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Introduction

Since they were first developed in the late 1970s, counseling programs for partner-abusive individuals have proliferated rapidly. Well over 1,000 such programs are currently in operation in the United States (Adams & Cayouette, 2002). Most programs serve predominantly court-mandated populations, and many work exclusively with men who have assaulted women. Although a range of program philosophies and practices exists, the overwhelming trend is to counsel abusive men in groups that focus primarily on gender socialization and its effects on power and control in relationships (Adams & Cayouette, 2002; Gondolf, 1985; Pence & Paymar, 1993; Stordeur & Stille, 1989). Many such programs also employ techniques from cognitive and behavioral therapies to address anger, self-control, and alternatives to aggression (e.g., Saunders, 1996; Sonkin & Durphy, 1997; Wexler, 2000).

Psychosocial counseling[1] for abusive individuals holds great promise as a response to the pernicious and pervasive public health problem of intimate partner violence. Counseling is a lower-cost alternative to incarceration and can be used in some cases to defer prosecution and related court costs. Many abused spouses want the abuse to end but are not interested in seeking punishment for the abuser. In fact, abused women often refuse to press charges or testify against their abusive partners for a variety of reasons. Many are financially dependent on the abusive spouse and may face social and economic disruption if he is incarcerated. Even after a woman manages to extricate herself from an abusive relationship and establish safety, the abuser remains at high risk of harming subsequent relationship partners. Therefore, counseling may serve to prevent abuse in future rela-

tionships. Finally, counseling reflects the humane recognition that many abusive individuals are themselves deeply troubled by emotional instability, substance abuse, or the deleterious long-term effects of childhood trauma. Although debates remain as to whether such factors play a causal role in spousal violence, an underlying assumption of most clinical approaches is that these difficulties are potentially important contributing factors worthy of therapeutic attention.

Yet, despite their potential promise, it is important to ask whether counseling interventions for abusive individuals in fact promote victim safety by effectively altering abusive behavior. Several early studies showed that group counseling focused on anger regulation and communication skills training produced significant reductions in abusive behavior relative to no-counseling control groups (Dutton, 1986a; Palmer, Braun, & Barrera, 1992; Waldo, 1988). More recent, large-scale studies, in contrast, have indicated that group counseling may not contribute significantly to the reduction of partner violence beyond the effects of prosecution and probation monitoring (Dunford, 2000; Feder & Ford, 1999).

A recent review of more than two dozen outcome studies revealed very small average effects of group counseling for partner-violent individuals. Focusing on the simple dichotomous outcome of any physical abuse recidivism (vs. no physical abuse recidivism), the outcome difference between treated and untreated groups in randomized experiments averaged about 0.1 standard deviation units, using either official police reports or victim partner reports to measure abusive behavior outcomes. This difference translates into an average reduction in violence recidivism rate of about 5% for those who receive counseling (Babcock, Green, & Robie, 2004). For example, if 40% of control group (untreated) individuals engage in recidivist violence, then 35% of individuals receiving standard counseling services for partner violence would be expected to engage in recidivist violence. Not only is this magnitude of influence far less than desirable, it is also far smaller than the effects found in other areas of research on psychotherapy and behavior change (Bowers & Clum, 1988; Lambert & Bergin, 1994). In addition, to date, no specific type of intervention for partner violence has been found to be consistently more effective than any other intervention (Babcock & LaTaillade, 2000). These results (reviewed at length in Chapter 4) indicate that there is substantial room for improvement in the design, implementation, and evaluation of counseling programs for partner-abusive individuals.

During the 1990s two prominent task forces examining domestic violence both concluded that a wider range of intervention approaches was needed to address this complex problem. In 1996, the American Psychological Association Presidential Task Force on Violence and the Family asserted that "although many advocates believe that short-term psychoedu-

cational programs are important to help stop physical violence immediately, recent studies suggest another promising approach: assigning different batterers to different types of short- and long-term programs, depending on their specific needs" (p. 87). Similarly, in 1998, the National Research Council and Institute of Medicine of the National Academy of Sciences recommended that treatment programs should "identify and develop program components that can address the needs of different types of batterers" (Chalk & King, 1998). Despite these recommendations, the widely available services for individuals who abuse intimate partners tend to be "one-size-fits-all" group programs (Healey, Smith, & O'Sullivan, 1998).

THE PURPOSE OF THIS BOOK

This book was written in response to concerns about the efficacy of standard group counseling for abusive clients. It reflects our clinical experience and the growing research literature on partner-violent individuals, both of which suggest that abusive clients are a heterogeneous population with varied treatment needs. As far as we can gather, there are as yet no well-specified and standardized individual therapy interventions for abusive clients in the literature and precious little empirical research to date on such interventions. We decided to develop such an approach in order to promote further research and clinical developments. The resulting treatment contains a number of innovations, as detailed below.

Individualized Treatment

There are many treatment manuals for working with partner-abusive clients, virtually all of which rely on the group format (e.g., Pence & Paymar, 1993; Stordeur & Stille, 1989; Stosny, 1995; Wexler, 2000). Groups have a number of advantages over individual treatment, most notably greater cost efficiency and the potential for constructive peer influence. However, groups also have several disadvantages. The first concern arises from group treatment research on delinquent adolescents (Dishion, McCord, & Poulin, 1999). For such individuals, group influence processes can produce negative treatment outcomes, such as increases in delinquent behavior relative to no-treatment controls. Apparently, peer reinforcement for deviant beliefs and behaviors can outstrip the prosocial messages provided by the treatment program (Dishion, Spracklen, Andrews, & Patterson, 1996). A recent qualitative analysis of poor outcome cases from Murphy's group cognitive-behavioral therapy (CBT) program for partner-violent men identified clustering of repeat recidivists within specific treatment groups characterized

by problematic peer influence processes and resistance to therapist influence (Lynch, DeDeyn, & Murphy, 2003). For certain combinations of clients, the group format may reinforce negative thinking and abusive tendencies. Clinical observations suggest that this process may be accelerated by therapist behaviors or program philosophies that promote an "us versus them" mentality in the group.

A second concern with the exclusive reliance on the group format in the literature on partner-violence intervention involves the lack of flexibility in implementing these programs. For example, some abusive clients present with concerns, such as a history of sexual abuse in childhood, that they are simply unwilling to acknowledge or discuss in the group context. Others are difficult or disruptive in the group setting or unresponsive to group intervention. In addition, an individualized approach may be the only way to provide partner-violence interventions in small towns or rural communities where the number of cases is not sufficient to develop groups.

The third, and most important, concern with the group format involves an inherent limitation in the capacity to tailor interventions to the specific needs of each client. Within the traditions of cognitive and behavioral therapies, group treatments tend to be successfully employed under one of two general conditions, neither of which directly applies to the treatment of partner-abusive clients. First, well-specified and focused intervention methods that have been carefully developed and empirically validated in the individual treatment format can be adapted to the group format and used productively with a homogeneous client population afflicted by the same condition. For example, panic control methods have been successfully translated to the group format with little, if any, loss of efficacy because the active ingredients of treatment were well-understood and targeted toward a homogeneous population with few complicating factors (e.g., serious addictive disorders) to inhibit treatment (Craske & Barlow, 2001). The second effective use of the group format is as a therapeutic context for social difficulties. The best example here is the treatment of social anxiety disorder through group role-play interventions (Turk, Heimberg, & Hope, 2001). In this case, the group itself provides a context for exposure therapy. Although other examples of effective group treatments exist, we believe that the decision to use a group format should be very carefully and thoroughly informed by the nature of the treatment population and the type of intervention methods needed to alter the problem behavior.

Partner-abuse treatments stand in stark contrast to most successful adaptations of structured behavioral interventions to the group treatment format. Group treatments for abusive clients do not have the benefit of extensive prior efforts to develop and test interventions in the individual treatment format. Treatment development has been hampered by the simultaneous need to address social and political concerns regarding gender and power, complex group processes, and technical implementation of interven-

tion methods. The result is often a loose adaptation of intervention techniques, such as relaxation training or cognitive restructuring, provided within a conceptual framework that is disconnected from the original formulation of the intervention technique and without sufficient technical knowledge of how, when, and whether such interventions will bring about therapeutic benefit for abusive clients.

In addition, partner-abusive clients are a very heterogeneous population in terms of motivations for engaging in abuse, co-occurring problems such as substance abuse and personality disorders, and motivation to change. Thus, it is very difficult to specify generic intervention strategies that will be effective in all or most cases. For example, one client may physically assault his partner exclusively to escape from conflict discussions, another in response to imagined infidelity, and a third in an attempt to force his partner to comply with his sexual demands. Although all may share certain beliefs that promote their use of interpersonal violence, a functional analysis of their abuse leads to quite different targets for shaping alternative thoughts and behaviors. Similarly, some abusive clients arrive at the clinic ready and willing to engage in active change, whereas others are angry, suspicious, and mistrustful toward the therapist and highly resistant to therapeutic influence. Distinct intervention strategies are needed for clients who are at vastly different points on the continuum of change.

Despite concerns about the lack of flexibility in exclusive reliance on the group format, potential negative peer influences, and the remarkable heterogeneity of abusive individuals, a number of states have adopted standards for the court-ordered counseling of abusive clients that either require it to be conducted in the group format, caution against the use of individual counseling for abusive clients, or state that individual counseling is "inappropriate" except in "special circumstances" (Austin & Dankwort, 1999). The "special circumstances" are not typically articulated.[2] As far as we can gather, there are no empirical data to support these standards, that is, no studies demonstrating that group intervention is more efficacious or safer than individual services for partner-abusive clients. Conversely, a recent controlled study found that an individual client intake approach based on the principles of motivational interviewing was more effective in stimulating abusive clients' subsequent involvement in treatment as compared to an intake approach that relied in part on the group format (Musser, Semiatin, Taft, & Murphy, 2005).

Case Formulation Approach

In response to the heterogeneity of partner-abusive clients and their diverse intervention needs, the treatment described in this book relies on individualized case formulation. We provide detailed suggestions and advice regarding functional assessment of abusive behavior and how to develop a case

formulation to guide intervention with each abusive client. This is a challenging clinical task, particularly in light of the difficulties in establishing a treatment alliance with angry and resistant clients (DiGiuseppe, Tafrate, & Eckhardt, 1994). Nevertheless, our clinical experience suggests that there is no substitute for a solid case formulation in directing treatment with this complex and heterogeneous population.

Emphasis on the Collaborative Working Alliance

Clinicians working with partner-violent individuals are often reluctant to do the very things that are most likely to promote successful change in abusive behavior, namely to provide a high level of reflective listening, warmth, and empathy in order to facilitate the development of a collaborative working alliance. Clinicians often express the fear that collaboration equals collusion, that is, that by showing concern and understanding, the clinician will inadvertently support abusive behaviors and beliefs. In fact, nothing could be farther from the truth. The more the clinician truly understands how a client thinks and feels and the more accurately such understanding is communicated, the more likely the clinician is to formulate the proper targets of change and the more likely the client is to accept therapeutic influence. In line with these clinical observations, recent studies have found that a strong working alliance between client and therapist in the group context predicts lower posttreatment abuse (Brown & O'Leary, 2000; Taft, Murphy, King, Musser, & DeDeyn, 2003). In addition, when motivational interviewing, which involves a high level of empathic reflection, is conducted in an individual format during the intake process, it enhances therapist ratings of the working alliance and compliance with directive therapy strategies during subsequent group treatment for abusive clients (Musser et al., 2005). In line with these findings, this manual provides suggestions for establishing a collaborative alliance and conducting treatment in a collaborative fashion.

Specification of Treatment Phases

Treatment of abusive clients progresses through some logically ordered phases, beginning with the outward manifestations of hostility and treatment resistance and moving toward underlying self-organizing principles that promote abusive and controlling styles of relating. Abusive clients vary widely in how rapidly they progress through these phases and in their need for attention to different treatment phases. Although the phases of treatment are not rigidly distinct, and movement back and forth between phases is expected in the change process, there is heuristic value in conceptualizing the major tasks of treatment along the lines of a four-phase model.

The first phase of treatment focuses on enhancing motivational readiness to change. The goals are to reduce client resistance to treatment, help the client resolve ambivalence about change, and establish collaborative goals and plans for the change process. The second phase of treatment focuses on enhancing safety and stabilization through understanding how and when abusive behaviors occur and implementing strategies to prevent the escalation of conflicts to abuse. In addition, this phase of treatment often focuses on helping clients stabilize chaotic or disrupted lifestyles. Examples include establishing sobriety, reducing risky substance use, solidifying the decision whether to separate from the relationship partner, promoting safe child visitation arrangements, addressing employment instability, and obtaining treatment for significant medical or psychiatric problems. The third phase of treatment focuses on enhancing relationship functioning through cognitive change and behavioral skills training. The main goal is to develop relationship beliefs and behaviors that provide an alternative to coercion and control, facilitating new strategies to resolve relationship problems and promote healthy interactions. The fourth phase of treatment focuses on relapse prevention and trauma recovery. The goal is to address concerns and difficulties that may inhibit long-term personal and family well being and that may facilitate a return to abusive behavior. For some clients, this phase is used to finalize a self-directed change effort and to promote active coping at the earliest stages of warning signs of return to abusive behavior. For many, this last phase of treatment also involves cognitive reprocessing of childhood trauma experiences that contribute to disrupted attachment relationships and underlying difficulties in establishing a secure bond with an intimate partner. Further information on the four phases of treatment is presented in Table 1.1.

Empirically Based Approach

There are four key ways in which the current treatment is informed by empirical research. First, we used the research literature on cognitive, behavioral, and emotional features of partner-abusive individuals to articulate targets for clinical assessment and intervention, most notably studies that compare abusive men to men in distressed, but nonviolent, relationships. Chapter 3 reviews the clinically relevant characteristics of abusive clients based on this research literature. Second, we used the research literature on psychotherapy and behavior change to develop general guidelines for this intervention. Across a wide array of clinical problem areas and theoretical approaches, research consistently points to the importance of empathic listening, the collaborative working alliance, and strategies to facilitate self-directed change as crucial elements of successful intervention. Third, we used the research literature on cognitive and behavioral thera-

TABLE 1.1. The Four Phases of Cognitive-Behavioral Therapy for Partner-Abusive Individuals

Phase 1: Stimulating and consolidating motivation to change
Goals: Decrease resistance; increase change talk (self-motivational statements); establish a working alliance; develop goals for personal change
Major techniques: Motivational Interviewing, including reflective listening; affirming autonomy; change planning
Phase 2: Promoting safety and stabilization
Goals: Eliminate the use of physically assaultive, sexually assaultive, and threatening behaviors; stabilize life circumstances; identify and address major barriers to effective treatment
Major techniques: Functional analysis of abusive behaviors; shaping of alternative behaviors; cognitive restructuring of abuse-promoting beliefs; directed problem solving; adjunctive treatment for substance abuse and severe mental disorders
Phase 3: Enhancing relationship functioning
Goals: Reduce distress-maintaining relationship cognitions; build relationship communication and problem-solving skills; enhance positive attributions about the partner and positive shared experiences; support responsible and effective parenting
Major techniques: Cognitive restructuring of problematic relationship assumptions and hostile attributions; education about healthy relationships; relationship skills training (active listening, nonabusive self-expression; problem solving); parenting skills training
Phase 4: Promoting trauma recovery and preventing relapse
Goals: Reduce toxic effects of trauma history on relationship functioning; Consolidate a self-directed change process; increase awareness of relapse process; prevent return to abusive behavior
Major techniques: Cognitive processing of traumatic experiences; identification of relapse pattern and relapse cues; promotion of active coping with relationship concerns; booster sessions

pies, most notably for relationship distress, personality disorders, mood and anxiety disorders, and trauma recovery, in order to inform the specific cognitive-behavioral interventions proposed here. Adaptations of CBT have been quite effective across a wide array of behavioral and emotional problem areas. However, counter to the popular misconception that CBT interventions must provide a rigid predetermined structure for each treatment session, modern CBT has evolved and expanded to treat complex problems with the use of flexible treatment principles and individual case formulation (e.g., Linehan, 1993a; Persons, 1989; Persons & Tompkins, 1997).

Fourth, we used the research on interventions for partner-violent men in order to support the need for an individual approach and, where possible, to identify specific treatment components that are likely to be effective with this population. Most notably, recent investigations have found that motivational interviewing (MI) can enhance involvement in active change elements of cognitive and behavioral treatment that are related in turn to successful violence cessation outcomes (Kistenmacher & Weiss, in press; Musser et al., 2005; Taft et al., 2003). MI was designed to reduce client resistance to change and to help clients resolve ambivalence about change, crucial tasks at the outset of treatment for most abusive clients.

In addition, group delivery of generic forms of CBT has been found to be no more successful in ending violence than unstructured supportive group treatment (Morrel, Elliott, Murphy, & Taft, 2003), process–psychodynamic group treatment (Saunders, 1996), or rigorous case monitoring (Dunford, 2000). Although several plausible explanations for these null findings exist, we believe that they indicate a need for more intensive delivery of cognitive-behavioral interventions that are tailored to specific individual problems and needs (e.g., Fruzzetti & Levensky, 2000).

Given the stark limitations of current knowledge about effective treatment for abusive clients, this book was written more to stimulate new research than to report on previous research. It is designed as a treatment manual to support clinical trials of individual CBT for abusive clients and as a guidebook for clinicians conducting individual work with this population. In the absence of a reasonable treatment manual, state-of-the-art intervention studies are not possible. A controlled investigation is currently underway using this book as a treatment manual to compare individualized CBT to standard group treatment as usual. Future studies may look at the combination of individual and group approaches, examine different components of CBT, or explore whether different approaches are more or less effective with distinct subgroups of abusive clients. In addition, referrals of women abusers are rapidly growing, and adaptations of treatment to gay and lesbian populations and diverse cultural groups are sorely needed. Thus, we see the current manual as a modest first step toward specifying treatments that can be studied in rigorous experiments and further developed and refined to maximize efficacy in ending partner abuse. As with any scientifically informed endeavor, it is inevitable that the recommendations and procedures outlined here will evolve to integrate new findings.

Practical Advice

Following the scientist-practitioner traditions in clinical psychology, the treatment recommendations in this book are not only informed by empirical research, but are also the result of extensive clinical experience in treat-

ing partner-abusive clients and in training and supervising therapists who work with this population. For the past decade, Murphy has served as the director of an abuser intervention program that serves about 100 clients each year. The program is housed within a comprehensive, community-based domestic violence agency and focuses on the combined missions of clinical service, training, and research. Many of the recommendations presented here derive from trial-and-error, and a great deal of credit is due to the dozens of clinical staff and doctoral students who have worked with the program over the years, as well as discussions with colleagues from other abuser intervention programs and fellow researchers.

Clinical Examples

In the spirit of promoting practical and procedural knowledge, we have provided clinical and case examples for many of the intervention techniques presented. Many of these examples were derived from audio recordings of treatment sessions conducted in research protocols, with editing to protect client anonymity and enhance the reading flow of spoken language transcripts. Some examples are hypothetical or an amalgam of statements drawn from different sessions. Throughout, we use clinical material to reinforce conceptual recommendations, realizing that there are no magical words or phrases and that the spirit in which an intervention is delivered and the intended goals of the intervention are more important than the precise verbalizations used by the therapist.

SUGGESTIONS ON HOW TO READ THIS BOOK

In this fast-paced, information rich world authors can no longer maintain the conceit that readers will plow through a book like this from beginning to end. Therefore, we decided to provide some "quick read" suggestions for different categories of readers, hoping to stimulate further consideration of the core ideas and interventions presented. If you are among the large number of readers already convinced that individual treatment for abusive clients can't and won't work and believe that the authors are irresponsible for suggesting such folly, and you are looking for a few juicy tidbits to support your critique, we suggest that you focus on the material on individual case formulation, the collaborative working alliance, and the use of reflective listening and motivational interviewing techniques promoted in Chapters 6 and 7. These methods are most out of line with current trends in the field.

If you are a clinician who has worked in this field for a while and you are disillusioned with the standard group approaches, we also suggest that

you begin by focusing on the material on individual case formulation, the collaborative working alliance, and the use of reflective listening and motivational interviewing techniques in Chapters 6 and 7. If these ideas strike your fancy, then we recommend that you read the chapters on assessment (Chapter 5) and specific cognitive and behavioral intervention strategies (Chapters 8–11).

If you are new to the field of partner-abuse intervention, but practice in other areas of mental health treatment, we suggest that you begin with Chapters 2–4, which describe the clinical phenomenon of abuse, traditions in the field, and characteristics of this treatment population. If we haven't lost you at that point, then the material on clinical assessment and case formulation should provide a good foundation for the subsequent chapters on intervention strategies.

If you are a researcher or practitioner searching for specific clinical topics or materials, if you are simply interested in getting the big picture quickly, or if you want to refer to key guidelines to facilitate treatment adherence, here is a rapid reading guide. The four phases of treatment are outlined in Table 1.1. Suggestions for functional and descriptive assessment of abusive behavior appear in Figure 5.1 (p. 78–85), and a general overview of the major areas for comprehensive clinical assessment of abusive clients appears in Table 5.2 (p. 107–108). The rationale for integrating motivational interviewing techniques with CBT is provided beginning on page 135 (in Chapter 7), and suggestions for implementing cognitive-behavioral interventions in the spirit of MI appear at the end of Chapter 7, beginning on page 161. Recommendations for how to conduct relationship skills training with this population begin on page 177. Common themes and variations in abusive thinking are provided in Table 9.1 (pp. 196–198), and a list of common cognitive distortions with examples is provided in Table 9.2 (pp. 205–206). Relapse prevention strategies are outlined on page 250–253. Trauma reprocessing techniques are discussed on pages 234–244. Although these materials outline the main ingredients of the treatment, as with most recipes the secret lies in the artful combination of ingredients and the nature and timing of the chef's ministrations.

NOTES

1. Throughout the book, we use the terms "counseling," "therapy," and "treatment" interchangeably to describe psychosocial intervention for partner-violent clients. There have been controversies in the field over whether these programs are educational or psychotherapeutic in nature. In part, these controversies have been theoretical, concerned with whether a "therapeutic" approach excuses responsibility for violent behavior through analogy to mental health disorders or medical disease. And in part, these controversies have been practical, concerned

with whether only mental health professionals can administer these interventions, as terms such as counseling and psychotherapy are legally protected areas of professional practice in many states. From our perspective, all of the programs described to date have a psychotherapeutic quality to them, even when the program authors characterize the interventions as purely educational in nature. All are concerned with stimulating behavior and attitude change, most use behavioral and/or cognitive therapy methods to do so, and most operate under the expectation that participants will reveal deeply personal information about their lives, family histories, relationships, and/or personal beliefs. In addition, given that a sizeable number of partner-violent clients have other mental health concerns or substance use problems, we assert that mental health training is an important qualification for conducting these interventions and that they should be delivered within the spirit and guidelines of mental health practice.

2. The content and focus of state standards for abuser intervention are summarized in a National Institute of Justice publication (Healey et al., 1998) and reviewed in articles by Austin and Dankwort (1999) and Maiuro, Hagar, Lin, and Olson (2002). Interested individuals should consult their own state regulations to determine if there are any professional practice limitations on the format of treatment for partner-abusive individuals. More detailed information is generally available through state coalitions against domestic violence.

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