

# Do Longer Intimate Partner Violence Interventions Improve Outcomes? A Meta-Analytic Study

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**Objective:** Interventions for those who perpetrate intimate partner violence (IPV) show mixed findings on effectiveness in meta-analytic reviews of the literature. Despite this lack of evidence, intervention standards in most U.S. states mandate that IPV intervention programs be of a specific length, typically considerably longer than interventions for a range of other problems. The assumption that longer programs may be more effective than shorter programs has received almost no empirical research to date. We conducted two separate studies, (a) a meta-regression to examine whether IPV intervention program length is associated with increased effectiveness among clinical trials of IPV interventions, and (b) a meta-regression using existing data from a prior meta-analysis, to examine whether IPV intervention program length is associated with increased effectiveness among experimental designs. **Method:** For Study 1, a systematic search conducted by a team of four coders, identified 593 articles for title and abstract review, with 78 undergoing full-text review. The final sample included 14 clinical trials ( $n = 1,857$ ) comparing IPV interventions to no treatment, treatment as usual, or an active control. For Study 2, we used a sample of 31 studies ( $n = 8,338$ ) from an existing meta-analysis. **Results:** For both studies, results showed no significant relationship between session length and intervention effectiveness for reported IPV behaviors. **Conclusions:** Results imply that longer IPV interventions are not always more effective than shorter interventions. For these reasons, policymakers may consider shorter interventions to increase access to care.

## Public Significance Statement

People with a history of using intimate partner violence are often required to complete intervention programs that are much longer than those used for many other mental health concerns. Findings from this study suggest that program length alone is not related to effectiveness, implying that the content and quality of interventions may matter more than the number of sessions.

**Keywords:** intimate partner violence, program length, abuser intervention, domestic violence, offenders

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Intimate partner violence (IPV) is a significant public health problem in the United States (Breiding et al., 2014). Approximately one in four women and one in five men report experiencing IPV over the course of their lives (Desmarais et al., 2012a, 2012b), with extensive mental and physical health consequences that include both

homicide and suicide (Afifi et al., 2009; Black et al., 2011; Campbell et al., 2007). The annual population economic costs of IPV including health care, lost worker productivity and earnings, criminal justice, and other costs exceed \$3.6 trillion over the course of victims' lifetimes (2014 U.S. dollars; Peterson et al., 2018). A common criminal justice response to IPV is to mandate perpetrators to complete an abuser intervention program; over half a million men and women are court mandated to participate in over 2,500 of these programs each year in the United States (Boal & Mankowski, 2014; Price & Rosenbaum, 2009). However, there is a lack of research that seeks to evaluate moderators of the effectiveness of these programs. The purpose of this study was to examine whether longer IPV interventions result in improved treatment effectiveness.

One potential moderator that has not been widely examined is program length. IPV state practice guidelines have been employed in 45 out of the 50 states (Babcock et al., 2016), and the majority of state standards (89%) require that programs consist of a certain number of sessions (ranging from 8 to 52) or hours (ranging from

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12 to 104; [Flasch et al., 2021](#)). For example, some states mandate relatively brief programs (e.g., approximately 8–12 weeks totaling 12–80 hr in Massachusetts and Utah), whereas others require substantially longer programs (e.g., 52 weeks totaling 104 hr in California; [Flasch et al., 2021](#)). These standards for program length are not based on empirical evidence, as research has not demonstrated the optimal number of sessions or hours or the superiority of longer or shorter programs ([Cissner & Puffett, 2006](#)). This is a clinically significant issue, as standards across states vary widely, and some states require clients to participate in interventions for an entire year and even more in some cases. Moreover, some shorter promising programs may not be able to be implemented in some states because they do not meet the program length requirement, which may hinder much-needed innovation in this field (see [Taft & Campbell, 2024](#)). Although prior reviews (e.g., [Babcock et al., 2024](#); [Cheng et al., 2021](#)) have found small or inconsistent average effects of IPV perpetrator programs, these mean effects mask substantial heterogeneity across intervention models. Given that program length is one of the most variable and policy-relevant features of these interventions, clarifying whether longer or shorter programs show different levels of effectiveness remains an important empirical question.

In psychotherapy and behavioral intervention research, dose–response models suggest that greater session quantity is often associated with clinical improvement, whereas good enough–level models propose that meaningful change may occur within relatively few sessions for many individuals ([Barkham et al., 2006](#); [Robinson et al., 2020](#)). Consistent with this, a recent systematic review found that psychoeducational interventions may produce clinically significant improvement in as few as four sessions, although higher intensity presentations may require substantially more sessions ([Robinson et al., 2020](#)).

To examine whether intimate partner violence (IPV) intervention program length is associated with intervention effectiveness, we conducted two meta-regressions. Study 1 examined the association between program length and treatment outcomes primarily among randomized clinical trials, and Study 2 reanalyzed data from an existing meta-analysis ([Babcock et al., 2024](#)) to assess the robustness and generalizability of findings from Study 1. Given the lack of prior evidence linking program length to IPV intervention outcomes, we hypothesized that any association between session count and intervention effectiveness would be small or inconsistent.

## Method

### Study 1

#### Literature Search

We conducted a systematic literature review through November 26, 2025, using APA PsycInfo, Psychology and Behavioral Collection, and APA PsycArticles. Keyword searches focused on IPV-related perpetrator interventions. Full details of the search strategy are provided in [Supplemental Materials](#). The initial search yielded 633 records. In addition, studies included in recent meta-analyses and systematic reviews (e.g., [Babcock et al., 2024](#); [Karakurt et al., 2019](#)) were reviewed, resulting in nine additional articles retained for full-text review.

### Inclusion and Exclusion Criteria

Please see [Figure 1](#) for our Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram regarding our process flow of the meta-analysis for Study 1. To be eligible for the study, the samples must be from a controlled trial that evaluated interventions designed to reduce IPV. Studies were required to include a control condition (e.g., no treatment, treatment as usual, or an active comparator) and report posttreatment or follow-up outcomes on IPV using the Conflict Tactics Scale or a similar measure. Studies reporting only arrest data or legal outcomes were excluded. Studies were included if they reported sufficient data to compute effect sizes. After screening titles and abstracts of 578 articles, and after removal of duplicates ( $n = 64$ ), 72 articles were retained for full text review. In addition, we also reviewed relevant articles from recent meta-analyses and systematic reviews ( $n = 9$ ). In total, 14 articles were determined to be eligible.

### Coding

Final coding for effect sizes and treatment length for Study 1 is presented in [Table 1](#). Coders prioritized partner-report physical IPV data when available; otherwise, self-report or total IPV scores were used. When multiple timepoints were reported, the earliest post-treatment or follow-up assessment was selected to standardize comparisons across studies. For Study 1, two post baccalaureate research assistants and one doctoral researcher completed initial screening of eligible articles and also conducted full text review. Discrepancies on what articles should be retained for full inclusion were discussed with the lead author, a doctoral-level researcher. After determining which articles to include, the final 14 articles were coded by two postbaccalaureate coders, and two doctoral-level coders went back to double check all coding. It should be noted that for this study, session length was defined as how many total sessions were given to participants.

### Data Analytic Plan

Effect sizes were entered as Hedges's  $g$  values, and a metaregression model was conducted to test whether intervention session length significantly moderated treatment effects. The analysis was conducted in R using the metafor package ([Viechtbauer, 2010](#)).

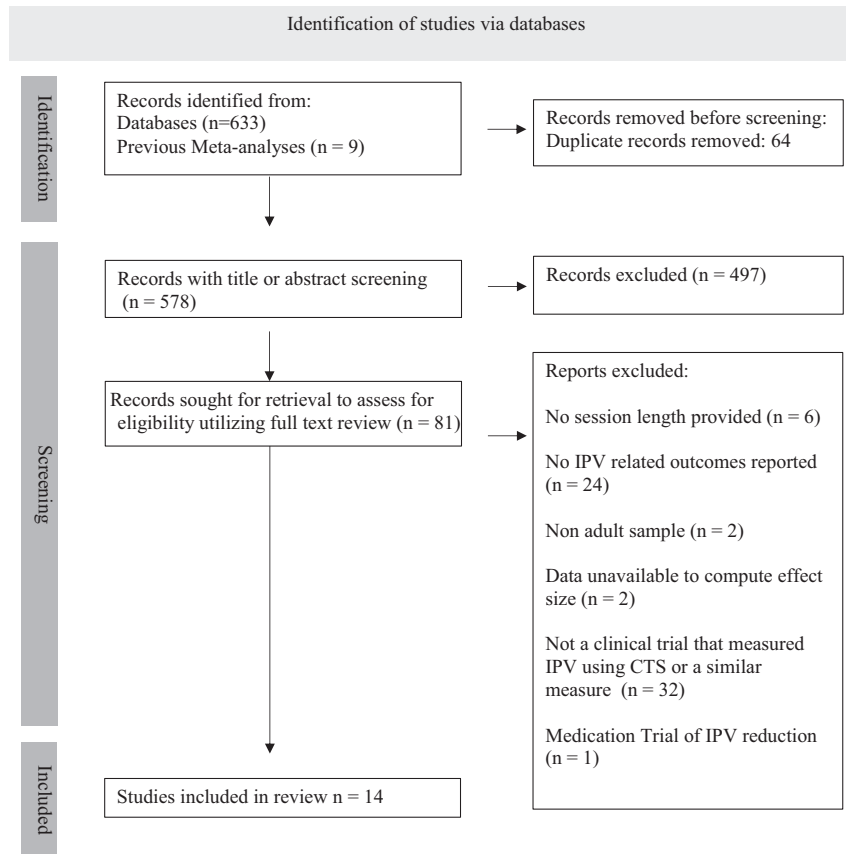
### Results

A random-effects meta-analysis was conducted to examine the overall effectiveness of IPV interventions for offenders. Fourteen independent studies were included in the analysis, with effect sizes converted to Hedges's  $g$  and variance calculated using standard formulas for independent group designs ([Borenstein et al., 2009](#)).

The overall effect size was small to medium and statistically significant ( $g = 0.26$ , 95% CI [0.13, 0.38],  $p < .001$ ), indicating that treatment groups demonstrated significantly greater reductions in IPV compared with control groups. The test for heterogeneity was not significant,  $Q(13) = 19.28$ ,  $p = .115$ .

The metaregression analysis showed that session length was not a significant moderator of effectiveness ( $b = -0.001$ , 95% CI [−0.016, 0.014],  $p = .869$ ). Residual heterogeneity remained nonsignificant,  $Q_e(12) = 19.157$ ,  $p = .085$ . Session length accounted for 0% of between-study heterogeneity ( $R^2 = 0.00\%$ ). Egger's regression test for funnel plot asymmetry was not significant ( $p = .599$ ),

**Figure 1**  
Preferred Reporting Items for Systematic Reviews and Meta-Analyses Flow Diagram  
for Study 1



Note. IPV = intimate partner violence; CTS = Conflict Tactics Scale.

suggesting no evidence of small-study effects or systematic bias in the published literature. Visual inspection of the funnel plot (see Figure 2) revealed relatively symmetric distribution of effect sizes around the mean effect.

## Method

### Study 2

Study 2 was conducted in a confirmatory fashion to see whether using a secondary data approach based on Babcock et al. (2024) would produce the same pattern of results: that treatment length is not related to treatment effectiveness. Of note, Babcock et al. completed a meta-analysis of IPV perpetration and reported session length information; however, they did not test session length as a moderator of treatment effectiveness. For Study 2, we used the summary tables published by Babcock et al. to compile our data set. Study 1 was conducted independently of Study 2, and only a subset of articles by Babcock et al. appear in Study 1, as Study 1 had a different time frame (through 2025) and different inclusion and search criteria. It is also important to note that Babcock et al. operationalized study length differently than in our original analysis (Study 1). In Study 1, session length was defined as the cumulative

number of sessions, whereas Babcock et al. defined session length as the number of weeks over which sessions were delivered.

### Inclusion and Exclusion Criteria

To be eligible for the study, the samples must be from the Babcock et al. (2024) meta-analysis, examining experimental designs comparing treatment to no treatment or quasi-experimental designs comparing treatment to no treatment or dropouts (e.g., Tables 1 and 2 from Babcock et al., 2024). For this study we dropped 11 studies for not having adequate information (e.g., reported that participants received a range of sessions that was variable) to calculate the exact program length. In total, 31 studies were determined to be eligible.

### Data Analytic Plan

A metaregression model was conducted in R using the metafor package (Viechtbauer, 2010).

### Results

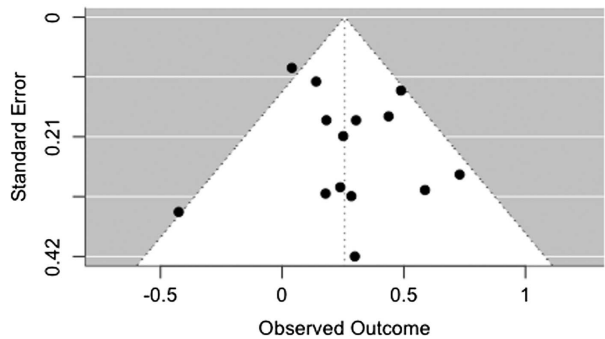
As this is a meta-reanalysis of a previously published article, we focus on our new analyses examining session length as a moderator.

**Table 1**  
*Clinical Trials Comparing Intimate Partner Violence Interventions and Session Length*

| Study                             | Hedges's <i>g</i> | Number of sessions | Country       | Sample size                                      | Report source  | Participant                                                                                                                                                    |
|-----------------------------------|-------------------|--------------------|---------------|--------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Brannen and Rubin (1996)          | 0.18              | 12                 | United States | Treatment <i>n</i> = 20; control <i>n</i> = 22   | Partner report | All clients were court-referred couples who had indicated a desire to remain in their current relationship.                                                    |
| Cleary Bradley and Gottman (2012) | 0.25              | 22                 | United States | Treatment <i>n</i> = 41; control <i>n</i> = 53   | Partner report | Couples in a committed relationship for at least 1 year                                                                                                        |
| Easton et al. (2018)              | 0.24              | 12                 | United States | Treatment <i>n</i> = 29; control <i>n</i> = 34   | Self-report    | Adult males seeking court-mandated treatment at a Drug Diversion Clinic                                                                                        |
| Fernández-Montalvo et al. (2019)  | 0.59              | 20                 | Spain         | Treatment <i>n</i> = 28; control <i>n</i> = 19   | Self-report    | Patients seeking addiction treatment                                                                                                                           |
| Gondolf (2007)                    | 0.14              | 16                 | United States | Treatment <i>n</i> = 162; control <i>n</i> = 152 | Partner report | African American men mandated to counseling for IPV prevention                                                                                                 |
| Gibbs et al. (2020)               | 0.04              | 21                 | South Africa  | Treatment <i>n</i> = 237; control <i>n</i> = 268 | Self-report    | Community members                                                                                                                                              |
| Lila et al. (2018)                | 0.18              | 35                 | Spain         | Treatment <i>n</i> = 64; control <i>n</i> = 59   | Self-report    | Men convicted of intimate partner violence                                                                                                                     |
| Mbilinyi et al. (2011)            | 0.30              | 2                  | United States | Treatment <i>n</i> = 58; control <i>n</i> = 66   | Self-report    | Adult men were recruited via a multimedia marketing campaign.                                                                                                  |
| Murphy et al., 2020               | −0.43             | 20                 | United States | Treatment <i>n</i> = 21; control <i>n</i> = 21   | Partner report | Partners of men presenting at a community-based domestic violence agency who met the following criteria.                                                       |
| Murray et al. (2020)              | 0.49              | 23                 | Zambia        | Treatment <i>n</i> = 123; control <i>n</i> = 125 | Partner report | Women who reported moderate or higher levels of IPV and their male partners with hazardous alcohol use were enrolled as a couple.                              |
| Schumacher et al., 2011           | 0.30              | 2                  | United States | Treatment <i>n</i> = 11; control <i>n</i> = 12   | Partner report | Participants were women with a current drug use disorder, who were recruited from an substance use disorder treatment program, along with their male partners. |
| Taft et al. (2016)                | 0.44              | 12                 | United States | Treatment <i>n</i> = 67; control <i>n</i> = 68   | Partner report | Veterans and their partners                                                                                                                                    |
| Woodin and O'Leary (2010)         | 0.28              | 1                  | United States | Treatment <i>n</i> = 21; control <i>n</i> = 20   | Partner report | Colleges students and their partners recruited from Stony Brook University                                                                                     |
| Zarling and Russell (2022)        | 0.73              | 24                 | United States | Treatment <i>n</i> = 29; control <i>n</i> = 27   | Partner report | Female partners of men who were court mandated to complete a domestic violence program after being convicted of assault against a female partner               |

*Note.* Effect sizes reflect the earliest posttreatment outcome reported. IPV = intimate partner violence.

**Figure 2**  
*Funnel Plot of Effect Sizes for Study 1*



*Note.* Funnel plot of study effect sizes against their standard errors.

The overall effect size across 31 studies was small to medium and statistically significant ( $g = 0.31$ , 95% CI [0.19, 0.42],  $p < .001$ ; see Babcock et al., 2024, for further information regarding study findings). A metaregression analysis was conducted to examine whether study length moderated treatment effectiveness. Study length was not a significant moderator ( $b = 0.001$ , 95% CI [-0.008, 0.009],  $p = .887$ ) and did not account for any of the observed heterogeneity ( $R^2 = 0.00\%$ ). Residual heterogeneity remained high and significant after accounting for study length,  $Q_e(29) = 116.13$ ,  $p < .001$ , indicating that other study characteristics likely explain the substantial variability in effect sizes.

**Discussion**

In two separate analyses, we found no clear evidence that the number of sessions or the length of the program significantly influences how effective those programs are. The negligible effect of session length on treatment outcomes held true across both a smaller sample of randomized controlled trials and a larger collection of experimental and quasi-experimental studies. These findings suggest that simply increasing the number of sessions does not always improve intervention success. Rather, intervention content and quality may be more critical determinants of program success than duration alone. This work is consistent with findings from prior studies that have also found that increased session count does not always improve outcomes. For example, a study by Barkham et al. (2006) found that the percentage of clients achieving reliable and clinically significant improvement did not increase with the number of sessions attended.

**Limitations**

There are several limitations worthy of note. For one, most sessions in our analyses were greater than five, so it is unclear whether brief interventions less than five are of similar effectiveness as studies that are around 10–12 sessions. In addition, some studies were not included in the analyses because they did not report session amount or had insufficient information to identify an effect size. Program length may also be relevant for certain subgroups such as individuals with comorbid mental health diagnoses like co-occurring PTSD or substance use or those and those with more violent offenses. An additional limitation is that the present analyses

do not account for the spread in sessions (i.e., the length of time between sessions). Variation in how sessions are distributed across time (e.g., multiple sessions per week vs. weekly sessions) may influence intervention effectiveness and should be examined in future research. Additionally, the effect of program length may also depend on one’s gender, or the type of intervention being delivered (i.e., educational vs. skill based). Last, the metaregression analyses may have been underpowered to detect small moderation effects. Accordingly, the absence of a significant moderation effect should not be interpreted as evidence of equivalence between shorter and longer programs but rather as indicating no detectable linear association within the observed range of program lengths.

**Future Directions**

Future research should examine whether very brief interventions (fewer than five sessions) are as effective as interventions of

**Table 2**  
*Study 2: Experimental or Quasi-Experimental Designs Comparing Intimate Partner Violence Interventions to No Intervention*

| Study                        | Hedges’s <i>g</i> | Session length (weeks) |
|------------------------------|-------------------|------------------------|
| Palmer et al. (1992)         | 0.76              | 10                     |
| Dunford (2000)               | 0.13              | 52                     |
| Feder and Dugan (2002)       | 0.03              | 26                     |
| Taylor et al. (2001)         | 0.26              | 8                      |
| Labriola et al. (2008)       | 0.05              | 26                     |
| Taylor and Mawell (2009)     | 0.03              | 1                      |
| Woodin and O’Leary (2010)    | 0.47              | 1                      |
| Taft et al. (2016)           | 0.26              | 12                     |
| Murray et al. (2020)         | 0.22              | 12                     |
| Edleson and Grusznski (1988) | −0.15             | 24                     |
| Waldo (1988)                 | 0.44              | 12                     |
| Chen et al. (1989)           | 0.41              | 8                      |
| Newell (1994)                | 0.17              | 12                     |
| Flournoy (1993)              | 0.02              | 8                      |
| Dutton et al. (1997)         | 0.11              | 16                     |
| Murphy et al. (1998)         | 2.00              | 22                     |
| Thomas (1999)                | −0.36             | 10                     |
| Babcock and Steiner (1999)   | 0.68              | 36                     |
| Menton (1999)                | −0.17             | 18                     |
| Morrel et al. (2003)         | 0.60              | 16                     |
| Stith et al. (2004)          | 1.56              | 12                     |
| Hendricks et al. (2006)      | 0.92              | 14                     |
| Ley (2006)                   | 0.34              | 26                     |
| Pitts et al. (2009)          | 1.40              | 1                      |
| Petrucci (2010)              | 0.35              | 52                     |
| Pascual-Leone et al. (2011)  | 0.21              | 12                     |
| Hasisi et al. (2016)         | 0.44              | 12                     |
| Grana Gomez et al. (2017)    | 0.24              | 23                     |
| Cox and Rivolta (2021)       | 0.20              | 26                     |
| McNeeley (2021)              | −0.14             | 16                     |
| Friedman et al. (2022)       | 0.86              | 52                     |

*Note.* Effect sizes presented are for the latest posttreatment outcome presented in the article based on partner report or, if unavailable, police report. All effect sizes and session length data were taken from “Which battering interventions work? An updated Meta-analytic review of intimate partner violence treatment outcome research,” by J. C. Babcock, M. W. Gallagher, A. Richardson, D. A. Godfrey, V. E. Reeves and J. D’Souza, 2024, *Clinical psychology Review*, 111, Article 102437 (<https://doi.org/10.1016/j.cpr.2024.102437>) for this meta-reanalysis. For more information regarding this data including report source and sample sizes, please refer to Babcock et al., 2024.

moderate length (10–16 sessions) or extended length (greater than 25 sessions). This would help determine whether our findings hold across the full spectrum of study length. It is also important to evaluate the utility of single-session interventions.

## Policy Implications

Findings from this study are incongruent with many current practice guidelines. Most state-level IPV intervention standards specify a set number of sessions or hours, often based on the assumption that longer programs are more effective (e.g., Flasch et al., 2021). Current findings suggest that the field may need to revisit such assumptions and avoid the assumption that longer interventions are required for effective intervention for abusive individuals or subgroups of such individuals. By disallowing the use of programs that are not the required length in some states, courts may be unintentionally preventing the certification and implementation of more effective interventions that may be shorter in length (Taft & Campbell, 2023).

Although program length was not associated with overall intervention effectiveness in the present analyses, this does not imply that duration is irrelevant for all individuals or contexts. It is possible that program length matters more for specific subgroups, such as individuals with higher risk profiles, co-occurring substance use or mental health disorders, or greater socioeconomic needs, who may require additional structure or support. Similarly, intervention modality may moderate the relevance of program length, with skills-based or motivational approaches potentially achieving meaningful change in fewer sessions, while other models may emphasize longer engagement. Additionally, the current findings suggest that what occurs within sessions may be more consequential than how many sessions are delivered. Intervention content, facilitator competence, cultural responsiveness, and the extent to which programs address motivation, accountability, and contextual stressors are likely critical drivers of change. From a systemic perspective, mandated program length may function less as a therapeutic dose and more as a mechanism of surveillance or punishment within the criminal legal system. In such contexts, longer programs may increase attrition without conferring additional benefit, particularly for marginalized individuals facing additional stressors and/or barriers to attendance. Future research should explicitly examine whether program length interacts with participant characteristics, intervention type, and delivery context to influence outcomes. These considerations underscore the need for policy standards that prioritize evidence-based content and delivery quality rather than relying on session count as the primary contributing factor for effectiveness.

Overall, our findings challenge common assumptions that longer IPV intervention are more likely to reduce IPV use among individuals enrolled in intervention programs. We are not aware of published data from any field indicating that lengthy programs are needed to assist individuals in changing problem behaviors. What is likely more important than program length is the content of the sessions and the ability of providers to facilitate an atmosphere that promotes motivation to change. Focusing on the evidence for the effectiveness of abuser interventions would appear to be a more empirically supported approach for certifying, and implementing IPV interventions and expanding how we view program length may assist in increasing access to care, reducing provider burden, and allowing more individuals in need of intervention to receive care.

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