Are current state standards for domestic violence perpetrator treatment adequately informed by research? A question of questions

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Are Current State Standards for Domestic Violence Perpetrator Treatment Adequately Informed by Research? A Question of Questions

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SUMMARY. An empirical review and critique of existing state standards for batterer programs in the domestic violence field appeared timely, given the current debate about their status and utility. Although there has been a considerable amount of polemic discussion of the topic, relatively limited data have been reported. The present article surveyed the content of standards developed in 30 states within the United States. Five categories of interest were examined including: (1) the minimum length of treatment specified; (2) specification of treatment orientation, methods, and content; (3) preferred or allowable modalities of treatment; (4) whether research findings were mentioned or endorsed as a basis for development of treatment standards; and (5) methods for developing and revising standards. A related area, the minimum education required for

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providers, was also included as an area of interest to further describe the current pool of practitioners targeted for regulation. An analysis of the content of these standards was then performed with regard to existing peer-reviewed research in the field. The results are discussed in terms of the strengths and weaknesses of current standards, the areas in which further research is needed, and specific recommendations regarding steps that might be taken to improve existing efforts. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: getinfo@haworthpressinc.com] Website: <http://www.HaworthPress.com> © 2001 by The Haworth Press, Inc. All rights reserved.]

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The development of standards, guidelines, or protocols to regulate batterer interventions in the United States has grown in importance as programs for domestically violent men have proliferated across North America. While these services have gained legitimacy within social service and criminal justice circles, a considerable amount of controversy has persisted regarding the causes of battering and how batterer intervention programs should be conducted (Adams, 1988; Dobash & Dobash, 1992; Edleson, 1996; Gondolf, 1997). For example, some practitioners and many battered women’s advocates have viewed domestic violence as resulting from patriarchal factors, thus supporting a focus on men’s socially reinforced abuse of power and control over their partners. On the other hand, other practitioners have approached the problem from a cognitive-behavioral or psychotherapeutic perspective, thus employing a variety of intervention strategies based on individual psychological or interpersonal dysfunction. These primary viewpoints, to various degrees, have contributed to the development of a variety of protocols, which have dictated preferred or required practice in the field in a significant number of states across the country.

An empirical review and critique of existing state standards for batterer programs in the domestic violence field appeared timely, given the current debate about their status and utility (Bennett, 1998; Geffner, 1995a, 1995b; Gondolf, 1995; Rosenbaum & Stewart, 1994). An important issue relates to whether, and to what degree, currently developed standards are based on scientific research. A review of the literature on standards revealed a considerable amount of polemic discussion of the topic, but relatively limited data in this regard (Austin & Dankwort, 1999). The present article attempts to provide such data
by surveying the content of standards developed in 30 states within the United States. An analysis of the content of these standards was then performed with regard to existing peer-reviewed research in the field. The results are discussed in terms of the strengths and weaknesses of current standards, the areas in which further research is needed, and specific recommendations regarding steps that might be taken to improve existing efforts.

METHOD

Standards governing the treatment of domestically violent perpetrators were obtained for 30 states that had completed and implemented written protocols for practice at the time of this writing. Copies of the standards were obtained from the Batterer’s Intervention State Committee, a national organization of treatment service providers, as well as through state governmental or provider/advocate coalition channels. The 30 sample states or jurisdictions included Alaska, Arizona, California (San Diego), Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana (Marion County), Iowa, Kentucky (Jefferson County), Maine, Maryland, Massachusetts, Michigan (Wayne County), Minnesota, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Washington, and Wisconsin. States with non-operational or “in development” draft protocols for batterer treatment were not included in the survey.

The standards were reviewed by three domestic violence practitioners. Five categories of interest were identified based upon empirical or face validity. Although many dimensions could have been evaluated, the following criteria for selection of domains were used. The domains had to be (a) clinically relevant or practice related; and (b) designed to limit or direct the basis or type of intervention employed by practitioners in the field. Thus, the resulting domains selected were commonly addressed parameters of practice (e.g., treatment length, orientation, and modality). A related area, the minimum education required for providers, was also included as an area of interest to further describe the current pool of practitioners targeted for regulation. The resulting six domains were operationalized in terms of questions for the reviewers. Because the information necessary to rate the protocols on each domain was explicitly written in the standards for each state, there was no inter-rater variability. Thus, the standards for each of the states were evaluated with regard to the following six questions:

1. Is minimum length of treatment specified?
2. Are treatment orientation, methods, and content dictated or specified?
3. Do standards dictate preferred, or allowable, modalities of treatment?
4. Are research findings mentioned or endorsed as a basis for development of treatment standards?
5. Do state standards for certification require a minimum education at the Bachelor’s level?
6. Are there formally documented methods for developing and revising standards?

The results were compiled and descriptive statistics were computed in terms of categories of responses. Excerpts were drawn from the standards from various states for purposes of illustration, critique, and discussion.

RESULTS AND DISCUSSION

Length of Treatment

The survey results indicated that the recommended treatment duration varied from state to state, ranging from a non-specified period of time to one year or more. However, it was noted that the majority of states (74%) surveyed require 16 or more weeks of treatment (see Figure 1). In most cases, the number of weeks specified also referred to the number of sessions of treatment, as a once-a-week schedule was assumed. While some state standards went so far as to specify the number of contact hours that had to be delivered (e.g., 80 hours for Massachusetts), this parameter remained unspecified for most states.

With the exception of Rosenbaum, Gearan, and Ondovic (in this volume), there are few comparative studies that have examined the relative efficacy of domestic violence treatment by number of sessions or by duration of treatment. However, the minimum requirement of 16 weeks would appear to have some basis in research as many of the available outcome studies have used 16 or more sessions (Dutton, 1986; Edleson & Tolman, 1992; Hamberger & Hastings, 1989). Moreover, Edleson and Syers (1991) provided data that raise questions as to whether violence reduction is significantly improved by a more intensive twice-a-week format, compared to a once-a-week briefer treatment format. Similarly, Rosenbaum, Gearan, and Ondovic provide recidivism data that question whether there are additional benefits to be derived from conducting treatment for more than 10 to 20 weeks for many perpetrators. In some cases, perhaps reflecting the dearth of comparative data on this topic, it appears that the pragmatic issues associated with the need to address a minimum set of content areas have dictated treatment length. For example, Florida State requires:
A minimum of two to three sessions (for a total of 24 weeks) must be devoted to each specific tactic of power and control.

However, there is also a question of how a successful outcome is defined in the treatment of perpetrators of domestic violence. We may find that fewer sessions are required to bring about lasting cessation of physical violence than might be required to impact the entire cluster of psychological and emotional abuse that is usually associated with physical violence. As O’Leary (1999) has effectively argued, the type of psychological abuse that takes place in domestic violence is worthy of attention in its own right. As new assessment and intervention techniques are developed for dealing with psychological abuse in domestically violent relationships (O’Leary & Maiuro, 2001), it will be important to look beyond the issue of recidivism as the sole criterion to determine the range of sessions required to achieve a “successful” outcome.

**Specification of Treatment Orientation and Content**

Since the paradigm of intervention for perpetrators of domestic violence is still emerging (Hamberger, 1994), it is not surprising to find that most states (75%) have not specified orientation, method, and content with regard to treatment. Although some standards specifically endorsed a particular orientation with respect to the causality of battering or appropriate areas of intervention, none of the standards reviewed went so far as to dictate a particular regimen (e.g., The Duluth Model by Pence & Paymar, 1993).

**FIGURE 1. Is Minimum Length of Treatment Specified?**

![Diagram showing the percentage of states specifying treatment lengths](image-url)
It should be noted that intervention for domestic violence has only recently begun to be embraced and mainstreamed by the traditional health disciplines (Maiuro & Avery, 1996; Maiuro, Vitaliano, Sugg, Thompson, Rivara, & Thompson, 2000). Moreover, since treatment providers tend to be from a number of disciplines, including social work, psychology, counseling, and substance abuse fields, a variety of literatures and theoretical perspectives could very well be emphasized. Without a minimum skill-set dictated and standardized by each social service and health care discipline, it may be difficult to come up with a common set of interventions which can be delivered by different practitioners with different levels of training and backgrounds. Given the current research literature supporting the presence of multiple typologies associated with battering (Gondolf, 1988; Gottman et al., 1995; Hamberger, Lohr, Bonge, & Tolin, 1996; Hershorn & Rosenbaum, 1991; Holtzworth-Munroe & Stuart, 1994; Saunders, 1992; Tweed & Dutton, 1998) and the lack of controlled comparative studies supporting one approach over another in terms of effectiveness, an attempt to develop a “one size fits all” standard for treatment content may be inappropriate.

Nonetheless, the standards of a significant minority of states (25%) provide some direction with regard to treatment orientation and content. Where present, specific directives relate to three primary areas, including: (a) whether treatment should be focused on individual psychopathology and addressed by psychotherapeutic methods, or whether the individual has simply learned a dominant gender role through socio-cultural, political influences which must be modified or relearned through educational methods; (b) generic versus violence-specific treatment, and (c) anger versus power and control as a source of motivation for the abuse of women.

**Individual Psychopathology versus Gender-Role/Social-Cultural Models**

In some of the states that specify a theoretical orientation, there appears to be an emphasis upon socio-cultural factors and an explicit de-emphasis of individual psychopathological factors. For example, New York standards state:

*The vast majority of men who batter are not psychologically disturbed in the conventional sense. Their abuse is related to cultural, social, and political practices (Gondolf, 1985). Programs designed to stop battering begin with and focus on that premise.*

Moreover, some standards go so far as to suggest that a focus on individual psychopathology may not only miss the point, but also provide a “sick role” or insanity type of excuse for violence. For example, Massachusetts’s standards state:
In his article “Treatment Models of Men Who Batter: A Profeminist Analysis,” David Adams of the Emerge Program in Massachusetts (1988) articulates how some of these clinical approaches fail to adequately address the violence by focusing on individual psychological issues that, although important, are not the cause of the violence. Furthermore, Adams notes that “. . . some of these approaches collude with batterers by not making their violence the primary issue or by implicitly legitimizing men’s excuses for the violence.” (Adams, 1988)

A review of the literature suggests little in the way of clear direction in these areas. While the early literature on domestic violence emphasized political and socio-cultural influences, the more recent research has emphasized the importance of individual psychological factors as a source of vulnerability or risk for violence toward women (Dutton, 1994; Hamberger, 1994). Despite the tendency for some workers in the field of domestic violence to argue for one viewpoint over another, the existing literature would suggest that both types of factors play an important role as contributing influences to domestic violence (Hamberger, 1994; Hamberger & Hastings, 1990; Rosenbaum & Maiuro, 1989). Furthermore, Hamberger (1994) has observed that socio-cultural variables may operate at a “distal” level, creating the general environmental circumstances, which encourage or condone the behavior, while individual psychological variables operate at a “proximal” level, to precipitate the individual’s attitudes, emotions, and behaviors. Other writers provide data to suggest that cultural factors alone may not be sufficient and that individual factors are necessary for domestic violence to occur, thereby emphasizing the necessity of focusing upon both types of factors (see Dutton, 1994, regarding “patriarchal fallacy”).

Whether Treatment Should Be Violence Specific or “Generic”

Another theme evident in the standards is an emphasis upon violence specific rather than “generic treatment,” with the latter term used to describe more traditional psychodynamic approaches. This emphasis appears to have been developed out of a pragmatic recognition that violent behavior should be prioritized as the focus of treatment rather than the dynamic “symptom” of some other underlying problem. Thus, Kentucky standards state:

The treatment must be violence specific rather than generic.

Based on a review of the literature, Saunders (1996) appears to be the only investigator to have compared violence specific, psychoeducational treatment methods with more traditional psychodynamic methods. In his study, Saunders randomly placed men with histories of domestic violence into either a Femi-
nist-Cognitive-Behavioral or a less structured Process-Psychodynamic treatment program. The psychodynamic treatment focused largely on general counseling and support issues, such as facilitating the participants' personal insight, self-awareness, and understanding of their own victimization within their families of origin. On the other hand, the cognitive-behavioral model focused on issues such as asserting needs, expressing feelings, challenging irrational thought processes, and modifying societal stereotypes of gender roles. Despite the differences in treatment approaches, no evidence was found for the superiority of one approach over the other with regard to the primary outcome of cessation of violence. There was, however, an interaction of treatment with the type of offender. Measured by self-report and partner reports, men with dependent personalities were found to have better outcomes in the process-psychodynamic treatment, whereas men with antisocial personalities had better outcomes in the feminist-cognitive behavioral treatment.

Paradigmatically speaking, some researchers believe the efficacy of intervention in this area has yet to be solidly demonstrated and replicated, let alone the superiority of one theoretical orientation over another. Moreover, in the course of controlled clinical trials, the issue of efficacy generally precedes a component analysis to determine what the key factors are in any regimen. More research is clearly needed in this area before definitive guidelines can be established to direct the "best" course or methods of intervention.

Anger versus Power and Control as a Source of Motivation

Another theme apparent in standards that specify program content is the issue of how much emphasis should be placed upon anger as a target of treatment. Much of the discussion of this topic appears to have taken the form of a debate regarding the motivation for domestic violence, with some feminist proponents suggesting that a focus upon anger detracts from the abusers' abuse of power and control to dominate women. As a result, while some states acknowledge that anger management may be a useful component of batterer's treatment, others explicitly disapprove of such approaches as a primary focus of treatment. For example, according to Florida State standards:

. . . Communication enhancement or anger management techniques, which lay primary causality on anger, are prohibited.

Gondolf and Russell (1986) suggested that anger management approaches were simplistic and ignored important socio-cultural dynamics, such as power and control. However, assuming that the program does not focus solely upon anger, it can be argued that focusing upon anger need not be simplistic, partic-
ularly if it is handled within a comprehensive cognitive-behavioral framework. For example, Jefferson County, Kentucky standards state:

Components of the individual or group therapy should include cognitive restructuring, anger management, stress management, sex-role stereotyping, power and control issues, conflict resolution, the cycle of violence, chemical abuse/dependency, empathy for the victim’s experience, and personal abuse history. The treatment should address cognitive, behavioral, and emotional processes.

Moreover, when one examines the actual research data, there appears to be fairly strong empirical support for a focus upon anger as a component of intervention in a large percentage of domestically violent men. Significant levels of anger and hostility have been found to be characteristic of domestically violent men across samples and across a variety of different measures (Boyle & Vivian, 1996; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Hanson, Cadsky, Harris & LaLonde, 1997; Hershorn & Rosenbaum, 1991; Maiuro, Cahn, & Vitaliano, 1986; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Margolin, John, & Gleberman, 1988).

Some of the debate in this area appears to be due to confusion regarding the differences between “state” anger (situationally provoked or experienced) and “trait” anger (a general tendency to respond to events with anger, regardless of the presence of provocation). In this regard, it is important to note that research data supporting the presence of anger problems in batterers have never been interpreted to suggest that the victim is to blame for this anger by somehow provoking the perpetrator’s violent behavior. Rather, current findings have supported the presence of anger as a trait characteristic of the perpetrator; a trait associated with negative emotional reactivity, hostile attitudinal sets, limited coping and conflict resolution skills, and negative family of origin influences such as abuse related trauma. Moreover, as increased attention has focused upon psychological and emotional forms of abuse in domestically violent relationships, few clinical researchers would question the role of anger in the perpetration of psychological and emotional abuse, verbal attacks to self-esteem, and threats to harm.

As is the case with other forms of violence in which vulnerable victims are abused and disempowered, there is a tendency for some domestic violence practitioners to form strong positions of advocacy and to adopt an “either/or” position when it comes to their beliefs about domestic violence. Such thinking can create an artificial dichotomy of “anger” versus “control” models when, in fact, both issues represent two different heads on the same dragon of abuse (see Dutton, 1994). When the research literature is examined, one finds support for
multivariate rather than single factor models of domestic violence. This would argue for an inclusive, rather than exclusive, approach to treatment guidelines (Hamberger, 1994; Maiuro & Avery, 1996), if for no other reason, to address the diversity of profiles present in samples of domestically violent men.

**Modalities of Treatment**

While many modalities of treatment are mentioned in the state standards surveyed, 90% of the guidelines surveyed emphasized group therapy as the primary choice for intervention (see Figure 2). Although there have been no comparative studies of efficacy across individual and group treatment modalities, a number of advantages can be identified in the clinical literature for group methods. These include combating social isolation as a risk factor (Hotaling & Sugarman, 1986), peer support to ventilate acute concerns (Lion, Christopher, & Madden, 1976), the development of a vicarious learning environment, and exposure to coping versus mastery models for change (Rosenbaum & Maiuro, 1989). Many therapists have also recognized the confrontive value of groups for male offenders of various types (Bernard & Bernard, 1984). When supportively guided by a trained therapist, such confrontation can be useful in identifying and modifying interpersonal insensitivity, cognitive distortions, and the type of minimization and denial often evidenced by domestically violent men.

Coping models, which begin with a variety of fears and failings, and then progressively foster the acquisition of skills and positive social judgements, can surpass mastery models in social influence (Rosenbaum & Maiuro, 1989). The use of coping models may be particularly relevant in the case of batterers, as some may have generalized conflicts with authority figures (Fagan, Stewart, & Hansen, 1983). Moreover, those men who present with a “macho” identity may require the social support of other aggressive males in order to let go of their defenses and consider alternatives to their psychological and behavioral weaponry.

Another attribute of group interventions relates to economy and efficiency of service delivery. Although domestic violence occurs across all socio-economic levels, a large proportion of cases come from low socio-economic strata (Hotaling & Sugarman, 1986; Straus, Gelles, & Steinmetz, 1980). By offering relatively less expensive group services, the therapist can decrease financial barriers to treatment for clients who lack comprehensive health insurance, have modest incomes, or partial employment. A related issue deals with the sheer magnitude of domestic violence as a problem. Even though individualized services may be indicated in some cases, such prevalence rates demand efficient service delivery methods to accommodate the needs of the community (Rosenbaum & Maiuro, 1989). Presumably for a combination of these
FIGURE 2. Do Standards Dictate Preferred or Allowable Modalities of Treatment?

reasons, many states such as Washington endorse a preference for group modalities of intervention over individual ones:

*The domestic violence perpetrator programs shall require participants to participate in weekly group treatment sessions unless there is a documented, clinical reason for another modality.*

However, in keeping with existing research, there appears to be no reason to exclude individualized approaches, as there are no studies that indicate group therapy is actually superior to one on one intervention. Thus, some states (55%) allow for the substitution of individual therapy for group therapy modalities (see Figure 2).

*Gender Specific Treatment*

The majority of states (65%) have specifically mentioned that treatment should be conducted in a gender-specific fashion so that male perpetrators are seen in men’s groups and female perpetrators are seen in women’s groups (see Figure 2). This arises from the belief that the treatment needs of women are different than those of men. The issue of gender-specific groups has received some preliminary support from clinical research, which has documented that the issues and problems of women who perpetrate domestic violence are, in many ways, different than those of men (Hamberger & Potente, 1994; Saunders, 1986).
Although the most important goal in treating either domestically violent men or women is to stop the violence and abuse, Hamberger and Potente (1994) found important gender differences based on the impact of the violence and on the motivation driving the violence. The fear-inducing and injurious impact of male-to-female violence is typically higher than that of female-to-male violence. In addition, the motivations recounted by men who commit domestic violence are more likely to be related to anger, power, and control over their partners, while women tend to be motivated by a cluster of anger, fear, and self-protection (Hamberger & Potente, 1994; Jacobson, 1994; Vivian & Malone, 1997). Thus, men’s groups focus on learning to cultivate non-abusive ways of resolving conflict and developing more egalitarian relationships. Women’s groups focus on aspects of empowerment, differentiating assertiveness from anger, increasing access to resources, and a variety of safety issues (Hamberger & Potente, 1994).

In addition, Saunders (1986) conducted a survey examining motives of domestically abusive women. Of the 52 women participants studied, 69% indicated they were actually engaging in self-defense or retaliation for violence perpetrated against them. Although the reference to research is not specifically documented and questionable in terms of the figures quoted for the overall percentage of women victimized in domestic violence incidents, Washington State standards appear to have been developed with data on gender differences in mind:

In light of consistent research findings that a victim of domestic violence is female in ninety-five percent of domestic violence incidents, the program shall give special consideration to a female participant with regard to prior domestic violence victimization.

Couples versus Individual Therapy

An issue related to gender-specific treatment is whether men and women should be seen together. While some states (55%) allow couples therapy when victim safety criteria permit (see Figure 2), many states (43%) explicitly preclude the use of couples therapy in the treatment of perpetrators of domestic violence. Washington State standards are a good example of precluding language:

Under no circumstances invite or require victims of group participants to attend perpetrator program counseling and education groups.

Other states indicate that couples therapy may be permissible on an ad hoc or an adjunctive basis. For example, the San Diego County Task Force on Domestic Violence states:
A couple's session (as opposed to on-going couple therapy) may be used to elicit information, arrange a separation, arrange visitation for children, or to teach anger management skills such as time out.

In addition, 35% of states surveyed will only allow couples therapy once gender-specific treatment of the perpetrator has been completed (see Figure 2). The reasons commonly cited for limiting the use of couples therapy include: (a) concern that such treatment will endanger or instill fear in the victim, or (b) diffuse responsibility for the violence and abuse from the batterer. The standards for Pennsylvania state:

It is the tendency of couples counselors to equalize responsibility for violence between the man and the woman.

Although research studies have been limited to date, recent studies indicate that couples therapy may be possible with rigorous and careful screening. Dunford's (1997) work with U.S. Navy personnel compared gender specific groups and conjoint groups with an added control condition. Dunford's data revealed no significant difference between the treatment conditions and the control condition. All three conditions had a recidivism rate of approximately 28% and an equal number of incidents during the course of therapy. Interestingly, Dunford's results also indicated that approximately 15% of the batterers accounted for 85% of the recidivism.

Contrary to the concerns raised by some advocates, O'Leary (1996, and in this volume) found that some victims preferred to receive treatment with their partners in a couples format. Moreover, O'Leary found that couples treatment is possible and equally effective if provided under certain conditions. These conditions include safety assessment and screening with regard to prior level of violence and current risk of violence. O'Leary points out that, unlike generic couples therapy, which is often based on systems theory in which both partners assume responsibility for dysfunctional patterns of behavior, violence-specific couples therapy holds the perpetrator accountable and responsible for the abuse.

Although limited, the current data suggest that the exclusion of couples therapy as a modality for domestic violence treatment may be premature. Moreover, some researchers have suggested that mutually occurring violence is more common than previously indicated in the literature (Cascardi, Langhinrichsen, & Vivian, 1992; Morse, 1995; Steinmetz & Lucca, 1987; Vivian & Langhinrichsen-Rohling, 1994) and that certain aspects of treatment for the husband (e.g., time-out techniques) can be more effective if the spouse is involved (Rosenbaum & Maiuro, 1989).
The most reasonable conclusion at this juncture appears to be that further, albeit cautious, investigation of couples modalities is warranted. Detailed protocols now exist for determining whether couples treatment may be safely conducted (Bograd & Mederos, 1999; Gauthier & Levendosky, 1996) and are in need of empirical validation. Of particular interest would be the question of whether there are subtypes of abuse and vulnerability profiles that indicate or contra-indicate the use of such treatment in the presence of willing participants. With proper and ongoing attention to safety issues for the victim, such studies would have merit and should not be precluded on an a priori basis.

Is the Use of Research Findings Formally Documented as a Basis for Developing Standards?

While many states (40%) provide documenting references for the positions taken within the standards, the present survey results also indicated the majority of the states (60%) do not provide any empirical or authoritative references. In the cases in which references are present, the citation is often a book or book chapter based on clinical impressions by early workers in the field. In some cases, these early impressions may have been generalizations or over-simplifications, which have since been modified by more recent findings in empirical research. For example, while some couples counselors may “equalize responsibility for violence between the man and the woman,” it may not be accurate to say that all couples counselors have the tendency to do this. Moreover, if the practitioner is a domestic violence treatment provider, it is likely that the practitioner employs a modified form of couples therapy that is violence-specific. In addition, it should be noted that caution regarding the equalization of responsibility for violence between the perpetrator and victim could be reasonably applied to any form of therapy or intervention. Such caution would apply equally to individual and group methods as the diffusion of personal accountability is not necessarily inherent in couples modalities. Thus, what may otherwise be a legitimate concern for practice in general becomes synonymous with a specific modality through a process of overgeneralization.

Although few would question the need for caution in employing certain methods in order to protect the safety of victims, there is a danger of prematurely dismissing potentially effective approaches. This risk is magnified by the fact that such generalizations may become officially codified in standards as a “known” basis for practice and, in some cases, replicated across a number of states. The seasoned observer of the domestic violence movement may recall numerous instances in which a piece of information was promulgated as research based fact (e.g., “domestic violence rates are highest on Superbowl Sunday”) in the absence of any such study. Moreover, there are instances in
which a particular finding gets quoted and re-quoted, often for dramatic effect, or because it sounds logical, regardless of the reliability or scientific rigor of the original source. This tendency may be affectionately termed the “Woozle Effect” based upon the Winnie-the-Pooh story (Milne, 1926; Himelstein & Mayer, 1995, pp. 5-6) in which Winnie and Piglet set out to find a Woozle by walking around a nearby tree after a snowfall:

At first there was one set of tracks
Then two, then three, then four
We walked around that tree again
And each time there were more
It absolutely, positively
Left a Woozle scent
I wonder where in the world
The Woozle went

Well, it really was a Woozle
Yes it was, was, was
Why it really was a Woozle, yes it was
Of course it was, I’m sure because
I think I saw some Woozle fuzz
It really was a Woozle, yes it was.

Further insight into the apparent gap between current research and existing standards for practice is gained by examining the data on prioritization of program evaluation in current statutes. Only 40% of the states surveyed actually reference research findings. Similarly, only 30% actively endorse program evaluation and applied research as a part of their program missions. Even more remarkable is the fact that only 5% have explicitly specified the inclusion of a qualified researcher on their domestic violence standards development committee.

Education

Some insight into the challenge of creating standards for the treatment of perpetrators of domestic violence is illustrated by the findings on education. Out of the 30 states surveyed, only 20% required a minimum education at the bachelor’s level. Furthermore, relatively few states recognize batterer treatment as a specialty that requires training beyond a bachelor’s degree. Wisconsin state standards illustrate this point:

The possession or attainment of a formal degree or formal education is viewed as neither necessary nor sufficient for educational qualifications to facilitate batterers treatment groups.
Although some state standards are written in a manner that appears to assume a background in mental health, very few actually require such a background. Of the 80% of the states that forgo a graduate or even a bachelor's degree for batterer treatment, the prevailing practice is to require a given number of hours of specialized training in the areas of domestic violence perpetration and victimization. Colorado state standards, for example, require an:

*entry level Bachelors Degree in a human service related area or an equivalent combination of college courses and applied experience to include a total of 155-169 clock hours in basic domestic violence and counseling related areas.*

The absence of a requirement for an advanced graduate degree in the social and health sciences may contribute to a lack of familiarity with research methods, findings, and resources. This may contribute to a failure to integrate such findings into practice standards for many states.

Although the presence of a graduate level degree in no way ensures better services or enhanced safety for victims, the lack of a documented minimum education requirement for most states is surprising, given the fact that domestic violence cases routinely involve delicate and complex questions of dangerousness. Such issues are often mandated areas of continuing education for mental health providers. The issue of potential dangerousness alone raises the question of whether it would be appropriate to have minimum credentials similar to those of mental health providers as a basic level of training upon which specialized skills in domestic violence are developed. A variation of this idea has been adopted by San Diego County in California:

*All treatment providers of domestic violence clients must meet the following criteria: Master's or Doctorate degree in a human services clinical field, currently licensed as a psychotherapist, or for unlicensed persons, agencies may exempt this by providing intense supervision, defined as the ability to have timely and direct access to a supervisor on a daily basis. Supervisors must meet the advanced graduate degree requirement and have at least one year of supervisory experience in domestic violence.*

**Method for Developing and Revising Standards**

Since the art and science of perpetrator treatment is rapidly expanding, one might expect that existing standards would be revisited often. For example, Colorado standards indicate that:
State standards should undergo continuous review and revision consistent with experiences of new knowledge, skills, and methods. The State Commission is committed to meeting at least twice per year to review the standards and to consider suggestions for improvement.

However, the current survey results suggest that this is not the case for the majority of the states, at least in an explicitly required manner. In this respect, 40% have a formally documented method for developing and revising treatment standards, while the majority (60%) does not.

Moreover, care must be taken in the make-up of committees to determine standards. Although the presence of an established researcher may be of some benefit to ensure that timely, valid, reliable, and representative sources are referenced, it may be of equal or greater importance to include an ethicist to guard against unethical practice or conflicts of interest. These conflicts of interest could include secondary gain in the form of training contracts for a particular intervention approach, or an agenda to put those competitors out of business who do or do not adopt a particular philosophy or offer a specific form of programming. The state of Colorado’s standards provide a good example of attention to such issues:

One-half of the board members shall be re-appointed every two years, and the board shall meet at least quarterly. No board member shall have a pecuniary interest in the treatment program or the services provided in connection therewith. The board and its individual members shall be immune from any liability, civil or criminal, and from termination of employment, for the good faith performance of their duties as specified in this subsection.

One method of ensuring balance is a multidisciplinary board as opposed to one solely comprised of advocates and practitioners. Again, the state of Colorado provides a good example of such a protocol:

The chief judge in each judicial district shall appoint a local board, which shall certify and monitor treatment programs for persons convicted of the crime of domestic violence. Said board shall consist of eight members: Two members from the victim services field; one member from law enforcement; one member from a prosecutor’s office; one member from the probation department; one member from the community at large; one member from the mental health profession; and one member from the state department of human services or county department of social services. The board should reflect the ethnic composition of the community in which it is located.
CONCLUSIONS

In many ways, the development of standards for treatment of perpetrators of domestic violence represents a positive advancement for the field. Existing standards not only serve to underscore the priority of victim safety but also validate the fact that perpetrator treatment is essential, from a public health perspective (see Maiuro, 1996; Maiuro & Avery, 1996). Moreover, the existence of standards for the assessment and treatment of domestic violence perpetrators also formalizes such intervention as a specialty that requires training and experience not routinely offered within the training curriculum of many social and health care professions. With this recognition, many states have been improving accountability and monitoring of existing, as well as new treatment programs through certification.

Several problem areas also exist. First, most states have unclear and undocumented methods or protocols for the development and revision of standards. Second, many state standards do not appear to be adequately informed by existing research on perpetrators of domestic violence. Third, even in cases in which state standards do make reference to the literature, there are a number of problems. These include: (a) repetition of clinical lore through the “Woozle Effect”; (b) confusion of theoretical orientation with case management methods, as well as unsubstantiated assumptions regarding supposedly inherent attitudes toward violence and victimization; (c) overgeneralization of limited findings to all cases of domestic violence; and (d) premature dismissal of potentially useful, and albeit conditional, treatment strategies on the basis of feared, but empirically unexplored side effects. Fourth, a significant number of states appear to have language that is positively biased toward sociopolitical theories and negatively biased toward individual factors as contributing variables and as valid targets of treatment. Fifth, some states have a rigid, “one size fits all” criteria for conducting treatment, despite: (a) growing evidence of heterogeneity along typological and severity dimensions, and (b) lack of data suggesting “a cure” or the clear superiority of some treatments over others. Sixth, there are some potential ethical problems related to matters of process, representation, and possible conflicts of interest. Specifically, there do not appear to be explicit safeguards to limit or avoid such influences in the development of protocols for most states.

Perhaps the most serious problem lies in the risk of stunting the development of new and alternative interventions for families afflicted with domestic violence. In this respect, more work is needed to assure that existing guidelines truly protect the well-being of victims without inadvertently impeding much needed program development, diversity, innovation, and advances in the field.
RECOMMENDATIONS

As reflected in the title of this article, the issue of whether existing state standards are adequately informed by research is a question of questions. In this regard, the answer depends on how one looks at the standards and what one expects from them. In some respects, there appears to be less than adequate input from empirical research in existing standards and/or the lack of documented protocols to ensure the use of reliable, valid, and representative authoritative sources. The current results also reflect the fact that the field is still young and in need of further research in many areas related to intervention. Most of the research performed to date is descriptive and correlational in nature (e.g., incidence and prevalence studies; studies of the relationship between substance abuse and victimization; assessment of skill deficits and psychological characteristics of battering men) rather than process or outcome related. Only recently have investigators begun to explore attempts to reduce risk factors for domestic violence (Hilton, Harris, Rice, Krans, & Lavigne, 1998) or study what happens when health practitioners take protective action, such as making reports to the police to reduce the risk of further injury (Lund, 1999). Moreover, there is little research focused on treatment failures or methods that increase risk for negative outcomes. Clearly, more research is needed with regard to these critical issues to provide a relevant database for practice and intervention.

However, it is also true that some matters of practice may never be adequately addressed by research and may remain an issue of ethics or “reasonable” standards of care. Due to the complicated and multifaceted nature of standards of care, state development committees might do well to consult respected sources in other fields, such as Standard of Care: The Law of American Bioethics for guidance to avoid reinventing the wheel or, in some cases, the flat tire (see Annas, 1993).

Based on the current state of the art and science, few practitioners would argue that the preferred method or cure for domestic violence has been proven or discovered. Given this reality, one might question whether the paradigm for perpetrator treatment is sufficiently developed to warrant detailed dictates regarding preferred modes of treatment or to preclude others. In this sense, one wonders whether the original intent of developing guidelines to help ensure the safety of victims has been overextended to areas of practice that are premature to regulate. If safety permits and until otherwise “known,” it may be important to preserve flexibility in methods for purposes of consumer choice, diversity of programming, and creative evolution of treatment technology. The state of Maryland provides a good example of such an approach in that they have opted for assessment guidelines to ensure safety, and a set of operational
guidelines, protocols, and principles to facilitate informed and state-of-the-art practice, rather than specific theoretical and intervention methods per se (Maryland Family Violence Council Report, 1996).

Given this state of affairs, perhaps the best recommendations are ones that facilitate the development of balanced, informed, and ethical protocols for developing and updating standards of practice. For example, while the current results suggest that the inclusion of an established researcher on the development board has been overlooked in most states and may improve the quality of the database for standards development, one could also argue that a number of other disciplines should be considered. These would include representatives from victim support agencies, a victim agency consumer, perpetrator treatment programs, a perpetrator agency consumer, representative mainstream social and health care organizations, the prosecutor’s office, the American Civil Liberties Union or a local public defender agency, as well as a risk management expert and an ethicist.

The issue of providing an explicitly stated protocol for critically reviewing and revising standards also appears to be important. Given the relatively new nature of the field and the significant increase in professional literature on the topic of domestic violence in specialty (e.g., *Family Violence and Sexual Assault Bulletin, Journal of Aggression, Maltreatment & Trauma, Journal of Emotional Abuse, Journal of Family Violence, Journal of Interpersonal Violence, Violence and Victims*) and mainstream journals (e.g., *American Journal of Public Health, Archives of Family Medicine, Journal of the American Medical Association*), frequent updates would appear to be essential. The development of a national blue ribbon panel of “experts” could be developed to provide consultation to state boards and help combat the possibility of unidirectional bias.

Another issue is the need to recognize that domestic violence intervention is rapidly becoming a multidisciplinary enterprise. In this regard, there appears to be a need to encourage cross disciplinary education as part of a continuing education requirement so that certain professional perspectives are not dismissed, stereotyped, or vilified due to either historical neglect of the area or differential weighting of contributory factors underlying domestic violence.

If the current standards of care are to develop to their fullest potential, union shop mentalities dictated by philosophy, discipline, or training will need to be tempered by a competent interdisciplinary practitioner base. Each discipline may bring a unique set of knowledge, skills, and technologies to the field. In this regard, it may be that credentialing and certification boards of the future should be discipline-specific. As treatment technologies and methods evolve, such an approach would allow true peer review and monitoring of intervention methods that are commonly, and sometimes exclusively, practiced within a
particular profession (e.g., psychopharmacology, psychotherapy, and dual diagnosis treatment of alcohol/substance abuse). With proper attention to process as well as content, the development of state standards for domestic violence intervention could conceivably facilitate the evolution of practice in this direction.

REFERENCES


