

BRIEF REPORT

Preliminary Examination of a Mutual Intimate Partner Violence Intervention Among Treatment-Mandated Couples

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Intimate partner violence (IPV) is a widespread global health problem. Despite growing evidence indicating that men and women commit IPV, most traditional interventions focus on male-to-female violence and do not address mutual violence. This circumscribed focus represents one potential reason traditional treatments have had only a modest effect on recidivism. The current study investigated a pilot intervention for mutually violent couples with ethnically diverse, treatment-mandated men and women. Using a longitudinal design, 121 couples were assessed (semistructured clinical interview, Conflict Tactics Scale—Revised [CTS-2]) and mandated to either the pilot intervention or another community agency. Of the 92 couples referred for the 12-week, pilot group intervention (plus 1–2 preparatory, individual sessions), 89% of couples had one or both partners complete. Posttreatment assessments were conducted (CTS-2, satisfaction ratings), anticipating reductions in perpetrated and received IPV among treatment completers. Using 1-year conviction data to assess recidivism (IPV and general violence convictions), it was hypothesized that the lowest recidivism rates would be found when both partners completed, intermediate rates when one partner completed, and the highest rates when neither completed. Consistent with hypotheses, men who completed treatment reported reduced perpetration of physical assault and received less injury, and women who completed reported receiving less physical assault and injury. At 1-year follow-up, couples who completed had lower recidivism rates, with couples in which both partners completed evidencing the best outcomes. Results provide preliminary support for the proposed mutual violence intervention. Clinical implications, including the effect of a thorough assessment and tailored treatment recommendations, are discussed.

Keywords: intimate partner violence, domestic violence, mutual violence, recidivism, Hispanic

Supplemental materials: <http://dx.doi.org/10.1037/a0032912.supp>

Intimate partner violence (IPV) is a worldwide public health issue, with significant physical and mental health consequences (Coker et al., 2002). Approximately 25% of individuals in the United States endorse having experienced physical, sexual, or emotional IPV (Coker et al., 2002). Nearly one in four couples aged 18–28 years report violence in their current relationship (Whitaker, Haileyesus, Swahn, & Saltzman, 2007). IPV is also a financial burden on society, with national yearly medical costs ranging from \$2.3–7.0 billion (Brown, Finkelstein, & Mercy, 2008).

The IPV treatment-of-choice, the Duluth model, views IPV as a male phenomenon perpetrated by a patriarchal society in which

men exert control over women (Pence & Paymar, 1993). Duluth model treatments are typically group-based and gender-specific and have only a modest effect, with an average 33% recidivism rate within 6 months, similar to groups receiving only criminal sanctions (Stover, Meadows, & Kaufman, 2009). They also demonstrate elevated attrition rates (18–84%; Babcock, Green, & Robie, 2004). However, rooted in the family violence approach, recent conceptualizations theorize that IPV is often the product of a dyadic relationship in which conflict escalates to aggression in both partners (Stith, McCollum, Amanor-Boadu, & Smith, 2012). Among couples who report physical violence in their relationship, 45–95% report mutual violence (Caetano, Ramisetty-Mikler, &

This article was published Online First June 10, 2013.

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The authors thank Dan Matthews, Kathleen Clapp, Alisa Hadfield, Michael Dougher, Brandi Fink, Tim Reed, Rene Rivas, Kathy Wiggins,

Peggy MacLean, Beth Leitman, and Seamus Gentz for their assistance with this project and Joshua Semiati for his assistance with the manuscript preparation. This research was supported by funds allocated by the New Mexico Legislature to the Second Judicial District Court of New Mexico.

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Field, 2005; Straus, 2008). Research also shows that the current rate of violent acts perpetrated by women is equal to or higher than male-perpetrated acts (Straus, 2008; Whitaker et al., 2007). In addition to gender symmetry in IPV rates, research indicates similarities in motives (e.g., dominance; Straus, 2008) and risk factors (e.g., childhood abuse; Dutton, Nicholls, & Spidel, 2006).

Although controversial within the IPV arena, dyadic interventions have been shown to be effective in reducing IPV (Stith et al., 2012) without increasing safety risks, such as retaliation for topics disclosed in therapy (e.g., Brannen & Rubin, 1996; O'Leary, Heyman, & Neidig, 1999). O'Leary et al. (1999) found that male-to-female and female-to-male IPV was significantly reduced among volunteer, intact, married couples after 14 weeks of couples therapy or traditional treatment. In addition, in a randomized trial, a 22-week, dyadic intervention performed equally well in reducing male-to-female IPV among court-mandated men as a 26-week, gender-specific treatment, with IPV cessation rates of 92% based on female report at 6-month follow-up (Brannen & Rubin, 1996). Conjoint interventions also have shown some advantages, such as lowering attrition and improving IPV outcomes (Brannen & Rubin, 1996; Stith et al., 2012).

In sum, IPV interventions have by and large focused on gender-specific treatments among court-mandated men, with a handful of studies evaluating conjoint treatments in intact, volunteer couples. This focus leaves the effectiveness of a dyadic intervention among court-mandated, mutually violent couples understudied. Further, few outcome studies have assessed posttreatment female IPV recidivism. Finally, there is a dearth of research on IPV among cultural and ethnic minorities (Friend, Langhinrichsen-Rohling, & Eichold, 2011). This is particularly concerning as ethnic minorities are overrepresented in justice settings (Field & Caetano, 2004) and important cultural differences such as gender equality may influence IPV (Esquivel-Santoveña & Dixon, 2012). Although evaluation of IPV patterns among Hispanic men is emerging (Welland & Ribner, 2010), only one investigation of a dyadic intervention with a primarily Hispanic sample was found (Brannen & Rubin, 1996). The current study aimed to expand the extant literature by investigating a mutual violence intervention for ethnically diverse couples experiencing IPV in which partners received the same treatment components but in separate, gender-specific settings.

Study Aims and Hypotheses

For couples referred to the pilot intervention, men and women completed all treatment components; treatment programming for men and women was identical so that each partner received the same intervention. The intervention was provided separately for several reasons: (a) the court-referred population had high percentages of protective orders, prohibiting couples from attending together and reducing the amount of couples who remained in a romantic relationship; (b) safety was prioritized by reducing couple interactions while encouraging individual acquisition of new skills; and (c) attrition rates are high among IPV samples, so interventions that do not rely on both partners' attendance may still prove fruitful in reducing overall couple IPV.

The following hypotheses were evaluated. First, among couples referred to the pilot intervention who completed treatment, significant reductions of self-reported physical assault and injury (perpetrated and received; Conflict Tactics Scale—Revised [CTS-2;

Straus, Hamby, Boney-McCoy, & Sugarman, 1996]) across genders at posttreatment was expected. Second, consistent with a family violence approach (Stith et al., 2012), among couples referred to the pilot intervention, it was anticipated that couples in which both partners completed treatment would have the lowest recidivism rates, whereas couples in which only one partner completed (man only [MO] or woman only [WO]) would have intermediate rates, and couples in which neither completed would have the highest rates (Both < MO/WO < Neither). Third, we assessed participant satisfaction to determine the level of favorableness toward treatment. Lastly, it is noteworthy that couples referred to the pilot intervention were compared to an assessment-only control group (AO) who did not receive the mutual violence pilot intervention but were instead court-mandated to another agency in the community on the basis of their individual treatment needs. As such, no specific hypotheses were made regarding the AO group because of limited available information regarding treatment compliance and outcomes.

Method

Participants

The current sample consisted of 289 court-referred couples who met basic eligibility requirements (English-proficient and coparent to at least one child). Because many participants had been granted restraining orders, it was not required that participants be romantically involved at baseline, only that they share a child, making it likely they will have continued interactions. The final sample consisted of 121 mutually violent couples (see Figure 1).

In the final sample, the male average age was 29.9 years ($SD = 7.1$ years). Men described their ethnicity as follows: Hispanic/Latino (65%, $n = 79$), Caucasian (16%, $n = 19$), African American (7%, $n = 9$), Asian American (3%, $n = 4$), Native American (2%, $n = 3$), and biracial/other (6%, $n = 7$). The average years of education was 12.7 years ($SD = 1.5$ years). Men reported knowing their partner for an average of 7.4 years ($SD = 5.1$ year). At baseline, most men reported that they had not been married (39.7%, $n = 48$), with fewer separated (24.0%, $n = 29$), married (19.0%, $n = 23$), or divorced (17.4%, $n = 21$). Female average age was 27.6 years ($SD = 6.8$ years). Women described their ethnicity as follows: Hispanic/Latino (55%, $n = 67$), Caucasian (31%, $n = 38$), Native American (7%, $n = 8$), African American (5%, $n = 6$), Asian American (1%, $n = 1$), and biracial/other (1%, $n = 1$). The average years of education was 13.2 years ($SD = 1.6$ years). Women reported knowing their partner for an average of 7.8 years ($SD = 6.2$ years). At baseline, most women reported that they had not been married (42.2%, $n = 51$), with fewer separated (25.6%, $n = 31$), divorced (20.6%, $n = 25$), or married (11.6%, $n = 14$).

Pilot Mutual Violence Intervention

The pilot intervention consisted of three phases: baseline assessment, 12-week group treatment, and exit interview (see Gerstle et al., 2010). Couples identified as having IPV within their relationship (e.g., orders of protection, mediation, child support hearings) were court-referred for assessment. On the basis of contemporary models of IPV suggesting the importance of differentiation as opposed to a "one-size fits all" approach (Ver Steegh & Dalton,

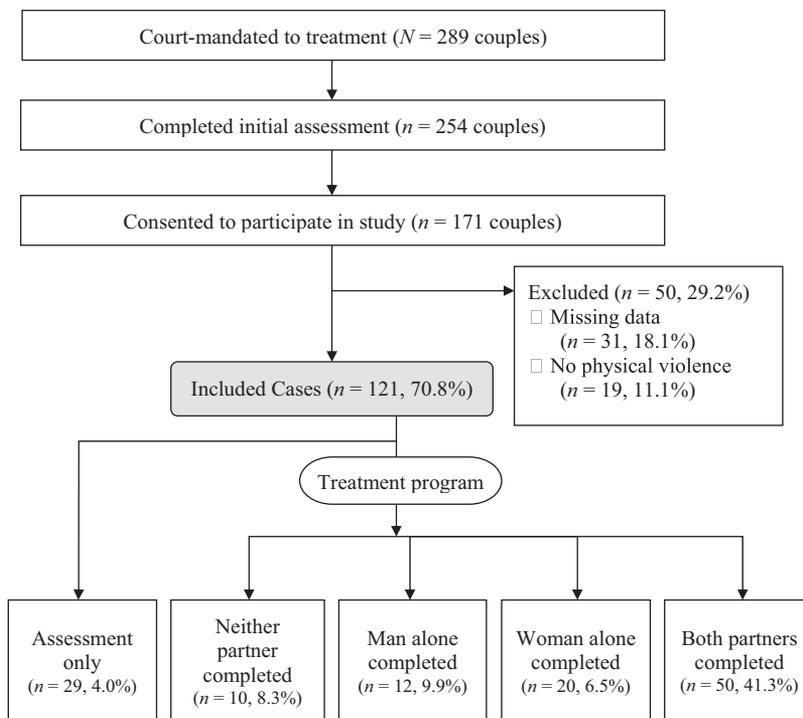


Figure 1. CONSORT diagram.

2008), a thorough assessment was conducted to tailor treatment recommendations. The assessment included: (a) a semistructured interview that explored past and current IPV within the relationship as well as other individual differences that may affect relationship behaviors (e.g., mental health and legal history, previous relationship/violence history); and (b) questionnaires evaluating relationship and IPV behaviors, personality, and other characteristics correlated with IPV such as substance use and posttraumatic stress (see Supplemental Table 1). Once assessed, each participant was mandated to the pilot intervention or another program within the community on the basis of each participant's specific treatment needs. Participants were assigned to a community agency for reasons such as if gender-specific treatment appeared most appropriate, if substance abuse treatment was needed, or if services in Spanish were preferred. Treatment referral decisions were made by the treatment team who met weekly to staff cases.

Before the 12-session group protocol, one to two individual sessions were included to introduce the group treatment and create individualized safety plans to prevent future IPV. The 12-session, closed, psychoeducational men's and women's groups were based on cognitive-behavioral principles and the work of Gottman and colleagues (e.g., Gottman, Ryan, Carrère, & Erley, 2002), with components of dyadic interventions (see Stith et al., 2012). The intervention contained four modules: (a) group orientation (2 sessions), (b) relationship skills (3 sessions), (c) emotional awareness skills (3 sessions), and (d) parenting/coparenting skills (4 sessions). The modules addressed the group objectives: (a) increase helpful relationship behaviors (i.e., validation, joy/surprise, affection, interest, sadness, anger); (b) reduce harmful relationship behaviors (i.e., contempt, belligerence, criticism, stonewalling,

defensiveness); (c) promote healthy and safe relationships (e.g., identification of unhealthy relationship "red flags," safety plan to leave unsafe relationships); (d) increase emotional awareness (e.g., the role of emotional dysregulation in conflict, increased awareness of emotions); and (e) foster healthy parenting/coparenting practices (e.g., practice "emotion coaching" by helping the child learn to identify, label, and respond to emotional reactions; discipline techniques emphasizing positive reinforcement). Each 90-minute session included review of homework, discussion of session material, and behavioral role-plays.

Attendance was closely monitored; treatment completion was dependent on participants receiving all 12 sessions in either group or make-up sessions. Although information disclosed during the intervention remained confidential, participants were informed that attendance was reported to the court. To assess treatment satisfaction and efficacy, participants completed a satisfaction measure and the CTS-2 during the exit interview.

Treatment groups. All 121 couples court-referred to the pilot program were assessed and subsequently mandated, on the basis of their individual treatment needs, to either the pilot program ($n = 92$ couples) or another IPV program within the community ($n = 29$ couples, AO group). Although couples in the AO group were referred to an alternative mandated treatment, it was considered an AO control group (with baseline and court record follow-up data only) because information regarding their completion of community treatment was not available, nor did they complete the exit interview. It is noteworthy that all participants, including the AO group, completed a thorough assessment to inform the treatment referral. Of the 92 couples referred to the pilot intervention, the couples were divided into four groups on the basis of completion

status (Both, MO, WO, and Neither; see Figure 1); these groups were then used in subsequent analyses.

Procedure and Measures

Participants were recruited during the baseline assessment and informed of the opportunity to have their clinical data and public court records used in a study evaluating IPV treatment. Participation was voluntary and did not influence court outcomes. All services were free of charge, and no financial compensation was provided for research participation. Psychology doctoral students or master's level clinicians conducted all stages of the pilot study. Licensed psychologists directly observed all groups to ensure treatment fidelity.

Demographics. At baseline, information was collected on race/ethnicity, education, annual income, marital status, and number of years each participant had known his or her partner.

IPV. The CTS-2 is a 39-item, Likert-scaled measure with well-documented reliability and validity (Straus et al., 1996). Similar to previous work (Huss & Ralston, 2008), two (Physical Assault, Injury) of the five scales (Psychological Aggression, Sexual Coercion, and Negotiation) were used to assess IPV. Scores indicate the number of IPV acts committed in the past year (physical assault-perpetrated, injury-perpetrated) and acts the participant's partner committed against the participant (physical assault-received, injury-received). Interpartner agreement was moderate (intraclass correlation coefficient [ICC] = .531). To assess treatment reductions in IPV among treatment completers, the CTS-2 Physical Assault and Injury subscales were administered before treatment and again at the exit interview.

Conviction data. Two categories of conviction data were collected from public court records: (a) IPV convictions against a household member (i.e., assault/battery, violation of an order of protection, false imprisonment, prevention/obstruction of sending a message, and trespassing); and (b) general violence convictions committed against nonintimate partners (assault/battery, assaulting an officer, kidnapping, homicide, public affray, robbery, and rape). Preferrable convictions were any convictions incurred before baseline and were adjusted for age. Follow-up convictions were any new conviction after the last day of services (e.g., AO and Non-

completers = 1-year postbaseline, Completers = 1-year posttreatment).

Subjective ratings of treatment satisfaction. Treatment satisfaction is an important component of treatment evaluation that is associated with retention and therapeutic alliance (Dearing, Barrick, Dermen, & Walitzer, 2005). Because participants were court-mandated, satisfaction ratings were of interest and assessed through a 6-item, Likert measure (see Table 1).

Results

Analytic Plan

SPSS v14 was used to conduct χ^2 and univariate analysis of variance (ANOVA) comparisons of demographics, mean scores on IPV self-report measures, mean IPV-related convictions, and mean general violence convictions. Follow-up group comparisons used the Bonferroni correction. Paired-sample *t* tests compared CTS-2 scores at baseline and follow-up. Subjective treatment ratings were assessed comparing primary categories using χ^2 comparisons.

Demographic and Baseline Behavior Comparisons

Treatment groups for men and women did not differ by age, years of education, marital status, annual income, length of acquaintance, or ethnicity. To determine if the treatment was differentially effective based on ethnicity (Hispanic vs. non-Hispanic), enrollment and completion status, sessions attended, CTS-2 scores, and baseline and follow-up convictions were compared across the two ethnic categories; no significant differences were found.

At baseline, men's treatment groups did not significantly differ on any variables related to violence perpetration, including the four subscales of the CTS-2, IPV convictions, or general violence convictions. Treatment groups for women differed only for the Injury-Perpetrated scale of the CTS-2, $F(4, 116) = 4.1, p < .01, \eta_p^2 = .13$, with women in the Neither group ($M = 4.2 [7.2]$) reporting significantly greater injury against their partner than any of the other groups (AO: $M = .48 [1.3]$, WO: $M = .61 [1.3]$, MO: $M = .83 [1.5]$, Both: $M = .84 [2.1]$). For more information, see Supplemental Table 2.

Table 1
Subjective Experience of Treatment

					χ^2	<i>p</i>
Men						
Overall program rating	Excellent (61%)	Good (36%)	Fair (0%)	Poor (3%)	13.7	<.01
Desired type of services?	Yes, definitely (53%)	Yes, generally (39%)	No, not really (4%)	No, definitely not (4%)	21.7	<.001
Recommend to a friend?	Yes, definitely (57%)	Yes, generally (39%)	No, not really (0%)	No, definitely not (4%)	12.5	<.01
Met your needs?	Almost all (43%)	Most (46%)	Only a few (7%)	None (4%)	17.4	<.01
Helped by the program?	Helped great deal (71%)	Helped somewhat (25%)	Didn't really help (0%)	No help at all (4%)	20.2	<.001
General satisfaction level	Very satisfied (54%)	Mostly satisfied (43%)	Mostly dissatisfied (0%)	Very dissatisfied (3%)	11.6	<.01
Women						
Overall program rating	Excellent (61%)	Good (36%)	Fair (3%)	Poor (0%)	13.8	<.01
Desired type of services?	Yes, definitely (50%)	Yes, generally (39%)	No, not really (11%)	No, definitely not (0%)	6.9	<.05
Recommend to a friend?	Yes, definitely (61%)	Yes, generally (36%)	No, not really (0%)	No, definitely not (3%)	13.8	<.01
Met your needs?	Almost all (43%)	Most (32%)	Only a few (25%)	None (0%)	1.4	<i>ns</i>
Helped by the program?	Helped great deal (61%)	Helped somewhat (32%)	Didn't really help (7%)	No help at all (0%)	12.1	<.001
General satisfaction level	Very satisfied (50%)	Mostly satisfied (39%)	Mostly dissatisfied (11%)	Very dissatisfied (0%)	6.9	<.05

Treatment Attendance

With an average of more than 11 of 12 sessions, completers attended significantly more group sessions ($M = 11.5$, $SD = 1.1$) than noncompleters ($M = 2.2$, $SD = 2.5$), $t(182) = 35.2$, $p < .01$. Treatment completers also attended significantly more individual sessions ($M = 1.7$, $SD = .48$) than noncompleters ($M = 1.2$, $SD = .37$), $t(182) = 6.4$, $p < .01$.

Comparisons at Treatment Completion

As seen in Figure 1, of the 92 couples referred to the pilot program, 62 men and 70 women completed the intervention. Of those completing the program, 47 men (75.81%) and 45 women (64.29%) completed the CTS-2 during the exit interview. Paired-sample t tests of baseline and posttreatment scores on the CTS-2 showed reductions in self-reported IPV. Men showed reduced perpetration of physical assault, $t(46) = 2.52$, $p < .05$, $d' = .39$, and a decrease in the number of injuries received from their female partner, $t(46) = 2.13$, $p < .05$, $d' = .35$. Women showed a decrease in physical assault received, $t(44) = 2.44$, $p < .05$, $d' = .39$, and injury received from their male partner, $t(44) = 2.05$, $p < .05$, $d' = .34$. When CTS-2 scores were aggregated across couples in which both partners completed treatment (i.e., sum of IPV acts within the couple), reductions in male perpetrated physical assault were significantly reduced posttreatment, $t(30) = 2.37$, $p < .05$, $d' = .52$. No other planned CTS-2 comparisons were statistically significant (see Supplemental Table 3).

Follow-Up Behavior Comparisons

Within-couple convictions by treatment group. When assessing aggregated convictions within each relationship (i.e., sum calculated for each couple based on whether either partner in the relationship, or both, received a conviction), at 1-year follow-up the treatment groups significantly differed in average convictions for IPV, $F(4, 116) = 3.6$, $p < .01$, $\eta_p^2 = .11$, and general violence, $F(4, 116) = 5.8$, $p < .01$, $\eta_p^2 = .17$. Consistent with hypotheses, for IPV, the Neither treatment group showed the most convictions ($M = .80$, $SD = .92$; 50% recidivism rate), with significantly more convictions than the Both group ($M = .04$, $SD = .20$; 4% recidivism rate). The MO and WO groups evidenced intermediate IPV convictions and did not significantly differ from any other groups. Follow-up contrasts indicated that, for general violence, the Neither group showed significantly more convictions ($M = .90$, $SD = 1.9$; 30% recidivism rate) than any other treatment group ($M = .04$, $SD = .12$; 6% recidivism rate). No other contrast comparisons were significantly different (see Supplemental Table 4).

Convictions by treatment group by gender. At 1-year follow-up, male treatment groups significantly differed in average number of IPV, $F(4, 116) = 3.4$, $p < .05$, $\eta_p^2 = .10$, and general violence convictions, $F(4, 116) = 4.5$, $p < .01$, $\eta_p^2 = .13$. In both cases, the Neither group (IPV: $M = .80$, $SD = .92$, 50% recidivism rate; general violence: $M = .80$, $SD = 1.9$, 20% recidivism rate) and the WO group (IPV: $M = .35$, $SD = 1.6$, 5% recidivism rate; general violence: $M = .10$, $SD = .10$, $SD = .45$, 5% recidivism rate) showed significantly more convictions than the other groups (IPV: $M = .04$, $SD = .19$, 3% recidivism rate; general violence: $M = .00$, $SD = .00$, 0% recidivism rate). Convictions for IPV did

not differ between women's treatment groups at 1-year follow-up. For women at follow-up, comparison showed a significant difference in convictions for general violence, $F(4, 116) = 3.0$, $p < .05$, $\eta_p^2 = .09$, with the Neither group showing significantly more convictions ($M = .10$, $SD = .32$, 10% recidivism rate) than all other groups ($M = .00$, $SD = .00$, 0% recidivism rate). See Supplemental Table 4.

Subjective Experience of Treatment

In response to program requirements, a subset of treatment completers (28 men and 28 women) completed subjective ratings of their experience during the program as part of the exit interview. Chi square comparisons of rating categories showed that, across genders, significantly more participants rated the program favorably than unfavorably (see Table 1).

Discussion

The current study investigated the effectiveness of a pilot intervention for reducing IPV among mutually violent couples by delivering a dyadic, IPV curriculum in an equivalent but separate format to each partner. The intervention reflects recent conceptualizations of IPV that emphasize differentiation in assessment and treatment of mutually violent couples while addressing many of the safety concerns and logistical constraints readily apparent in the IPV demographic. Overall, this study provides support for dyadic intervention with mutually violent couples that is superior to effects seen in traditional interventions (e.g., ~33% recidivism, Babcock et al., 2004) when both partners (4.0%) or either partner completed (MO = 8.3%; WO = 10%). Consistent with hypotheses, findings indicated that, at treatment completion, self-reports of participants' own behavior and their partners' behavior revealed decreased IPV. Specifically, men reported perpetrating fewer acts of physical assault and experiencing less injury inflicted by their partner. Women reported that their partner committed fewer acts of physical assault and inflicted less injury. In addition, at 1-year follow-up, completion of the intervention was associated with not only reduced IPV recidivism rates for men but (also) fewer general violence convictions for men and women who completed treatment.

Taken together, these findings indicate that, although the intervention was partially supported for women, it appeared most effective for men. For example, although significant self- and partner-reported reductions in male IPV were noted, female IPV only trended toward significant reductions. Likewise, although general violence convictions were lowest among female completers, significant differences in IPV convictions did not emerge among female treatment groups. This finding may be a product of the paucity of sensitive female IPV measures. For example, prior research shows that, although women commit equal numbers of or more IPV acts, their partner violence often results in less injury than men's IPV (Whitaker et al., 2007), which may make it difficult to distinguish differences in the effect of female IPV. Null findings may also be an artifact of the low base rates of IPV convictions among women (0–8.3% in this sample), indicating a need to include more sensitive measures of female IPV. It is also possible that current interventions may not adequately address women's IPV, suggesting that future research with partner-violent

women is critical (Swan, Gambone, Caldwell, Sullivan, & Snow, 2008).

Similar to previous studies (e.g., Brannen & Rubin, 1996; O'Leary et al., 1999), the group in which both partners completed did not significantly outperform the AO control group, with individual-based and dyadic interventions appearing effective in reducing IPV recidivism (AO = 0%; Both = 4%). Although this may be an artifact of study limitations (e.g., lack of data from the AO group), it may also reflect the utility of a comprehensive assessment aimed at improving intervention relevancy and adherence. Lending further support, attrition rates in this sample were lower than most traditional treatments (Babcock et al., 2004); of the 92 couples referred to the pilot program, 89% of couples had one or both partners complete.

Finally, as evidenced by encouraging IPV outcomes, favorable participant ratings, and preliminary analyses accounting for ethnicity, the intervention appeared successful across Caucasian and ethnic minority groups (predominantly Hispanic). This finding represents an initial step in evaluating the effectiveness of a mutual violence intervention, not only with ethnic minorities but (also) with both partners of a couple. It has been argued that, for interventions to be relevant to the Hispanic community, cultural features must be taken into account (familialism, Pabon, 1998); by involving both partners, the current study emphasized this intrinsic cultural value. Interventions outside of the IPV arena have shown the power of family involvement for behavior change (e.g., Brown, Garcia, Kouzekanani, & Hanis, 2002). Because IPV occurs within a family system, addressing relationships may be important in any cultural group. Because of the limited sample size of this study, only preliminary ethnicity analyses were conducted, and cultural variables were not measured; thus, many key questions remain for future research.

Limitations and Future Directions

Although this study had several strengths, including using data from ethnically diverse couples and using a longitudinal design to evaluate an innovative intervention, the promising, yet preliminary, findings should be interpreted within the context of some limitations. First, although wait-list control groups are rarely implemented in IPV research because of the ethical concerns of withholding treatment (e.g., O'Leary et al., 1999), it should be noted that this pilot intervention was assessed using a quasi-experimental design lacking random assignment or a wait-list control group. It is possible that the promising findings may be the result of maturation or a third variable rather than the causal effect of the intervention. Second, although the current study used self and partner report as well as convictions as behavioral measures of recidivism, both measures have limitations. Self-reported IPV is often minimized, and conviction data often capture only the extreme incidents. Third, although all intervention sessions were closely supervised, no formal treatment fidelity checks were available. Fourth, for the AO control group, only recidivism data were available, with questions remaining about what treatments those couples received. Fifth, information about the number of couples who were still romantic partners was unavailable. Finally, although low attrition rates and high satisfaction marks indicated that the intervention was well received, no data about why individuals stopped attending or their level of IPV at drop-out were

available. These limitations suggest directions for future research: a multiple baseline approach, random assignment to a control intervention, comprehensive assessment across all treatment groups at each time point, incorporation of data about the romantic status of the couple, incorporation of data from noncompleters, inclusion of treatment fidelity measures (independent raters that code intervention delivery), and the measurement of cultural variables with a larger sample to determine the intervention's fit across ethnic groups.

Implications

These findings offer some preliminary, yet promising, news for IPV clinicians. First, not only did a dyadic intervention appear equally effective as individual interventions, it did not appear to pose any additional safety concerns, an argument often raised in the IPV arena despite growing evidence to the contrary (Brannen & Rubin, 1996; O'Leary et al., 1999). Second, the intervention remained effective even when only one partner completes, a finding that is particularly promising given the high attrition rates in IPV samples (Babcock et al., 2004). Finally, innovative programs in which partners separately receive the same intervention may be a useful way to address mutual IPV and accommodate the unique needs of the IPV demographic.

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Received October 7, 2012

Revision received March 5, 2013

Accepted March 11, 2013 ■