violence interventions with offenders. IGT views witnessing or experiencing domestic violence during childhood development as a likely contributor to future violence or victimization later during an individual's lifetime (Cochran et al., 2011). When children reach adulthood, they imitate the aggressive behaviors that they witnessed growing up (Cochran et al., 2011). Additional researchers have demonstrated the prevalence of intimate partner victimization, repeated victimization, and the frequency of victimization increase among those who have learned more rewards and fewer costs associated with domestic violence (Cochran et al., 2011). Helping clients explore the learned behaviors within the family context can serve as a beneficial intervention.

Per Abbassi and Aslinia (2010), family violence can be classified in three categories: "physical violence (including child and spousal beating), emotional violence (including verbal and non-verbal and/or negligence), and incest (including all types of sexual abuse)" (p. 17). Social learning theory researchers have viewed dysfunctional behaviors within the family as more circular than linear (Abbassi & Aslinia, 2010). This is also related to the concept of intergenerational behaviors, where behaviors are passed from one generation to the next (Abbassi & Aslinia, 2010). Social learning theory is built on the concept that people learn behaviors through repeated trial and error (Abbassi &

Aslinia, 2010). Trauma within the family may discourage a teenager from seeking parental advice about risk-taking. In addition, a lack of a healthy family structure can contribute to teens being disillusioned about the complexity of life dilemmas (Abbassi & Aslinia, 2010). Typically, dysfunctional families do not provide the structure needed to keep adolescents from taking part in risky behaviors (Abbassi & Aslinia, 2010). Adolescence from abusive families may not connect to their parents, leading them to seek unhealthy intimate relationships outside of the family (Abbassi & Aslinia, 2010). Social learning theorists have suggested that individuals meet their needs in either healthy or unhealthy ways.

Healthy and unhealthy behaviors are learned in the same way. For example, parents may shame children, which often contributes to poor attachments (Abbassi & Aslinia, 2010). Those children who learn to use aggression to substitute for a lack of attachments often abuse their partners when they reach adulthood (Abbassi & Aslinia, 2010). Some of the learned elements that researchers have cited as shaping behavior include: symbolizing, self-efficacy, self-regulation, self-reflection, and forethought (Abbassi & Aslinia, 2010). According to social learning theory, an emphasis on healthy adaptive behaviors and discouraging maladaptive behaviors is crucial to addressing children who have been physically abused, as well as preventing the perpetuation of the cycle of abuse (Abbassi & Aslinia, 2010). Focusing on skills as alternatives to these maladaptive behaviors assists perpetrators in gaining a healthy skill set as a replacement.

Individual Approach

One approach to domestic violence intervention is a focus on individual skill deficits. One method that takes this direction is the individual approach (Adams, 2012). The individual approach places emphasis on helping domestic violence offenders address their dysfunctional learned behaviors and teach them healthy adaptive skills (Adams, 2012). Critics of this approach have perceived that this does not hold the offender accountable for his or her actions and does not segregate the offender from others in a way that promotes safety (Adams, 2012). There is also a fear that the offenders might learn how to continue their behavior to offend without being prosecuted (Adams, 2012). Addressing skill deficits as part of an overall treatment approach which integrates interventions for building empathy and accountability would appear to address safety concerns, while meeting individual needs, which engages clients into the process.

One challenge for treatment providers is to engage domestic offenders, without colluding with them. If a therapist directly challenges the domestic violence offenders' feelings of disempowerment in the initial stages of treatment, the offenders may disengage and drop out (Adams, 2012). In contrast, if therapists use a more empathetic approach, they risk validating the offenders' justifications for violence (Adams, 2012). It is important to build a therapeutic alliance with clients, but therapists need to avoid language which can foster collusion (Adams, 2012). Focusing on the message that violence sends to others can be a helpful method of balancing.

Dr. David Wexler's STOP Program

Using language that portrays a violent event as communicating a message to the victim and affecting their perceptions in a social context has the potential to engage perpetrators of violence, without colluding with them (Adams, 2012). There are four essentials to this type of language shift. The first is to help domestic violence offenders understand that language helps them to shape social realities and perceptions others have of them (Adams, 2012). Second, the offenders must understand that violence communicates a message, so the practitioner must use language to help them to identify what message their violence is sending (Adams, 2012). Third, violence occurs within the context of other dysfunctional behaviors, which often increase the negative impact of the violent event (Adams, 2012). Finally, violence is impacted by the meaning and value that an offender puts on things (Adams, 2012). Through the development of the STOP Program, David Wexler attempted to balance meeting individual needs with holding domestic violence offenders accountable for their abusive behavioral choices.

The Wexler approach focuses on social skill building and elements meant to assist the perpetrators to become more aware of and accountable of their abuse. The Wexler approach seeks to build on both previous approaches and research-based evidence. Langhinrichsen-Rohling and Friend (2008) described David Wexler's STOP Program as an integrated approach. The curriculum is progressive in nature, with the first 12 sessions focusing on self-management and the last 12 sessions focusing on specific relationship skills (Langhinrichsen-Rohling & Friend, 2008). The STOP program attempts to build on the feminist approaches and assist clients in acquiring skills to address their identified

needs (Langhinrichsen-Rohling & Friend, 2008). The approach seeks to move from a one-size-fits-all model to integrated model to address domestic violence (Langhinrichsen-Rohling & Friend, 2008). It addresses the motivational needs subtypes that offenders possess (Langhinrichsen-Rohling & Friend, 2008). The STOP Program assumes that all domestic violence offenders have skill deficits for managing complex emotions and relationships (Langhinrichsen-Rohling & Friend, 2008). Wexler's methodology attempts to address unmet needs that leave men feeling powerless without colluding. The approach emphasizes personal accountability for dysfunctional behaviors (Langhinrichsen-Rohling & Friend, 2008). The Wexler approach appears to be best suited to address risk-need-responsivity, as Olver et al. (2011) noted while addressing individual needs, and as Gondolf (2009) suggested.

Domestic violence interventions integrate varied approaches which could be used within the family system and facilitate reunification. Family systems and social learning theory are commonly used systems to address reunification. Scholars have concluded that screening is necessary to determine which intervention approach is appropriate, including working within a family system or approaching treatment from a pro-feminist approach.

Risk Levels

Overview

Identifying risk levels is essential when determining which treatment intervention is appropriate. Risk levels need to be determined when deciding if the intervention of treatment-approved contact between domestic violence offenders and their victims is appropriate. The issue of risk assessment of domestic violence offenders is complicated

and includes many facets to be considered. There have been studies demonstrating what to consider when assessing risk of violence and have led to the development of evidence-based risk assessments. Many therapists who work with families that are not engaged in the legal system often overlook the need to engage in risk assessment.

Family Therapists

Family therapists often work with families in which violence has taken place, yet they often do not assess for domestic violence. Schacht et al. (2009) completed a national survey of 620 couple therapists randomly selected from the American Association for Marriage and Family Therapists. The researchers conducted this study to assess therapists' strategies for assessing domestic violence and selecting a treatment modality when violence is present (Schact et al., 2009). Fewer than 4 % of the participants reported consistently adhering to key published guidelines for domestic violence screening. A small percentage reported that they take the victim's safety into account when deciding a treatment plan. Schacht et al. indicated that current researchers have estimated that half to two thirds of couples seeking couple-oriented therapy reported a situation involving physical aggression within the previous year. Schacht et al. reported addressing domestic violence within couple therapy safe when treating couples who have demonstrated low levels of violence but not when treating couples where a cycle of physical aggression used for power and control has taken place. There are two risk assessments which have demonstrated effectiveness at assessing risk among domestic violence offenders.

Level of Service Scales Case Management Inventory (LSCMI)

The first and most widely used assessment is the Level of Service Scales Case Management Inventory (LSCMI). Olver et al. (2011) conducted a meta-analysis of the (LSCMI), measuring their predictive accuracy, ability to determine risks, and identify needs using 128 studies comprised of 151 independent samples with 137,931 individual offenders. The purpose of the study was to explore how a variety of independent variables impacted treatment outcomes and recidivism (Olver et al., 2011). The core independent variables were "criminal history, antisocial attitudes, antisocial personality patterns, and antisocial associations" (Olver et al., 2011, p. 172). The researchers found higher scorers in antisocial behaviors, antisocial behaviors attitudes, and criminal history directly correlated with future criminal behaviors (Olver et al., 2011). The LSCMI had the highest level of accuracy predicting recidivism in violent male offenders but was less accurate predicting recidivism in women and minorities, though still significantly accurate in predicting future criminal behaviors (Olver et al., 2011). The researchers noted the need for an LSCMI for minorities and women. The researchers stated that the implication for treatment was the need to address specific criminal needs within afore mentioned categories (Olver et al., 2011). The LSCMI effectively identifies those perpetrators who are most likely to commit further acts of violence. There are other risk assessments that focus on risk of violence within a couple.

Spousal Assault Risk Assessment (SARA)

The SARA has demonstrated significant validity in establishing risk among domestic violence offenders (Belfrage et al., 2013). SARA has demonstrated predictive

validity when used by law enforcement agencies (Belfrage et al., 2013). Belfrage et al. concluded that SARA can be used as a tool to both establish risk and identify need, both of which would assist intervention programs in suppressing future violence. Categorizing types of offenders can assist professionals in identifying which clients are most likely to continue to engage in violence.

Risk Behavior

Identifying violence levels and focusing on how long perpetrators remain in each level is one approach to identifying risk. Jones and Gondolf (2002) explored the recidivism trajectories of perpetrators to predict future behavior based on types of behaviors (Jones & Gondolf, 2002). The researchers categorized participants into four behavioral risk levels and measured how much time each client spent within each risk level (Jones & Gondolf, 2002). Sixty percent of the participants were in the minimal risk level and were unlikely to escalate to a higher level (Jones & Gondolf, 2002). Ten percent of the participants were in the highest risk level, and these individuals were highly likely to continue a violent pattern of violence (Jones & Gondolf, 2002). Those who were in the second and third levels of risk of violence were most likely to change (Jones & Gondolf, 2002). Those who were in the second level of risk were likely to move either up or down in risk level (Jones & Gondolf, 2002). Those who were in the lowest risk level were highly unlikely to escalate to the highest risk level (Jones & Gondolf, 2002). There appeared to be a clear distinction between those clients who were likely to reoffend and those who were not. It appears interventions may make the most impact when focused on those in the middle who are most likely to change either for the better or

worse in terms of violence. Identifying whether the violence is incidental or a pattern is another way of assessing risk.

Domestic violence offenders typically either have a distinct repeating pattern of violence or have violence in situations where they lack the skills to meet their needs in healthier ways. Capaldi et al. (2009) completed a study to explore the police reports of 47 domestic violence cases. According to Capaldi et al., domestic violence offenses can be categorized into two groups: patriarchal violence, which happens with great frequency and severity, and couple-based violence, which is lower in severity, less frequent within the relationship, is perpetrated by both men and women, and is unlikely to result in severe injury (Capaldi et al., 2009). The most common types of violent acts include "pushing, grabbing, shoving, and slapping," which are categorized as minor violence (Capaldi et al., 2009, p. 502). Partner violence, which includes hitting a partner with an object, restraining or choking a partner, and burning a partner, was only perpetrated by men (Capaldi et al., 2009). The report of injury was 21% for men and 83% for women, but incidents of severe injury requiring medical attention were rare (Capaldi et al., 2009). The prevalence of severe injuries and injuries requiring medical attention, however, were relatively low (Capaldi et al., 2009). These scholars demonstrated that clear knowledge concerning the nature of the violent incident is important during risk assessment.

Treatment Completion

Treatment completion is a principal factor to consider when assessing risk. Gover et al. (2011) completed a study on domestic violence intervention treatment completion stating couples often decide to remain together after the perpetrator begins treatment, but

the victim is three times more likely to be re-assaulted if the perpetrator begins and does not complete treatment. Gover et al. (2011) suggested that perpetrators' capacity to complete treatment should be carefully examined when assessing the safety of their victim (Gover et al., 2011). Remaining with their partner, employment, and abstinence from alcohol appeared to be the most crucial factors to treatment completion (Gover et al., 2011). The other key factor was that first-time offenders were much more likely to complete than repeat offenders (Gover et al., 2011).

Other Risk Factors

Men often become less violent as they become older. Kim, Laurent, Capaldi, and Feingold (2008) conducted a study tracking the level of violence and emotional aggression of domestic violence offenders over a 10-year period, beginning while they in their early 20s (Kim et al., 2008). The researchers revealed a natural decrease in aggressive and violent behaviors as men aged from their twenties into their thirties. Jones and Gondolf (2002) indicated that male perpetrators who committed more severe violence and had other psychological diagnosis were most likely to re-offend, although a substantial portion of these men still did not re-offend. The authors posited that the most accurate predictor of future risk is past behavior.

Researchers have examined domestic violence offenders who killed their wives in order to identify which characteristics should be considered when assessing risk of violence. Eke et al. (2011) completed a study exploring common characteristics of men who killed their wives. Almost half of the participants had perpetrated some type of violence against their wife before the assault leading to her death (Eke et al., 2011).

Twenty-four percent of the men who murdered their wives had no formal contact with the mental health system or law enforcement (Eke et al., 2011). Among the men who had previous documented assaults, almost all demonstrated risk factors which put them in the top 10% of those most likely to re-assault (Eke et al., 2011). The female victims were much more likely to be victims of severe bodily harm or death if they divorced or were separated from the male offenders (Eke et al., 2011). These researchers demonstrated the need for risk assessment after an assault and additionally highlighted the risk of separation or divorce. Understanding and assessing these risks is important when attempting to keep all those involved safe.

The safety of all members of the violent offender's family is always a focus. By understanding what contributes to risk level and being able to screen for these factors, treatment providers will be supported in identifying appropriate treatment for each domestic violence offender. If the risk level would put the victim or the offender's family in danger, then interventions other than reunification need to be considered. If practitioners determine the risk for re-offense to be low and the impact of segregation to be negative, reunification should be considered in some contexts.

Impact on Children

Children are often a motivation for treatment-facilitated contact and the most vulnerable to negative impact. Approximately 17 million children in the United States live in homes where they witness domestic violence (Stover & Morgos, 2013). Approximately 60% of men who have committed domestic violence are fathers (Stover &

Morgos, 2013). Perpetrators often remain in contact with their children, even after law enforcement becomes involved.

Holt (2015) compiled a study using questionnaires filled out from 219 mothers who were victim-partners of domestic violence offenders. Holt's aim was to measure the involvement of fathers in the lives of their children after post-conviction separation between them and the father. Regardless of whether there was a no-contact order with the mother, the highest level of contact was with children between the ages of 6 and 12 years old. Holt reported that 54% of the children in that age range had regular overnight visits with their fathers. Most the contact for children that age was through direct contact, with limited indirect contact such as phone calls or texting. Mothers who had children who were 13 to 18 years old reported that most of this contact was indirect, through texting. Children in the study reported their fathers' need for control and lack of nurturing ability (Holt, 2015). This author interviewed six fathers, who reported a deep sense of loss, combined with bitterness towards the other parent (Holt, 2015).

Stanley et al. (2012) compiled a structured interview of domestic violence offending fathers who were engaged in program aimed at helping them be better parents. The overwhelming report from the fathers was contact with their children was a motivation for positive change (Stanley et al, 2012). The study contained the reports of the fathers but did not give quantitative evidence of change.

Stover and Morgos (2013) accepted the reality of fathers who have committed domestic violence against their partners having visitation with their children and explored how the fathers could be supported in being safe with their children. The focus of most

interventions concerning domestic violence is on the partner relationship and few interventions consider the parenting role of the perpetrator of the domestic violence (Stover & Morgos, 2013). The role of the father in the home has been demonstrated to be important to the development of children, but the effects of witnessing violence complicate the issue of contact with the father (Stover & Morgos, 2013). Both the removal of the father from the lives of children and witnessing further violence have negative impacts on the lives of children (Stover & Morgos, 2013). Many fathers do not understand the impact their violence has on children (Stover & Morgos, 2013). In a survey of 453 fathers, 53% indicated concern about the long-term impact witnessing violence would have on their children. Stover and Morgos suggested that practitioners answer the following questions when deciding the continued role of the father with the children:

1. What was the nature and severity of the abuse?
2. What is the risk for further violence?
3. Did he recognize that his use of violence was wrong and take some responsibility for his actions?
4. What were his legal and mental-health status?
5. What is motivating him to want to participate?
6. Was he engaged in other treatment that will address other mental-health or substance-abuse concerns?
7. Did the child want to attend treatment with his or her father?

8. Did the child still have significant contact or will he or she likely have contact with the father in the future, in which case intervention could be beneficial?
9. How did the child's mother feel about the child attending sessions with his or her father?
10. What would be the goals of father– child-focused treatment sessions? (Stover & Morgos, 2013, p. 250)

Silverman, Mesh, Cuthbert, and Slote (2004) reported that children of female victims of domestic violence are also collateral victims of the violence. Visitation has been identified as an avenue for abusive men to continue to abuse the women they victimized (Silverman et al., 2004). There have been concerns among victims' advocates concerning granting custody of children to men who had committed violence towards women, allowing unsupervised visitation to men who had committed violence towards mothers, failing to consider evidence of domestic violence during custody disputes, and failing to investigate evidence of domestic violence (Silverman et al., 2004). It is often a difficult decision whether the impact of having the father leave the home outweighs the impact of a child who has witnessed family violence.

Emery and Buehler (2009) evaluated the negative impact on the children when women remained in an abusive relationship in comparison to those who chose to leave. These researchers demonstrated the effect of the female victim who remained in a marriage while being subjected to ongoing violence was increased behavioral problems among their children. When the violence was severe, behavioral problems among the children were less likely because the behavior of the children became less significant in

the victim's decision. When male perpetrators of violence ceased their violent behaviors, the negative behaviors of the children decreased. The researchers reported that while further research was needed, the results indicated that remaining in abusive relationships would be more harmful towards the children than leaving the relationship. Witnessing violence can contribute to many psychological problems for children who are involved (Emery & Buehler, 2009).

Litrownik et al. (2003) explored the characteristics of children removed due to violence from their homes prior to 3.5 years of age and placed permanently at the age of 6 years, compared to those who had been reunified with their families (Litrownik et al., 2003). The researchers reported that children who are exposed to violence as children are more likely to engage in violent behaviors (Litrownik et al., 2003). The children who were placed back into violent homes consistently demonstrated aggressive behaviors; however, those who were adopted had behavior which was dependent on the type of home they were placed into. The amount of aggressive behaviors of the children were dependent on the amount of violence the children witnessed (Litrownik et al., 2003).

Obadina (2013) reported that children who have caregivers who are violent or aggressive can develop disorganized attachments. Children are often fearful of their caregivers due to a lack of consistency, such as receiving positive affection in one moment and physical abuse in the next (Obadina, 2013). Children raised in such an environment tend to behave emotionally erratically, like their caregivers (Obadina, 2013). The children often have difficulties controlling their emotions and have difficulties trusting people (Obadina, 2013). They are typically detached from their parents and

develop poor social coping skills (Obadina, 2013). Researchers have revealed that approximately 80% of children raised in homes where domestic violence is present demonstrate disorganized attachments (Obadina, 2013).

Howarth et al. (2015) completed a meta-analysis using 8,764 records to explore the effectiveness of interventions for children exposed to domestic violence. The authors concluded that the most frequent outcome measured was psychological outcomes such as PTSD symptoms. The scholars reported that children improved with interventions which targeted their specific psychological symptoms. Howarth et al. reported that helping children to express and understand their feelings was a vital component of effective interventions and indicated that safety planning was often a part of the interventions. They reported that helping children understand and talk about the violence which they witnessed was key (Howarth et al., 2015).

Lee et al. (2012) evaluated the effectiveness of a 10-session intervention for children who witnessed domestic violence. The program had five primary targeted outcomes: (a) alleviation of guilt/shame, (b) improvement of self-esteem, (c) establishment of trust/teamwork skills, (d) enhancement of personal safety and assertiveness skills, and (e) abuse prevention (Lee et al., 2012). They demonstrated significant lower levels of depression, problematic behaviors, and psychosocial impairments in the children after the intervention (Lee et al., 2012)

McKee and Payne (2014) compiled a study using 375 random phone calls with 67 participants who reported having witnessed some type of violence between their parents while they were growing up. There were no higher levels of emotional reactivity for

those who had been abused as children compared to those who had not witnessed domestic violence. While the findings were not what the researchers expected, the findings demonstrated victims' resiliency to heal from emotional trauma over time (McKee & Payne, 2014).

Feroz, Jami, and Masood (2015) explored the relationship to violence in university students with exposure to violence in early childhood. These authors found a strong correlation between students who had witnessed violence with those who had developed aggressive tendencies. When determining whether this correlated with violence against children, however, the authors did not identify a significant correlation (Feroz et al., 2015).

Psychological Impact of Domestic Violence on Women

The impact on female victims needs to be carefully considered when exploring treatment facilitated reunification. Physical abuse has the most obvious evidence such as bruises and broken bones, which are visible and easily documented. The psychological effects may be less obvious and longer lasting and may impact interactions when reunited with their abuser.

Klopper, Schweinle, Ractliffe, and Elhai (2013) completed a study to explore the effects of domestic violence on 252 women from five Midwestern women's shelters. They discovered that women responded well when they had access to mental health services (Klopper et al., 2013). Caucasian women tend to be more open to using mental health services, but these women were more susceptible to PTSD than other populations (Klopper et al., 2013). There appeared to be various barriers to minority women's access

to mental health services (Klopper et al., 2013). PTSD symptoms, which were more prevalent in Caucasian women, were correlated with a more positive view concerning accessing mental health services (Klopper et al., 2013).

Minor et al. (2012) reported women who are victims of domestic violence suffer a variety of costs such as the cost to relocate, physical pain, injury, and death. If a woman has children who have a father who is not their current partner, they are at a much higher risk of abuse and an increased risk of death at the hands of their partner. Minor et al. (2012) reported their study demonstrated women who have children from a different father than the one they are currently being abused by typically endure more severe physical abuse.

Domestic violence correlates significantly with poor self-esteem among female victims (Lynch, 2013). Researchers have concluded that psychological and physical abuse erodes woman's sense of self and compels them to focus on the desires of their abusers, which contributes to further violence (Lynch, 2013). Lynch completed a study with 100 female participants who had been subjected to a variety types of domestic violence. Most the participants used positive words to describe themselves, such as "strong" and "assertive," yet reported that they often place the needs of others ahead of themselves (Lynch, 2013). Approximately half of the female participants described themselves as different around their male partners. Some of the women from violent homes described a loss of sense of self (Lynch, 2013).

There is a need to carefully consider the past and present psychological impact of the abuse. Victims need to be assessed to ensure that reunification will not cause further

psychological harm. Practitioners should assess the victims to determine whether they are choosing to participate in reunification freely or due to the conditioning of the abuse (Griffing et al., 2005).

Summary and Conclusions

Researchers who explored recidivism of domestic violence offenders and attrition rates of those participating in domestic violence treatment appeared to indicate a need for different treatment approaches. Scholars have demonstrated that the traditional one-size-fits-all approach is not effective. The lack of individualized treatment interventions has contributed to high attrition and recidivism rates among those who participate in domestic violence intervention. Domestic violence intervention models which indefinitely separate domestic violence offenders who commit incidental domestic violence rather than a defined cycle of power and control needs to have its efficacy examined. Domestic violence intervention which integrated family system and social learning approaches appeared to best address the need of family reunification. When considering reunification, all parties involved need to be evaluated and held accountable for their contributions to the family violence. Risk assessments need to be used when exploring which method is appropriate to determine the risks and benefits of using each approach with specific types of domestic violence offenders.

The gap in the literature is a study which explores the efficacy of having treatment-facilitated contact in a quantitative study. Several scholars have suggested that such an approach may be helpful; for example, Todahl et al. (2012) performed a study from a qualitative perspective where participants reported it to be valuable. In this study,

I explored the impact of treatment-facilitated contact on treatment outcomes such as completion rates and recidivism in order to determine the impact on domestic violence intervention treatment.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore differences in treatment groups in relation to treatment completion and recidivism patterns among individuals who were charged with domestic violence against an intimate partner and were court-ordered to participate in a batterer intervention program (BIP). Those treatment groups were court-ordered no-contact with victim-partner or with minor children during BIP, treatment-approved contact with the victim-partner during BIP, and treatment-approved minor children in the home during BIP.

Research Design and Rationale

In this quasi-experimental quantitative study, I explored the relationship between the independent variable of BIP mode of treatment and dependent variables of recidivism and treatment completion. There are three conditions for BIP mode of treatment: no contact with victim-partners or families, treatment-approved contact with victim-partners, and minor children approved to be present in their homes during treatment.

The independent variables in this study were treatment with or without court-ordered no-contact with victim-partners and with or without minor children approved to remain in the home. The dependent variables were completion of court-mandated BIP, recidivism for any crime, and recidivism for person-on-person crimes. I chose a quantitative approach using chi-square analysis because it is appropriate for testing a traditional hypothesis such as segregation of perpetrators from their victim-families leads to lower recidivism of domestic violence incidents (Olver et al., 2011). In this study, I

used chi-square analysis to compare treatment groups of domestic violence offenders who participated in BIP to test the hypothesis that segregation from victim-families leads to lower recidivism rates. Researchers have demonstrated that family support contributes to higher levels of participation in treatment among criminal offenders in general (Spjeldnes et al., 2012). My hypothesis was that family contact contributes to a higher level of treatment completion among domestic violence offenders, as it does among other types of criminal offenders. I also predicted that family contact would be associated with lower recidivism rates. I used chi-square analysis to test these hypotheses by evaluating the degree of association between these variables.

Aalsma et al. (2015) used chi-square analysis when exploring the effectiveness of BIPs by measuring their relationship to recidivism. Ryan, Abrams, and Huang (2014) also used chi-square analysis to measure the relationship that different types of legal system interventions had with first-time juvenile offenders in relation to recidivism. Wikoff, Linhorst, and Morani (2012) used chi-square analysis to determine whether re-entry programs were associated with lower recidivism rates. In a similar manner, I used a chi-square analysis to explore the relationship between victim-family contact, recidivism rates, and BIP completion rates.

Methodology

Population

The general population of this study was those charged with a domestic violence related crime and referred to batterer intervention in the Northwestern United States from 2010 through 2012 (Walden IRB approval no. 08-01-18-0226462). The participants in

this study were referred by their parole officers for committing crimes that, according to ORS 135.230, were considered domestic violence. According to ORS 135.230 (2012), abuse includes:

> (a) Attempting to cause or intentionally, knowingly or recklessly causing physical injury;(b) Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury; or (c) Committing sexual abuse in any degree as defined in ORS 163.415 (Sexual abuse in the third degree), 163.425 (Sexual abuse in the second degree) and 163.427 (Sexual abuse in the first degree).

Those who are released and placed on criminal supervision initially have no-contact orders with victim-partners. According to ORS 135.250(2015), "If the defendant is charged with an offense that also constitutes domestic violence, the court shall include as a condition of the release agreement that the defendant not contact the victim of the violence." According to ORS 107.720(2015):

> Enforcement of the no-contact order applies to release agreements executed by defendants charged with an offense that constitutes domestic violence, except that proof of service of the release agreement is not required and the agreement may not be terminated at the request of the victim without a hearing.

Those who participated in treatment-approved victim-family contact entered the process of having the no-contact order lifted.

The population included domestic violence perpetrators who participated in one of three treatment groups, each using a hybrid curriculum with the Duluth Model and additional skill application assignments: (a) domestic violence perpetrators who

participated in traditional domestic violence intervention that did not include treatment-approved contact with their victim-partner, (b) perpetrators who participated in domestic violence intervention and had treatment-approved contact with their victim-partners, and (c) perpetrators who participated in domestic violence intervention and had treatment-approved in-home contact with their minor children.

The participants who engaged in treatment-approved victim-partner contact were recruited by a staffing agreement between treatment and their referral sources, typically a social worker from the department of human services and their parole officers. The victim-partners had to separately state their wish to participate and were referred to the local women's shelter to receive counseling before engaging in the process to have contact approved.

The population for this study consisted of 678 individuals who were referred for BIP from 2010 through 2012. The referrals to the domestic violence program were due to domestic violence charges, being referred by their parole officer, and requiring domestic violence intervention by a state certified BIP.

My rationale for the use of data from the years 2010 to 2012 was threefold. First, during this period, an approved pilot program in the Northwestern United States allowed for treatment-approved contact between domestic violence offenders and their victim-partners if approved by both the domestic violence program and the referral agent. Second, the population is the same population that Todahl et al. (2012) sampled from. This investigation is intended to build on his earlier research. Third, 5 years has passed their participation in BIP, which is an adequate amount of time to measure recidivism

after treatment. Lawson et al. (2012) reported that program developers have been attempting to integrate victim-partners into BIP treatment, but there has been considerable pushback from women's advocacy groups. The BIP program in the Northwestern United States, was forced to curtail their pilot program due to such pressure.

Each of the participants in the study participated in an State Standard BIP, per Rule 180.070 (2012). The program being studied used an integrated Duluth Model curriculum for domestic violence intervention. The Duluth Model curriculum was used to facilitate abuse awareness and was integrated with further relational skill-building. The curriculum used was part of a locally certified program and was in accordance with Oregon State Revised Standards (see Appendix B). The Duluth Model is a standard curriculum that meets the Revised Standards for BIP. Participants are required to attend between 36 and 52 weeks of domestic violence intervention classes, depending on the nature of the offense. They are required to complete written assignments, including a letter of accountability, a victim impact letter, and a plan for safety. Treatment is deemed complete when a participant has attended all required sessions, has completed the written homework, and has been evaluated as complete by both the treatment provider and the referring agent. In this study, treatment completion meant the treatment provider and the referral agent considered the person complete. Participation in the treatment indicated that they were present for at least five sessions; otherwise, they were considered not to have taken part in the intervention.

Participants who have treatment-approved family contact had additional assignments along with their standard BIP treatment. If they could have minors in their home, then they were typically required to write a safety plan demonstrating how they might avoid having their children exposed to further violence. Minor children who are in homes where there has been domestic violence are typically assigned a Department of Human Services (DHS) worker. The worker would serve as an advocate for the child while also assessing and working with the family with a main goal of protecting the child. The DHS worker would typically require the participant to address any safety needs such as by taking parenting classes. The worker would be part of the approval process for allowing the child to be in the perpetrator's home.

Treatment-approved victim-partner contact means the treatment provider and referral agent have set aside the typical no-contact order. Victim-partner contact means the domestic violence offender can have contact, and the no-contact order has in some manner been lifted but does not define the nature or amount of the contact. The archival data set confirmed contact approval but did not provide details as to the nature of the contact.

The process to secure treatment-approved victim-contact involved several steps. Victims must initially request the contact; then they must attend 10 sessions at a local women's shelter for assessment of whether it would be appropriate for them to participate in treatment-approved contact and so they can become more aware of the impact of violence. Once they have completed 10 sessions, both the offender and the victim-partner develop safety plans for preventing future violence and what to do if early warning signs

of violence occur such as relying on relevant safety resources. Contact was approved on an incremental basis starting with a date in a public place. Each incremental step is assessed for safety before the next step is approved, possibly leading to the victim-partner being approved to be in the home.

Domestic violence offenders in the program for assorted reasons but not convicted of a criminal charge were not part of this study. The participants in BIP were measured by the dependent variable of treatment outcomes. The specific treatment outcomes being measured are general recidivism, recidivism for person-on-person specific crimes, and treatment completion. The amount of crimes or the nature of crime were not explored under the general recidivism question, but rather, whether they had any additional conviction during that time. The 5-year period meant that the period of measurement was uniform for all offenders and was long enough to measure recidivism.

Person-on-person crime recidivism was defined as an offender being convicted of any crime that is person-on-person in nature during the 5 years after their initial intake in the program. The state does not have distinct domestic violence charges. For example, it would be difficult to know whether an assault charge was a domestic violence charge or a charge stemming from a bar fight. Specific charges considered to fall under the category of domestic violence in the state include Assault IV Misdemeanor and Assault IV Felony; Harassment; Strangulation; Menacing; Coercion; Assault I, II, and III; Kidnapping I and II; Robbery I, II, and III; Rape I, II, and III; Sodomy I, II, and III; and Sexual Abuse I, II, and III.

I defined treatment completion as an offender having attended all required sessions and being considered complete by both the treatment program and the referring agent. Those who are considered to not have completed are those who were referred to BIP and participated in at least five sessions but did not complete by either dropping from the program or by not being deemed complete by the treatment program and referral agent.

Sampling Procedures

The sample included three treatment groups: (a) those who received traditionally segregated domestic violence intervention, (b) those who participated in treatment-facilitated victim contact with their partners while participating in domestic violence intervention, and (c) those who had treatment-approved contact with their victim-partners and were allowed to have their minor children in the home. I received permission from the domestic violence treatment program to use archival data from 2010 through 2012 that demonstrates completion rates, compliance with treatment, recidivism, victim-partner contact, and minor children in the home. Those years were used because they were from the same population as the Todahl et al. (2012) study and because they provide a large enough population according to G*Power analysis for this study, while also allowing an adequate amount of time to measure for recidivism post-treatment. The data were organized and coded by the treating domestic violence intervention provider, so individual identities were not revealed.

I conducted a power analysis to determine the minimum sample size of the study and to prevent Type I errors. I conducted a G*Power analysis to ensure, to at least 95%,

that the sample size is large enough to determine the relationship between the dependent and independent variables with a significance level of .05 (Balkin & Sheperis, 2011). The G*Power analysis for a chi-square analysis with an effect size of w = .30 (medium), alpha = .05, power = .95, and df = 3 indicated a minimum sample size of 172.

Those offenders who dropped out of or were suspended from the program before completing at least five sessions were excluded. The study was limited to men over the age of 18 years because men are significantly more likely to have been referred to BIP than women. I excluded those offenders who were referred by the Department of Human Services because they often do not have no-contact orders and were not likely to have gone through the process of having contact with their victim-partners. Criminal history was a large part of this study; therefore, I included mean amount of prison/jail time and whether they were repeat criminal offenders as descriptors of the sample and subgroups. Other demographic descriptors I included were the level of education, race, history of school suspension, and employment status.

Data Collection Method

A domestic violence treatment program granted me permission to use archival data from 2010 through 2012. These data included completion rates, compliance with treatment, and recidivism rates (see Appendix A). This domestic violence program was recruited for the study because they had participated in a pilot study conducted by the BIP during the years of 2010 through 2012 in which they allowed treatment-approved family contact for participants in their family reunification program. The data was archival data from a database of information collected and coded by therapists at the

domestic violence intervention clinic in the Northwestern United States. The treatment provider has collected the data and put it into an Excel spreadsheet. The participant data collected and organized by the treatment program included data on 678 individuals. I was given an Excel data sheet with the names coded by the treatment provider; I was provided no individual-specific identifying information. The archival treatment records contained data for treatment completion rates, recidivism for any crime, whether there was contact allowed with minor children, whether there was approved contact with the victim-partner, recidivism for a new violent crime, and demographic data such as age and race.

Data Analysis Plan

I performed chi-square analysis to analyze the data. This allowed for a straightforward analysis of three treatments with two possible outcome contingency tables to test the hypothesis. I analyzed whether the treatment modes of no family contact, approved victim-partner contact, or victim-partner contact and approved minor children contact differ in their ability to predict the outcomes of treatment completion, general recidivism, and person-on-person crime recidivism.

I utilized descriptive correlational statistics to examine the relationships between victim-family contact yes/no with recidivism and treatment completion. I explored the demographic data and calculated descriptive statistics using SPSS 22.0 for Windows. I used a chi-square test for association to explore the relationships between nominal variables with a $p < .05$ significant result.

Research Questions

The research questions and associated hypotheses that I developed to guide this

study were as follows:

RQ1. Is there a statistically significant difference in the recidivism rates for any crime during the period of 5 years following BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families during BIP treatment and those who did not?

$H1_0$: There is no statistically significant difference in the recidivism rate for convictions of any new crimes between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H1_A$: There is a statistically significant difference in the recidivism rate for convictions of any new crime between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact.

RQ2. Is there a statistically significant difference in the recidivism rates for the 5-year period following BIP treatment for convictions of new person-on-person specific crimes, as defined by the State Revised Statutes, between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact?

$H2_0$: There is no statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H2_A$: There is a statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

RQ3. Is there a statistically significant difference in completion rates of domestic violence offenders who attended at least five sessions of BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not?

$H3_0$: There is no statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H3_A$: There is a statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

Data Source

I acquired the archival data with permission from a domestic violence intervention program in the Northwestern United States. Public court records were accessed by the treatment provider to provide recidivism based on new convictions in general and new violent conviction for this study and for a program efficacy review. The recidivism records were obtained by the treatment program as part of an internal review completed by the program on itself previous to this study. The recidivism data were contained in an Excel data sheet, which is organized and collected by the treatment

program was in the form of yes/no data. Data such as completion rates, ethnicity, and education levels were also contained on the Excel sheet. General demographic data were used as descriptors of the participants and attendance records were used to acquire completion rates. The data contained in the Excel sheet were collected by individuals at the domestic violence intervention program is the source of the data. The domestic violence program coded the data to remove identifying info. The study was based on data collected by the Lane County domestic violence intervention program, and no data were used to identify individual participants.

Threats to Validity

One threat to validity included that the procedure for having contact for those who were referred by the Department of Human Services (DHS) may not be the same as for those who have been convicted of a criminal charge. According to State Revised Standard 135.247(2015) those convicted of a crime involving domestic violence have no contact with their victim either direct or through a third party. Those who had gained contact with their victim-partners have gone through a level of scrutiny to have contact and the contact has been at the request of the victim-partner, while that may not be true of those who have not been convicted of a crime. For both of these reasons, I excluded those who were referred by DHS or have not been convicted of a crime from this study.

While all participants likely started out with no-contact orders with their victim-partners and victim-families, the most violent offenders were less likely to be approved for the program and more likely to recidivate and/or not complete treatment. While this might be true, it is also be an indication of the treatment providers' ability to screen for

those most likely to re-offend and how effective they were at identifying such individuals. Those who have victim-partner contact and/or are allowed to have their minor children in their home had more contact with the treatment provider and with other supports in the system due to the nature of the contact. It was impossible to know how much those extra supports have a relationship on treatment outcomes and what is due to the contact they are having with their partner and/or children. Those who are allowed to have contact with their minor children were typically working with DHS workers and required to do more assignments such as parenting classes and have more contact with workers within the system.

Those who were referred to treatment, but never engaged in treatment could have invalidated the results because they would have never taken part in the intervention being studied. To account for those who were never engaged in treatment, I excluded those who did not meet the drop out minimum of five sessions because they were not considered to have sufficiently engaged in the program before dropping out. This study was following a pilot study completed in the Northwestern United States by the intervention program and as part of the Todahl et al. (2012) qualitative study. In this study, I evaluated the same data pool from the same BI treatment program as Todahl et al. to perform a quantitative follow-up study. The results contained in this study were based on domestic violence interventions performed at domestic violence intervention clinic in the Northwestern United States.has a population of 351,715, of which 88.3% are Caucasian and 7.4% are Hispanic, according to the 2010 Census report. The median household income for a

family in Lane County in 2010 was $55,817. If a researcher were to perform this study at a similar clinic in an area with different demographics, the results may not be the same.

It was impossible to account for all independent variables such as the personality of the domestic violence facilitators, how much specific time they spend with each client, and different nuances in how they present their approach. The treatment program did not include in their records clear assessments of all risks such as other mental health diagnosis. It was possible that certain mental health diagnoses—which would have limited a participant's likelihood of being allowed victim-partner contact—could also result in a higher risk to recidivate or not complete treatment. A further study which assessed for risks better such as complete mental health and substance abuse assessments as well as urinalysis and the use of the SARA might be helpful and would likely provide additional information.

Ethical Procedures

I submitted this study for review by the Internal Review Board (IRB) at Walden University. In order to access the data, I did not include any information containing individual identities remained with the treatment provider, nor was any identifying information in my possession at any time. The data were collected and put into an Excel data sheet prior to this study by the treatment provider. The treatment provider removed the names of the participants and replace them with codes to represent the participants in the study. The data set was stored on a password-protected computer accessible only to me. The raw data were returned to the treatment provider after the study's completion.

Summary

In this study, I explored the relationship domestic violence intervention treatment outcomes of recidivism, person-on-person crime recidivism, and completion rates with treatment-facilitated contact between domestic violence offenders and the partners they victimized compared to those who did not have victim-partner contact. I aimed to measure what type of impact the intervention of treatment-facilitated contact has on domestic violence intervention treatment. I analyzed archival data in the form of a file review to perform chi-square analysis and determine the presence of a statistically significant relationship.

Chapter 4: Results

Data Analysis and Summary of Findings

The purpose of this study was to evaluate between-group differences in the outcomes of general or person-on-person crime recidivism and treatment completion among individuals convicted of a domestic violence charge who did or did not have court-ordered treatment that included approved contact with their victim-partners/families during intervention. The research questions and accompanying hypotheses that guided this study were as follows:

RQ1. Is there a statistically significant difference in the recidivism rates for any crime during the period of 5 years following BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families during BIP treatment and those who did not?

$H1_0$: There is no statistically significant difference in the recidivism rates for convictions of any new crimes between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H1_A$: There is a statistically significant difference in the recidivism rates for convictions of any new crimes between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact.

RQ2. Is there a statistically significant difference in the recidivism rates for the 5-year period following BIP treatment for convictions of new person-on-

person specific crimes, as defined by the State Revised Statutes, between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact?

$H2_0$: There is no statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H2_A$: There is a statistically significant difference in the person-on-person specific recidivism rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

RQ3. Is there a statistically significant difference in completion rates of domestic violence offenders who attended at least five sessions of BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not?

$H3_0$: There is no statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

$H3_A$: There is a statistically significant difference in the treatment completion rates of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not.

Data Identification and Collection

I sourced the participants in this study from de-identified archival data from a nonprofit organization in the Northwestern United States. Permission was given by a domestic violence treatment program to use archival data from 2010 through 2012 concerning completion rates, compliance with treatment, and recidivism rates (see Appendix A). I chose this domestic violence program for the current study because they had participated in a pilot study conducted by the BIP during the years 2010 to 2012 in which they allowed treatment-approved family contact for participants in their family reunification program. I analyzed archival data from a database of information collected and coded by therapists at the domestic violence intervention clinic in the Northwestern United States. The treatment provider collected the data and put it into an Excel spreadsheet. I collected and organized the participants' data from the treatment program from of a population of 678, which I reduced to a sample of 213 by employing the exclusion criteria described below. I was given an Excel data sheet coded by treatment provider to remove the names from the data set. The archival treatment records contain data for treatment completion rates, recidivism for any crime, whether there was contact allowed with minor children, whether there was approved contact with the victim-partner, recidivism for a new violent crime, and demographic data such as age and race.

Exclusions and Inclusions

The study population included those who were referred for BIP between 2010 and 2012 in the Northwestern United States. I excluded those who dropped out or were suspended from the program before completing at least five sessions. The study was

limited to men over the age of 18 years, as men are significantly more likely to have been referred to BIP than women.

Sample Demographics

The racial demographics of the study population are presented in Table 1 and were generally representative of population in the Northwestern United States (U.S. Census Bureau, 2010). There was a higher percentage of Native Americans and African Americans and a lower percentage of Hispanics in the sample compared to the county population.

Table 1

Racial Demographics of the Sample Compared to County

Race	Sample	County
Caucasian	78.1%	88.3%
Native American	8.9%	1.2%
African American	4.7%	1.0%
Hispanic	5.2%	7.4%
Other	4.2%	NA

The educational status of the sample differed from the population of men age 25 years and older a census in the Northwestern United States (U.S. Census Bureau, 2010) in that they were generally less educated (see Table 2).

Table 2

Education Demographics of Sample Compared to County

Education Level	Sample	County
11th grade or less	24.3%	12.5%
GED or higher	75.7%	87.5%
Some college	29.1%	35.0%
4-year degree or higher	3.2%	25.5%

The mean age for the sample was 31.8 years, with a range from 18 to 69 years. There was no way to compare this to the age of men in the county because I did not have access to that information. The sample was comprised of 91.5% participants who had multiple domestic violence convictions before their intake. Eighteen percent of the participants had spent time in prison for their convictions, whereas 96.2% had spent time in jail. Forty-four percent of the participants had children who were either living at home or present at the time of the domestic violence offense. Fifty-one percent of participants reported during their intake that drugs and/or alcohol were involved in their domestic violence offense.

Partner Contact Group Demographics

The ethnic distribution in the group that had no partner contact had a slightly higher percentage of Caucasian participants compared to the group with partner contact. The treatment group that had partner contact had a higher percentage of Hispanic participants and no African American participants compared to the group without partner contact.

Table 3

Racial Makeup of Partner Versus No Partner

	Partner Contact		
Race	No	Yes	Sample
Caucasian	77.5%	69.2%	78.1%
Native American	9.4%	7.7%	8.9%
African American	4.2%	0	4.7%
Hispanic	5.1%	15.4%	5.2%
Other	3.7%	6.5%	3.7%

The treatment group that had treatment-approved partner contact had a similar distribution of education status as the no-contact treatment group and the entire sample. The treatment-approved partner contact group had a slightly higher percentage of those who had a GED or higher compared to the no contact group, but also had slightly fewer individuals with some college and no participants with a 4-year degree or higher.

Table 4

Education Demographics of Partner Contact Versus No Partner Contact

	Partner Contact		
Education	No	Yes	Sample
Less than 11th	24.2%	23.1%	24.2%
GED or higher	43.6%	50.0%	43.7%
Some college	28.4%	26.9%	28.5%
BA/BS or higher	3.8%	0	3.7%

Individuals in the no contact group had a mean age of 35.56 years with a standard deviation of 11.01; the treatment group with approved contact had a mean age of 31.40 years with a standard deviation of 8.30. The difference was not significant according to an independent sample t test comparison. There were almost twice as many in the age range of 18 to 25 years in the partner contact group than in the no-contact group.

Table 5

Range Demographic of No Partner Contact Versus Partner Contact

	Partner Contact	
Age Range	No	Yes
18-25	23.6%	43.3%
26-35	34.0%	30.0%
36-45	25.0%	16.7%
46-55	12.7%	6.7%
56-70	4.7%	3.3%

Those who reported that drugs and alcohol were involved as part of their offense were higher in the group that did not have partner contact (54.4%) compared to those who had treatment-approved contact (34.6%). Using a $X^2(4) = 345.4$, $p = 0$, a significant relationship between drug and alcohol use for those who did not have contact compared to those who did. Those who had contact had a significantly higher amount of drug and alcohol use compared to those who did not have contact. The rest of the demographics were similar between treatment groups.

Of those who did not have partner contact, 91.5% had multiple domestic violence convictions, compared to 90.3% in those with partner contact. In the treatment group with no partner contact, 96.2% had spent time in jail and 17.8% had spent time in prison, compared to 96.8% and 16.1% in those with partner contact. Among those who did not have treatment-approved contact, 44.1% reported that their children witnessed their crime, compared to 48.4% of those who did have treatment-approved partner contact.

Demographics of Those With Children

The group that had treatment-approved contact with their minor children had a similar racial demographic to those who had children but had no contact with them. The only difference was the group with contact had fewer African Americans and more Caucasians.

Table 6

Racial Demographics of Child Contact Versus No Child Contact

	Child Contact		
Race	No	Yes	Entire Sample
African American	9.1%	4.2%	11.2%
Native American	9.1%	9.4%	4.1%
Hispanic	6.8%	5.2%	3.1%
Caucasian	70.5%	77.5%	78.6%
Other	4.5%	3.7%	3.1%

The treatment group that was allowed contact with their minor children had slightly fewer participants with college or higher than the treatment group that did not have contact, but both were similar in education demographics.

Table 7

Education Demographics Child Contact Versus No Child Contact

	Child Contact		
Education	No	Yes	Entire Sample
11th or less	26.9%	25.0%	24.3%
GED or more	42.3%	50.0%	43.7%
Some college	27.8%	22.7%	28.4%
College degree	3.1%	2.1%	3.7%

The individuals with children with no contact and those with children who had contact were similar in age of the entire study sample.

Table 8

Age Demographics Child Contact Versus No Child Contact

	Child Contact		
Age Range	No	Yes	Entire Sample
18-25	25.0%	23.6%	23.6%
26-35	35.4%	33.0%	34.0%
36-45	20.8%	29.2%	25.0%
46-55	16.7%	11.3%	12.7%
56-70	2.1%	2.8%	4.7%

Of the individuals in the treatment group who were allowed treatment-approved contact with minor children, 89.7% had multiple domestic violence convictions, compared to 97.9% with the treatment group that was not allowed contact with their minor children. In the treatment group with contact, 95.3% had spent time in jail and 17.8% had spent time in prison, compared to 100% and 16.7%, respectively, for the no-contact treatment group. Of the group that had contact with their children, 47.7% reported that drugs and alcohol were part of their offense, compared to 55.7% of the no-contact group. Children were present during the offense of record for 89.9% of those who were in the contact group and 86.9% of those in the no-contact group.

Data Screening and Coding

The data set I used and analyzed for this study was collected from January 1, 2010, to December 31, 2011. The G*Power analysis indicated that 172 was the minimum number of participants based on the study's characteristics and specific hypotheses. There were 213 participants in my sample, which was an adequate number of participants. I removed all names and identifying information from the data set. The data revealed the presence or absence of recidivism, treatment completion, partner contact, whether they had children, and approved contact with children. The "yes" answers were translated into a score of 1, and the "no" answers were translated as a 0 for data analysis purposes.

Results

RQ1. Is there a statistically significant difference in the recidivism rates for any crime during the period of 5 years following BIP treatment between a cohort of domestic violence offenders who had treatment-approved

contact with their victim-partners/families during BIP treatment and those who did not?

The dependent variable for this evaluation was categorical (i.e., yes, no); therefore, I performed nonparametric statistical analysis, specifically a 2x2 chi-square test of independence, to evaluate the research hypotheses.

Contact With Partner Versus No Contact With Partner

The independent variable was treatment group (i.e., contact or no contact with victim-partners during treatment) and the dependent variable was occurrence of recidivism for any crime within the 5-year period following BIP treatment (i.e., yes, no). I used a 2x2 chi-square test of independence to evaluate the research hypothesis. The independent variable was treatment group (i.e., contact or no contact with victim-partners during treatment) and the dependent variable was occurrence of recidivism for any crime within the 5-year period following BIP treatment (i.e., yes, no). There was no statistically significant relationship between the treatment groups with respect to contact with partner during the treatment period and general recidivism, $\chi^2(1) = .095$, $p = .76$.

Table 9

Cross-Tabulation Chi-Square General Recidivism by Victim

	Victim-Partner Contact					
Recidivism	No	Yes	Total	Chi-Square	*df*	*p*
No	77	13	90	0.95	1	.758
Yes	11	18	29			
Total	88	31	119			

Contact With Children Versus No Contact With Children

For the next analysis, only those in treatment who had children in their homes were considered. Here, the independent variable was treatment group (i.e., contact or no contact with children in the home during treatment) and the dependent variable was occurrence of recidivism for any crime within the 5-year period following BIP treatment (i.e., yes, no). I evaluated the 2x2 distribution of events of recidivism for the two treatment groups. I determined there was no statistically significant difference between the treatment groups in general recidivism, χ^2 (1) = 1.450, p =.231.

Table 10

Cross-Tabulation Chi-Square for General Recidivism by Child Contact

	Child Contact					
Recidivism	No	Yes	Total	Chi-Square	*df*	*p*
No	39	12	51	1.450	1	229
Yes	77	14	91			
Total	116	26	142			

RQ2. Is there a statistically significant difference in the recidivism rates for the 5-year period following BIP treatment for convictions of new person-on-person specific crimes, as defined by the State Revised Statutes, between domestic violence offenders who had treatment-approved contact with their victim-partners/families and those referred for domestic violence treatment who did not have treatment-approved contact?

I addressed this question by performing a chi-square analysis measuring the relationship between partner contact and recidivism for person-on-person crime and contact with children in the home and recidivism for a person-on-person crime. Again, I used a 2x2 chi-square test of independence to evaluate the research hypotheses. The independent variable was treatment group (i.e., contact or no contact with victim-partners during treatment) and the dependent variable was occurrence of recidivism for a person-on-person crime within the 5-year period following BIP treatment (i.e., yes, no). There was not a statistically significant difference between the treatment groups in person-on-person recidivism, χ^2 (1) = 2.960, p =.085.

Table 11

Cross-Tabulation Chi-Square Person-on-Person Recidivism by Partner Contact

	Victim-Partner Contact					
Recidivism	No	Yes	Total	Chi-Square	*df*	*P*
No	87	20	107	2.960	1	.085
Yes	95	11	106			
Total	182	31	213			

For the next analysis, only those in treatment who had children in their homes were considered. Here, the independent variable was treatment group (i.e., contact or no contact with children in the home during treatment) and the dependent variable was occurrence of recidivism for a person-on-person crime within the 5-year period following BI treatment (yes, no).

I used a 2x2 chi-square test of independence to evaluate the research hypothesis. The independent variable was treatment group (i.e., contact or no contact with children during treatment) and the dependent variable was occurrence of person-on-person recidivism within the 5-year period following BI treatment (i.e., yes, no). There was no statistically significant difference between the treatment groups in person on person recidivism, $\chi^2(1) = .453$, $p = .501$.

Table 12

Cross-Tabulation Chi-Square Person-on-Person Recidivism by Child Contact

	Child					
Recidivism	No	Yes	Total	Chi-Square	*df*	*P*
No	54	14	69	.453	1	.501
Yes	62	12	74			
Total	116	26	142			

RQ3. Is there a statistically significant difference in completion rates of domestic violence offenders who attended at least five sessions of BIP treatment between a cohort of domestic violence offenders who had treatment-approved contact with their victim-partners/families and those who did not?

The dependent variable for this evaluation was categorical (i.e., yes, no); therefore, I performed nonparametric statistical analysis, specifically a 2x2 chi-square test of independence, to evaluation the research hypotheses. The independent variable was treatment group (i.e., contact or no contact with victim-partners during treatment) and the

dependent variable was occurrence of recidivism for treatment completion from BI treatment (i.e., yes, no). I evaluated the 2x2 distribution of events treatment completion for the two treatment groups. There was no significant difference between the treatment groups in treatment completion, $\chi^2(1) = .650$, $p = .42$.

Table 13

Cross-Tabulation Chi-Square Treatment Completion by Partner Contact

	Partner Contact					
Recidivism	No	Yes	Total	Chi-Square	*df*	*P*
No	74	108	182	.650	1	.420
Yes	15	16	31			
Total	89	124	213			

For the next analysis, I only considered those in treatment who had children in their homes. Here, the independent variable was treatment group (i.e., contact or no contact with children in the home during treatment) and the dependent variable was occurrence of treatment completion of BI treatment (i.e., yes, no). I evaluated the 2 2 distribution of events of person-on-person recidivism for the two treatment groups. There was no significant difference between the treatment groups in treatment completion, chi-$\chi^2(2) = .055$ $p = .815$.

Table 14

Cross-Tabulation Chi-Square for Treatment Completion by Child Contact

	Child Contact					
Recidivism	No	Yes	Total	Chi-Square	*df*	*p*
No	52	11	63	.055	1	.815
Yes	64	15	79			
Total	116	26	142			

Summary

In this study, I compared the treatment groups of treatment-approved partner contact and no treatment-approved victim-partner contact and the treatment groups of those who have children and treatment-approved contact and those who have children, but do not have treatment-approved contact have a relationship with treatment completion, general recidivism, and/or recidivism for person-on-person crimes. My hypothesis was that family contact would increase completion rates because of the family support and increase recidivism rates because of increased contact with the victim. The results of the chi-square analyses, however, did not support rejecting any of the null hypotheses for the three research questions. In Chapter 5, I will present a summary and discussion of the findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to compare the intervention outcomes of completion rates, general recidivism, and person-on-person crime recidivism for domestic violence offenders who had approved contact with victim-partners alone or with victim-partners and children at home during their treatment compared to those who participated in domestic violence intervention treatment without victim-partner contact. The findings generally indicated no relationship between family contact during treatment and completion rates, general recidivism, and person-on-person crime recidivism.

Interpretation of the Findings

The recidivism rates of domestic violence offenders are high and the safety of all involved should be considered. The sample in this study exhibited a 50% recidivism rate for person-on-person crimes and a 70% recidivism rate for person-on-person crimes for those did not complete treatment. Those recidivism rates should be considered with any domestic violence intervention. While intervention that included victim-family contact did not demonstrate a relationship to higher recidivism rates when compared to those who did not have victim-partner contact, there still was a high level of recidivism. There is a need for better interventions and more research.

According to the findings, victim-family contact neither increased nor decreased general recidivism or person-on-person crime recidivism. Although participants in the qualitative study of Todahl et al. (2012) described a higher level of risk for victimization, they also described feeling safe because of the skills they were learning. In this study, I

did not find a relationship between partner/family contact and the positive treatment outcomes of increased treatment completion, lower general recidivism, or lower person-on-person recidivism. It is possible that either these offenders did not experience the same benefits from the partner/family contact or that any skills they gained in treatment with their partners were negated by circumstances after treatment.

There were treatment outcomes that appeared to relate to victim-partner contact and/or child contact. To test this theory, I performed chi-square analysis using demographic variables as predictors of each of the outcome variables. The results of the chi-square analysis revealed a nonsignificant association between victim-partner contact and/or child contact with the treatment outcomes of general recidivism, person-on-person recidivism, and treatment completion. Thus, I concluded that there is not a statistically significant association between victim-partner and/or child contact and the treatment outcomes of general recidivism, person-on-person recidivism, or treatment completion. I could not reject the null hypothesis that there is no relationship between victim-partner contact and/or child contact.

While there are no recent studies concerning the intervention of victim-family contact during domestic violence intervention, Lila, Gracia, and Catalá-Miñana (2018) completed a study comparing 80 participants who had individual treatment for domestic violence intervention to 80 participants in traditional domestic violence intervention programs. Those who had individual treatment plans and motivational interviewing had significantly higher motivation for change ratings and lower ratings of violence than those who were in the traditional domestic violence intervention program. The limitation

to the study was it was based on self-reported data. The findings did support the utilization of interventions that address specific needs rather than the traditional one-size-fits-all approach (Lila et al., 2018). The researchers recommended future explorations of interventions that address the specific needs of individual participants.

Schneider (2008) stated that the primary goal of domestic violence intervention is to keep people safe, and segregation of domestic violence offenders and their victim-partners has been assumed to be necessary to meet that goal. Bischoff (2006) completed a meta-analysis and revealed that most domestic violence intervention programs are based on segregation between male domestic violence offenders and female victim-partners. Bischoff further stated that most practitioners consider female victim contact with their abusers to be harmful and putting women at risk. The participants in the study demonstrated no relationship between recidivism for person-on-person crimes and victim-partner and/or child contact. The analysis of child contact verses no contact was a subset of the group data and was underpowered. A larger sample size exploring the treatment outcomes of those who have contact with their children versus those who did not would be beneficial.

The Duluth Model was based on a community model to keep victims safe. This program emphasized segregation between domestic violence offenders and their victim-partners as part of the program (Barner & Carney, 2011). At one point, the Duluth Model had become part of the statutes on domestic violence intervention in all 50 states (Olver et al., 2011). The findings of the current study do not support that there is a relationship between recidivism for person-on-person crimes and whether offenders had victim-

partner contact or were segregated from their victim-partner. Due to the small sample size, this study should be viewed as a pilot study to support undergoing larger studies or meta-analyses.

The STOP Program from David Wexler retains some of the strengths of the feminist approach while integrating it with skills training (Langhinrichsen-Rohling & Friend, 2008). It also has moved away from a one-size-fits-all approach to consider treatment alternatives such as including victim-partners in treatment (Langhinrichsen-Rohling & Friend, 2008). According to this study, there would be no relationship to recidivism using the alternative of having victims be part of treatment, but it also did not demonstrate a relationship to treatment completion.

Corvo and Dutton (2009) stated that traditional BIP, where domestic violence offenders are segregated and mandated to go to classes where they learn about patterns of abuse has little impact on recidivism. There was no significant relationship difference between those segregated from their victim-partners and/or children and those who were not and their recidivism rates for both general and person-on-person crimes. There was no relationship between those who had victim-family contact and completion rates in this study. Spjeldnes et al. (2012) reported that family support contributes to lower general recidivism rates for criminal offenders. The authors hypothesized that victim-family contact would lead to higher completion rates due to added family support, but this was not supported in the results. There was no significant relationship between completion rates for those who had treatment-approved partner contact and/or approved contact with their children. Gover et al. (2011) reported that couples often decide to remain together

after a domestic violence charge, but if perpetrators do not complete treatment, they are three times as likely to reassault their victim.

In a qualitative study, Stanley et al. (2012) explored the impact contact with children had on domestic violence offenders, finding that the offenders perceived contact with their children as a positive motivation for change. Stanley et al. did not find a relationship between contact with the children and treatment completion. It is possible, however, that there were other factors that changed after contact with their children because treatment completion is only one measurement. There was no relationship between child contact and treatment completion in this study, which supports Stanley et al. (2012).

Limitations

A limitation was that in many of the criminal records it was difficult to tell with absolute certainty whether it was a charge or a conviction. I excluded those in which this was uncertain, which decreased the sample size. Although the sample size was large enough to meet G*Power standards, it would have been better if it could have been larger for those with children. Having multiple convictions of domestic violence before intake is a risk factor that would have been beneficial to explore further. With the data file here, it was impossible to know whether the multiple convictions were due to one arrest or if they were separate incidents. It was also impossible to know what type of multiple convictions these were.

The treatment group with no treatment-approved contact had a mean age of 34.8 years, while the treatment group with treatment-approved contact had a mean age of 30.3

years. There were almost twice as many in the age range of 18 to 25 years in the partner contact group than in the no-contact group. Clark (2011) indicated young age as one the greatest predictors of recidivism; therefore, the younger age of the treatment-approved contact group raised the chances of recidivism by participants in that group.

This was a quasi-experimental study, so the participants in the two groups were not chosen randomly. Those in the contact group, for example, had a significantly lower relationship with drug and alcohol use at conviction than those who were not allowed contact with their partners. It would likely be difficult to have a true experimental study because risk factors, such as alcohol use, need to be explored for the safety of the victim participants. The nature of the quasi-experimental study does demonstrate that the therapists were able to identify the risk factors well enough that victim contact did not have a relationship with higher recidivism.

The racial demographic of the group was overwhelmingly Caucasian. It would be helpful in the future to perform studies that included more African Americans, Hispanics, and Asians to assess whether race plays a role in treatment completion. It is also possible that recidivism in relationship to family contact may differ among races and/or ethic groups; this would need to be explored using a more diverse sample. Differences in cultural attitudes concerning violence toward partners and values about family unity may impact treatment outcomes.

There is limited knowledge on the treatment providers of these intervention programs. They are individuals with master's degrees in social work or counseling who are either licensed at the master's level or working toward licensure. I did not know the

age or race of any of these individuals. Those factors might be helpful in knowing how they match with the demographics of the sample. For example, if there are therapists from all races but African American, this exclusion might contribute to lower treatment completion of African Americans.

Recommendations

Practitioners have previously assumed that victim contact would raise recidivism rates, especially person-on-person crime recidivism rates (Schneider, 2008). My findings did not indicate any relationship between victim-family contact and general or person-on-person crime recidivism rates. While I think all risk factors need to be considered when allowing victim-partner contact, my findings demonstrated that it is possible to have approved victim-partner contact without a significant relationship to recidivism rates. I recommend that this be viewed as a pilot study used to validate the need for larger, more in-depth studies.

It would be beneficial to perform a 7-year study on a program that integrates victim-partners into treatment where the treatment interventions are more specifically - documented and all major risk factors are explored. The investigators of such a study could document the interventions, risk factors, and all relevant demographics for 2 years and allow 5 years for recidivism. Factors such as mental health diagnosis, type of crimes, and other evaluations should be included.

I also recommend further exploration of why there was no relationship in this study between family contact and treatment completion when previous authors, such as Spjeldnes et al. (2012), suggested family support should have a positive relationship in

treatment completion. It is possible some participants concentrated so much on being reunited with their families that it distracted them and they did not complete treatment. It might help to have family contact more directly tied to treatment completion. Assisting the family in supporting the offender to complete treatment might also be beneficial. If I were to recommend a change at the community level, it would be that if offenders drop from a domestic violence program, their no-contact order should be reinstated until they complete a domestic violence intervention program. This may increase treatment completion by tying family reunification to finishing the program.

There have been few studies exploring the relationship between treatment outcomes of domestic violence offenders and contact with their children. A mixed-method study involving contact with children would be helpful. Nothing is known about these children other than that they are under 18 years old and whether their parent had contact with them during their domestic violence intervention treatment. I recommend a study to measure the impact on these children before, during, and after the treatment, as well as to track demographics about the children's age, grade level, and academic performance. I would also recommend including the qualitative element of a mixed study to allow the children to voice the impact from their point of view in addition to exploring the statistical impact.

Implications for Social Change

The first implication for social change is the demonstrated ability to explore new interventions without having a significant relationship with recidivism. Rather than having a one-size-fits-all approach, exploration of treatment interventions that fit the

family needs appear more appropriate. My findings support the assertion that there are different ways to address domestic violence intervention without increasing domestic violence recidivism. The results indicate no relationship with recidivism and may open the door to exploring other similar interventions because there is not a relationship between victim-partner contact or child contact with recidivism, as previously assumed (Schneider, 2008).

There is a need for interventions that address the needs, but keep participants engaged enough to complete the program. The findings of this and other studies suggest a significant relationship between treatment completion and person-on-person crime recidivism. My results demonstrated no significant relationship between victim-family contact and treatment completion.

Many of the State Statutes are predicated on the assumption that segregation of domestic violence offenders from their victim-families is necessary to keep families safe (ORS 135.250, 2015). It has been assumed there is a relationship between victim-partner contact and higher recidivism. In this study, there was not a relationship between recidivism for person-on-person crimes and victim-family contact like this assumption would suggest. This study would not indicate a need to change the statutes, but a need to be creative when exploring alternatives on a larger scale.

In my practice, I work with couples and families, the majority of which have reported violence as a component of their problems on some level. Through the process of performing the current literature review and study, I have become more aware of the need to find more effective ways of addressing violence in families. I am currently

working with families to create a group practice with the primary goal of addressing violence in families. It is my hope that fellow practitioners will consider studying the subject of violence in families to identify innovative ways to help address the problem. The findings of this study demonstrated that the current assumption that there is a relationship between recidivism and victim-family contact is not true; through innovative research, it would be possible to identify other current assumptions that are untrue.

Conclusion

The purpose of this study was to explore the relationship between outcomes of general recidivism, person-on-person crime recidivism, and treatment completion and victim-family contact. I assumed there would be a positive relationship with treatment completion and a negative relationship with recidivism. The results of this study, however, indicated there was no relationship between family contact and the treatment outcomes of general recidivism, person-on-person crime recidivism, and treatment completion. While the findings demonstrated no relationship between victim-family contact and treatment outcomes, further studies need to be completed to measure the full efficacy and safety of such interventions. Based on the current results, I recommend the exploration of victim-family contact on a larger, more detailed scale.

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Appendix: State Revised BIP Standards

(1) Basic Intervention Curriculum Requirements. Challenging and confronting participant beliefs and behaviors shall be balanced by creating a safe and respectful environment for change. To accord with these standards, a curriculum for batterers shall include, but is not limited to, the following basic requirements:

(a) Addressing belief systems that legitimize and sustain battering of women and abuse of children;

(b) Informing participants about the types of battering as defined in ORS 137-087-0005(2);

(c) Challenging participants to identify the patterns of their battering behaviors and all tactics used to justify battering such as denial, victim blaming, and minimizing; increasing participant recognition of the criminal aspect of his thoughts and behavior; reinforcing participant identification and acceptance of personal responsibility and accountability for all such tactics; and reinforcing alternatives to non-battering behavior;

(d) Encouraging participants to identify the cultural factors that are used by a batterer to legitimize both individual acts of abuse and control and battering;

(e) Modeling respectful and egalitarian behaviors and attitudes;

(f) Increasing participants' understanding and acceptance of the adverse legal, interpersonal and social consequences of battering;

(g) Increasing the participants' overall understanding of the effects of battering upon their victims, themselves, and their community, and encouraging participants to go

beyond the minimum requirements of the law in providing victims and their children with financial support and restitution for the losses caused by their battering;

(h) Identifying the effects on children of battering directed at their mothers, including but not limited to the incompatibility of the participant's battering with the child's well-being, the damage done to children witnessing battering, and educating participants about the child's need for a close mother-child bond, nurturance, age-appropriate interactions, and safety;

(i) Encouraging participants to recognize the responsibility of being a father including the emotional, physical and financial support necessary to provide an environment to children that encourages growth and stability;

(j) Facilitating participants' examination of values and beliefs that are used to justify and excuse battering;

(k) Requiring participants to speak with respect about their partners and other women, and challenging participants to respect their partner and other women and to recognize their partner and other women as equals who have the right to make their own choices;

(l) Encouraging empathy and awareness of the effect of participants' behavior on others;

(m) Challenging participants to accept personal responsibility and accountability for their actions;

(n) Encouraging participants to challenge and change their own battering beliefs and behaviors; and

(o) Identifying how the participant uses alcohol and other drugs to support battering behaviors.

(2) Accountability Plan. A BIP shall require every participant to develop an Accountability Plan (Plan), and a BIP's curriculum which shall provide information that a participant can use to develop his Plan. Accountability planning is an ongoing process intended to increase the batterer's self-awareness, honesty and acceptance of responsibility for battering and its consequences. A participant's Plan shall include specific and concrete steps to be identified and implemented by the participant. A BIP shall always prioritize the safety and best interests of the victim when teaching and reporting on accountability planning. Under no circumstances may the terms of a Plan require, or imply authorization of or permission for, conduct that violates the terms of a court order or other legally binding requirements.

(3) Elements of the Plan. The Plan shall include, but need not be limited to, the following elements:

(a)sic (enumeration was not updated to match revisions to the statutes) Description of the conduct to stop and to be accountable for, including:

(A) Description of the specific actions that caused harm, including the entire range of attempts used to control and dominate the victim(s) or partner(s), specific actions that led to the participant being in the BIP, and the participant's intentions or purposes in choosing those actions.

(B) Identification of the beliefs, values, and thinking patterns the participant used:

(i) To prepare himself and plan to batter;

(ii) To justify his battering to himself and to others;

(iii) To blame other persons and circumstances outside his control for his battering; and

(iv) To minimize and deny his battering, its harmful effects, and his personal accountability and responsibility for the battering and its effects.

(C) Identification of the full range of effects and consequences of the battering on the victim(s), partner(s), children, the community and the participant.

(b) Participant's plan for choosing to treat his former, current or future partner(s) and children in a continually respectful and egalitarian manner, including:

(A) Description of the excuses and underlying beliefs used to justify his battering;

(B) Description of the participant's plan for intervening in his battering to prevent himself from continuing his pattern of battering;

(C) Description of battering the participant is currently addressing and how he is utilizing his Plan;

(D) Description of how the participant is intervening in his battering including the excuses, beliefs and behaviors he is addressing;

(E) Description of how the participant was chosen to act in ways that no longer cause harm to the victim(s), partner(s), children and the community;

(F) Description of how the participant took responsibility for choosing to act in ways that no longer cause harm to the victim(s), partner(s), children and the community;

(G) Description of the thoughts, beliefs and actions the participant shall need to change to become non-abusive and non-controlling, and a description of alternative

thoughts, beliefs and actions he can use to make non-abusive and non-controlling choices; and

(H) Description of the thoughts, beliefs and actions that the participant uses in other areas of his life that demonstrate that he is already aware and capable of making responsible non-abusive and non-controlling choices.

(c) Acceptance of full responsibility for the participant's choices and their consequences, including:

(A) Acknowledgement that the participant's actions causing harm to the victim(s), partner(s), children and the community were his choice, that he had other options, and that he is fully accountable for his choices and the consequences of those choices for himself and others;

(B) Acceptance of full responsibility for having brought the criminal justice system into his life, if applicable, and for other consequences of his behaviors; and

(C) Participant's plan for beginning and continuing to make reparation and restitution for the harms caused, either directly to the victim(s) if appropriate, approved by the victim(s), and not manipulative, or indirectly by anonymous donation or community service when the victim wants no contact with the participant (ORS 180.070, 2012).

According the State Revised Standard 180.070 (2012), treatment completion is when an offender has completed the required curriculum as stated above, has completed a minimum of 36 weeks, and is deemed completed by both the treatment provider and the

referring agent. Treatment may be extended for a variety of reasons such as non-compliance, level of risk of the offender, or poor attendance (ORS 180.070, 2012).