The State of Intimate Partner Violence Intervention: Progress and Continuing Challenges

Jill Theresa Messing, Allison Ward-Lasher, Jonel Thaller, and Meredith E. Bagwell-Gray

Over the past 40 years, intimate partner violence (IPV) has evolved from an emerging social problem to a socially unacceptable crime. The Violence Against Women Act of 1994 encourages state policies that focus on criminal justice intervention, including mandatory arrest and prosecution. Services offered to victim-survivors of IPV are often tied to criminal justice intervention, or otherwise encourage separation. These interventions have been seen as effectively using the authority of the state to enhance women's power relative to that of abusive men. However, these interventions do not serve the needs of women who, for cultural or personal reasons, want to remain in their relationship, or marginalized women who fear the power of the state due to institutionalized violence, heterosexism, and racism. The one-size-fits-all approach that encourages prosecution and batterer intervention programs for offenders and shelter and advocacy for victim-survivors fails to adhere to the social work value of client self-determination and the practice principle of meeting clients where they are. It is imperative that social workers in all areas of practice are aware of IPV policies, services, and laws. Social workers' challenge moving forward is to develop innovative and evidence-based interventions that serve all victim-survivors of IPV.

KEY WORDS: *criminal justice; domestic violence; domestic violence services; intimate partner violence; Violence Against Women Act*

In 1976, *Social Work* published an article identifying intimate partner violence (IPV) as an emerging social problem (Schuyler, 1976). Since that time, laws and policies to combat IPV have proliferated, social services interventions for victim-survivors and perpetrators have become institutionalized, and IPV is no longer widely socially acceptable (Pierotti, 2013). Yet pervasive patriarchal gender norms and myths about IPV continue to influence public perceptions of victim-survivors and debates about public policy, and much work remains to be done (Dragiewicz, 2008; Thaller & Messing, 2014). The purpose of this article is to examine the current state of IPV intervention, progress made in the last four decades, and continuing challenges.

DOMESTIC VIOLENCE LAW AND POLICY

Violence Against Women Act

The Violence Against Women Act (VAWA) of 1994 (P.L. 103-322) was the first U.S. federal policy implemented to combat IPV, and VAWA continues to be influential in guiding the social work and criminal justice response to violence against women. VAWA (1994), and its subsequent reauthorizations (2000, 2005, 2013), is a multifaceted policy aimed to address violence against women by declaring civil rights for victim-survivors of gender-based violence and creating new laws to protect them; funding programs and services; and providing resources, education, and training to law enforcement, judges, prosecutors, victim advocates, and other community members (Biden, 1993). VAWA reauthorizations have typically been universally uncontested, but the more recent reauthorization of 2013 was met with Republican opposition in regard to protection for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) victim-survivors; tribal court jurisdiction over cases for offenders without tribal affiliation; and an increase in the number of visas available for immigrant women affected by violence (Weissman, 2013). Despite this opposition, the bill passed (Sargent, 2013).

The strong criminal justice focus of VAWA is intended to strengthen the position of women relative to their abusers by invoking the power of the state on their behalf, yet the criminal justice focus results in relatively fewer resources for social services

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(Goodmark, 2012). For example, in 1994, VAWA appropriated approximately 62 percent of funds for criminal justice and 38 percent for social services. Whereas VAWA authorizations have nearly doubled to $3.1 billion in 2013, the proportion of funding for social services has decreased to approximately 15 percent of the total, resulting in a smaller dollar amount appropriated for social services in 2013 than in 1994.

Feminist efforts led to the adoption of VAWA, yet both feminists and antifeminists have criticized the act (Dragiewicz, 2008; Goodmark, 2012). VAWA, and the criminalization of domestic violence generally, is based on the premise that IPV is the result of patriarchy and that criminal justice intervention (for example, arrest, prosecution) for IPV will increase women's power (Goodmark, 2012). However, the strong focus on criminal justice intervention in response to IPV has been harmful for marginalized women who, for example, have reason to distrust law enforcement (Arnold & Ake, 2013). Some feminists argue that VAWA further perpetuates patriarchal control because women are compelled to cooperate with a male-dominated criminal justice system, and victim-survivors who conform to patriarchal ideals of legitimacy (for example, married, heterosexual) are more likely to be helped (Goodmark, 2012; Villalón, 2010). Men's rights activists suggest that VAWA lends undue focus to gender and patriarchy, places a premium on women's stories, and separates families (Dragiewicz, 2008). The adoption and reauthorization of federal policy condemning IPV is significant. It is important that federal legislation continue to advocate for inclusivity and increase the focus on marginalized women, social services intervention, and victim-survivors who choose to remain in their relationship.

State-Level Laws and Policies

Since the inception of VAWA, all states have strengthened the criminal justice response to IPV. VAWA makes recommendations and supports training programs consistent with their recommendations, but final decisions about laws and policies—for example, child custody, restraining orders, and consequences for crimes—are left to state law (National Task Force to End Sexual and Domestic Violence Against Women, 2012).

Arrest. Arrest policies have been implemented throughout the United States in the past three decades in an effort to hold offenders accountable through mandatory, preferred, or discretionary arrest laws. Mandatory arrest policies, adopted by the majority of states, require law enforcement to make an arrest in IPV cases in which there is probable cause, regardless of the victim's desires (Hirschel, 2008; Mills, 2003). Mandatory arrest policies were intended to remove officer discretion regarding arrest (Ammar, Orloff, Dutton, & Aguilar-Hass, 2005; Hirschel, 2008). States with preferred arrest policies maintain that arrest is the desired outcome in IPV situations where appropriate, but allow more flexibility (Hirschel, Buzawa, Pattavina, & Faggiani, 2007). The most flexible policies are discretionary arrest laws, which outline situations in which officers "may" make an arrest, but allow decisions on a case-by-case basis (Hirschel, 2008). Even in jurisdictions with mandatory arrest laws, the likelihood of arrest is about 50 percent (Eitle, 2005).

Mandatory arrest policies have been widely criticized, in part because they have led to an increase in dual arrests, or the arrest of both partners during incidents of IPV (Hirschel & Buzawa, 2009). In 2005, VAWA stated that departments receiving VAWA funds should enact policy preventing dual arrest and, subsequently, 34 states implemented primary aggressor policies intended to help police officers identify the primary offender in an IPV situation (Hirschel & Buzawa, 2012). Though dual-arrest rates have decreased, there is some indication that officers interpret primary aggressor policies as intended to assist in identifying the primary offender in the current incident, rather than throughout the relationship (Hirschel & Buzawa, 2012). Mandatory arrest laws have also been under scrutiny because, in cases in which the victim does not want her partner arrested, mandatory policies take power from the victim-survivor and give it to law enforcement, substituting the patriarchal control of a partner for the patriarchal control of the state (Cramer, 2004; Mills, 2003).

Prosecution. Similarly, mandatory prosecution policies have been implemented in the majority of prosecutors' offices. Evidence-based, no-drop policies are those in which selected cases move forward based on evidence rather than victim testimony (Nichols, 2014), and universal-filing, no-drop policies are those in which all cases are filed but most are later dropped because of lack of evidence or victim-survivor support (Davis, O'Sullivan, Farole, & Rempel, 2008). Before the implementation of no-drop policies, prosecutors demonstrated more tolerance for intimate

partner crimes than crimes against strangers (Bennett, Goodman, & Dutton, 1999). Evidence suggests that no-drop policies have led to an increase in convictions (Davis, Smith, & Davies, 2001), with prosecution rates in one study rising from 15 percent to 66 percent (Buzawa & Buzawa, 2003) and dismissal rates declining (Davis et al., 2001).

Like mandatory arrest, mandatory prosecution is criticized for removing victim-survivor self-determination and placing victim-survivors of IPV at risk of revictimization by their partners, the criminal justice system, or both (Nichols, 2014). If a woman supports arrest and prosecution efforts, she will likely fear retaliation from her partner, regardless of whether jail time is served (Dichter, Cerulli, Kothari, Barg, & Rhodes, 2011). When the criminal justice system prosecutes an offender without victim-survivor support, the victim-survivor is revictimized through her lack of agency. In some cases, women who do not cooperate with the criminal justice system have been jailed (Nichols, 2014). Moving forward without a victim-survivor's cooperation may not enhance safety. Evidence from an experimental study found that women who were permitted to drop but chose to pursue charges experienced significantly less violence on follow-up (D. A. Ford & Regoli, 1993). More recently, another study compared jurisdictions with evidence-based policies and victim-centered policies and found that women who participated in court proceedings under the victim-centered policy were less likely to report subsequent IPV (Finn, 2013). Mandatory prosecution policies can additionally have negative consequences for women who rely on their partners for health insurance, income, food, or other necessities (Dichter et al., 2011).

Domestic Violence Courts. Domestic violence courts have similarly proliferated since the 1980s and 1990s in an effort to address concerns that courts were not taking domestic violence seriously (Keilitz, 2004; Petrucci, 2010). Specialized domestic violence courts are intended to ensure that professionals (including judges) who are knowledgeable about the power and control dynamics of IPV will be responsible for criminal judgment, monitoring, and law enforcement, and additionally aim to increase victim-survivor safety through the coordination of community services and treatment programs (Petrucci, 2010). However, domestic violence courts may not be specialized enough (Coulter, Alexander, & Harrison, 2005); a national survey found that judges—even those who only heard domestic violence cases—lacked sufficient training (Keilitz, 2004). Nevertheless, in one study, recidivism rates for perpetrators adjudicated through domestic violence courts were significantly lower (Gover, MacDonald, & Alpert, 2003), suggesting that a coordinated response to IPV by specialized courts that offer IPV-specific services and supervision may have some impact in the reduction of subsequent IPV.

SOCIAL SERVICES FOR VICTIM-SURVIVORS

Domestic Violence Shelters and Services

Critics of VAWA have argued that the legislation relies too heavily on the criminal justice system and that increased investment in social services may more effectively prevent violent crimes against intimates (National Public Radio, 2012). Services for victim-survivors of IPV emerged from grassroots advocacy and empowerment movements of the 1960s and 1970s, when women became conscious of their shared experience of IPV and began creating safe houses for victim-survivors who needed to escape (Chanmugam, 2011; Stark, 2007). These safe houses became the first domestic violence emergency shelters, a service that has remained relatively unchanged, despite the changing and varied needs of victim-survivors (Barner & Carney, 2011; Stark, 2007). Today, shelters remain the primary entry point for services such as emergency and transitional housing, therapy and support groups, advocacy for the attainment of resources, and legal advocacy; shelters also commonly house crisis hotlines (Barner & Carney, 2011; Macy, Giattina, Sangster, Crosby, & Montijo, 2009). As such, women who stay in shelters receive more services than those who do not (Grossman, Lundy, George, & Crabtree-Nelson, 2010). According to the National Census of Domestic Violence Services, domestic violence agencies served 66,581 survivors in a single day in 2013, and 36,348 of those services were emergency shelter or transitional housing to provide refuge for survivors seeking safety. On that same day, 20,267 hotline calls were answered, and there were 9,654 unmet requests for services (National Network to End Domestic Violence, 2013).

Services for IPV victim-survivors vary widely, making it difficult to define what these services entail across providers (Macy et al., 2009). Perceived efficacy of formal help-seeking strategies is high, with between 67.5 percent to 79 percent of women reporting that staying at a shelter or seeking domestic violence services was helpful or made their situation better (Goodkind, Sullivan, & Bybee, 2004; Goodman,

Dutton, Weinfurt, & Cook, 2003). Ramsay et al., 2009, in their meta-analysis of 10 randomized controlled studies ($n = 1,526$), found that advocacy interventions increased social support and women's use of safety planning and services and decreased violence at 12- to 24-month follow-up. Though there is insufficient evidence that advocacy improves victim-survivors' health and well-being (Ramsay et al., 2009), advocacy and empowerment have been considered best practices in domestic violence intervention since the movement's inception, and women who feel more control over the process are generally more satisfied (Zweig & Burt, 2007). Providing women with tangible resources that allow them to become self-sufficient—such as well-paid employment and child care—may be more powerful than advocacy alone (Rollins et al., 2012). Indeed, providing community-based housing assistance to victim-survivors in a "housing first" model has shown success by establishing victim-survivors in permanent housing for up to 18 months, increasing women's perceptions of safety for themselves and their children, and allowing victim-survivors the stability to focus on goals beyond housing (for example, employment, education) (Mbilinyi, 2015).

Safety Planning. Individualized safety planning is commonly provided to mitigate the immediate and specific risks that female victim-survivors and their children face (Davies, 2009). Traditional safety plans assist victim-survivors in planning for emergencies. Comprehensive safety plans address basic needs and map a life plan by collaboratively building on the victim-survivors' strengths and successes while taking into account risk of homicide (Campbell, 2001; Davies, 2009). Although safety plans are typically thought to lead to relationship dissolution, they can also be used as a woman attempts to maintain safety within the relationship (Davies, Lyon, & Monti-Catania, 1998). Women tend to feel safer after completing a safety plan (Kendall et al., 2009), but completing a safety plan does not necessarily reduce homicide risk (Glass, Eden, Bloom, & Perrin, 2009). Safety planning and risk assessment are dynamic processes and should be revisited as a victim-survivor's risk and decisions change over time (Messing & Thaller, 2014).

Challenges Facing Services for Victim-Survivors

Professionalization. The professionalization of services for victim-survivors has brought a code of ethics and mental health services intended to empower women to regain control in their lives on an individual level (Arnold & Ake, 2013). Academic and professional training in domestic violence prepares social workers by increasing their self-efficacy in identifying abuse, assessing risk, and conducting safety planning with clients (Danis, 2004). Women have reported that shelter services closely match their needs for safety, support, basic needs, parental services, and planning for leaving a shelter (Chanmugam, 2011). However, survivors have also reported that shelters are restrictive, invade their privacy, and are similar to the controlling environments in which they experienced abuse (Haj-Yahia & Cohen, 2009). Increasing bureaucratization, the proliferation of rules (for example, chores, curfew, sobriety), and a shift to locating the problem in individual pathology may be seen as movement away from feminist tenets (Finley, 2010; Stark, 2007). Whereas many service providers adopt a hierarchal structure for administration and services delivery (that is, one characterized by power *over* rather than power *with*), those whose operations strive toward the cooperation and partnership more common to the earlier days of the movement challenge notions of compulsory power and control (Finley, 2010).

Sexual Assault. Nearly one in 10 U.S. women (9.4 percent) are raped by an intimate partner in their lifetime (Black et al., 2011). Among women seeking formal assistance due to IPV, between 26 percent (Messing, Thaller, & Bagwell, 2014) and 68 percent (McFarlane et al., 2005) report being raped by their intimate partner, making sexual assault services a necessary component of domestic violence intervention. Women who experience sexual violence by an intimate partner have exacerbated mental health consequences, including posttraumatic stress disorder, depression, and suicidal thoughts (Weaver et al., 2007). Yet there is a marked lack of attention to sexual assault services in domestic violence agencies (Macy, Giattina, Parish, & Crosby, 2010). Some practitioners argue that integration of services is unnecessary because victims of domestic violence will seek out specialized sexual assault services to better meet their needs (Macy et al., 2009). However, traditional sexual assault services may not appropriately cover the trauma that occurs when a woman's rapist is also her intimate partner, a man whom she loves and trusts. Combined domestic violence and sexual assault services can be tailored to the specific needs of victim-survivors who may have difficulty processing their sexual assault (Macy et al., 2009).

Disparities in Service Use. Heterosexism may inhibit seeking or receiving help for IPV among same-sex couples. Heterosexism manifests in harmful gender-based myths, such as the lesbian utopia (that is, women would never hurt other women) and hegemonic masculinity (that is, men cannot be abused) (Duke & Davidson, 2009). Additional barriers to help seeking among LGBTQ survivors include fear of outing, homophobia, internalized oppression, and fear of re-victimization (Duke & Davidson, 2009; McClennon, Summers, & Vaughan, 2008). Many domestic violence programs are not equipped for these challenges: One study of IPV services found that staff had little to no training in LGBTQ issues, although nearly half had assisted LGBTQ victim-survivors (C. L. Ford, Slavin, Hilton, & Holt, 2012).

In addition, victim-survivors who are ethnic minorities often face institutional barriers—such as negative stereotyping, lack of cultural competency, language barriers, and documentation status—that prevent service utilization (Bent-Goodley, 2007; Rizo & Macy, 2010). Latina women are less likely to stay in a shelter, call the police, or receive housing assistance (Lipsky, Caetano, Field, & Larkin, 2006), and African American women face challenges such as inaccessible services, a lack of cultural competence that results in stereotyping, racial loyalty (that is, protecting the community), and a fear of child welfare involvement (Bent-Goodley, 2004). Immigrant and refugee women from a diverse range of nationalities and cultural backgrounds have also reported inadequate services provision, such as a lack of translation services, unmet dietary needs, and lack of options to remain safe upon separation (Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005; Kulwicki, Aswad, Carmona, & Ballout, 2010; Pyles, Katie, Mariame, Suzette, & DeChiro, 2012).

IPV affects a range of individuals and, thus, effective intervention is not homogeneous. A culturally competent approach to IPV intervention includes understanding the reasons why some victim-survivors may choose not to leave their relationships or to seek help (Manzano, Spencer, & Arias, 2011; Sokoloff & Dupont, 2005). Victim-survivors from cultural groups that value collectivism may assign higher importance to community needs, choosing to maintain discretion and uphold traditional family configurations (Lockhart & Danis, 2010). Training is necessary to assist domestic violence advocates in understanding the particular challenges faced by marginalized victim-survivors and, in particular, those with intersecting marginalized identities.

OFFENDER TREATMENT

Batterer intervention programs (BIPs) have proliferated with the increased criminalization of IPV, as an overwhelming majority of BIP enrollees are court mandated (Family Violence Prevention Fund [FVPF], 2010; Labriola, Bradley, O'Sullivan, Rempel, & Moore, 2006). The first BIP in the United States was Emerge, established in 1977 in Boston (Adams & Cayouette, 2002); concurrently, the Domestic Abuse Intervention Project, or the Duluth model, was established in Duluth, Minnesota (Pence & Paymar, 1993). In best practice, BIPs function as one link within a coordinated community response that includes the criminal justice system, victim services, and child protective services (Price & Rosenbaum, 2009). For offenders who complete the intervention, BIPs have a modest but significant effect on recidivism (see Babcock, Green, & Robie, 2004; Bennett & Williams, 2001; Gondolf, 2012). However, noncompleters may be more than twice as likely to reoffend as those who complete the program (Daly & Pelowski, 2000; Gondolf, 2012; Saunders, 2008). Outcomes for African American and white program completers are similar (Buttell & Carney, 2005; Buttell & Pike, 2003), but perpetrators who are not white and from lower socioeconomic backgrounds are less likely to complete a BIP (Olver, Stockdale, & Wormith, 2011). High noncompletion rates have been attributed, at least partially, to lack of culturally sensitive approaches to intervention, such as those tailored to specific racial and ethnic groups (Bennett & Williams, 2001). Evidence suggests that treatment may be more effective when facilitators and perpetrators share a similar language and race or ethnicity, and when cultural influences on violence are acknowledged (Bennett & Williams, 2001; Gondolf, 2012).

DISCUSSION

The original feminist movement focused on patriarchy as the basis of IPV, vociferating against scholarship that identified women as the cause of men's violence (Goodmark, 2012). Yet, despite gains in intervention and awareness of IPV, our patriarchal social structure is a barrier to effective IPV intervention and continues to ensure that women carry the larger burden of consequences from IPV. Today, a focus on individual pathology rather than deficits in

the broader social structure characterizes the bulk of IPV interventions (Finley, 2010; Stark, 2007). At the same time, an antifeminist backlash in the form of father's rights or men's rights groups is working to reduce sanctions against IPV, particularly in the civil courts (Dragiewicz, 2011).

Despite evidence that not all men who commit IPV are the same (for example, Holtzworth-Munroe & Meehan, 2004; Johnson, 2008), criminal justice and social services interventions targeting offenders largely use a one-size-fits-all approach. Various estimates indicate that a small proportion (20 percent to 25 percent) of perpetrators account for the majority of severe and repeat IPV (Bennett & Williams, 2001; Maxwell, Garner, & Fagan, 2002), and BIPs are less effective for these chronically violent, high-risk offenders (FVPF, 2010). Risk assessment holds promise for differentiating offenders based on the level of risk they pose (Messing & Thaller, 2014). A more recent approach to batterer intervention includes assessing the perpetrator's level of risk and unique needs to determine a customized plan for confinement or rehabilitation (Lowenkamp, Latessa, & Holsinger, 2006). Courts, for example, can require concurrent substance abuse or mental health services with BIP attendance (Gondolf, 2012; Saunders, 2008). However, reducing the risks posed by men on the micro level must be combined with efforts at the macro level to advocate for reducing structural inequalities that perpetuate men's violence.

Over the past four decades, the legal system has become the core response to IPV. Social workers intervening with IPV offenders and victims are involved with the justice system on all levels—offender treatment is primarily court mandated, victim advocates are hired by or housed in police departments, shelter workers assist women in obtaining orders of protection, and legal advocacy is a component of many domestic violence agencies. There is evidence that a coordinated response to IPV can increase women's safety behaviors and reduce repeat violence (for example, Messing et al., 2014). Anecdotally, high-risk teams that bring together law enforcement and advocacy agencies to prevent homicide appear to do just that (Snyder, 2013). Victim safety is an important goal and the primary focus of domestic violence services, but these services are limited in scope and cannot address the larger social structures that condone IPV through continued gender inequality. Many victim-survivors choose not to engage in traditional services, perhaps because this system of separation-based interventions does not serve their needs (Goodmark, 2012). Moreover, women may reject interventions delivered through a "dominator model" that mirrors the situation they are attempting to escape (Eisler, 2000; Finley, 2010).

A new movement of "intersectionality-oriented feminist activists" is developing grassroots interventions to repoliticize the domestic violence movement and to serve women who have historically been underserved (Arnold & Ake, 2013). Prevention efforts within this movement address the continued need for structural change and focus on macro-level issues such as poverty (Arnold & Ake, 2013). By taking an intersectional, feminist approach to IPV advocacy and intervention, individual victim-survivors' voices are prioritized over the criminal justice system response (Nichols, 2013). When practitioners and advocates take an approach that recognizes structural and individual inequalities such as those based on ethnicity, socioeconomic status, sexual orientation, gender, ability and immigration status, there are better outcomes for victim-survivors (Nichols, 2013).

In conclusion, as practitioners seek to empower clients toward safety, they should take into account the factors affecting women's choice to sever or remain in their relationship and the many ways they are connected to their partners (for example, love, finances, children) (Davies, 2009). Safety decision aids can be used to help clients clarify their priorities and make difficult decisions (Eden et al., 2015). Victim-survivors of IPV do not choose their abuse—they want it to stop, but may want alternatives to leaving their relationship or staying in a shelter. The "housing first" model has been adopted by some domestic violence agencies to provide women with a stable alternative to either living in a shelter or with an abusive partner (Mbilinyi, 2015). It is the ethical obligation of social workers to determine the best intervention for each client, taking into account the best available research evidence, practitioner knowledge, and client self-determination (Gambrill, 2006). An evolving social services response to IPV requires that practitioners apply an evidence-based framework and develop cultural competence while continuing to challenge larger patriarchal structures that result in gender inequality. SW

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Jill Theresa Messing, PhD, MSW, *is associate professor, and* ***Allison Ward-Lasher, MSW,*** *is a doctoral student, School of Social Work, Arizona State University, Phoenix.* ***Jonel Thaller, PhD, MSW,*** *is assistant professor of social work, Ball State University, Muncie, IN.* ***Meredith E. Bagwell-Gray, MSSW, LMSW,*** *is a PhD candidate, Arizona State University, Phoenix. Address correspondence to Jill Theresa Messing, School of Social Work, Arizona State University, 411 North Central Avenue, Suite 800, Phoenix, AZ 85004; e-mail: Jill.Messing@asu.edu.*

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