FEATURED INTERVIEW

Learning About the Treatment of Intimate Partner Violence Perpetration

Christopher M. Murphy, PhD

Dr. Murphy is Professor of Psychology at the University of Maryland, Baltimore County. He earned a BA in Psychology from the University of New Hampshire, and a PhD in Clinical Psychology from Stony Brook University. His research focuses on the efficacy of cognitive-behavioral, motivational, trauma-informed, and comprehensive interventions for individuals who engage in intimate partner violence; the identification of personal, contextual, and intervention factors that facilitate and inhibit treatment response in this population, and the prevention of intimate partner abuse and sexual assault in emerging adulthood. Dr. Murphy has published over 100 peer reviewed articles and his research has been supported by the National Institutes of Health, the U.S. Office of Violence Against Women, and various state and local agencies and private foundations. Dr. Murphy was the recipient of the 2015 Linda Saltzman Memorial Intimate Partner Violence Researcher Award from the Institute on Violence, Abuse, and Trauma.

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Dr. McCarroll: Intimate partner violence (IPV) is a worldwide public health problem. Interventions to reduce abuse and violence require the effective treatment of perpetrators and victims. As a clinical psychologist, you have invested many years in treating perpetrators of IPV. How have you seen treatment for IPV perpetrators change over the years?

Dr. Murphy: Domestic violence intervention programs date back to the late 1970s. The original programs were mostly run by men's collectives that were connected in some way to the battered women's movement of the 1960s and 70s and had an explicitly pro-feminist perspective. This approach was based on the theory

In This Issue

The focus of this issue of *JFJF* is on the clinical treatment of perpetrators of intimate partner violence (IPV). In our highlighted interview, Chris Murphy, Professor of Psychology at the University of Maryland, Baltimore County, and a subject matter expert on this topic, shares his experiences on the origins and development of IPV perpetrator treatment. A key part of Dr. Murphy's approach to treatment is the recognition of the importance of trauma-informed care (TIC). Both perpetrators and victims of IPV can have a history of significant traumatic events that affect many aspects of their lives. As background to Dr. Murphy's interview, we describe TIC as it has developed in assisting children and adults with a history of traumatic experiences. Our statistics article, Building Bridges to Research, describes the concept of validity as it applies to the development of two instruments that Dr. Murphy noted are used in clinical practice: the Spousal Assault Risk Assessment Guide (SARA) and the Danger Assessment (DA). The SARA estimates the risk of spousal aggression; the DA estimates the risk of femicide. Why is it important to discuss the validity of these instruments? They are used to estimate risk. The user of these instruments should have knowledge of how they were developed and how much confidence to have in the results of their use. Finally, our Websites of Interest page presents resources for information about trauma, trauma and violence, trauma-informed care, and understanding trauma in children.

Contents

We work with a cognitive-behavioral approach, which means that we assumed that abuse and violence are learned behaviors and that clients can learn more constructive ways to deal with their feelings and change the way they interact with relationship partners.

that IPV is primarily a gender-based problem where men use various controlling tactics and physical abuse and that these acts are supported by a society that made it acceptable and unlikely that men would be held responsible and punished for engaging in abuse. That philosophy is still at the core of a lot of the work in the field. Some of those programs for IPV perpetrators were actually started at the request of women's organizations who had set up shelters and safe houses for battered women and wanted some place that the abusive partners could go and talk about what was happening, to have them resocialized to not be controlling and abusive. There have been other changes over time as well. Now, women, gay men and lesbian women, and gender-diverse individuals are also referred to our programs.

Another aspect of the early work was the view that the people who engaged in abusive behavior need to be held accountable. Providers were encouraged to confront abusive clients and to point out all the ways they were controlling and all the ways they engaged in victim blaming. In my opinion these recommendations make it difficult for providers to establish a connection and rapport with the abusive client. Without that kind of trust and relationship, it is very hard to promote change. Part of what has happened over the years is that providers have realized that they need to have a softer way of confronting. They need

to use empathy and understand that a lot of the clients that they work with have trauma histories themselves and were abused as children. An empathic stance is used to build the connection, which then helps motivate a person to want to change their behavior. This is an important part of the work. We cannot just point our fingers and tell our clients that they are controlling and behave in bad ways. That kind of shaming is rarely valuable or productive even though we still believe that society needs to hold abusive individuals accountable. Finding that balance between confronting the problem and building rapport and an alliance is one of the core challenges of this work.

Dr. McCarroll: What is the approach of the programs that you conducted and your research?

Dr. Murphy: For about 25 years, I directed a community-based IPV intervention program in Howard County, Maryland, which is a diverse suburban county between Baltimore and Washington, DC. These programs are commonly called batterer programs, but I generally do not use that term because I feel it is ambiguous and stigmatizing. We use the term *abuse intervention programs*. About 85% of our cases were court-referred. We would get 80 to 100 referrals per year. About 10-15% were self-referred and the rest came from various court-referrals, some from probation, some from deferred prosecution, and some from civil court proceedings. We had a smaller program for women; a larger program for men.

There is a lot of variation in the frequency and severity of the abuse and violence. We would see people across this spectrum. Some of them had been physically violent very infrequently or only once, while some had been frequently and severely violent with multiple relationship partners. We also had clients referred for being emotionally abusive. Some had never been physically assaultive with their relationship partners, but had done other things such as destroying property, harassment, stalking or unwanted pursuits after breaking up. These are problem behaviors that are also very disturbing to the victim.

We worked in gender-specific groups with a cognitive-behavioral approach, which means that we assumed that abuse and violence are learned behaviors and that clients can learn

At one point, we ran both closed-ended and open-ended groups. There are pluses and minuses with both of these approaches. With closed-ended groups, people tended to build more connection and rapport. With the open-ended groups, the more experienced members can help the less experienced members. A lot of the clients that we work with listen to one another more than to the counselors.

more constructive ways to deal with their feelings and change the way they interact with relationship partners. The vast majority of our clients would go into group treatment, but we did have options. We could provide individual counseling if we thought they would benefit more from that or if they had a mental health problem or other characteristics that would not make them a good group candidate. Some people might have issues that they would not feel comfortable talking about in group, such as a sexual abuse history, or they might have significant emotional conditions like mood disorders, bipolar disorder, or psychotic thought processes.

We had weekly two-hour sessions. At one point, we ran our programs with closed-ended groups and then shifted to open-ended groups with ongoing enrollment. There are pluses and minuses with both of those approaches. With closed-ended groups, people tended to build more connection and rapport because they are working with the same group of peers for the whole time. With the open-ended groups, the more experienced members can help the less experienced members. These groups are, in my opinion, the best way to do the work because a lot of the clients that we work with listen to one another more than to the counselors. They have many different reasons as to why they might not trust the counselors or facilitators. If the facilitators are skillful, they can create an atmosphere where there is open dialogue and encouragement of one another.

We did a small study comparing one-on-one therapy to group therapy. Both were based on a cognitive-behavioral model. We originally had the idea that the one-on-one therapy might be more effective because you can tailor what you are doing to the individual and their specific problems and needs. We found no evidence that the individual work was more effective and, in some scenarios, the groups had better outcomes.

Dr. McCarroll: Can you describe a typical session?

Dr. Murphy: Our program had a balance of structured and unstructured time. Each week we would review some of the things that the individuals were asked to work on. We would have some focus topic for the group. It could be anger cues, anger triggers, stress management, communication skills, listening, problem-solving, respect, and other similar issues. We

would typically have discussion, role plays, or vignettes with scenarios that we asked them to consider. Next, we would typically have 45 minutes to an hour for more of a process-oriented group experience in which people would help one another. Sometimes that would focus on one or two people and things they were struggling with. At other times, we would focus on common themes or common challenges that many people were having. The unstructured open-ended format gave people the opportunity to talk and bond and help one another, which may be more important than the structured cognitive-behavioral training. If they cannot make it relevant to their own situation, then the other things that we had for them to work on and learn are not going to be effective. When people give advice, they are more likely to take it. Sometimes it is easier to analyze and think about someone else's situation than your own. When they see someone else's situation or they see some things that they know are wrong, it makes it easier for them to start applying the same ideas and principals to their own situation and in this way begin handling things differently.

Dr. McCarroll: You have described two interesting techniques you have used: first, the perception of whether the effects of their violence were positive or negative or helpful or not helpful, and then, secondly, their long-term expectancies of the effects of their violence.

Dr. Murphy: We have developed a measure of these positive and negative expectancies, sometimes called the pros and cons of engaging in abusive behavior: what are you getting out of this; what is this costing you (Miles-McLean, LaMotte, & Murphy, 2021). We would administer a questionnaire during the intake process and then use their responses to help stimulate a discussion about change. For example, if someone says, "The only way to get your point across is to yell or shout," or "Sometimes, you have to intimidate people." We would use their responses to these sorts of items to say, "You said you believe this. Can we talk more about that?" Or you said, "If you are abusive toward your partner, she is going to leave you." You also said that "If you are abusive toward your partner, you are going to end up in jail." They might endorse many of these kinds of statements, which helps to stimulate a discussion about

Ongoing abuse of alcohol is a really big problem in this population. About half of our clients have some unhealthy and problematic patterns of alcohol or other drug use. Some of them use alcohol to cope with negative experiences including anger problems, histories of trauma, and posttraumatic stress symptoms.

their motivations, why they might continue to use these controlling and abusive behaviors, and why they need to change.

Most of the positive consequences are short-term. They might say, "Sometimes I get my way by yelling and screaming." Some of the negative consequences can have longer lasting effects. "Your behavior can have a negative impact on children." "You might end up in jail." "Your partner's not going to trust you." What we would tend to find is what you would call a self-control trap where you have short-term reinforcement and long-term punishment. It is often hard to change those behaviors, but we would start by making people aware of them and then saying "Do you see why it would be helpful to have other ways to try to address these short-term goals and outcomes that you are looking for without the long-term negative consequences?" "If you can find another way to express how angry you are without being abusive, then wouldn't that be better?"

Dr. McCarroll: You have spent a lot of your career studying the role of alcohol in domestic violence.

Dr. Murphy: Ongoing abuse of alcohol is a very big problem in this population. About half of our clients have some unhealthy and problematic patterns of alcohol or other drug use. Some of them use alcohol to cope with negative experiences including anger problems, histories of trauma, and posttraumatic stress symptoms. Alcohol is one of the biggest risk factors for continuing to be abusive and violent during and after engaging in these programs. When you interview women abuse survivors, one very common theme is that the abusive partner is much more abusive when drinking. You need a variety of strategies to address alcohol problems depending on how severe it is and how intense the difficulties are.

The first order of business is to try to get them on board, recognizing how it is negatively affecting their relationships and to help them understand why they are using. We then provide a brief motivational intervention to try to address their drinking, give them feedback about the way their drinking was causing problems, and try to get them to plan for changes. However, sometimes people need more extended alcohol treatment.

Dr. McCarroll: You have some people in your groups whose partners have left them and some who are thinking about it. Do you talk with them in any different ways?

Dr. Murphy: The idea of learning to have better relationships is pretty consistent across people whether they are still with a partner or they have moved on. Sometimes they have goals of understanding what happened in their relationship, so as not to repeat the problem in the future. It is challenging to engage people who have ended their relationship and have the attitude that they do not ever want to be in a relationship again. So, if somebody says, "That doesn't apply to me. I am not planning on having relationships," then we have to help them develop other goals. But we can still deal with the issues of emotion regulation, of wanting to be in control, and the effects of their childhood experiences. A lot of those issues are common regardless of where someone is in relationships in the present.

Dr. McCarroll: How do you work with people who have a history of abuse as a child?

Dr. Murphy: I had the good fortune to collaborate on the development of the Strength at Home program, which is used in many VA hospitals (Taft, Macdonald, Creech, Monson, & Murphy, 2016). Casey Taft has done great work in expanding our model of cognitive-behavioral therapy to be much more trauma-informed. Part of that focus is to help people understand that some of the traumatic experiences they have had either in childhood, in combat, or in other contexts have had negative impacts on their relationships. This is particularly important in terms of their ability to trust other people or the desire to be in control of everything, including their relationship partners or their children. Often, these experiences also have had a negative impact on their self-esteem. In that case, we focus more on the aftereffects of trauma, the ways in which these experiences have negatively impacted their ability to have healthy relationships. We generally do not get into the details of the trauma in the way you would in trauma-focused therapies. But if someone wanted or needed that we would provide or arrange it as an additional treatment for them.

A trauma-informed focus helps people understand that some of their traumatic experiences have had negative impacts on their relationships, particularly in their ability to trust other people or the desire to be in control of everything.

Dr. McCarroll: In one of your articles on trauma you found significant differences in trauma histories of women and men (LaMotte, Gower, Miles-McLean, Farzan-Kashani, & Murphy, 2018).

Dr. Murphy: Women are more likely to report having experienced gender-based trauma, intimate partner violence or sexual assault, but the rates of other types of trauma experiences, such as childhood abuse and witnessing violence, are high in both men and women. We did not find many differences, but where we did find differences in trauma exposure, women were more likely than men to report gender-based trauma exposures.

When we compared women and men in our group program, women were more likely to have a level of trauma symptoms that met the cutoff for PTSD. The men reported fewer PTSD symptoms overall. Importantly, we find that trauma has negative effects on their relationships, even if they do not have PTSD. One of the biggest is the ability to trust, which comes out in being suspicious in their relationships, being controlling, wanting to monitor what the other person is doing, wanting to know where they are all the time. I think it is helpful for people to understand that this is coming from somewhere for them and is not just something that they cooked up one day. There are reasons why they feel that need to be in control, sometimes because they felt so out of control during trauma exposures or because they were hurt by people who they were supposed to be able to trust. We can help them understand that and, hopefully, let go of some of the problems that result from always wanting to control things. There are ways to build trust and to recognize that a lot of the mistrust is not what the other person is doing, it is their own personal history that is causing them to be so mistrustful.

Dr. McCarroll: Do you see differences in the groups for women compared to those for men?

Dr. Murphy: The facilitators running women's groups usually report that the clients bonded more quickly and were more open about what was happening in their relationships. With men's groups, we typically would get to the same place, but it takes a little more time. Men often need to see other men sharing before they are comfortable doing it. The women's groups also tended to focus more on

their own experiences of trauma and their own histories of being abused in relationships, more often by men. It comes up in the men's groups, but it is not as consistent a focus. The content that we would focus on was fairly similar in terms of the basic ways in which their relating was not as healthy and productive as it could be, such as in their ability to understand, accept, and handle their emotions. Military veterans also tend to have rapid bonding and openness. Because of shared experiences, some veterans are more likely to trust other veterans than civilians or people who have never been in the military. There is a culture-specific element for some groups, that enables them to get to a deeper level quickly. Alternatively, in other groups, background and experiences can make it harder for people to trust or to open up and hold one another accountable, and that may take a bit more time. It is also important to acknowledge that men, in particular, may be uncomfortable at first and that talking about feelings and personal issues in a group setting can be scary.

Dr. McCarroll: What are the challenges and issues with having mixed male and female groups?

Dr. Murphy: Over the years I have heard very positive experiences reported from people who have run mixed groups. Part of what they say is that often the men or the women in these groups have very generalized views of the opposite sex. The men will say, "All women think this way; all women want this; all women act this way." Facilitators have also reported that in mixed groups, members have the ability for direct feedback and to challenge some of these overgeneralized beliefs and thoughts. People can tell you directly, "No, that is not true." or "I do not think that way."

But there are dangers and risks, particularly for the women who have been the victims of sexual assault or domestic violence. The concern is whether they feel safe in a mixed gender group and if it can be triggering for them in some way. Also, there might be some gender-specific content. With the men, we talk about men's socialization in terms of what is acceptable social behavior, how you have to be tough, not show your feelings, and so on. While these conversations tend to flow a certain way in all-men's groups, it is possible to hold these

There are some good risk assessment instruments for this population. These include the Spousal Assault Risk Assessment and the Danger Assessment. They count up the number of risk factors to assign someone to a risk level. A lot of risk factors co-occur. Individuals who have alcohol problems are more likely to have mental health symptoms and a history of violence and so forth. I tend to focus on more specific clinical or psychosocial factors that could possibly be addressed and try to identify a smaller set of these factors that can be incorporated into people's treatment plans.

conversations in a mixed-gender group. My feeling is that people are very sensitive to safety and comfort and if the facilitators are highly skillful and thoughtful, a lot of different things may be possible and may work.

Dr. McCarroll: I imagine you have had some concern about severe aggression and fatalities occurring with the people you work with, either at the time or when they leave. How do you think about this risk?

Dr. Murphy: We operate under the standard principles of mental health practice. If we thought there was imminent danger, we would inform the person in danger, involve the authorities, and seek hospitalization if necessary. There is ongoing danger for everybody who comes into these programs. I believe it is part of ethical practice to do vigorous outreach to the partners for everybody who comes through these programs. In other words, you may not know that this person is in imminent danger to be abused today or tomorrow, but you know that this person is at risk to be the victim of violence from your client at some point over time and so I think we should contact partners to inquire about their feelings of safety, do some basic assessment, provide safety planning if needed, give them resources, and make sure they know they can reach out to us. That outreach requires the abusive client's consent. We would generally not accept someone into our program if they weren't willing to provide that consent for partner outreach.

Dr. McCarroll: How did you assess risk?

Dr. Murphy: There are some good risk assessment instruments specifically for this population. There is The Spousal Assault Risk Assessment Guide (*https://storefront.mhs.com/collections/sara*) and the Danger Assessment (https://vawnet.org/material/danger-assessment). They count up the number of different factors to assign someone to a risk level. A lot of risk factors aggregate and co-occur. Individuals who have alcohol problems are more likely to have mental health symptoms and a history of violence, and so forth. My perspective has been a bit different. I tend to focus on more specific clinical or psychosocial factors that could potentially be addressed and try to identify a smaller set of these factors that can be incorporated into people's treatment plans.

Some of the data from my program found

that certain specific risk factors are often equally predictive of recidivism as an overall risk score. In other words, certain key factors seem to be very associated with risk for continued violence. One of them is unemployment, which does not get a lot of attention in this field. There is little research on trying to address it through employment support or other types of interventions. We found that people who are employed full-time have substantially lower rates of violence than people who are not employed full-time when they come to our program. Other significant risk factors are generalized anger problems, alcohol problems, and PTSD. So, my view is that managing some of these specific risk factors may be more useful than simply getting an overall risk score or categorizing individuals as high or low risk.

Dr. McCarroll: What about follow-up? I know that recidivism in terms of re-arrest and other elements are one measure that some people use. How do you assess the effects of your program?

Dr. Murphy: For many years, our primary outcomes were based on contacting the victim partner and then re-contacting them every three months or every six months over a period of about a year. Partner reports of abuse are the gold standard for evaluating outcome. We would ask about a range of emotionally and physically abusive behaviors to see whether these behaviors had stopped or were continuing. However, with so many cell phones, it is harder and harder to contact people. In recent years it has been a challenge to contact even half of the partners. The other aspect of follow up is that typically we have just assessed the abusive behaviors, but we have not done as good a job of assessing the ways in which these things have been harmful to the survivors. I think that it is very important to better understand the negative experiences they are having and how our program could help them to feel better, safer, and more comfortable.

When we were able to reach partners, we often found that they appreciated it and wanted to talk about what was going on. Some partners would say they have difficulties themselves with anger and aggression and want help in those areas. We try to see if they are interested in engaging with the victim counseling services or other resources. However, some partners have left the relationship, were getting beyond it, and were not particularly interested in going back

and talking about the past.

The other piece of follow-up is short-term changes in behavior that we hope have evolved into long-term changes in reducing abusive violence. Are they learning how to regulate their emotions better? Are they learning how to communicate their needs more effectively? How to be a better listener, how to be supportive? Are they developing these sorts of capacities and skills and is that what is leading to a change in the outcome for them? Or, are they just avoiding being physically violent to avoid going back to jail?

Dr. McCarroll: What did I not ask you that you wish I had?

Dr. Murphy: I think the biggest thing we did not talk much about is "Are these programs effective? Are they a good use of resources and what are the alternatives, if any, if they are not as effective as we would like?" My perspective, after having been in this for a long time and doing research, is that the programs do have a positive benefit, particularly in reducing criminal recidivism and engagement with the criminal justice system. However, the programs are not nearly as effective as we would like them to be, so it is sort of a glass half-full / half-empty situation. We do not have many great alternatives. We cannot just lock everybody up and we know that locking people up does not necessarily fix these problems, although for some people, that may be what is needed. Some people are so dangerous that incarceration may be necessary, but that is not a wonderful solution. Neither can we do nothing, not prosecute or not address the problem. Given that the abuse intervention programs have some benefit, my perspective is that we should invest in them and figure out how to make them more effective. We should also learn how to use them as a way to better meet the needs of survivors who are often not connected to services or supports. I do wish that the programs were more effective, but they do have positive benefits. That is where we are starting, but we really need to look at new models. We need to look at ways to extend and expand their impact, so that we can have a better effect overall on the safety and well-being of everyone who is affected by partner violence.

Dr. McCarroll: Thank you so very much for your willingness to talk and for explaining your approach to treating domestic violence perpetrators.

Dr. Murphy: You are very welcome.

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Are these programs effective? Are they a good use of resources and what are the alternatives, if any? My perspective is that they have a positive benefit in reducing criminal recidivism. However, we should also learn how to use these programs to meet the needs of survivors. We need to look at ways to expand their impact so that we can have a better overall effect on the safety and well-being of everyone who is affected by partner violence.

Trauma-Informed Care and Its Role in the Treatment of Intimate Partner Violence Perpetrators

James E. McCarroll, PhD, Ronald J. Whalen, PhD, Joshua C. Morganstein, MD, Robert J. Ursano, MD

Trauma and posttraumatic stress symptoms (PTSS) are important risk factors in the perpetration of IPV.

The search for an effective treatment program for intimate partner violence (IPV) perpetrators has long been the Holy Grail for practitioners, advocates, courts, and victims. Early studies of IPV perpetrator cessation programs have almost universally failed to show effectiveness of any one approach or differences in outcomes between approaches. However, it should be noted that intervention research is inherently difficult due to variations in counseling approach, program duration, extent of services, linkages to the court, victim services, and connections to other community agencies (Gondolf, 1999). In a review of significant questions about intervention programs, the most frequent question was "do the programs work?" (Gondolf, 1997). Gondolf concluded that their effectiveness had not been satisfactorily determined. A subsequent comparison of program outcome from four sites found no significant differences in the re-assault rate, proportion of men making threats, or victim quality of life. However, batterer programs did appear to contribute to the cessation of violence in some men over a 6-month follow-up period. The author concluded that intervention systems that conform to fundamental standards (e.g., holding perpetrators accountable) can achieve similar results (Gondolf, 1999).

An evaluation of an intervention for Navy service members and their partners who had physically assaulted their partner compared four different groups. These groups were: men only, a couple's group, a rigorously monitored group in which perpetrators were seen monthly for individual counseling and a court record check every six weeks, and a control group in which men received no family advocacy treatment, but partners received assistance in stabilization and safety planning (Dunford, 2000). A cognitive-behavioral intervention was used in the men's and conjoint groups. Outcomes after an 18-month interval found nonsignificant differences. A meta-analytic review of 22 studies that evaluated treatment efficacy found that treatment effects of programs (primarily power and control versus cognitive-behavior therapy) were in the small range. The conclusion was that the interventions had a minimal effect on recidivism beyond the effect of being arrested (Babcock, Green, & Robie, 2004).

A new twist was added to intervention programs for IPV cessation when trauma-informed care (TIC) was added to traditional treatment (Voith, Logan-Greene, Strodthoff, & Bender, 2020). This approach is theoretically grounded in social learning theory which posits that violence is a learned behavior in which aggression modeled by adults is subsequently adopted by children (Bandura & Badar, 1971). Interventions attempt to produce new learning based on negative consequence of aggressive behavior and by observation of appropriate models of behavior.

TIC is a broad educational approach that promotes awareness of the effects of trauma through classes, seminars, webinars, and in treatment that raises the awareness of trauma and its effects on behavior and psychopathology (Berliner & Kolko, 2016). TIC is distinguished from trauma-specific care, which refers to the application of a treatment method for a particular distress such as posttraumatic stress disorder (PTSD) (Ennis, Sijercic, & Monson, 2021).

Dr. Murphy described TIC as part of his approach to the treatment of perpetrators of IPV. Trauma and posttraumatic stress symptoms (PTSS) are important risk factors in the perpetration of IPV. A history of trauma is common in IPV perpetrators and often figures heavily in their lives. For example, male perpetrators of IPV presenting for treatment (n=293) in a community-based program were assessed for traumatic event exposure, PTSS, depression, and alcohol problems. Over three quarters reported past trauma exposures, 62% reported multiple exposures, and 11% screened positive for probable PTSD. PTSD symptom levels significantly predicted relationship dysfunction and relationship abuse over and above alcohol problems, drug use, and depression (Semiatin, Torres, LaMotte, Portnoy, & Murphy, 2017). Those with probable PTSD at pre-treatment had four times higher odds of general violence recidivism even when controlling for substance abuse and depression during the two years after the scheduled completion of a 20-session treatment. Higher levels of PTSS were also associated with lower task orientation and group cohesion

later in treatment. The authors concluded that trauma symptoms affect violence cessation in IPV treatment thereby highlighting the need to assess for unique clinical issues and the mechanisms associated with PTSS in this population (Miles-McLean et al., 2019). PTSD symptoms have also been associated with treatment engagement and criminal recidivism (Miles-McLean et al., 2019).

In addition to PTSS, the centrality of a traumatic event if often crucial for the person's identity. When a traumatic event is central to identity, it marks a key point in life that influences the meaning of subsequent posttraumatic events. Treatment for IPV perpetration may be enhanced by decentering the trauma within the person's narrative such as by challenging beliefs related to the centrality of such beliefs (Webermann et al., 2020).

While the above research involved male IPV perpetrators, a similar study with female perpetrators also found significant effects of trauma exposure for women who perpetrate IPV. In an exploratory study of 32 women who were demographically similar to 64 men who participated in a community-based abuse intervention program, 93.5% of the women reported trauma exposure and 43.8% screened positive for probable PTSD, higher than that of the male participants. Women's PTSD symptoms correlated significantly with emotional abuse perpetration and, after controlling for substance use, with physical assault. Importantly, gender did not significantly moderate the associations between PTSD symptoms and IPV perpetration (Miles-McLean, LaMotte, Williams, & Murphy, 2021).

A program on reducing violence in military couples, Strength at Home (SAH), tested its efficacy on reducing violence. SAH is a cognitive-behavioral trauma-informed IPV preventive intervention for married or partnered military couples (Taft, Creech, et al., 2016). Couples (135 male veterans and service members and 111 female partners) were recruited between February 2010 and August 2013 at two Veterans Affairs hospitals for participation in a randomized trial of a 12-week group treatment. Those randomized to SAH were compared to a supportive prevention treatment group in which there was minimal therapist intervention beyond encouraging members to support each other and focus on relationship issues. Those participating in SAH had greater reductions in physical and psychological IPV and reduced controlling behaviors involving

Trauma-informed care (TIC) posits that violence is a learned behavior in which aggression modeled by adults is adopted by children, but it can also be unlearned through education, observation, and appropriate behavior modeled by others.

isolation and monitoring of the partner at follow-up at 3 and 6 months (Taft, Macdonald, Creech, Monson, & Murphy, 2016).

SAH has since been introduced as part of a national program of the U.S. Department of Veterans Affairs to help veterans who use or experience IPV (Taft, Macdonald, et al., 2016). Further research is ongoing to replicate these findings examining psychopathology in addition to PTSD, types of traumas experienced, and relationship satisfaction. Further work is also needed to determine if the SAH program is effective for women veterans (Taft, Creech, et al., 2016).

IPV cessation treatment is difficult to evaluate, but an increasing body of evidence highlights the need for trauma-informed care of IPV perpetrators. The mitigating and moderating effects of trauma are just beginning to be understood and applied in the practice of TIC. As a result of the importance of trauma in IPV, screening for trauma exposure and PTSD should be part of routine practice in IPV perpetrator treatment (Semiatin et al., 2017).

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Validity in Measures of the Risk of Intimate Partner Violence — "Do the Measures Measure What They Say They Measure? For Whom?"

By James E. McCarroll, PhD, Ronald J. Whalen, PhD, Joshua C. Morganstein, MD, and Robert J. Ursano, MD

Validation of instruments is a complex task that involves determining that the instrument measures that which it is purported to measure.

In his interview, Dr. Murphy noted instruments that can be used in research and clinical care of perpetrators of intimate partner violence (IPV) like the Spouse Assault Risk Assessment Guide (SARA) (Kropp & Hart, 2000) and the Danger Assessment (DA) (Campbell, Webster, & Glass, 2009; Campbell et al., 2003). These instruments estimate the risk of IPV recidivism and femicide, respectively. Both instruments are validated for their purpose, but what does validated mean and how should it be interpreted?

Much research in the social sciences involves estimates of some characteristic of behavior or the prediction of a future event. Such characteristics are commonly called *constructs*. A construct is an unobserved, abstract characteristic of interest, such as intelligence, based on observation or theory (see "Websites of Interest" for more on the statistical concepts involved in validity).

In reports of the outcomes of studies that have used instruments (paper and pencil, verbal, or internet) to measure a given construct, authors often report that the instrument has been validated. To some readers, this is enough information for them to accept that the measure is ready to use in practice. However, the validation of instruments is a complex task involving the determination that an instrument measures what it is purported to measure, so it is important that the reader ask at least some of the following questions: How was validity established? What kind of validity? Valid for whom? Validated when?

The SARA is a tool for making judgments about the risk for spousal violence, a more general prediction than the DA, which measures the risk of spousal homicide. The SARA is based on 20 risk factors, 10 related to violence in general and 10 that are specifically related to spousal violence. Examples of general violence risk factors are: "Past assault of strangers or acquaintances," 'Recent substance abuse/dependence," and "Personality disorder with anger, impulsivity, or behavioral instability." Examples of spousal violence risk factors are: "Past physical assault," "Past violation of 'No Contact' orders," and "Past sexual assault/sexual jealousy." Items are coded by an evaluator.

The SARA was validated in samples of male IPV offenders (N=2,681) with a documented history of spousal assault in British Columbia, Canada, in 1996-1997 in participants with and without such history. Some offenders were federal prison inmates and others were probationers. Assessments for the SARA ratings were based on interviews or evaluations of files for each of the 20 risk factors. Validation was based on the differentiation of risk factors by groups. It was found that despite the variability in risk factors, there was a consistent pattern of differences between inmates and probationers in which inmates had higher scores on risk factors than probationers. The authors concluded that the SARA had good validity and that their analyses supported the use of the SARA in clinical and forensic decision making and in research on the perpetration of spousal assault. Further clarification regarding the uses of the SARA noted that it is an instrument to guide *structured professional judgment* (authors' italics), and that final decisions about risk should include judgments of external factors, such as the nature of the environment into which an individual would be released. Further research using the SARA in Sweden found that it had significant predictive validity for IPV recidivism when used by police officers over an 18-month period (Belfrage et al., 2011).

The DA, designed to predict the likelihood of lethal or near lethal IPV of women by their partner or ex-intimate partners, was found to be a valid instrument capable of assessing intimate partner violence in clinical and research settings. The research supporting the predictive validity of the DA was conducted by comparing data from 310 women that had been killed with 324 abused control women in urban American cities. Data of deceased women were collected from records and

interviews of proxies who knew the deceased women's relationships with intimate or former intimate partners. Information collected included demographics, relationship characteristics, type, frequency, and severity of abuse, harassment, weapon availability, and substance use. Control women were identified through random digit dialing. They were considered abused if physically assaulted or threatened with a weapon by a current or former intimate partner within the past two years. Results of this study produced the final version of the DA, 20 items scored Yes or No. Examples are: "Has the physical violence increased in severity or frequency over the past year?" "Does he own a gun?" and "Do you believe he is capable of killing you?" Odds ratios from analyses of the femicides and abused controls were used to develop an algorithm for four levels of risk based on the DA score: variable danger, increased danger, severe danger, and extreme danger.

This version of the DA was also used in a subsequent study with an independent sample of 194 women victims of attempted femicide who were compared to controls. The DA scores of attempted femicide victims were similar to the femicides, more than twice as high as the scores of the abused controls, and were more likely to fall into the three higher danger categories (increased, severe, and extreme danger) than controls. The authors concluded that the DA provided acceptable levels of sensitivity and specificity and could accurately identify the majority of abused women at risk of femicide or attempted femicide, distinguish the women at the lowest risk, and provide risk factors for prevention.

Similar to the SARA, the DA is expected to be used collaboratively with others involved in the assessment of risk such as advocates, health care professionals, criminal justice practitioners and the abused woman. Knowledge of risk can be useful in developing safety plans and interventions for the woman as well as for the abuser.

This brief description of the background of two instruments widely used in services for IPV victims and abusers and for researchers gives only the highlights of the research that established their validity. In this summary we attempt to make readers more aware of validation procedures in general as well as some specific information about the two measures described here.

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Websites of Interest

The Substance Abuse and Mental Health Services Administration (SAMHSA) has taken the federal lead in informing the public about the effects of trauma on children and adults. Several websites listed below provide information and links to their resources.

TRAUMA
https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/trauma

TRAUMA-INFORMED CARE
https://www.samhsa.gov/resource/ebp/tip-57-trauma-informed-care-behavioral-health-services

TRAUMA AND VIOLENCE
https://www.samhsa.gov/trauma-violence

RESOURCES FOR CHILD TRAUMA-INFORMED CARE
https://www.samhsa.gov/childrens-awareness-day/past-events/2018/child-traumatic-stress-resources

UNDERSTANDING CHILD TRAUMA
https://www.samhsa.gov/child-trauma/understanding-child-trauma

Finally, the following link is a presentation that reviews the terminology associated with determining validity. It is a product of the National Assessment Governing Board, a federal agency that sets policy for the National Assessment of Educational Progress, the nation's report card. The presentation discusses the statistical concept of validity in its many forms: sources, evidence, and issues in validity theory.

https://www.nagb.gov/content/dam/nagb/en/documents/naep/cizek-introduction-validity.pdf

Validity is important.

* "one of the major deities in the pantheon of the psychometrician..."
(Ebel, 1961, p. 640)

* "the most fundamental consideration in developing and evaluating tests"
(AERA, APA, NCME, 1999, p. 9)

These two quotes highlight the importance of validity in measurement and assessment. The first of these quotes is by a renowned psychometrician, Robert Ebel. The second quote is from the Standards for Educational and Psychological Testing.

Two Important Concepts

1) **Construct**
* a label used to describe behavior
* refers to an unobserved (latent) characteristic of interest
* Examples: creativity, intelligence, reading comprehension, preparedness

There are two important concepts to validity. The first one is the notion of a construct. Constructs can be defined as labels used to describe an unobserved behavior, such as honesty. Such behaviors vary across individuals; although they may leave an impression, they cannot be directly measured. In the social sciences virtually everything is a construct.

Two Important Concepts

2) **Inference**
* "Informed leap" from an observed, measured value to an estimate of underlying standing on a construct

* Short vs. Long Inferential Leaps (e.g. writing assessment)