From Culture Clash to New Possibilities: A Harm Reduction Approach to Family Violence and Child Protection Services

Aron Shlonsky, MSW, MPH, PhD
Colleen Friend, PhD, LCSW
Liz Lambert, MSW

This article examines the separate but sometimes overlapping foci of domestic violence (DV) and child protection services. When these sectors interact, the resulting tension becomes part of a complex dialectic and multiple opposing propositions that are explored here with respect for how they affect practice. A review of 30 years of DV discourse leads to systematic examinations of the DV literature for battered women, mental health, children, and offenders. The article proposes a radical shift by pairing a harm reduction approach with an evidence-based practice model when DV and child protection intersect. The implications of Stage of Change theory are considered in relationship to the harm reduction approach. [Brief Treatment and Crisis Intervention 7:345–363 (2007)]

KEY WORDS: Domestic violence, Child maltreatment, Child abuse, Harm reduction, Evidence-based practice.

Fundamental assumptions guide philosophies of care, and these beliefs are called into question when challenged by opposing frameworks. Such is the case with child protection service (CPS) and domestic violence (DV) service. Each system assumes a primary victim protection mandate:

(a) CPS to protect children from further maltreatment at the hands of their birth parents or homes in which they are placed and (b) DV to prevent primarily women from further victimization at the hands of an abusive partner. This, then, is the foundation upon which services are developed and delivered. Yet moving forward from these base assumptions generates tension both within and outside their respective systems. For CPS, the protection of children occurs within a legal framework that while it also strongly considers parental rights and strengths, there is the ultimate authority to remove the child (Pecora, Maluccio, Whittaker, Barth, & Plotnick, 2000) and a fairly well-developed ideological stance that economic and social disadvantage are the root cause of child maltreatment (Lindsey,
For DV, the protection of individual women occurs within the context of a mandatory arrest and prosecution system that looks to find the primary aggressor, but the overall protection of women occurs within the context of a fairly well-developed feminist ideology that places the blame for interpersonal violence on the unequal power differential between men and women. Often these cases go unreported and, for better or worse, women in such situations are left only with the private protection of the extended family, friends, community, and other social supports.

The tensions and unresolved issues within each system are magnified when the two sectors are forced to interact with one another over cases they often have in common (Alaggia & Vine, 2006). Women’s involvement in violence (not merely as responders, but as initiators) is well documented (Hamel, 2006; Straus, 1999), yet this seemingly intractable finding is at odds with the dominant DV advocacy paradigm which views women only as victims (Dutton, 2005). This duality of beliefs and approaches to service provision has caused tension between CPS and DV advocates. Even within the DV advocate ranks, there are different theoretical viewpoints. For DV services, the intrusion of children’s services may mean that the victim of battering is defined as someone who fails to protect her own children (Hartley, 2004). For CPS, the primary victim is not the woman but the child. These differences can be seen as complex, opposing propositions that are set against each other in order to discover a more objective truth. In this paper, we will present a brief review of three decades of discourse surrounding DV and the provision of DV services in order to better understand these complexities. This discourse is then augmented with critical reviews of the treatment literature for adult and child victims of DV, as well as a review of the evidence of effectiveness of batterer intervention programs. The paper ends with a philosophical framework (harm reduction [HR]) and practical methodology (evidence-based practice [EBP]), which promotes the use of evidence across disparate approaches to service.

The Discourse of Victimization

Social workers, health care professionals, researchers, activists, criminal justice professionals, social service providers, and child welfare workers have each grappled to understand and respond to the issue of DV. The professional discourse that has developed in each sector has shaped not only the way that a particular sector responds to the issue but has also influenced legislative changes, social policies, and public perception of the issue. The discourse around DV is complex, multilayered, and by no means static. From the 1970s when the women’s movement fought to have DV acknowledged as a serious social problem until now, the discourse has changed in significant ways. Because the evolution of discourse is neither a linear nor static process, we have decided not to explore it in a strictly chronological fashion. Rather, because conceptualizations of “the victim” have remained at the heart of DV discourse, we focus on this discrete and pivotal aspect.

The social movements of the 1960s that “challenged conceptions of power based on race, sex, and sexual orientation” (Miccio, 2005, 248) paved the way for the emergence of the battered women’s movement and the anti-rape movement in the early 1970s. Grassroots activists successfully battled to bring the issue of violence against women into the public consciousness, framing it as a political and structural issue arising from and perpetuated by oppression based on gender (Cary, 2005; Martin, 1976). They emphasized that women’s safety was of paramount importance (Cary, 2005) and insisted that resources be allocated to protect female victims of violence with the
provision of shelters, rape crisis lines, and other community-based programs. Along with consciousness-raising groups and campaigns, they fought for legal reform as well (Kilpatrick, 2004; Riger et al., 2002). Professionals organized themselves to understand and respond to the phenomenon of DV that had been brought into the public spotlight. At that time, DV was viewed by most professionals as a response to stress and conflict within marriages (Mears & Visher, 2005). Accordingly, interventions deemed appropriate to solve these marital problems, mostly involved couples therapy and/or individual counseling for women. However, women’s rights activists and feminist therapists later criticized these interventions because the power imbalance between the victim and batterer played out in therapy sessions, potentially leading to heightening danger and revictimization (Libow, Raskin, & Caust, 1982; Mankowski, Haaken, & Silvergleid, 2002). Often, the intention of these interventions was biased toward maintenance of the nuclear family at the expense of women’s safety and well-being (Pyles & Postmus, 2004). Although feminists fought against victim blaming, some professional discourses portrayed female victims as contributing to, or being entirely responsible for, their victimization (Libow et al., 1982). For feminists, the appalling message underlying this discourse was that battered women deserved what they got because they were aggressive, provoking, masochistic, or sexually frigid (Schechter, 1982).

In the late 1970s, intense political opposition to the battered women’s movement’s exposure of the patriarchal underpinnings of DV forced activists to downplay their feminist agendas to secure funding for shelters and other victim programs (Berns, 2001). As a result, the discourse around DV became infused with clinical, gender-neutral language that emphasized microlevel solutions to the problem (Cary, 2005). What feminists had termed “violence against women” was repositioned as “family violence” and “couples violence”; and the feminist stance that cultural and structural forces perpetuated violence against women became marginalized (Berns, 2001; Cary, 2005). These competing viewpoints were indicative of a deep divide during these years (and throughout the 1980s) between those who viewed DV as “part of a pattern of violence occurring among all family members” (Kurz, 1989, 490), known as the family violence approach (Gelles, 1979; Gelles & Strauss, 1988) and the feminist approach that identified inequality between the genders as the core issue (see e.g., Dobash & Dobash, 1979; Dobash, Dobash, Wilson, & Daly, 1992; Russell, 1982; Stark, Flitcraft, & Frazier, 1979). The former paradigm was informed by research findings indicating that men and women have very similar rates of violence. These studies, which relied on the Conflict Tactics Scale developed by Straus (1979), were used and continue to be used as evidence to support the assertion that DV is not a unidirectional, gendered issue (Hamel, 2006). Proponents of the “feminist approach,” however, argued that relying solely on the Conflict Tactics Scale gave a false representation of DV because the tool does not account for who initiated the violence, the motivation behind the violence, and the level of injury (Kurz, 1989). Although feminists continued to see women as the primary victims of DV, proponents of the family violence approach argued that women and men were equally involved, and each parties possessed some level of culpability. That is, women were both victims and offenders (Miller, 2005).

In search of an explanation for the discrepancies in the prevalence and nature of DV, researchers focused on pinpointing and isolating the causes and effects of family violence. Health care professionals became increasingly aware that some women who had experienced battering suffered from mental health issues such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Golding, 1999; Kamphuis.
Women’s experiences and responses to domestic abuse became increasingly medicalized and pathologized. Often women’s symptoms such as anger, depression, and substance abuse were mistakenly interpreted by professionals as the cause or causes of women’s problems. These symptoms were seen as explanations for why she got into the relationship or reasons she did not leave the relationship (Brown, 1992), rather than as reactions to, or the effects of, violence (Campbell, 1993). Perhaps the best illustration of this trend was Walker’s (1984) use of the term “The Battered Women’s Syndrome.” The term “battered woman,” hearkening back to the watershed article of Kempe and colleagues (Kempe, Silverman, Steele, Droegmueller, & Silver, 1962) describing child physical abuse, conjured up a notion of a victim who was weak, irrational, traumatized, and had poor self-worth (Colarossi, 2005). The portrayal of the victim as too traumatized to make rational decisions or to self-advocate fueled legal interventions such as mandatory arrest policies.

In this same timeframe through the late 1980s and early 1990s, two landmark American court cases admonished law enforcement agencies for not responding to victims of domestic assault: Sorichetti v. City of New York (65 N.Y. 2d 461, 1985) and Thurman v. City of Torrington (595 F. Supp. 1521, 1984). The latter included substantial damages awarded, prompting greater awareness on the part of law enforcement agencies in the United States. The first study to assess the effectiveness of arrest on recidivism, known as the Minneapolis Study, concluded that arrest of the perpetrator reduced future violence (Sherman & Berk, 1984) and, by 1994, mandatory arrest policies were widely adopted in the United States and Canada with legislative support such as the Violence Against Women Act of 1994. These policies created a deep chasm among feminists. Some feminists believed that these policies were the only way to keep women safe and hold men accountable; others thought they perpetuated the stereotype of the victim as incapable of making her own decisions and in need of the state to be the “arbiter of women’s lives” (Miccio, 2005, p. 322).

During the 1990s, the discourse around victims transformed. Study of Jacqueline Campbell and colleagues (Campbell, Rose, Kub, & Nedd, 1998) of female victims’ responses to DV revealed that women exhibited great resourcefulness, strength, and resilience in their resistance to patterns of violent control. In other words, women were not necessarily staying in abusive relationships because they were weak, had mental health issues, or were masochistic. Here, women shed their label of “victim,” and refashioned themselves as “survivors.” An influx of articles from the perspectives of women experiencing DV helped professionals understand that a woman’s decision to stay or to leave an abusive relationship was complicated (Pyles & Postmus, 2004). Women were forced to confront and consider many barriers including fear, emotional attachment to the abuser, economic issues, immigration status, and the well-being of their children (Health Canada, 2005). The discourse became centralized around the decisions women make to escape their abuser, end the violence, or cope with it in some other way (Johnson & Ferraro, 2000). Intervention strategies became heavily focused on empowering women to leave abusive relationships. However, whereas some women were celebrated for leaving abusive relationships, others continued to be pathologized for staying (Berns, 2004).

Wilson and Daly’s (1994) landmark examination of rates of domestic homicide in Canada between 1974 and 1992, as well as Campbell’s (1995) work, revealed that women were actually at the greatest risk of femicide after leaving...
abusive relationships. The discourse then shifted from “empowering women to leave the abuser” to “empowering women to leave the abuser but first making an appropriate safety plan.” Women who stayed in abusive relationships were labeled as “victims,” and those who left were labeled as “survivors.” This dichotomous labeling negated the possibility of the presence of both agency and oppression in women’s lives (Miccio, 2005). In other words, there was no acknowledgment of the possibility that some women may not have any desire to end their relationships. They may want to stay with their partners and hopefully develop nonviolent means of communication and interaction. These women did not necessarily see themselves as victims but as strong, independent women who were making a decision to stay in their relationship.

From the mid-1990s onwards, there has been a growing discourse on same sex partner violence and violence in diverse communities that has allowed for a deeper understanding of how different oppressions such as race, class, sexual orientation, and disabilities intersect with violence (Bograd, 1999; Cary, 2005; Humphreys, Sharps, & Campbell, 2005; Johnson & Ferraro, 2000; Pyles & Postmus, 2004; Renzetti, 1989). Prior to this time, white, middle-class, married women were the stereotypical victims. For example, between 1967 and 1987, there were very few articles that acknowledged the experiences of Black battered women despite research indicating that Black women experience as much, if not more, violence at the hands of their intimate partners than White women (Coley & Beckett, 1988). An explosion of research around DV and diversity shattered previous constructions of “the victim,” recognizing the fact that victims of violence by no means constituted a homogeneous group. White, heterosexual able-bodied women were not the only ones who experienced DV. People from every walk of life experienced violence; no one was immune.

In the past 10 years, however, in response to what many scholars are calling an anti-feminist backlash, the discourse around DV has again become gender neutral, victim centered, and individualized (DeKeseredy, 1999; Johnson, 1996). The unintended consequences of this shift is that women are seen as responsible for getting into violent relationships, blamed for staying in them, and charged with the responsibility of leaving and getting treatment for themselves and their children. A clear illustration of the burden on women was the “failure to protect” concept, increasingly used to justify CPS interventions in cases of DV. The failure-to-protect concept stems from the premise that parents have an obligation to protect their children from avoidable harm (Hayes, Trocme, & Jenney, 2006). This concept essentially blames the mother for failing to remove herself and her child(ren) from the abusive situation. However, this position is limited in acknowledging that victims of DV often have few choices and that some stay in a violent situation because they may believe that leaving would put themselves and their children at increased risk of harm (Carter, Weithorn, & Behrman, 1999). The return of so-called “de-politicized” discourse around DV reinforces individual solutions to the problem but may still disempower female victims by making them feel responsible for their victimization.

The way a problem is framed is of critical importance because it shapes how we will respond to the problem. The evolving discourse on DV has, no doubt, influenced the way providers from various service sectors respond to issues of DV. Taking batterer intervention services as an example, a recent National Institute of Justice Report (Jackson, Feder, Davis, Maxwell, & Taylor, 2003) urges that, although the evidence of effectiveness of batterer intervention programs is inconclusive, it is too soon to abandon the concept. Yet it may be the right time to pursue different models of treatment. Dutton (2005)
makes the point that theories of psychopathology and attachment explain DV more completely than feminist concepts of patriarchy, yet feminist theory drives the majority of batterer’s treatment programs. This may or may not be the case, but it is an empirical question that should be explored. Other questions include the extent to which DV services and CPS can work together in the face of different belief systems, mandates, and scarce resources. Conflict in the home, ironically, created conflict in the provision of services by agencies charged with different yet overlapping missions. Service providers, academics, and other interested parties may be so entrenched in their respective systems that they are unable to quickly transition to different, more holistic approaches to care.

We propose that the discourse surrounding DV and child maltreatment move from ideology to practicality. That is, ideology and theory should not be conflated with evidence of effectiveness. Theories and discourse can guide our understanding and even generate interventions that might work, but theories should generate interventions and these should then be tested. If they do not have merit, they should be discarded. Yet Dutton (2005) claims that the staunch adherence to outmoded, ineffective batterer treatment may have less to do with ideology than with the fear of losing scarce resources. If this is the case in DV services, it may also be the case with CPS and, indeed, with academia itself. The vehement defense of funding can be compared to the rigorous defense of the opinions and findings of academics, even when findings indicate otherwise (see e.g., the debate over multisystemic therapy in Littell, 2005). In addition, academic compartmentalization is both according to discipline and philosophy. This disciplinary isolation is dysfunctional in many ways, not the least of which is that it disallows potentially valuable information from outside our respective fields. As it currently stands, we often fail to read and cite outside of our discipline and it causes us to operate from very narrow assumptions.

Children, families, and practitioners coming into contact with the CPS and DV systems are likely unaware of the ever-present conflict over mandates and variations in theoretical orientations. Unfortunately, if the field is mired in these differences rather than seeking out current best evidence and finding a way to coordinate and deliver high quality to services, children and families will likely pay the price. In order to move this discussion into practice evidence, we now turn to a review of the research.

Review of DV Services

A review of the literature was undertaken with the aim of identifying effective services for child victims of DV, adult victims of DV, and adult batterers. Database searches of Psycinfo, Medline, CINAHL, Campbell Collaboration, Cochrane DSR, ACP Journal Club, DARE, and CCTR were conducted in December, 2006 by combining key word (title, abstract, descriptors) searches of DV search terms (domestic violence OR intimate partner violence OR woman abuse* OR spousal abuse* OR batterer OR battering) with treatment effectiveness methodological filters (random* control* trial* OR RCT OR control* clinical trial* OR clinical trial* OR random* assign* OR experiment* design OR meta-anal* OR metaanal* OR meta anal*). The 612 unduplicated “hits” were then reviewed for inclusion in this paper. This literature review is not a systematic review, per se, because there were no formal, prespecified inclusion criteria for articles. Nonetheless, studies of greater methodological rigor falling into each of the three categories (child victims, adult victims, and batterers) are highlighted and supplemented with findings from other subject-specific reviews conducted by the authors.
Interventions for Battered Women

Treatment interventions targeted at abused women are diverse in terms of desired outcomes, making syntheses of study findings somewhat complicated. Although cessation or diminution of further DV may be one of the goals, also of concern are the consequences of DV. These are most often expressed as PTSD or elements thereof, depression, or other mental health problems.

In one of the larger studies trying to make sense of DV interventions aimed at decreasing recurrence of violence, Wather and MacMillan (2003) conducted a systematic review from the perspective of primary health care. Following the protocol for quality of study established by the Canadian Task Force on prevention health care, each study was categorized as good, fair, or poor. Limiting this discussion to the good and fair studies, the following conclusions were drawn:

- No study to date has shown the effectiveness of screening for intimate partner violence (IPV) where the end point was improved outcomes for women. Data about the potential harm associated with screening are also lacking.
- Although 11 studies were reviewed that claimed value for primary care clinicians in making referrals for such services as advocacy, shelter, and personal counseling, only one study met the criteria of fair and none met the criteria for ‘good.’ In that study, Sullivan and Baybee (1999) evaluated advocacy counseling after a shelter stay. Women who had spent at least one night in a shelter were randomly assigned to either receive weekly advocacy services for 10 weeks or to have no advocacy services. The intervention was focused on safety planning and accessing resources. Women in the intervention group reported three important changes: less reabuse, less violence, and improved quality of life after 2 years of follow-up. However, after 3 years of follow-up, women in the treatment group were just as likely as women in the control group to have experienced reabuse (Bybee & Sullivan, 2005).
- Currently, no high quality evidence exists regarding the effectiveness of shelter stays for decreasing future abuse.
- Among the 10 studies of batterers and couples’ treatment programs reviewed, only one study was rated as ‘good.’ Known as the San Diego Experiment, this study tested three types of interventions over a 1-year period using a sample of military personnel (Dunford, 2000). The three interventions were groups for men, conjoint groups for men and women, and a third intervention consisting of rigorous monitoring for further DV and monthly individual counseling. The control group received no treatment although partners received Safety Planning Assistance and stabilization, as did all partners in the experiment. The recidivism rate among the intervention participants did not differ from controls, but the overall recidivism rate (ranging from 3 to 6%) was noticeably low. Although certain advantages accrued to this study such as a low dropout rate and accessibility to longitudinal data, it was not clear whether these results can be generalized to nonmilitary populations.
- Community-based interventions (public education and joint law enforcement/social worker home visits) did not prompt greater awareness about DV issues or increase utilization of services.
- In the area of legal and policy interventions, the well publicized series of studies known as the Minneapolis
Domestic Violence Experiment and its successors showed mixed results. Although the original study found that recidivism rates were lower up to 6 months after arrest, results were not replicated in follow-up studies (Garner & Maxwell, 1995; Sherman et al., 1992). These conclusions raise some controversial issues. They seem to indicate that, given the current state of evidence, screening for DV in health care settings may not be advisable because services offer little or no apparent benefit in terms of preventing the recurrence of DV. The authors make a compelling case and, perhaps, mandatory screening should not proceed until effective services are generated. Certainly, the case for universal screening cannot be made without some sort of effective intervention waiting in the wings. That is, it does little good to identify a problem for which there is no solution. On the other hand, recurrence of DV may not be the only measure of effect worth considering. Specifically, interventions triggered by screening may be helpful for the mental health of women who have children because we do have effective treatment for those victims whose children have experienced DV (Groves, 1999).

Interventions Aimed at DV and Mental Health

Women who have been victims of DV need effective interventions aimed at helping them cope with the potentially traumatic psychological effects of abuse. The most prevalent psychological problem associated with interpersonal violence appears to be PTSD. Although pharmacotherapy (Stein, Ipser, & Seedat, 2006) and psychological treatments, particularly trauma-focused cognitive-behavioral therapy (Bisson, 2005), have been rigorously examined through systematic reviews and show some evidence of effectiveness, there are few carefully evaluated interventions focusing solely on PTSD as a result of DV.

There is, however, reason to believe that PTSD as a result of DV can be effectively treated using these same approaches. First, many of the subjects participating in rigorous trials were victims of sexual assault and assault (though it is unclear how many were victims of DV). Second, although there is reason for caution when employing these interventions with women who have experienced DV given the relationship between the victim and abuser, there is little reason to believe that PTSD symptoms resulting from DV are not treatable with similar approaches. Finally, some of the core elements of these interventions have been adapted for use on DV populations. For instance, Johnson & Zlotnick (2006) conducted a promising pilot of a cognitive-behavioral treatment for women who had experienced DV in the month prior to shelter admission and who exhibited PTSD or subthreshold PTSD symptoms as a result of the abuse. Although no control group was used, pre–post measures found decreases in PTSD symptomology.

Structural impediments to leaving an abusive relationship can also be addressed and may result in long-term outcomes not usually measured in clinical trials. Although the relationship between poverty and DV has been well established (Pyles, 2006), interventions have not adequately addressed this issue. Rather than long-term solutions required for economic sufficiency (i.e., employment supports such as child care and transportation, living wage employment, education, and job training), interventions have instead focused on short-term economic provisions that may be insufficient to cope with more enduring conditions (Pyles, 2006).
Interventions for Women and Children

Although awareness of the impact of DV on women has grown over the years, recognition of the needs of children in these households has lagged. In recent years, one of the most crucial issues in both the discourse and debate of this neglected topic is the effect of DV on children. Although it seems clear that children who have been injured in the context of a DV incident or specifically targeted by an abusive parent have been physically abused parents, the impact of witnessing DV (also deemed exposure) on mental health is less clear.

Some studies have emphasized children’s resiliency and the difficulty of ferreting out the effects of in-home exposure to violence from community exposure to similar violence (Edleson, 1999, 2004). Others have made a clear case that exposure to DV negatively affects children’s social, emotional, and cognitive development (Groves, 1999), thus lending support to the contention that this exposure amounts to psychological or emotional abuse. Still others have lobbied for this exposure to be seen as a “ripple effect” of the primary problem, causing secondary psychological impacts on child witnesses (Wolfe & Jaffe, 1999). We are now beginning to see that children’s reactions to overwhelming psychological stressors reside on a complex continuum. At one end, there are children with single incident traumatic events, whereas on the opposite end there are children experiencing early onset, multiple, extended, and sometimes highly invasive traumatic events at the hands of their caregivers. Children at this high end may experience what we have come to conceptualize as complex post-traumatic states or complex trauma (Briere & Spinazzola, 2005).

What is most striking about these such trauma reactions is how much of the literature does not control for child maltreatment when positing interparental violence as a cause of later problems. For example, 44% of the 220 empirical studies reviewed by Cunningham and Baker (2004) did not control for child maltreatment, despite the documented overlap between the two factors (Edleson, 2004). In 2000, a lawsuit was initiated against the New York City Administration for Children and Youth Services for their tendency to remove children who were merely exposed to parental violence (Nicholson v. Williams, 2002). Although the ultimate ruling prohibited this practice, the ACYS maintained that they only removed children after assessing each individual child for the effects of witnessing DV. Both sides agreed that the disruption caused by removing a child from their parent(s) can be a more harmful “cure” than the original problem, though this is clearly not always the case.

In their review of DV services that address trauma for both children and mothers, the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2007) found two “promising” programs that were highly relevant for child welfare. First, Child Parent Psychotherapy for Family Violence is a one-to-one treatment model that combines many theoretical approaches (e.g., psychodynamic, cognitive-behavioral, and social learning) to improve or restore the primary relationship between parent and child (ages 7 or under who have experienced physical abuse and physical neglect), with a particular sensitivity toward the child’s developmental context (CEBC). In a random controlled trial of this intervention used with a sample of families where children had been...
exposed to IPV (Lieberman, Van Horn, & Ghosh-Ippen, 2005), the treatment group showed greater improvement in child behavior problems and traumatic stress symptoms.

Second, the CEBC identified Project SUPPORT as a promising program for reducing behavior problems among 4- to 9-year-old children whose mothers seek shelter care for DV. The program provides concrete services and emotional support, as well as parenting techniques designed to help mothers better manage their child’s behavior and attend to their needs (CEBC). A small \( n = 36 \) random controlled trial of Project SUPPORT among a shelter care population found that, after 2 years of follow-up, children in the treatment group exhibited lower levels of conduct problems, had higher levels of happiness as reported by their mothers, and mothers were less likely to employ coercive child management strategies. However, the recurrence of DV was similar for both groups (CEBC; McDonald, Jouriles, & Skopp, 2006).

Although promising, studies supporting these interventions are limited, have fairly small sample sizes, and have generally been conducted by the creators of the programs. Nonetheless, these programs show potential and are bolstered by the fact that they employ strategies that have been effective in helping other populations (namely, social learning theory, and cognitive behavioral approaches), and no studies were found where children or families were harmed.

**Batterer Intervention Programs**

The development of batterer intervention programs has been quite active over the last two decades. Although the number of rigorous studies in this area is substantial, the effect of treatment has been fairly disappointing to date. Batterer intervention programs, usually offered to men as an alternative to prison or as part of a voluntary service contract (e.g., CPS service plan), generally involve fairly short-term attendance at psychoeducational groups designed to stop further violence. The most commonly used programs include feminist theory-based psychoeducational men’s groups, cognitive-behavioral men’s groups, anger management, and couples’ therapy (Babcock, Green, & Robie, 2004).

Given the large number of studies in this area with conflicting findings, a systematic review of the evidence appears warranted. However, there is much debate within the research community as to the correct inclusion criteria for such reviews and meta-analyses, specification of relevant outcomes, sources of information, and differences in these a priori designs inevitably result in variability of outcomes. For instance, the inclusion of quasi-experimental studies (as opposed to random controlled trials), failing to properly control for attrition (i.e., looking only at treatment completers rather than all who received the intervention), and including only official reports of recidivism (as opposed to victim reports) yield different results that are difficult to interpret.

There have been two major meta-analytic studies of batterer intervention programs (Babcock et al., 2004; Feder & Wilson, 2005), both of which go to considerable lengths to sort out disparate findings related to differences in study designs. Although both studies were conducted at similar times, Feder and Wilson (2005) come closest to a proper systematic review of the extant literature. Focusing solely on batterer inter-

---

3Systematic reviews involve comprehensive, prespecified searches of published and unpublished literature in a given topic area. The results are then synthesized, often using meta-analysis (combining results of like studies to generate an overall effect size). Examples of properly conducted systematic reviews can be found at the Cochrane Collaboration for medicine (www.cochrane.org) and Campbell Collaboration for social interventions (www.campbellcollaboration.org).
vention programs for men following an arrest, they provide detail on their search strategy and databases used, dates of the search (1986–2003), and make an attempt to include some of the “gray literature” (studies not published in peer reviewed journals) through searches of government and related databases as well as searches of bibliographies and reference lists. In contrast, Babcock et al. (2004) do not specify a replicable search, use only one database (PsycInfo), and are more liberal in their inclusion criteria (incorporating studies with men who were not arrested for DV).

Nonetheless, both studies found, at best, “minimal” (Babcock et al., 2004), or “modest” (Feder & Wilson, 2005) treatment effects in terms of future incidents of interpersonal violence. Specifically, Feder and Wilson found that well-controlled experimental studies using police reports had small effect sizes, whereas studies using victim report of DV had a null mean effect (meaning they were neither beneficial nor harmful). Findings from less-controlled quasi-experimental designs varied, with studies using a “no treatment” control showing an overall harmful effect and studies using a “completers only” design showed a large positive effect. Thus, synthesis of the most rigorous studies using, arguably, the most sensitive outcome indicator (i.e., experimental designs using victim report) casts serious doubt on the effectiveness of batterer intervention programs.

Few studies have compared the effectiveness of these programs to one another, instead evaluating them with respect to treatment as usual or no treatment. Nonetheless, if the treatment effect is null or very small, comparisons will likely turn up few differences between the treatments tested to date (see e.g., Babcock et al., 2004).

Building on the more rigorous Feder and Wilson (2005) study, we used basic EBP search strategies (see e.g., Gibbs, 2003), including methodological filters, to ascertain whether there have been any subsequent published studies meeting Feder and Wilson’s inclusion criteria. PsycInfo, Medline, ERIC, Social Services Abstracts, Social Sciences Abstracts, C2-Spectr, and “All EBM Reviews” (Cochrane DSR, ACP Journal Club, DARE, and CCTR) were searched for entries between 2003 and March 2007. Titles, abstracts, and keywords were searched (with wild cards) using the following search strategy: [domestic violence OR intimate partner violence OR woman abuse] AND (batter OR batterer OR battering) AND (random control* trial OR control* clinical trial OR rct OR random* assign* OR experiment* or quasi*)]. This process yielded 17 unduplicated “hits” and all but one of these were eliminated for the following reasons: simulated jury verdict (1), victim intervention program (1), critical review (1), Feder and Wilson’s (2005) meta-analysis (1), editorial (1), lack of recidivism outcome (1), animal abuse (1), Cochrane or Campbell Collaboration protocol (2), review (3), conference abstract without subsequent paper (1).

The one study (Stith, Rosen, McCollum, & Thomsen, 2004) that came close to meeting the inclusion criteria was a quasi-experimental design incorporating a small sample of men who may or may not have been arrested for DV. Couples with a history of DV were referred from service providers (e.g., probation officers) or volunteered through advertisements. Pre–post interviews were conducted and the control group (n = 9) consisted of couples that were eligible for therapy but did not choose to participate (a substantial bias). Couples were then assigned to individual couples therapy (n = 20) or multicouple therapy (n = 22) and women were followed for 2 years. Outcome measures included victim self-report using the Conflict Tactics Scale (Strauss, 1979). Although the authors report that treated couples (both individual and group) were less likely to have a recurrence of DV, recidivism was only reported for treatment completers. The authors do make
an attempt to control for loss to follow-up by conducting an intent to treat analysis (essentially, assuming all couples lost to follow-up experienced DV) and still find a significant and modest effect. However, given the bias of using only treatment completers identified in Feder and Wilson (2005) and Babcock et al. (2004), as well as the very small sample size and inclusion of a nonequivalent control group, findings from this study are somewhat difficult to interpret and do not substantially add to what is already known from these larger and other (Jackson et al., 2003) reviews.

In summary, batterer intervention programs, if they work at all, have a very small overall effect on the likelihood of future DV. Such findings are, indeed, discouraging. Nonetheless, there may be other gains made through these interventions and other programs designed to help traumatized families that are of value, and the search for more effective forms of intervention has continued.

**A HR Approach: Can It Work for Family Violence?**

Understanding is often enhanced when two seemingly disparate ideas or structures are considered together. Such is the case with DV and child maltreatment. In many ways, the two systems have found themselves at odds with one another, seemingly serving the same clients differently, each with its own ideology, standards, tools, and methods. Over time, this clash has probably been detrimental to clients served by both sectors (Hartley, 2004), perhaps creating tension and uncertainty among the very people each system is attempting to help.

This culture clash gets to the heart of how we, as academics, service providers, and the society writ large, respond to family violence. There is very limited evidence that batterer intervention programs, no matter how coercive, are more than modestly effective (Babcock et al., 2004; Feder & Wilson, 2005; Jackson et al., 2003). Placing children in foster care might improve the lives of some children by removing them from one type of harm, but this heavy-handed approach does not stand the test of our limited knowledge. Negative outcomes for youth emancipating from care (Courtney et al., 2005) and our limited ability to predict which children will be reabused (Shlonsky & Wagner, 2005), not to mention the right of parents to raise their own children, encourages us to consider all alternatives to removal first. Likewise, many abused women are unable or unwilling to leave their abusive partners, so the option of shelter care is simply not viable. Although we would all like to see the elimination of child maltreatment and intimate partner violence, is it realistic to hope that this will occur? If this is unrealistic, are programs and services that define success exclusively on the absolute elimination of family violence also being impractical? To what extent does idealism mix with evidence? To what extent does idealism, no matter how well-intentioned, lead to missed opportunities or, worse, harm?

These questions are posed to highlight the inherent inconsistencies in the current assumptions underlying DV and CM services. In doing so, an opportunity is created for introducing a more nuanced framework and corresponding method of service provision. If we cannot hope to stop all forms of abuse, does it make sense to reframe “success” in this area as being “the reduction of violence and the minimization of harm? That is, if we presume that service success lies on a continuum, with absolute success being the eradication of violence and optimal well-being (for all family members) on one end and repeated recurrence of violence and personal harm on the other, can a range of success be found somewhere between the two poles?

An explicit HR framework, as outlined by Marlatt (1998) for substance misuse services,
coupled with EBP methodology as developed in medicine by David Sackett and Colleagues (Sackett, Richardson, Rosenberg, & Haynes, 1997; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000) and more recently applied to social services (Gibbs, 2003; Gibbs & Gambrill, 2002), would radically shift service provision in both child maltreatment and DV.

The process of EBP, rather than the mere mindless application of interventions that have been evaluated as effective, involves the integration of current best evidence, client preferences and actions, and client clinical state and circumstances (Sackett et al., 1997, 2000). More than a philosophy, this approach involves a practical application consisting of a five step process: (a) posing a critical practice question, (b) a systematic search of the literature, (c) consideration of what is found with respect to client preferences/actions and clinical state/circumstances (a process that should include the client to the greatest extent possible); and (d) application and evaluation of the chosen intervention. The process of EBP can also be seen as cyclical in nature (Shlonsky & Wagner, 2005), with each problem or need subjected to the same collaborative progression. Although such an approach is potentially time-consuming, it fosters a dialogue around the issues facing clients and empowers clients to make informed choices about their lives. The approach can also easily facilitate more cooperative approaches in child welfare such as family group decision making.

The complexity of DV and CM services may also require an overarching framework that drives the generation of services and the approach taken with clients. It is not enough to find and evaluate the evidence without a thoughtful and practical approach as to how evidence is applied in each situation. Indeed, this is the most crucial step. A higher order, complementary ideological framework, HR, can guide both the search for evidence as well as the integration of services with particular client needs, and it can also expand the array of intervention options available to service providers and clients alike.

At its core, HR promotes the consideration of a range of options available to diminish harm to a client, and this would seem to include the possible harm caused by the intervention itself (e.g., removing a child from parents and community). In this vein, HR creates a set of strategies designed to encourage individuals to move toward an ideal or to at least mitigate the harm caused to themselves and others if the behavior continues (Marlatt, 1998). For instance, with substance abuse, complete abstinence is the ideal but movement toward that goal (i.e., reducing drug intake) or reducing harm associated with substance abuse (i.e., HIV transmission or driving while intoxicated) are considered successes. The model encourages choice but also insists, without stigma, that clients take responsibility for their actions. This approach has been used at individual and community levels through such programs as needle exchange, methadone maintenance, and condom distribution. Although objectors might argue that this approach encourages the very same harmful behaviors being targeted by the intervention, there does not seem to be much evidence that this is the case.

Very little has been written about a full-scale HR approach to CP or DV services, probably because it is difficult to concede that both of the following are true: children are sometimes left in harms way and the placement of children in out-of-home care can be harmful. Also, as noted earlier, the situations being addressed in child welfare move far beyond the behaviors and individual choice of the actor. That is, a traditional HR approach focuses on individual behavior and its direct consequences to the actor. Child protection largely focuses on individual behavior (parent) that directly harms a vulnerable other (child). Whereas it can be strongly argued that
Cultural, social, and economic factors influence whether a woman leaves an abusive relationship, DV may be a better fit for an HR approach in the sense that individual behavior (i.e., choosing not to leave an abusive relationship) results in harm to the actor (victim). Finfgeld (2001) argues for an HR approach in DV services, urging that the transtheoretical model of change be employed to work with individual family members at each of Prochaska and DiClemente’s (Prochasha & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, et al., 1994) stages of change (precontemplation, contemplation, preparation, action, and maintenance). Cavanaugh and Gelles (2005) call for using a transtheoretical approach according to a more refined batterer’s typology (categorizing batterers into more and less dangerous groups) in order to better manage risk. However, when children are considered, the model quickly degenerates. Nonetheless, a more rigid form of HR, where behavioral choices must conform to standards of safety for others, especially safety for children, may hold some merit.

Some HR models from substance abuse treatment might have a more nuanced approach that DV and CPS can learn from. Gruber (Gruber & Fleetwood, 2004) describes a substance use intervention program for parents that moves well beyond the solitary treatment model. This intervention involves the active reintegration of parents into their families using in-home services that address relational as well as substance use issues. If home-based treatments are a necessary adjunct to reintegrate the substance abuser back into the family, might it be the same for DV? That is, in some cases, treating the batterer might require in-home services that extend beyond simply visiting the home and making sure everything is safe. Such services would be less case management oriented and more therapeutic. Family and community resources could also be used to maintain safety and address fundamental relationship issues (see e.g., the restorative justice approach detailed in Friend, in press). Child welfare workers and DV advocates must somehow work together to generalize and maintain the, as yet, modest gains made in batterer intervention and victim treatment.

If the boundaries of acceptable behavior and risk of harm can be defined and codified, more nuanced decisions that consider all forms of harm can be made. For instance, what is the risk that a child exposed to DV will suffer harmful effects and what do these effects involve? Next, to what extent will the array of public child welfare and DV services involve both harm and benefit to the child(ren)? To the parent(s)? How might the mix of potential harm and benefit be mitigated by the type and scope of services? Is there a continuum of desired outcomes and can services be tailored to individual families to promote movement toward positive change?

To a great extent, we believe that such a philosophy of practice is already in operation at the clinical level in both DV and CP services. Clinicians, caseworkers, and advocates are well aware of many of the perils and pitfalls of the services they offer and, by the same token, they are aware of how helpful services have been to many of their clients. A seasoned helping professional comes to each interaction with a set of preconceived ideas of harm and help, and they use this rubric in organizing a treatment response. Ask any social worker who has removed children from marginal situations and, most likely, they will tell you that they worried about whether they made the right decision. If we are so sure of our services and their effect, why worry? The answer is that, no matter how good the agency or the services made available or imposed, we know that, at some level, taking action in such complicated situations where there are any number of unknowns is bound to harm someone at some point. Equally likely is the eventual harm caused by doing nothing.
The trick seems to be to weigh the potential benefit and harm of each action and to live with ambiguous results.

Unfortunately, unguided decisions are prone to many biases and errors in thinking (Gambrill, 1990, 2006; Nisbett & Ross, 1980), making them inherently unreliable. To the extent that decision aids that capture basic probabilities in outcomes can be employed, beginning with risk assessment (see e.g., Shlonsky and Friend, this issue), these inconsistencies can be limited prompting better service decisions for all involved. A HR philosophy would encourage the identification of a continuum of key goals as well as EBP, including the use of decision aids and validated guidelines. It would dictate that the harms and benefits of each intervention, in the service of moving clients along the continuum, are weighed using current best evidence.

**Conclusion**

The last 30 years of discourse have led us to the point where we need to challenge the fundamental assumptions of both the DV and child maltreatment service systems. The time has come for a coordinated, cross-sector effort to work with families and, in so doing, to bring the very best evidence to bear in these complex situations. There are, however, no simple answers. Few programs are more than moderately successful for treating exposure to DV and preventing future acts of violence. The complexity of the problem requires a nuanced approach that is somehow able to weigh the benefits and risks of doing nothing, providing coercive forms of service, providing services of unknown quality, and providing high quality, effective services. Although such an accounting may prove difficult, it is our responsibility to help our clients be informed consumers and to determine, to the greatest extent possible, the course of their lives. A HR framework that considers risk and harm on a continuum and is driven by an EBP approach holds great promise for involving clients in their own treatment and, ultimately, for reducing family violence.

**Acknowledgment**

Conflict of Interest: None declared.

**References**


