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CURRENT ISSUES

Promoting the Use of Evidence-Based Practice for Those Who Engage in Intimate Partner Violence

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Intimate partner violence (IPV), typically defined as physical, sexual, or psychological aggression toward a relationship partner, including coercive, controlling behaviors, is a significant public health problem.[1] Approximately 1 in 4 women and 1 in 5 men report experiencing IPV in their lifetime,[2,3] with consequences ranging from extensive negative mental and physical health outcomes to death, including both homicide and suicide.[4–6] People of color are disproportionately impacted by IPV in the U.S., with rates up to 2.7 times higher than those of their White counterparts.[7] The annual population economic costs of IPV, including health care, lost worker productivity, criminal justice, lost earnings, and other costs, exceed $3.6 trillion over the course of victims' lifetimes (2014 U.S. dollars).[8] Given its scope and consequences, one might think that research focused on addressing IPV at the source, meaning programs working with the individuals engaging in these behaviors, sometimes referred to as batterer intervention programs and labeled in this paper as IPV intervention programs, would be a top funding priority. In fact, federal agencies rarely direct funds for research focused on discovering and disseminating the most effective behavior change interventions for those who engage in IPV. Examining effective ways to prevent IPV escalation is such a neglected area of study that the field has almost ceased to exist. This kind of secondary prevention—to stop IPV—is what many if not most of those who are experiencing IPV desire rather than dissolution of the relationship or criminal justice actions against their partners.[9] Federal funding is necessary because the kind of studies that are needed are expensive, complex clinical trials that attend to partner safety and community contexts.

It may be illustrative to compare research conducted on IPV interventions with that conducted in another field that began at roughly the same time, interventions for posttraumatic stress disorder (PTSD). PTSD was first classified as a diagnosis by the American Psychiatric Association in 1980 in the DSM-III.[10] At about the same time, IPV interventions began to proliferate, stemming from the battered women's shelter movement and domestic violence laws in the late 1970s.[11] Comparing the development of interventions for these 2 problems, a review of published meta-analyses and other relevant literature reviews reveal that there have been >300 RCTs examining the effectiveness of PTSD interventions[12] and only 8 RCTs examining the effectiveness of IPV intervention programs, which have also often been described as lacking methodologic rigor.[13] The substantial difference between these 2 fields demonstrates a lack of focus on preventing trauma, with almost all funding focused on working with those who experience trauma rather than those who may be inflicting such trauma. It is unclear whether this lack of funding is due to the need to devote resources primarily to survivors because IPV is not a diagnosable disorder that falls within the scope of large national funders, or because the usual funding levels of some federal agencies are insufficient to support the complex RCTs needed to adequately research this area.

Perhaps, not surprisingly, given the limited targeted funding in this area, there has been a lack of demonstrated programmatic effectiveness. Earlier meta-analyses of these programs, most of which identify as being based on the Duluth or cognitive behavioral therapy models, demonstrate only a 5% reduction in recidivism relative to untreated groups,[14] and studies using gold standard IPV assessment methods using reports from survivors show no significant reductions in IPV.[15] This lack of demonstrated effectiveness is troubling considering that it has been estimated that approximately half a million men and women are court mandated to participate in >2,500 of these programs each year.[16,17] The

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danger of this situation should be obvious; considerable resources are poured into ineffective programs with the false notion that they are effective in rehabilitating those who engage in IPV. Continuing to rely on ineffective programs places survivors and their children at risk for serious negative health outcomes, including death.

Funders of IPV interventions often do not require evidence-based practice. If those who fund and support intervention implementation do not place sufficient value on their effectiveness, there will be little uptake of evidence-based interventions regardless of the data. Relatedly, state practice guidelines on IPV used in 45 of the 50 U.S. states do not require demonstrated effectiveness through empirical evidence, and many common standards are not scientifically based.[18] For example, most state standards (89%) require that programs consist of a certain number of sessions (ranging from 8 to 52) or hours (ranging from 12 to 104) without evidence supporting such requirements.[19] Likewise, some standards require that certain content or theoretical perspectives be represented in their curricula without clear links to evidence for such requirements.[19] Although it may be useful to set minimum guidelines for programs, if they are not evidence based, they run the risk of preventing promising evidence-based programs from being certified and implemented.[20]

A common view is that although RCTs are the gold standard generally for intervention research, challenges in randomizing violent individuals and accounting for other simultaneous criminal justice interventions (e.g., protective orders, obtaining shelter) render them less useful in researching IPV intervention effectiveness.[21] These are important challenges, but they strengthen, not weaken, the imperative to conduct RCTs. Especially because there are many factors that can create change in abusive behavior, RCTs must be used to confidently attribute observed change to the IPV intervention programs beyond these other factors. Because some will likely end their violence owing to legal deterrence strategies and partner safety measures,[22] to truly know whether a program is working, one needs to compare those from the same pool of individuals who complete one intervention with those who complete another intervention, with ingredients for change other than the IPV intervention program randomly distributed across comparison groups. Because there are a multitude of factors that may contribute to IPV cessation, true RCTs that make use of survivor reports may be best suited to answer the most critical questions of impact. Complex RCTs for other behavioral interventions considering challenges of serious potential risks, multiple causative factors, and multifaceted contexts are successfully implemented in other fields.

IPV intervention proponents themselves may take advantage of public ignorance about research and misuse scientific language. Programs describe themselves as evidence based despite never having conducted an empirical study or having scientific evidence that showed a program to be ineffective. Those involved in these IPV intervention systems sometimes become pessimistic regarding effectiveness, and this has stifled innovation and positive change. What is needed is greater humility on the part of those within the systems, from those in the criminal justice system to the IPV intervention providers, to truly question how well programs are working. Rather than tinkering around the edges, they may need to consider more effective alternatives. The concept of deimplementation from the implementation science field may have particular relevance.[23] To implement more evidence-based interventions, it may be necessary to actively discontinue existing ineffective interventions.

Another negative outcome of this lack of focus on effectiveness is that IPV intervention programs are almost always exclusively involuntary and carceral in nature. More ideally, effective approaches for voluntary clients would be identified and made available through mainstream healthcare systems as an important component to enhancing and improving health and safety. For example, after the Veterans Affairs Healthcare System accumulated evidence of the effectiveness of an IPV intervention for veterans, it assisted in funding its national implementation.[24] There is much interest in behavioral health in healthcare systems and a great deal of interest in expanding insurance and Medicaid coverage to offset the costs of behavioral health interventions. Investment in IPV intervention programs through the healthcare system could result in mental and physical health cost savings both for those who engage in IPV and their partners who experience the abuse.

There is a reason for optimism in the search for effective IPV intervention programs because some newer programs have shown positive initial evidence. In 2 separate RCTs, an intervention based on mindfulness and acceptance-based interventions that addresses emotion dysregulation and experiential avoidance—Achieving Change through Value-Based Behavior—has produced greater reductions in IPV than more traditional Duluth Model or other cognitive behavioral comparison conditions.[25,26] The Strength at Home program, an intervention that uses trauma-informed strategies to address social information processing biases that may contribute to IPV, has shown positive effects in an RCT of a military veteran sample,[27] and the program has shown additional benefits in reducing symptoms of PTSD and alcohol use problems.[24] Others have reported the benefits of motivational interviewing strategies for reducing IPV in RCTs, with programs including motivational components evidencing better outcomes than those that do not.[28]

RECOMMENDATIONS

On the basis of the points discussed earlier, the following recommendations are provided for funders, policymakers, program administrators, and researchers to move toward becoming more consistent with models of evidence-based care in other fields. Because these stakeholders are interdependent, coordination of these efforts would likely further enhance prevention effects, as has been shown in research on coordinated community efforts to prevent IPV.[29]

Recommendations for Funders

The recommendations for funders are as follows:

- Increase funding for IPV intervention programs, especially secondary prevention research to stop or reduce IPV in its early stages. This could increase safety for those who experience violence and reduce physical and mental health problems.
- Emphasize funding for RCTs, the gold standard for determining the effectiveness of interventions in other fields. One area in need of investigation is the comparison of promising practices with existing psychoeducational programs that proliferate in the community. Other research designs are also of value and merit funding, such as quasi-experimental studies, qualitative and mixed methods research, community-led or survivor-involved research, and other culturally relevant approaches.

Recommendations for Policymakers

The recommendations for policymakers are as follows:

- Broaden practice guidelines such that they emphasize and are based on scientific evidence rather than on clinical assumptions and lore.
- Focus on integrating IPV intervention into healthcare systems that include voluntary referrals and insurance compensation for these interventions.

Recommendations for Program Administrators

The recommendations for program administrators are as follows:

- Administrators should carefully evaluate claims made by programs that they are evidence based before implementation decisions are made. Determination of whether an intervention is evidence based should follow commonly accepted practices in other fields.
- IPV interventions that have been developed through community-based methods and/or adaptations of long-standing existing programs can find partners to help them evaluate their effectiveness. Organizations trusted by both groups can broker truly equitable partnerships.

Recommendations for Researchers

The recommendations for researchers are as follows:

- IPV intervention researchers should take a more active role in engaging in collaborations with providers, working with coalitions and participating in ongoing revision of guidelines and standards, finding effective ways to communicate research, and assisting in identifying and studying promising practices from practitioners.
- Avenues for improving IPV intervention science should be nurtured by scientists, such as through research groups, think tanks, conferences, and listservs.

General Recommendation

The general recommendation is as follows:

- Believe those who experience and use violence when they say that they want to keep and improve their relationships and end the violence and help them find ways to do so effectively.

CONCLUSIONS

Developing and implementing evidence-based IPV interventions should be an important national priority. Given the complexity of IPV and the multiple levels of intervention required to end the violence, it is important to utilize the most rigorous research methods to discover intervention approaches that produce maximum benefit. Despite widespread acknowledgment that the most prominent and long-standing IPV intervention programs are relatively ineffective, movement away from these programs has been slow. This has been true even with available promising alternative approaches that may better address important risk factors for IPV such as trauma, emotion dysregulation, and low motivational readiness for change. Rather than eschewing the role of science to deal with this problem, the field should insist on rigorous examination of programs given what is at stake. There must be a willingness to follow what other behavior change fields have done in using gold standard research methods to evaluate programs before disseminating them. What is needed is for those in areas of grant funding, policy, criminal justice, and intervention to demonstrate courage by challenging existing paradigms and insisting that the scientific method is followed in best promoting health and nonviolence in the population.

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REFERENCES

1. Breiding MJ, Chen J, Black MC. Intimate Partner Violence in the United States — 2010. Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf. Published 2014. Accessed May 25, 2023.
2. Desmarais SL, Reeves KA, Nicholls TL, Telford RP, Fiebert MS. Prevalence of physical violence in intimate relationships, part 1: rates of male and female victimization. *Partner Abuse.* 2012;3(2):140–169. https://doi.org/10.1891/1946-6560.3.2.140.
3. Desmarais SL, Reeves KA, Nicholls TL, Telford RP, Fiebert MS. Prevalence of physical violence in intimate relationships, part 2: rates of male and female perpetration. *Partner Abuse.* 2012;3(2):170–198. https://doi.org/10.1891/1946-6560.3.2.170.
4. Afifi TO, MacMillan H, Cox BJ, Asmundson GJG, Stein MB, Sareen J. Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. *J Interpers Violence.* 2009;24(8):1398–1417. https://doi.org/10.1177/0886260508322192.
5. Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. *Am J Lifestyle Med.* 2011;5(5):428–439. https://doi.org/10.1177/1559827611410265.
6. Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-associated deaths from homicide, suicide, and drug overdose: review of research and the intersection with intimate partner violence. *J Womens Health (Larchmt).* 2021;30(2):236–244. https://doi.org/10.1089/jwh.2020.8875.
7. Voith LA, Lee H, Russell K. How trauma, depression, and gender roles lead to intimate partner violence perpetration among a sample of predominately low-income Black, indigenous, men of color: a mixed methods study. *J Interpers Violence.* 2022;37(9–10):NP6487–NP6513. https://doi.org/10.1177/0886260520967139.
8. Peterson C, Kearns MC, McIntosh WL, et al. Lifetime economic burden of intimate partner violence among U.S. adults. *Am J Prev Med.* 2018;55(4):433–444. https://doi.org/10.1016/j.amepre.2018.04.049.
9. Campbell J, Rose L, Kub J, Nedd D. Voices of Strength and resistance: a contextual and longitudinal analysis of women's responses to battering. *J Interpers Violence.* 1998;13(6):743–762. https://doi.org/10.1177/088626098013006005.
10. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. Washinton, DC: The American Psychiatric Association, 1980.
11. Murphy CM, Rosenbaum A, Hamberger LK. Relationship violence perpetrator intervention programs: history and models. In: Geffner R, White JW, Hamberger LK, Rosenbaum A, Vaughan-Eden V, Vieth VI, eds. Handbook of Interpersonal Violence and Abuse Across the Lifespan. Berlin, Germany: Springer International Publishing, 2022:3387–3415.
12. O'Neil ME, Harik JM, McDonagh MS, et al. Development of the PTSD-repository: a publicly available repository of randomized controlled trials for posttraumatic stress disorder. *J Trauma Stress.* 2020;33(4):410–419. https://doi.org/10.1002/jts.22520.
13. Eckhardt CI, Murphy CM, Whitaker DJ, Sprunger J, Dykstra R, Woodard K. The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse.* 2013;4(2):196–231. https://doi.org/10.1891/1946-6560.4.2.196.
14. Babcock JC, Green CE, Robie C. Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clin Psychol Rev.* 2004;23(8):1023–1053. https://doi.org/10.1016/j.cpr.2002.07.001.
15. Cheng SY, Davis M, Jonson-Reid M, Yaeger L. Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma Violence Abuse.* 2021;22(3):496–511. https://doi.org/10.1177/1524838019865927.
16. Boal AL, Mankowski ES. The impact of legislative standards on batterer intervention program practices and characteristics. *Am J Community Psychol.* 2014;53(1–2):218–230. https://doi.org/10.1007/s10464-014-9637-3.
17. Price BJ, Rosenbaum A. Batterer intervention programs: a report from the field. *Violence Vict.* 2009;24(6):757–770. https://doi.org/10.1891/0886-6708.24.6.757.
18. Babcock J, Armenti N, Cannon C, et al. Domestic violence perpetrator programs: a proposal for evidence-based standards in the United States. *Partner Abuse.* 2016;7(4):355–460. https://doi.org/10.1891/1946-6560.7.4.355.
19. Flasch P, Haiyasoso M, Fall K, Evans K, Dunlap C, Nesichi T. State standards for batterer intervention programs: a content analysis. *Violence Vict.* 2021;36(6):683–705. https://doi.org/10.1891/VV-D-20-00079.
20. Austin JB, Dankwort J. Standards for batterer programs: a review and analysis. *J Interpers Violence.* 1999;14(2):152–168. https://doi.org/10.1177/088626099014002004.
21. Gondolf EW. *The Future of Batterer Programs: Reassessing Evidence-Based Practice.* Boston, MA: Northeastern University Press, 2012.
22. Sechrist SM, Weil JD. Assessing the impact of a focused deterrence strategy to combat intimate partner domestic violence. *Violence Against Women.* 2018;24(3):243–265. https://doi.org/10.1177/1077801216687877.
23. Norton WE, Chambers DA. Unpacking the complexities of de-implementing inappropriate health interventions. *Implement Sci.* 2020;15(1):2. https://doi.org/10.1186/s13012-019-0960-9.
24. Creech SK, Benzer JK, Bruce L, Taft CT. Evaluation of the Strength at Home group intervention for intimate partner violence in the Veterans Affairs health system. *JAMA Netw Open.* 2023;6(3):e232997. https://doi.org/10.1001/jamanetworkopen.2023.2997.
25. Lawrence E, Mazurek C, Reardon KW. Comparing recidivism rates among domestically violent men enrolled in ACTV versus Duluth/CBT. *J Consult Clin Psychol.* 2021;89(5):469–475. https://doi.org/10.1037/ccp0000649.
26. Berta M, Zarling A. A preliminary examination of an acceptance and commitment therapy-based program for incarcerated domestic violence offenders. *Violence Vict.* 2019;34(2):213–228. https://doi.org/10.1891/0886-6708.VV-D-17-00106.
27. Taft CT, Creech SK, Gallagher MW, Macdonald A, Murphy CM, Monson CM. Strength at Home Couples program to prevent military partner violence: a randomized controlled trial. *J Consult Clin Psychol.* 2016;84(11):935–945. https://doi.org/10.1037/ccp0000129.
28. Santirso FA, Gilchrist G, Lila M, Gracia E. Motivational strategies in interventions for intimate partner violence offenders: a systematic review and meta-analysis of randomized controlled trials. *Psychosoc Interv.* 2020;29(3):175–190. https://doi.org/10.5093/pi2020a13.
29. Shorey RC, Tirone V, Stuart GL. Coordinated community response components for victims of intimate partner violence: a review of the literature. *Aggress Violent Behav.* 2014;19(4):363–371. https://doi.org/10.1016/j.avb.2014.06.001.