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Violence Against Women: Synthesis of Research on Offender Interventions

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This report provides an overview of the latest research on interventions for men who assault women—wives, girlfriends, and acquaintances. The assaults may be physical or sexual, and they almost always involve psychological abuse. The overview begins with a description of the major components of current programs and then describes what is known about effective assessment and treatment methods. Several topics are covered that are often of interest to practitioners, including methods for enhancing treatment motivation, assessment of dangerousness, and culturally competent practice. The role of research in resolving controversial issues and the characteristics of sound evaluations are also discussed. Programs reviewed will be those commonly labeled as "social service," "treatment," and "psycho-educational," as opposed to purely criminal justice interventions.

Because the domestic violence and sexual assault fields developed separately, with separate service and research traditions (Finkelhor, 1983), many sections of this report address these two areas of interventions separately. The domestic violence field emerged from the women's movement of the 1970s and the sexual assault field emerged from child protective services and the rape crisis movement. One reason for the distinct systems is that sexual assault offender programs tend to serve a greater variety of offender types, including rapists and child molesters inside and outside of the family, and both juvenile and adult offenders.

Although many State advocacy coalitions have a combined focus on domestic violence and sexual assault, interventions for offenders are almost always separate. On a theoretical level, some researchers discuss domestic violence and sexual assault as subtypes of general criminal offending or within sociocultural theories, and some empirical work is progressing (Fagan and Wexler, 1987; Hanson and Wallace-Capretta 2000), however, direct comparisons between domestic violence and sexual assault are rare. Researchers and practitioners might benefit from placing their work in the broader context of violent crime in general (e.g., Lipsey and Wilson, 1998; Rice, 1997). One example of overlap between the fields is the controversy over whether it is effective to treat anger in domestic violence offenders, sexual assault offenders, and criminals in general (e.g., Loza and Loza-Fanous, 1999). One exception to the separateness of these fields is the area of dating violence: Prevention and intervention programs for date rape, dating violence, and sexual harassment are often integrated (e.g., Kivel and Creighton, 1997). Marital rape would seem to be a form of abuse that would unite the fields, but policy, direct practice, and research traditions regarding marital rape remain distinct. Marital rape has been addressed in programs for men who batter (e.g., Pence and Paymar, 1993; Wexler, 2000), but it tends to be covered late in treatment and only if other physical abuse has occurred (Yllo, 1999).

Despite the separation between the fields, it is evident that some program methods, innovations, and controversies are parallel. This report may foster some fruitful exchanges between the fields by reinforcing common ground and pointing out opportunities to learn from differences. For example, sex offender programs have much more experience in prison settings than domestic violence programs, but domestic violence programs are more often integrated with victim services.

Program Configurations: Settings, Ingredients, and Formats

Programs for both domestic violence offenders and sex offenders tend to integrate several approaches through a number of phases; first they expand offenders' definitions of abuse and hold them responsible for it, then they teach them alternative reactions and behaviors (Freeman-Longo et al., 1995; Gondolf, 1997). Programs differ within and across the domestic violence and sexual assault fields in the emphasis they place on these two dimensions (Rosenbaum and Leisring, 2001), as described below.

There are various formats for delivering services. Men's groups are the format of choice, followed by individual counseling (Marshall, 1999; Pirog-Good and Stets-Kealey, 1985). No studies have compared individual and group formats. Studies comparing men's groups and couples' groups for domestic violence will be reviewed later.

Domestic Violence

Domestic abuser programs were operated originally by profeminist men's groups, traditional social service agencies, and battered women's shelters (for histories, see Bennett and Williams, 2001; Gondolf, 2002; Mederos, 2002). Some programs have also been affiliated with probation departments and courts or located in prisons and jails. Little evidence is available about whether the type of setting affects the type of approach used (Feazell, Myers, and Deschner, 1984). Surprisingly, one study found that shelter-run programs focused less on patriarchal norms than did other programs (Eddy and Myers, 1984). A recent survey of programs' cultural competence found that about half of them made no special effort to understand the needs of minority communities (Williams and Becker, 1994).

Programs tend to use an eclectic mix of methods, yet a few core elements are found in most programs. A 1985 national survey revealed that more than 80 percent of the programs attempted to increase offender self-esteem and change sex-role attitudes (Pirog-Good and Stets-Kealey, 1985). Gondolf (1990) surveyed 15 model programs and 15 other randomly selected programs. Model programs had existed for at least 5 years and were highly visible. Programs were classified as therapeutic (treatment of emotional pains and psychological problems), psychoeducational (instruction in cognitive and social skills), and didactic/confrontational (consciousness-raising about the consequences of and responsibility for abuse). Most programs fell into the psychoeducational category (47 percent), but model programs were more likely to be didactic/confrontational. Many programs (63 percent) combined court- and noncourt-referred offenders in the same groups, but many (60 percent) would not accept offenders diverted from the court process.

Interventions can be classified along several dimensions based on their underlying assumptions (Saunders, 1996b; for other categorizations, see Aldarondo, 2002; Healey, Smith, and O'Sullivan, 1998):

- ♦ Skills training is based on social learning assumptions about the behavioral deficits and behavioral excesses of offenders. Modeling of positive behavior by group leaders and

behavioral rehearsal by members are used in skill-building approaches to enhance relationship skills that replace destructive behaviors.

- Cognitive approaches assume that faulty patterns of thinking lead to negative emotions, which in turn lead to abusive behavior. Restructuring of these thoughts is likely to reduce anger and the fear and hurt that often underlies it. These approaches can also be used to help men become aware of the core belief systems they developed in childhood, including rigid beliefs about gender roles.

- Sex role resocialization helps men see the negative effects of constricted male roles and the benefits of gender equality (Saunders, 1984). Male dominance is viewed as one of the effects of this rigid socialization.

- Methods to build awareness of control tactics are designed to help men take ownership of their intentions to control others (Pence and Paymar, 1993). An emphasis is placed on expanding the definition of abuse to include isolation, demeaning language, control of finances, and other means of control. Awareness is also built about the impact of the abuse on and building empathy for victims.

- Family systems approaches assume that couples unknowingly engage in repeated cycles of interaction that may culminate in abuse (Neidig and Friedman, 1984). The focus is on analyzing and changing communication patterns.

- Trauma-based approaches are based on the assumption that the men need to resolve their childhood traumas, in particular those of witnessing parental violence and being physically abused by parents (Browne, Saunders, and Staecker, 1997). One assumption is that they cannot empathize well with others because they are cut off from their own painful memories.

The first four approaches described above seem to be integrated most commonly into the same program (e.g., Ganley, 1989; Rosenbaum and Leisring, 2001). For example, the EMERGE program in Boston (EMERGE, 2000) combines awareness of abusive behaviors with cognitive restructuring. The “Duluth model” (Pence and Paymar, 1993) emphasizes awareness of violent and nonviolent control tactics and, to a lesser extent, learning skills. Family systems approaches that use couples counseling are the most controversial. Critics charge that this approach explicitly or implicitly holds the victim responsible for the abuse. Further discussion of couples approaches is presented later.

Sexual Assault

Cognitive-behavioral approaches are especially prevalent in sex offender treatment, where specific techniques such as relapse prevention are emphasized (Burton and Smith-Darden, 2001; Marshall and Serran, 2000). There is more acceptance in sex offender treatment than in domestic violence treatment for exploring and resolving past traumas. More than 70 percent of sex offender programs focus on childhood victimizations (Burton and Smith-Darden, 2001;

Freeman-Longo et al., 1995). Shaming and other forms of aggressive confrontation have been discredited as techniques and have almost disappeared from use (Burton and Smith-Darden, 2001; Marshall, Anderson, and Fernandez, 1999). Restorative justice, broadly defined to include community service and apologies to victims, is being used increasingly but has yet to be evaluated (Burton and Smith-Darden, 2001).

Components of treatment programs for both juvenile and adult sex offenders have been conceptualized as follows (Hamill, 2001):

- ♦ Comprehensive evaluation and risk assessment (discussed below).
- ♦ Psycho-social-sexual education uses a structured curriculum in which program staff work with offenders and family members to prepare them for treatment and enhance the ultimate impact of other intervention components. Juvenile offenders are the most likely to be involved in family programs, such as multisystemic treatment that targets all types of juvenile offending (Henggeler et al., 1998).
- ♦ Process treatment employs sex offense-specific individual, group, and family therapies to instill honesty, responsibility, empathy, and remorse.
- ♦ Focused treatment involves sessions to train abusers to gain control over specific acts of offending and rehearse the skills necessary to maintain recovery. The most prevalent method is relapse prevention, which works toward three goals: to increase awareness and range of choices concerning behavior, to develop specific coping skills and self-control capacities, and to create a general sense of mastery or control (Pithers and Cumming, 1995). Another focused method is counterconditioning.
- ♦ Behavioral supervision allows caregivers, family members, and/or community supervision personnel to monitor and control abusers' everyday living environment to minimize their opportunity to reoffend and teach them internal control in a progressive and safe manner.
- ♦ Case management involves managing interventions along the continuum of care to ensure accountability and participation in offense-specific treatment and maintain offenders' placement in the least restrictive safe settings.
- ♦ Medication is used in about half of programs in conjunction with other methods (Burton and Smith-Darden, 2001). Antidepressants are often used. Some offenders are prescribed antiandrogens, which act to reduce sexual urges in the most compulsive offenders.

Sex offender treatment programs typically focus on three clusters of goals (Hamill, 2001). The first is offense-specific and involves analyzing the abusive behavior and learning how to interrupt the chain of thoughts, feelings, stimuli, and behaviors before they lead an offender to commit another offense. For example, using the relapse prevention model (Pithers et al., 1983), the offender breaks his offense cycle into four phases: buildup, acting out, justification, and pretend-

normal. After the offender identifies the offense cycle, he develops a safety plan so he can recognize and avoid a reoffense. In the pretend-normal phase, the offender identifies skill deficits, habits, and sources of emotional imbalance in his life.

The second cluster of goals focuses on teaching important life skills that allow offenders to meet their needs in an adaptive, legal manner. The third cluster of goals focuses on trauma resolution. Although they cannot change their personal histories, clients can find ways to lessen the impact of traumatic experiences and regain control over the direction of their lives.

Many States offer a full continuum of care to meet the needs of juvenile and adult sex offenders. Options include foster care with outpatient sex offender treatment, community supervision, specialized residential group homes, independent living programs, residential treatment centers, medium or maximum security training schools, partial hospitalization, inpatient psychiatric hospitals, correctional facilities with sex offender programs, and posttreatment support groups. A specific comprehensive approach involving many of these systems and the family, called multi-systemic treatment, has been developed specifically for juveniles (Henggeler et al., 1998).

About three-fourths of all clients are treated in community programs, often court sponsored, and the remaining fourth are in residential programs, most in prison (Burton and Darden-Smith, 2001). The majority of adults are in treatment for more than 2 years, and most adolescent treatment lasts from 12 to 24 months. Residential programs have about twice as many group sessions and 30 percent more individual sessions than community programs. Across all settings, adults in treatment outnumber adolescents by four to one. Adult rapists and pedophiles/child molesters are more likely to be treated in residential programs; adult incest offenders are more likely to be treated in community programs. Juvenile offenders are found in about equal rates across residential and community programs.

Reducing Attrition

Domestic Violence

One of the greatest challenges in working with men who batter is increasing their motivation for treatment. They have attrition rates higher than mental health outpatients (Daly and Pelowski, 2000). One rationale for a coordinated communitywide response that includes criminal justice sanctions is the belief that it will keep the men in treatment. Most available evidence does not support this contention, but the evidence is not based on rigorous research (Daly and Pelowski, 2000). Some evidence shows that criminal justice mandates may help keep younger, less educated men in treatment (Saunders and Parker, 1989).

In one study, court-referred men had higher completion rates than self-referred men for a 20-session program but not for programs of 7 or 10 sessions (Rosenbaum, Gearan, and Ondovic, 2001). One problem with studies of court-mandated treatment is that the consequences for noncompliance were either not reported or administered unevenly. One study showed that "attendance checking" by partners or legal/social service personnel was associated with continuation in treatment (DeHart et al., 1999). Mandatory court reviews may also reduce attrition. In one

jurisdiction, monthly court reviews appeared to decrease attrition from 52 to 35 percent (Gondolf, 2000b). Most studies find that those with less education and who are unemployed tend to drop out at higher rates than those who are employed and with more education (e.g., DeMaris, 1989; Rooney and Hanson, 2001; Saunders and Parker, 1989). The educational level of materials used in treatment programs may help explain some clients' resistance.

One method for improving retention is the use of a marathon orientation group (Tolman and Bhosley, 1991). One marathon group studied was held over a day and a half (12 hours total), and participants were provided with an overview of upcoming treatment and taught some concrete skills. Men were assigned randomly to the marathon group or to normal orientation groups, which consisted of four hourly sessions over 4 weeks. Normal orientation provided support, taught timeout from anger, and allowed brief practice of cognitive-behavioral methods. The men in the normal orientation groups had significantly higher dropout rates than those in the marathon group.

Another innovation for overcoming resistance facilitated the development of compassionate feelings in the first group session (Stosny, 1994). The men received a presentation on how compassion is incompatible with aggression. They viewed a video, "Shadows of the Heart," which depicts a resistant, court-ordered offender in his first session. The video then switches to a scene of the offender as a child witnessing his father's violence against his mother. Those in groups with the 20-minute video and related discussion were more likely to be active in group sessions, take optional homework, and stay in treatment.

Methods for improving attendance based on more traditional approaches have relied on supportive phone calls and handwritten notes from therapists at the outset of treatment and after missed sessions. Even after controlling for demographic variables, one study showed that these motivational enhancement procedures were related to continuation in treatment (Taft et al., 2001).

Some studies have shown that men of color are more likely to leave treatment prematurely than white men (Gondolf and Williams, 2001; Saunders and Parker, 1989) and thus may benefit from specialized orientation or treatment groups. The motivational enhancement methods described above seem to be especially effective with minority clients (Taft et al., 2001). Some evidence from qualitative studies has shown that African-American men in same-race groups feel more cohesion than those in multirace groups (Williams, 1998). However, it was not clear whether this sense of cohesion results in higher retention rates. Because unemployment and low educational level may be crucial factors in explaining lower rates of attendance by many minority men, they may need help meeting basic material needs before they can focus on treatment. One experiment compared culturally focused groups of all African-Americans, conventional groups of all African-Americans, and conventional, racially mixed groups (Gondolf, 2003). Completion rates were significantly higher in the two groups with all African-Americans; they were especially high for men with high cultural identification who were in the culturally focused groups.

Sexual Assault

As with men who batter, only a small percentage of sex offenders enroll in therapy voluntarily. Some use prevention and referral programs, such as Stop It Now (http://www.stopitnow.com), as a means to maintain their motivation for change. Following assessment, some offenders require additional interventions (e.g., polygraph testing) because of their high levels of denial and/or minimization. Winn (1996) describes the application of strategic and systemic methods to increase motivation, including challenging the offender to challenge himself, and eliciting the offender's permission to confront him about his abuse. These methods have not been evaluated.

States vary greatly in the degree to which they provide specialized sex offender treatment to incarcerated perpetrators. Most States provide prison-based treatment, but it is rarely provided in local jails. Some States (e.g., Minnesota; Huot, 1999) provide multitier systems that include correctional system equivalents of specialized residential treatment facilities. In most prisons, however, group therapy is the sole treatment format.

Many convicted sex offenders who reside in the community are mandated to participate in sex offender treatment as a condition of probation or parole. Increasingly, probation and parole departments are using specially trained personnel to supervise sex offenders. Typically, these personnel work closely with treatment providers and often follow the sex offender containment model promoted by the Center for Sex Offender Management (CSOM) (CSOM, 2000a; English, Pullen, and Jones, 1996). Whether these methods actually decrease attrition remains to be seen. Predictors of completion in community or residential programs include being married (Miner and Dwyer, 1995; Shaw, Herkov, and Greer, 1995), being less rigid, having more empathy for the victim (Miner and Dwyer, 1995), and having a higher reading ability (Shaw, Herkov, and Greer, 1995). Offense characteristics do not appear to distinguish completers from noncompleters. The relatively high rate of attrition among juveniles, often from treatment failure, is most prevalent among older adolescent, impulsive offenders (Righthand and Welch, 2001).

Attrition may be less of a problem in prison programs because completion of treatment is usually a prerequisite for early release or specific privileges. In one study of a prison-based program, however, only 50 percent of the offenders completed treatment (Moore, Bergman, and Knox, 1999). Completers among these prisoners were more likely to be substance abusers and have a history of nonviolent offenses and less likely to have antisocial personalities.

Assessing Dangerousness and Risk of Recidivism

Domestic Violence

Practitioners in offender programs may be required to warn or protect potential victims if lethal violence is assessed to be imminent (Hart, 1988; McNeill, 1987). They may also be asked to make predictions about the recurrence of severe violence to provide specialized treatment or recommend closer supervision. Measures of psychopathology alone are not adequate predictors of dangerousness and need to be combined with measures of past behavior and environmental indicators to be useful predictors. (Monahan, 1996).

Studies of types of offenders provide some clues for identifying the most severely violent type. These men are more likely to have experienced severe abuse in their childhoods, abuse alcohol and other drugs, be violent outside of the family, and have other antisocial traits (Holtzworth-Munroe et al., 2000; Saunders, 1994). These offenders may be the most severely violent during the relationship, but another type of offender may be the most violent at the threatened or actual breakup of the relationship and may ultimately be the most lethal. These men, with dependent or borderline traits, are the most likely to fear abandonment and may be the most likely to stalk their partners (Dutton, 1999).

Because homicide is relatively rare, it is difficult to predict, but assessment checklists have been constructed to try to identify those at greatest risk of committing homicide. Campbell's (1986) Danger Assessment instrument for use with battered women is a 15-item checklist that correlates with violence severity and distinguishes between victims who go to emergency rooms and those who do not (Campbell, 1994). The MOSAIC–20 (de Becker, 1997) emphasizes the role of survivor's intuition. One study confirms the accuracy of this intuition in predicting severe violence (Weisz, Tolman, and Saunders, 2000). Also, fatality review boards are providing useful risk indicators for homicide, including separation or attempted separation, use of firearms, prior police contacts, obsessively possessive beliefs, and threats to kill (Websdale, Town, and Johnson, 1999).

Some brief checklists are showing promise in the prediction of recidivism, including the Violence Risk Appraisal Guide (Hilton, Harris, and Rice, 2001) and the Domestic Violence Screening Inventory (Watterworth et al., 2000). Other risk assessment tools for recidivism are longer. The Spousal Assault Risk Assessment Guide (Kropp et al., 1999) uses reports from many sources, including interviews with offenders and victims, official records, and standardized tests. There is some support for its predictive ability (Grann and Wedin, 2002; Kropp and Hart, 2000). The Domestic Violence Inventory relies on a questionnaire administered to offenders and contains the following subscales: truthfulness, alcohol, control, drug, violence, and stress coping (Risk & Needs Assessment, 1996). Reviews of various instruments point out that their predictive ability is not well tested, and they seem most useful in predicting violence in the short term and in stimulating communication among professionals (Dutton and Kropp, 2000; Roehl and Guertin, 2000; Websdale, 2000).

Factors are also being identified that are associated with violence after treatment. One factor that is consistently found is alcohol abuse (DeMaris and Jackson, 1987; Hamberger and Hastings, 1990; Jones and Gondolf, 1997). Severe personality disorders are also associated with reabuse (Dutton et al., 1997a; Hamberger and Hastings, 1990; Jones and Gondolf, 1997). Not surprisingly, the chronicity (Tolman and Bhosley, 1991) and severity (Jones and Gondolf, 1997) of assaults before intervention and prior arrests (Hamm, 1991) are good predictors of assault after treatment.

Sexual Assault

Research on the prediction of recidivism by sex offenders has lead to the creation of many measures. These measures usually require the evaluator to enter information about the offender's

personal and offense history, and age, and the age and gender of the victim. Unfortunately, many risk assessment measures are not well validated, their validity is not specifically of the prediction of future behavior, or the predicted behavior is for any reoffense and not specifically for sexual offenses (Doren, 2002). It has become clear that the use of actuarial methods (combinations of risk factors specified prior to assessment) as opposed to unstructured clinical methods are increasingly accepted because they are usually more valid (Hanson, Morton, and Harris, in press). Some procedures still rely excessively on clinical judgment and are not developed enough to support legal testimony (Campbell, 2000). Nonetheless, practitioners are lending their expertise in court proceedings and therefore need to have reliable prediction instruments (Seto and Lalumiere, 2000). As of January 2001, 15 States had civil commitment laws of "1 year to life" for dangerous sexual offenders and "sexual predators" (Association for the Treatment of Sexual Abusers, 2001a). Clinical decisionmaking models have been developed to enhance accuracy for clinicians and the court (Heilbrun et al., 1998).

Among the measures used frequently in the evaluation of sex offenders is the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR) (Hanson, 1997). RRASOR uses four predictors: prior convictions for sexual offenses, nonfamily victim, male victim, and offender younger than 25. Another frequently used instrument, the Minnesota Sex Offender Screening Tool–Revised (MnSOST–R), assesses a wider range of variables and predicts recidivism over a 6-year period (Hanlon, 1999). MnSOST–R incorporates dynamic (changeable) variables with static (unchanging) variables. A newer measure is the Static–99 (Hanson and Thornton, 1999), a 10-item scale that combines elements of RRASOR and a second instrument, the Structured Anchored Clinical Judgment. Another promising measure is the Structured Risk Assessment–1999, which combines the Static–99 items and items that assess several "dynamic" factors, or those subject to change. Among the variables that are most predictive of reoffending are a prior conviction for a sex offense, noncontact sex offenses (e.g., exhibitionism, voyeurism), a prior conviction for a use-of-force offense, a victim who is unrelated to the offender, a victim who is a stranger, a male victim, an offender who is single, and an offender who is under the age of 25 (Hanson and Thornton, 1999). Prediction might be enhanced by specifying the type of sexual offense. For example, although younger age of the offender is generally a predictor, the relationship holds primarily for rapists and does not hold for extrafamilial child molesters (Hanson, 2002).

The Sexual Offender Risk Appraisal Guide (Quinsey, Harris, and Rice, 1995; Seto and Lalumiere, 2000) uses general criminal history, a psychopathy measure, a physiological measure of sexual deviance, and other indicators. Its development revealed the importance of including many years of posttreatment followup and making separate predictions for violent and nonviolent offenses and for rape and child molestation. The Hare Psychopathy Checklist is an important part of the Risk Appraisal Guide and has seen increasing use in sex offender evaluations. It has been used to classify offenders more accurately (Seto and Barbaree, 1999). Hanson and Bussière (1998) conclude from their analysis of 61 datasets that no single factor should be used in isolation and that previous sexual offending and deviant sexual preferences are the best predictors of future sexual offending (see CSOM, 2001b, for a recent review). A study of the predictive validity of the above measures showed that the Sex Offender Risk Appraisal Guide, the RRASOR, and the Static–99 were the best predictors of sexual recidivism (Barbaree et al., 2001).

The Psychopathy Checklist-Revised was not an accurate predictor of sexual recidivism. Some reviews of risk prediction measures conclude that more development is needed of the dynamic factors that are possible to change and thus reduce risk (Craig, Browne, and Stringer, 2003a; Hanson, Morton, and Harris, in press). For example, there is evidence that intimacy deficits and attitudes tolerant of sexual assault go beyond the static factors in predicting recidivism (Hanson, Morton, and Harris, in press).

Because many sex offenders are not honest about the nature of their sexual interests, some physiological measures were developed that are difficult to fake. The penile plethysmograph was designed to obtain information on an offender's degree of sexual deviance and risk of recidivism. The plethysmograph measures changes in penile tumescence as sexual arousal increases in response to a set of stimulus slides. However, the use of this method has been criticized for lack of standardization (Howes, 1995). Several researchers have identified other shortcomings, including low test-retest reliability (e.g., Howes, 1995; Simon and Schouten, 1993). More recently, the Abel Assessment for Sexual Interest was developed to measure an offender's viewing time as he watches a standard set of stimulus slides. Both the plethysmograph and the Abel Assessment for Sexual Interests provide examiners with information about subjects' sexual interests but not necessarily what offenses they have committed.

The polygraph is another tool to help uncover offenders' sexual interests, even though it cannot be used in court to verify criminal history. A polygraph evaluation can address the honesty of a client's stance regarding the current offense; and whether he is in compliance with his conditions of probation, parole, or safety plan, and the degree to which his written personal history of sexual acting out is exhaustive. With respect to this last use, offenders are required to list all sex offenses they have committed and then are given a polygraph evaluation to determine whether the list is complete. Treatment plans can be redesigned if other offenses are revealed. Several States now mandate that sex offenders take polygraph evaluations as a regular part of their treatment/supervision program.

Assessing and Addressing Complicating Factors: Domestic Violence and Sexual Assault

Programs vary greatly in the extent to which they assess for possible complicating factors, such as illiteracy, suicidality, mental illness, and substance abuse (Healey, Smith, and O'Sullivan, 1998; Marshall, 1999). Some programs provide individual counseling for men with severe disorders and others refer them to other agencies. Although there may not be a higher than normal rate of severe mental disorders, some screening methods for these disorders seem essential. Measures that focus on personality disorders, such as the Millon Clinical Multiaxial Inventory, seem to be used most often because these disorders are the most prevalent among offenders. In the domestic violence field, it is not clear what percentage of men might need treatment in addition to or in place of group counseling, but some evidence shows that the percentage is small (White and Gondolf, 2000).

The Minnesota Multiphasic Personality Inventory–2, a measure of mental disorders, is widely used in sex offender programs, partly because of its ability to detect deception. A screen for neurological problems would also be advisable (Cohen et al., 1999). Practitioners seem increasingly comfortable using random urine screens to assess for alcohol and other substance abuse.

Among juvenile sex offenders, a high percentage appear to suffer from learning disabilities (Awad, Saunders, and Levine, 1984). In addition, about half have social skills deficits that contribute to heightened social isolation (Awad, Saunders, and Levine, 1984). The identification of sex offenders who are mentally retarded and/or severely developmentally delayed has lead to a proliferation of specialized techniques to address sexual perpetration issues in this population.

Culturally Competent Interventions

Domestic Violence

Williams and Becker (1994) distinguish between color-blind programs that claim that "differences don't make a difference," culturally focused programs that pay attention to historical and contemporary experiences of particular cultural groups, and culturally centered programs that place a particular culture at the center of treatment and use culturally significant rituals. For example, some programs for Native American men integrate native rituals into the treatment process. As programs become more culturally sensitive, they are offering specialized programs that give men the choice of same-race or mixed-race groups. In addition to the Afrocentric models being developed by Williams (1994) and others (Donnelly, Smith, and Williams, 2002; EMERGE, 2000), programs are available for Southeast Asian men, Native American men, immigrant and nonimmigrant Latinos, and men from other ethnic and racial groups (Aldarondo and Mederos, 2002b; Carrillo and Tello, 1998; EMERGE, 2000; Healey, Smith, and O'Sullivan, 1998).

One of the first issues that needs to be addressed for men of color is their heightened resentment toward the criminal justice system—and society as a whole—for the racial discrimination they have suffered. The EMERGE program in Boston has learned that a nonconfrontational, Socratic approach seems to work best for clients from particular cultures. EMERGE staff also learned to appreciate the diversity within particular cultural groups (Healey, Smith, and O'Sullivan, 1998).

Beyond specific interventions, the entire organizational structure and climate of intervention programs may need to change. Williams and Becker (1994) point out that more than training and information are needed. Efforts must be made to network with the minority community and consult with experts on minority clients. Evaluations of these efforts will provide guidance on working with minority clients.

Sexual Assault

Similar gaps in culturally competent programming have been found in the sexual assault field. One group of practitioners from diverse cultures (Jones et al., 1999) points out that current models of sex offender treatment have developed within Anglo cultural frameworks. They

describe the institutional racism, professional and individual ethnocentrism, and emotional reactions to the “race issue” that are barriers to cross-cultural knowledge. During assessment, practitioners need to be aware that most psychological tests have not been normed on minority clients and racial bias can exist even with interview checklists that would seem to remove bias (Barrigher, 1997). Mistrust of the dominant culture, help-seeking patterns in collectivist cultures, and subcultural communication styles might better explain resistance to treatment by minority clients than intrapsychic mechanisms (Lewis, 1999).

Evidence similar to that shown for Afrocentric groups for domestic violence offenders shows that blending traditional Aboriginal healing methods with contemporary approaches improves retention in treatment (Ellerby and Stonechild, 1998). The success reported in outcome studies might be even higher if the cultural and world views of all clients were supported by the treatment model and clinicians’ knowledge base (Jones et al., 1999). Fortunately, many new programs address diverse cultural backgrounds (Lewis, 1999; Marshall et al., 1998).

Jones and colleagues (1999) specify the organizational changes, diversity training, and specific assessment and treatment methods that can enhance an agency’s response to diverse client groups. Model sex offender programs exist for Native Americans (Ellerby and Stonechild, 1998; Ertz, 1998; Wyse and Thomasson, 1999), African-Americans (Jones et al., 1998), and Hispanics (Jones et al., 1998), and general guidelines exist for treatment of all of the above groups and others (LaClaire, 1999). Because minority clients are overrepresented in programs, Jones et al. (1999) specify steps for evaluation studies, including qualitative information on cultural initiatives, and culturally relevant outcome measures.

Judging the Quality of Domestic Violence and Sexual Assault Program Evaluations

Because program evaluation in this area is still in its infancy, practitioners may want suggestions for judging the quality of future evaluations. (For past discussions of problems with evaluation studies, see Gondolf, 1997, 2001; Hamberger and Hastings, 1993; Holtzworth-Munroe, Beatty, and Anglin, 1995; Marques, 1999; McConaghy, 1999; Rosenfeld, 1992; Tolman and Edleson, 1995.) The following questions seem important to ask.

Outcome Measures

How comprehensive is the set of outcome measures? Does the set of outcome measures go beyond physical or sexual abuse to include other aspects of functioning? Does the study report a reduction in violence, the rate of complete cessation, or both? Intermediate goals might be based on men’s self-reports if they are adjusted for impression management, self-deception, and other forms of response bias, or physiological measures or role-play tests might be used, which are less subject to response bias. Some evaluations of domestic violence and most of those of sexual abuse programs continue to rely on official reports of recidivism, which are likely to show only the “tip of the iceberg” of actual reabuse (CSOM, 2001b). In the sexual abuse field, some attempts have been made to develop statistical models to estimate unidentified recidivism

(Hanson, 1998). Serious underestimation of offending occurs when only conviction or incarceration rates are used and when followups do not extend for many years (Aldarondo, 2002; Prentky et al., 1997). The reliance on official reports can be offset somewhat with followup periods spanning many years. Across studies, recidivism may be defined in a variety of ways, for example, as any probation violation, a repeat sexual offense, or a repeat offense of any type. In both the domestic and sexual assault fields, debate exists over whether some relapse should be considered normal or whether absolute criteria of success are needed.

Treatment Integrity and Practitioner Competence

Is there evidence that the treatments proposed were the ones that were delivered? Treatments might be standardized through the use of a manual or with close supervision. Experimental tests of "pure" approaches that show good treatment integrity and positive outcomes, however, may be difficult to implement or prove effective in routine clinical programs that are more eclectic. Attention also should be paid to the quality of the treatment, sometimes assessed through ratings of practitioner competence in delivering the service. Such assessments are superior to making assumptions based on leader experience or education.

Attrition

Does the report include information on attrition before, during, and after treatment? Attrition might occur between referral and the first intake session, during the assessment phase, and during treatment. Extremely high rates of attrition limit the generalizability of findings and may indicate that only the "cream of the crop" entered or completed treatment. Screening out many cases of severe violence would have a similar effect. If two or more treatments are compared, different rates of attrition or attrition for different reasons may be found. Such attrition changes an experimental design into a quasi-experimental design.

Comparison Groups

Were comparison or control groups used? Firm conclusions are impossible if the design does not include a comparison group. Experimental designs are touted as the most rigorous, yet in real-world settings, field experiments nearly always become quasi-experimental because of attrition and other factors. A case can be made for alternatives to experimental designs that consider contextual factors (Gondolf, 2001) and that are ethically and practically more feasible (Marshall, Anderson, and Fernandez, 1999). It is not surprising that knowledge accumulation in this field is slow. Researchers face complex practical and ethical dilemmas (Gondolf, 2000a; Saunders, 1988). Fortunately, the rigor of research seems to be improving, while also improving safety for survivors and their children (Gondolf, 2000a).

Outcome Studies

Domestic Violence

More than 30 studies on program effectiveness exist, but few have rigorous designs that allow for firm conclusions (see also reviews by Aldarondo, 2002; Babcock, Green, and Robie, in press;

Davis and Taylor, 1999; Gondolf, 2002; Tolman and Edleson, 1995). More rigorous evaluations tend to use experimental designs[1] and longer followup periods (e.g., 1 to 4 years). Interview completion rates of 80 percent or more with offenders' partners are becoming more common. In addition to physical abuse, measures increasingly include sexual and emotional abuse, stalking, fear of abuse, relationship equality, parenting skills, safety of children, economic support by the offender, and other variables (Saunders, 1996a; Tolman and Edleson, 1995).

Early nonexperimental evaluations of cognitive-behavior/gender resocialization groups, which could not rule out nontreatment effects, showed promise for changing attitudes about gender roles, reducing anger directed at the partner, and decreasing child abuse (e.g., Hamberger and Hastings, 1990; Saunders and Hanusa, 1986; for reviews, see Hamberger and Hastings, 1993; Holtzworth-Munroe and Stuart, 1994; Rosenfeld, 1992; Saunders and Azar, 1989; Tolman and Edleson, 1995). Some studies adjusted offenders' reports of attitudes and emotional problems to correct for the tendency to respond in a socially desirable manner (Saunders and Hanusa, 1986; Tutty et al., 2001). Several studies compared treatment completers and noncompleters (e.g., Dutton et al., 1997b; Edleson and Grusznski, 1988; Hamberger and Hastings, 1988) and generally showed recidivism rates to be higher for noncompleters. However, as described earlier, completers and noncompleters are likely to differ on their motivational levels and important demographic characteristics.

Five of the quasi-experimental studies used reports of official records that, unlike victim reports, are likely to underestimate greatly the actual rates of violence (e.g., Aldarondo, 2002; Rosenfeld, 1992; Saunders, 1996b). Significantly lower recidivism rates were found for the treated groups (Babcock and Steiner, 1999; Chen et al., 1989; Dutton, 1986; Palmer, Brown, and Barrera, 1992). Comparison groups included men who lived too far away, had the wrong schedule, or were "unsuitable"; untreated offenders selected randomly from municipal court records; and a "wait list" control group. The treatment effect reported in one evaluation was not significant when controlling for prior charges and other variables (Chen et al., 1989). In contrast, another study found that treatment effects were maintained after controlling for prior arrests and demographics when considering only those in chemical dependency treatment; however, the initial effects of treatment did not hold after controlling for these variables (Babcock and Steiner, 1999). One study did not include a nontreated comparison group but instead compared four programs that ranged from 3 to 6 months and had different orientations (cognitive-behavioral, humanistic, profeminist, and eclectic) (Hanson and Wallace-Capretta, 2000). Arrest and conviction rates did not differ across the programs.

Other quasi-experimental studies relied on partner reports.[2] Harrell (1991) assessed the impact of three cognitive-behavioral programs (ranging from 8 to 18 sessions) combined with arrest and probation, which were compared with arrest and probation alone. Abuse reported by partners and the men's self-reported attitudes did not differ between the programs and the combined conditions. Gondolf (1997, 1999, 2000c) conducted a large-scale, quasi-experimental comparison of programs in four different cities with followup extending to 30 months. The programs differed by length (3, 6, and 9 months), whether they were pretrial or postconviction, and by levels of additional services for men and women. No major differences were found across the four

systems. The 9-month, more comprehensive program had the lowest rate of severe assault; however, injury level and nonphysical abuse did not differ across the sites. Statistical controls for demographic and violence variables did not change these results substantially. As in other studies, completers had lower recidivism rates than dropouts. The men reported that methods such as “timeout” and self-talk helped them the most to avoid being abusive (Gondolf, 2000d); the certainty and severity of sanctions were not related to dropout or reassault rates (Heckert and Gondolf, 2000).

Several experimental evaluations have been conducted. Edleson and Syers (1990, 1991) conducted the first experimental comparison of men’s groups They compared semi-structured self-help groups, a structured educational model, and a combination of the two. Sixty percent of the men or their partners were interviewed 6 months after treatment but only 46 percent were interviewed at 18 months posttreatment. The differences between groups for physical abuse and terroristic threats, based on reports by the men’s partners, were not significant.

Saunders (1996a) compared a feminist-cognitive-behavioral model with a process-psychodynamic model in a randomized experiment. No differences were found in the 20-session programs on victim reports of violence, fear, general changes in their partners, or relationship equality at 22 or more months after treatment. As predicted from research on typologies, offenders with dependent personalities had significantly lower rates of recidivism in the process-psychodynamic groups; those with antisocial personalities had lower recidivism rates in the structured, feminist-cognitive-behavioral groups.

Davis, Taylor, and Maxwell (2000) compared court-mandated treatment with a community service control condition. Treatment lasted 39 hours over either 8 or 26 weeks and the community service lasted 40 hours. At 6 and 12 months after treatment, the 26-week condition had significantly lower rates of criminal justice incidents than the 8-week or control conditions. Reports from victims showed a similar pattern, but the differences between the treatment conditions were not significant. Controlling for demographics and arrest history produced the same results. A time-to-failure analysis also showed the superiority of the 26-week condition.

Feder and Forde (2000) compared men assigned randomly to 6 months of treatment and 1 year of probation with men on 1 year of probation only. No significant differences were found between these conditions in the average frequency of violence reported by offenders or victims. However, only 22 percent of the victims were interviewed at followup. Posttreatment rates of violence were not reported separately, but a multivariate analysis indicated that number of sessions attended was associated with lower probation violation and arrest rates. Overall, no differences were observed between the conditions in rates of probation violations and arrests. The strengths and weaknesses of the Davis, Taylor, and Maxwell and the Feder and Forde studies are reviewed in more detail elsewhere (Gondolf, 2002; Jackson et al., 2003).

Studies comparing couples groups and men’s groups have begun to appear. Brannen and Rubin (1996) studied court-ordered, intact couples who wanted to remain together. They were randomly assigned to either gender-specific or couples group treatment, each lasting 12 sessions. No

differences were found in treatment outcome overall. However, the couples group had better outcomes for cases involving alcohol abuse.

O'Leary, Heyman, and Neidig (1999) also compared gender-specific (men's and women's groups) and couples groups. Only volunteer, intact couples and women who reported no injuries or fear of abuse were included in the study. The women in the gender-specific condition attended a women's group. Significant reductions in physical and psychological abuse were found for both treatments, but they did not differ from each other on these and other outcomes. This study and the Brannen and Rubin study were limited because of their small sample sizes and because findings can be generalized only to those who meet the selection criteria.

In contrast, sample sizes were large in an experimental comparison of treatments involving Navy men and their partners (Dunford, 2000). The study looked at more than 300 cases of completed posttreatment interviews with each of four randomly assigned conditions: cognitive-behavioral men's groups, cognitive-behavioral "quasi" couples groups, rigorous monitoring, and stabilization and safety. The men's groups and quasi couples groups used similar content, but the couples groups placed more emphasis on communication training. The couples' condition is labeled quasi because many of the men's partners did not attend the sessions or attended them sporadically. Rigorous monitoring involved regular safety checks with the men's partners and monthly meetings between the men and case managers. Stabilization and safety involved pretreatment screening, safety planning, and referrals for the women. This can be considered a no-treatment control condition, while the rigorous monitoring can be considered a minimal treatment control. The study achieved a high interview completion rate with the men's partners (about 80 percent) a year after treatment.

No differences were found across the four conditions after treatment on measures such as physical and psychological abuse and fear of endangerment (Dunford, 2000). There is speculation that a "surveillance effect" produced change across all conditions because the men were in the Navy and sanctions for reoffense could be severe. However, an analysis of the men's fears of sanctions did not support this contention. Any findings from this study should not be generalized beyond a Navy population, in part because Navy men differ demographically from other men and because of possible setting effects.

Across all types of evaluation designs, approximately a third of the victims report the recurrence of abuse about a year after treatment; one study that used a 30-month followup showed a 41-percent recidivism rate (Aldarondo, 2002; Bennett and Williams, 2001). When only police reports are used, recidivism rates for treated groups range from about 10 percent to 20 percent.

Recent meta-analyses, the statistical combination of many studies, concluded that the effects of treatment were small (Babcock, Green, and Robie, in press; Levesque, 1998). The treatment effects in experimental studies that relied on victim reports were particularly small. In one meta-analysis, no significant differences in average effect size were found when comparing cognitive-behavioral and feminist "Duluth style" programs (Babcock, Green, and Robie, in press). Although treatment effects overall seem to be small, this may not be too surprising because

clients are generally unmotivated and have chronic problems; medical treatments are endorsed with equally small effect sizes (Gondolf, 2002). Moreover, both the quasi-experimental and experimental studies have serious design and implementation problems. Moderate effect sizes were found in a multisite quasi-experimental study that used complex statistical controls (Gondolf and Jones, in press)

A promising avenue for further research is the matching of offender type to type of treatment. A meta-analysis of general offender rehabilitation programs showed the importance of matching (Andrews et al., 1990). Another avenue of research applies theories about the stages of development of the offender. The trans-theoretical approach, for example, assumes that the motivational stage of the offender is more important for treatment effectiveness than any particular theoretical approach. Interventions are posited as being most effective when tailored to match the "stage of change" of the offender (Begun et al., 2001). Preliminary work has been done on the development of measures and the validation of a stage process (Begun et al., 2003; Levesque, Gelles, and Velicer, 2000). Theories about stages of moral development have also been applied, but an initial test of cognitive-behavioral treatment failed to show an impact on moral reasoning (Buttell, 2001). A closely related trend is to gather qualitative accounts from victims and offenders on their perceptions of the intervention change process (e.g., Austin and Dankwort, 1999a; Gondolf, 2002; Gregory and Erez, 2002; Scott and Wolfe, 2000).

Sexual Assault

The success of sex offender treatment has been the subject of much controversy. In 1989, a major review of the outcomes of sex offender treatment programs found little evidence that such treatment had an impact on recidivism (Furby, Weinrott, and Blackshaw, 1989). The authors noted that most of the outcome studies were methodologically flawed. Critics also observed that the studies included many different types of sex offenders in different types of settings. As in the domestic violence field, critics of this review also noted that most of the programs operated in isolation, without coordination with probation and parole. Despite the criticisms of the Furby and colleagues (1989) review, it received widespread attention and is partly responsible for the popular belief that sex offender treatment is ineffective.

The results of several recent meta-analyses show promising treatment outcomes. For example, Hall (1995) included only studies conducted since the Furby and colleagues (1989) review and found a small but significant effect favoring treatment. Comprehensive cognitive-behavioral treatment was superior to behavioral treatment. Alexander (1999) found positive treatment effects for both rapists and child molesters across 79 studies. The analysis of 25 studies by Gallagher and associates (1999) found a significant effect for cognitive-behavioral treatment. The findings from these meta-analyses are weakened somewhat because they sometimes or exclusively compared completers and dropouts or compared treated and untreated offenders from different studies. In the Hall meta-analysis, removal of the dropout studies reduced the treatment effect to nonsignificance (Harris, Rice, and Quinsey, 1998). Sometimes a single study can skew the results: The Hall analysis that found support for medical/hormonal treatments was not found in the Gallagher and colleagues' analysis because one study was excluded in the latter analysis (Hanson et al., in press).

The most rigorous meta-analysis, coordinated by the Association for the Treatment of Sexual Abusers (ATSA), involved 42 studies of psychological treatment in both community and institutional settings (Hanson et al., 2002). Of those who received treatment over an average of 4 to 5 years after treatment, 10 percent committed another sexual offense, compared with 18 percent in comparison groups; for any type of offense, the rates were 29 percent versus 42 percent, respectively. For the 15 most rigorous studies, the sexual offense recidivism rates were 10 percent for the treated offenders and 17 percent for the untreated offenders. Both institutional and community-based treatments were associated with lowered rates of recidivism. Offenders who were referred out of an apparent need for treatment by clinicians had higher recidivism rates than those not considered in need of treatment.

Since these meta-analyses, a small prison-based study of cognitive-behavioral treatment (McGrath et al., 2003) tracked 195 sex offenders for an average of 5 years following their release. Treatment completers had significantly lower sexual offense recidivism (4 percent) than noncompleters (24 percent) or those who refused treatment or denied the offense (26 percent). Again, as in the review of domestic violence studies, comparisons between completers and noncompleters is likely to be inadequate (Hanson, Morton, and Harris, in press). In reviews of recent sex offender treatment studies, only a third of the studies were judged to have used sound methodological techniques (Craig, Browne, and Stringer, 2003b; Polizzi, MacKenzie, and Hickman, 1999).

Practitioners often attribute the increased success rate of interventions in recent years to a shift in treatment methodology that occurred in the mid-1980s, specifically the application of cognitive-behavioral methods such as relapse prevention (e.g., Pithers et al., 1983). In support of this belief, the Hanson and colleagues (2002) meta-analysis shows somewhat more positive results with current treatments. Relapse prevention, a widely used current treatment, has been modified from its original use with substance abusers. Although it shows encouraging results, it often is not tested in isolation (Marshall, Anderson and Fernandez, 1999); for example, building empathy for victims often precedes it (Laws, 1999). It also might work best only with those with impulse disorders (Laws, 1999). Unlike some evaluations in the domestic violence field, evaluations of sex offender treatment have not focused on effectiveness of particular types of treatment for particular types of offenders (Polizzi, MacKenzie, and Hickman, 1999).

Many programs supplement individual and group therapy with medications that lower testosterone levels. These medications provide relief to some compulsive sex offenders (Fedoroff et al., 1992; Robinson and Valcour, 1995), but their mandated use is controversial (Miller, 1998; Prentky, 1997). One review cautioned strongly against their use as exclusive treatments for sexual aggressors (Prentky, 1997).

Although many of the same cognitive-behavioral methods are used in domestic violence programs, it is not clear if the generally more positive outcomes for sex offenders are from more intensive implementation in sex offender treatment, etiological differences between the types of assaults, different research methods, or other factors. For example, relapse prevention techniques

have been used in the domestic violence field, but practitioners and researchers rarely conceptualize domestic violence as a compulsion or addiction (Bennett and Lawson, 1994).

The efficacy of treatments for juvenile sex offenders has been investigated less often because juvenile records are sealed or otherwise difficult to obtain. Since the development of programs for juvenile offenders in the 1970s, only 10 outcome studies have been published (Worling and Curwen, 2000). Of these, eight did not include a comparison group, and none had followup periods beyond 4 years. The Hanson and colleagues (2002) meta-analysis showed positive results for adolescent treatment, but only four studies met the criteria of a rigorous design. Some evidence exists that involving multiple systems is more effective than individual treatment; no evidence has been found to support a "heavy handed," correctional approach (Righthand and Welch, 2001). In particular, involvement of the family, neighborhood, school, and community through multisystem therapy focused on general offending shows promising results (Henggeler et al., 1998).

Innovations and Issues Requiring Further Research

A number of innovations are being implemented but have yet to be evaluated. Some controversial issues have also arisen that might be resolved through research. The following are some examples (for a discussion of others, see Aldarondo and Mederos, 2002a; Bennett and Williams, 2001; Rosenbaum and Leisring, 2001).

- **Prison programs.** Prison-based programs are common for sex offenders, but they are seldom used for domestic violence offenders, most likely because only a small percentage of men who batter are identified in prison populations. Some steps are being taken to develop and assess these programs (see the report from Donnelly, Smith, and Williams, 2002; Menton, 1999; Wolfus and Bierman, 1996).

- **Integrated substance abuse and offender interventions.** Integration with substance abuse services is difficult, probably because some basic assumptions about the causes of problem behaviors differ so much (Bennett and Lawson, 1994). The greatest promise might come from programs that use the same group leaders for both problem areas, such as that used by the AMEND program in Denver (Healey, Smith and O'Sullivan, 1998).

- **Attachment disorders.** Increasing attention is focusing on attachment disorders in domestic violence and sex offender treatment. Risk factor research with offenders is progressing in this area (Dutton, 1998; Prentky et al., 1989), but trauma-based interventions for attachment disorders need further development and evaluation.

- **Leader gender.** In both the sexual assault and domestic violence fields, controversies exist over the effectiveness of male-female versus male-male co-therapy or co-leadership of groups, but as yet no outcome studies have been published.

- **Treatment length.** In the domestic violence field, evidence on the impact of treatment length or intensity is inconsistent (Davis, Taylor, and Maxwell, 2000; Edleson and Syers, 1990, 1991; Rosenbaum, Gearan, and Ondovic, 2001). In the sexual assault field, many clinicians believe that 18 to 24 or more months of treatment is needed, but the impact of treatment length has not been investigated (Marshall and Serran, 2000).

- **Conjoint versus gender-specific formats.** In the domestic violence field, a significant controversy exists over these two formats. Some State standards prohibit conjoint counseling until after the offender completes gender-specific counseling and careful screening takes place (Austin and Dankwort, 1999b). Some marital clinics, abuser programs, and the studies previously cited describe screening mechanisms to ensure that women are motivated for conjoint counseling, feel safe, and have not suffered severe violence (Aldarondo and Mederos, 2002b; O'Leary, 2001).

- **Program standards.** The primary policy enhancement in the domestic violence field is the development of State and local standards. Controversy occurs in some cases because the standards may be highly specific, written into State laws, and tie government funding to program certification (Austin and Dankwort, 1999b; Geffner and Rosenbaum, 2001). Further research on many standard facets, such as treatment length and theoretical orientation, will help to inform this controversy (Saunders, 2001). Standards of practice in the sex offender field have been developed at the national level through ATSA and were recently revised and expanded (ATSA, 2001b, 2002).

Coordinated Community Response

Offender programs may hold the most promise when their efforts are combined with coordinated, communitywide efforts. Only a few studies will be mentioned here because this topic is covered in more detail elsewhere.

Domestic Violence

A major criticism of the arrest and treatment studies is that they expect too much from a single form of intervention. Fortunately, many communities have developed coordinated community response plans (e.g., Brygger and Edleson, 1986; Clark et al., 1996; Hart, 1995), and there is some evidence of their effectiveness. Three studies that used nonexperimental methods indicate that a combined intervention (arrest plus prosecution and/or treatment) is more effective than any single form of response (Steinman, 1990, 1991; Syers and Edleson, 1992). More offender involvement with prosecution, probation, and counseling was related to less recidivism in one study (Murphy, Musser, and Maton, 1998). Another study found that information sharing among agencies regarding danger assessment seemed to be useful (Shepard, Falk, and Elliott, 2002). As previously mentioned, court reviews seem to be effective in improving treatment compliance (Gondolf, 1997).

Sexual Assault

On a local level, many probation and parole units have specialized sexual offender caseloads. Intensive coordination between treatment providers and supervision personnel allows for more effective surveillance to try to prevent reoffenses; some States strongly promote this containment model (English, Pullen, and Jones, 1996). Many treatment staff work with these officers to return sex offenders to prison or a residential facility if they violate the safety plan; for example, by using alcohol or pornography. Thus far, little research has been conducted on the effectiveness of community supervision (CSOM, 2000a). Unlike domestic violence programs, collaboration with victim programs is in its infancy, whether they are rape crisis centers, child advocacy centers, or other victim programs (CSOM, 2000b).

Every State now has sex offender registries and mechanisms for community notification. Information is usually compiled by treatment providers about an offender's modus operandi, preferred victims, and offense strategy. A number of implementation problems from community perspectives have been noted (Walker, 2001). The costs to the criminal justice system are high, and the pressures on offenders also need to be examined (Zevitz and Farkas, 2000). Research on notification is sparse: One State found little impact on recidivism (CSOM, 2001b). ATSA believes that notification should be made only for those offenders who are judged to be at the highest risk to reoffend (ATSA, 1996).

On State and national levels, professionals often join together in multidisciplinary training and support organizations. Training and research has been facilitated by ATSA. By coordinating research and providing professional training, ATSA has become a vital force in attempting to improve sex offender treatment services. The U.S. Department of Justice created the Center for Sex Offender Management, an information and training resource center that provides funding for innovative projects designed to reduce recidivism and improve community safety.

Conclusions

Both domestic violence and sexual assault programs rely heavily on cognitive-behavioral groups. Despite an accumulation of studies evaluating programs for domestic violence offenders, rigorous studies are few and firm conclusions cannot be made yet about intervention effectiveness. The meta-analyses of outcome studies on sexual assault offenders appear to offer more promising results. Among the limitations of these analyses, however, are the heavy reliance on nonexperimental designs and on official records of recidivism as the outcome measure. Practitioners can be alert to the strengths and weaknesses of current and future evaluations.

A promising avenue for research is the matching of offender type with the type of treatment. It is difficult to evaluate many programs in both areas because of high attrition and other implementation problems. Outcome research may show more positive results in the future if treatments can be implemented more diligently. Fortunately, innovations yielding some promising results are appearing for the common problem of treatment attrition. Another promising development is increased attention to training in cultural competence and use of culturally specific interventions.

Systemwide coordination may provide the key to the most effective intervention for both sex assault and domestic violence offenders. Eventually, the most dangerous offenders might be reliably identified and placed into special intervention "tracks." However, the greatest hope for ending violence against women may come not from interventions but from primary prevention initiatives in which offender program staff and clients can play important roles.

Notes

1. Experimental designs randomly assign offenders to one or more treatment conditions and a no-treatment or minimal treatment control condition. Quasi-experimental designs compare treatment conditions with groups that were not randomly assigned and may try to equate their baseline characteristics through statistical procedures or matching. Nonexperimental designs usually measure change from before to after treatment and cannot rule out nontreatment causes of change.

2. A study in Great Britain combined data from two similar 6-month court-mandated offender programs and compared them with data from untreated offenders (matched on relevant variables) who received criminal justice sanctions (Dobash et al., 1999). Only 86 of the original 932 cases were included in this analysis, however.

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