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Conjoint Treatment of Intimate Partner Violence: A Cognitive Behavioral Approach

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The purpose of this article is to describe the rationale and methods of couple-based interventions designed to treat and prevent intimate partner violence. Cognitive, affective, and behavioral individual and couple risk factors for violence are reviewed, as are therapeutic concerns regarding the use of conjoint treatment. Current conjoint treatments that are intended to reduce the incidence of abusive behavior among couples in which one or both partners have engaged in forms of psychological and/or mild to moderate physical aggression, do not engage in battering or severe violence, and desire to improve their relationships and stay together are described. We focus on our Couples Abuse Prevention Program (CAPP) that compares the efficacy of cognitive-behavioral couple therapy procedures and treatment as usual at a university-based couple and family therapy clinic. Outcomes from the CAPP project and evaluations of the other programs demonstrate the potential of judiciously applied conjoint interventions for aggressive behavior in couple relationships.

Keywords: intimate partner violence; domestic violence; cognitive behavioral therapy; couple treatment

Approximately 30% of all married couples in the United States report at least one incident of violence between them (Straus & Gelles, 1990), and 1,300 deaths have occurred nationwide each year as a result of intimate partner violence (IPV; Centers for Disease Control, 2003). Although women do use aggression in rates comparable to males when a range of mild to moderate violent acts are considered (Archer, 2000; Frieze, 2005), research indicates that women are more severely victimized than men (Felson, Messner, Hoskin, & Deane, 2002) and male violence has more severe psychological and physical consequences (for a review, see Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002). Given their greater size and strength, men are more likely to inflict severe bodily harm on their female victims (Browne, 1993). In fact, national survey data indicate that each year, up to 2 million women are severely assaulted by their male partners (Straus & Gelles, 1990), and they are more likely to sustain injuries requiring medical attention (Stets & Straus, 1990).

Types of Couple Violence

There is a growing consensus that couple violence can be differentiated into the less commonly occurring *severe physical aggression* (male battering of a female partner for the purpose of dominating and controlling her, combined with relatively low-level female aggression, mostly for self-defense, and found among men court-ordered to violence treatment programs) and *common couple violence* (both partners engaging in mild to moderate physical aggression, more commonly occurring in distressed couples, and less likely to endanger the female and cause her fear; Frieze, 2005; Holtzworth-Munroe et al., 2002). Whereas even the milder forms of violence can elicit fear in both men and women and a sense of being a hostage, severe aggression is likely to be particularly traumatic and commonly deters some women from leaving the abusive relationship (Barnett, Lee, & Thelen, 1997; Towns & Adams, 2000).

Furthermore, forms of *psychological aggression* including hostile withdrawal, denigration of the partner, domination and threats of violence, and restriction of the partner's freedom and access to resources have been found to precede and co-occur with physical aggression, and the negative impact of psychological aggression on victims' psychological and physical well-being have been found to be similar to or even more severe than effects of physical aggression (Follingstad, Rutledge, Berg, Hause, & Polek, 1990; O'Leary, 2001). In addition, psychological aggression has been found to be a stronger predictor of marital dissolution than physical aggression (Jacobson, Gottman, Gortner, Berns, & Shortt, 1996). Reciprocity of verbal aggression and other forms of psychological abuse between partners is a hallmark of distressed couple relationships (Epstein & Baucom, 2002; Epstein, Baucom, & Rankin, 1993; Weiss & Heyman, 1997). Partners' use of psychologically aggressive behaviors may be developmental precursors to first instances of physical aggression. Murphy and O'Leary (1989) found that individuals' own psychological aggression predicted their first instances of violence in the marriage. Surprisingly, prior levels of marital distress were not predictive of first instances of IPV. Murphy and O'Leary concluded that the way in which couples resolve conflict, rather than solely partners' satisfaction with their relationship, is critical in understanding the development of IPV.

Thus, there is considerable evidence that many couples engage in reciprocal psychological aggression and mild to moderate levels of physical aggression. Although identification of female aggression in no way holds women responsible for males' abuse of them, researchers and clinicians need to attend to ways in which both partners contribute to an atmosphere of aggression and should design interventions that reduce all sources of violence in relationships.

Consequences of Couple Violence

In addition to physical injury, women in violent relationships are at risk for a number of physical health problems and psychological disorders. Both severe and milder physical aggression have been identified as precursors to many women's mental and physical health problems, including depression, post-traumatic stress disorder, anxiety, cognitive impairment, substance abuse, and physical illnesses (Astin, Lawrence, & Foy, 1993; Caetano & Cunradi, 2003; Campbell & Lewandowski, 1997; Cascardi, Langhinrichsen, & Vivian, 1992; Holtzworth-Munroe et al., 2002; Holtzworth-Munroe, Smutzler, & Sandin, 1997; Hoskins, La Taillade, Epstein, & Werlinich, 2004; La Taillade & Jacobson, 1997; Pianta & England, 1994; Russo, 1985). There is evidence that IPV-related physical and mental health illnesses have proliferated, particularly for women (Smith, Thornton, DeVellis, Earp, & Coker, 2002).

Children from domestically violent homes also are at elevated risk for several negative outcomes, including experiencing child abuse and experiencing behavior disorders and social and academic problems (Holtzworth-Munroe et al., 2002; Margolin, 1998). Thus, the impact of intimate partner violence on the victims, their families, and society is substantial. The cumula-

tive psychological, social, and financial costs to society have led professionals in political, legal, public, and mental health spheres to classify domestic violence as a serious social and public health problem.

Can Conjoint Approaches Address IPV?

The treatment approach most often used to address IPV involves gender-specific groups (i.e., separate men's and women's groups) focused on anger management and modification of perpetrators' personal beliefs that support the use of aggression toward partners during conflict. Research on these approaches, however, has shown that they have limited effectiveness in reducing violence; in fact, a high percentage of men who participate in such programs reoffend after treatment (Babcock & La Taillade, 2000; Murphy & Eckhardt, 2005). These programs target the most severe population of batterers, in terms of psychopathology, criminal history, severity of violence, and their ability to instill fear in their partners. This population is less likely to be amenable to establishing and maintaining treatment gains. Also, because persons who use violence against their partners tend to be heterogeneous as a group, in terms of their frequency and severity of violence, presence of psychopathology, use of violence outside the relationship, marital satisfaction, and relationship stability (Holtzworth-Munroe & Stuart, 1994; Jacobson & Gottman, 1998), gender-specific approaches are not likely to be universally relevant or effective. In fact, there is increasing consensus in the field of violence intervention and prevention that all offenders do not need the same treatment approach (Stith, Rosen, McCollum, & Thomsen, 2004).

Whereas gender-specific treatment is designed to address male batterers who engage in severe IPV and their female victims separately, for couples who report low to moderate levels of violence, tend to be in stable relationships, and do not fear each other, a conjoint approach that addresses systemic as well as individual cognitive and behavioral risk factors for IPV may be the most appropriate and effective treatment. Because relationship distress and conflict are strong predictors of IPV, failure to address these issues within the context of the couple relationship may increase the risk for violence. The many couples whose relationships are not characterized by battering but may be at risk for future violence would not be appropriate for existing gender-specific treatment programs. Therefore, it seems crucial to develop conjoint treatment programs designed to reduce prevalent psychological and physical aggression between partners.

Risk Factors for Perpetration of IPV as Targets for Treatment

In developing effective conjoint treatment programs, it is important to consider those factors that may increase the risk for IPV. Conjoint treatment approaches should include the key goals of reducing risk factors for aggressive behavior as well as enhancing protective factors against relationship violence (Coie et al., 1993). Consequently, information on the correlates of individuals' psychological and physical aggression toward significant others is essential for both assessment and planning of interventions to reduce risk of future occurrences of IPV.

Family Background and Psychological Correlates of Battering and IPV

Research examining family-of-origin variables has reported inconsistent findings, with history of child abuse victimization being an inconsistent predictor and witnessing parental violence a more consistent predictor across studies (Dutton, 1988; Gottman et al., 1995). Concerning psychopathology and IPV, personality disorders (e.g., borderline personality disorder) and other psychological problems, such as anxiety, depression, bipolar disorder, psychotic disorders,

and substance abuse, have been found to be more common in violent versus nonviolent men (Campbell, Sharps, Gary, Campbell, & Lopez, 2002; Dutton & Golant, 1995; Gottman et al., 1995; Leonard & Roberts, 1998; Magdol et al., 1997; Murphy & Eckhardt, 2005). Furthermore, a number of personality characteristics do not constitute diagnosable psychopathology but nevertheless are risk factors for IPV. Several researchers and theorists have suggested that men who are highly dependent on their partners are jealous and hypervigilant regarding potential threats to the security of their relationships, resorting to violence when they fear the loss of their partners (Dutton & Golant, 1995). Compared to nonviolent men, men who use violence have been found to score higher on measures of jealousy (e.g., Holtzworth-Munroe, Stuart, & Hutchinson, 1997) and on measures of fearful and preoccupied attachment to their partners (e.g., Holtzworth-Munroe, Stuart, et al., 1997; Murphy, Meyer, & O'Leary, 1994).

Cognitive Risk Factors for IPV

Violent men are more likely than those who are nonviolent to make attributions that their female partners' negative behaviors are due to hostile intentions, an inference that may lead men to view their own aggression as justified retaliation against a threatening partner (Holtzworth-Munroe et al., 2002). Also, males who hold beliefs that adversarial interactions and violence are acceptable in couple relationships are more violent toward their dating partners (Bookwala, Frieze, Smith, & Ryan, 1992). Similarly, verbally aggressive communication has been found to be associated with perpetrators' deficits in assertive skills as well as with tendencies to make negative attributions about a partner's motives (Epstein & Baucom, 2002). Some studies have found violent men report significantly greater assertion problems than distressed nonviolent men (e.g., O'Leary & Curley, 1986) and are more likely to attribute hostile intentions to the partners' negative actions, which may help a man to justify his own aggression as it may be seen as justified retaliation against a threatening partner (Holtzworth-Munroe et al., 2002). In addition, male abusers often provide less competent and more aggressive responses than nonviolent men when presented with hypothetical conflict situations and may be more likely to endorse hostile and adversarial attitudes toward their female partners (Holtzworth-Munroe, 2000). Southard and Epstein (2004) found that in a sample of clinic couples both females and males who blamed their partners for relationship problems and made more negative attributions about their partners' intentions engaged in more psychological aggression toward the partners, as assessed through both self-reports and observations of couple communication samples. Thus, cognitive interventions are appropriate with both members of couples who exhibit psychological and/or physical forms of IPV.

Gender Roles and Power as Risk Factors for IPV

Consistent with feminist theory, some researchers (e.g., Margolin & Burman, 1993; Straus, 1990) have posited that males' use of violence functions to establish and/or maintain power in their couple relationships. In support of this idea, some studies have found that men who abuse their partners report being more likely to use violence when they perceive themselves to be powerless and feel out of control (Stets, 1988) and that both husbands and wives in violent relationships feel more coercively controlled by their partners than do those in nonviolent relationships (Ehrensaft, Langhinrichsen-Rohling, Heyman, O'Leary, & Lawrence, 1999). Other researchers have operationalized dimensions of power in relationships—specifically, socioeconomic resources (educational attainment, income, occupational status), decision-making power, and communication behaviors (e.g., withdrawal, belligerence, use of threats)—in order to ascertain how they may be differentially related to males' use of violence. An equal distribution of socioeconomic power between partners has been associated with less relationship distress, increased ability to prevent conflict escalation, and lower risk of IPV (Goodyear-Smith & Laidlaw, 1999). Conversely, an

unequal distribution of socioeconomic power in which the husband has fewer resources than his wife is associated with increased risk for IPV (Babcock, Waltz, Jacobson, & Gottman, 1993). Babcock et al. (1993) found that, compared to distressed but nonviolent couples, males in violent relationships are more likely to demand or put pressure on their partners through criticism or complaints, whereas their female partners are more likely to withdraw in response to the male aggression through defensiveness or avoidance. The authors surmised that violent men may be using physical aggression to compensate for a perceived lack of power associated with the demander role.

Couple Interaction Patterns and IPV

In an effort to understand the process by which conflicts escalate to violence, several researchers have employed behavior observation methods to examine how the interactions of violent couples are distinct from couples whose disagreements do not result in abuse. Several consistent findings have emerged across studies. As compared to nonviolent men, during discussions of couple problems violent men display more negative behaviors, including defensiveness and overtly hostile behavior (e.g., Margolin, Burman, & John, 1989). Even when compared to men in distressed but nonviolent couple relationships, men in domestically violent relationships display more hostile and provocative forms of anger, such as contempt and belligerence (Jacobson et al., 1994). Furthermore, both male and female partners in violent relationships are more likely to engage in negative reciprocity; that is, to continue behaving negatively in response to each other's negative acts once a negative exchange has begun (Cordova, Jacobson, Gottman, Rushe, & Cox, 1993; Margolin, John, & Gleberman, 1988). Whereas wives report that their violence escalates in response to their husbands' physical and/or psychological abuse, males' violence escalates in response to nonviolent as well as violent behaviors on the part of wives, including attempts by the wife to withdraw during the argument (Jacobson et al., 1994). That is, once the violence starts there is nothing the female partner can do to stop its escalation (La Taillade & Jacobson, 1997). It is important that these gender differences in aggressive behavior be taken into account in conjoint approaches to the treatment of IPV.

Therapeutic Considerations in Conjoint Treatment of IPV

Assessment of Violence

Therapists may fail to detect the presence of intimate partner violence, because couples presenting for treatment often do not spontaneously report it as a presenting problem (Holtzworth-Munroe et al., 2002; Rathus & Feindler, 2004). Epstein and Werlinich (2003) found that only 5% of persons calling a university clinic to request couple therapy cited abuse in response to an open-ended question on presenting problems. During individual interviews about violence, however, 30% of couples reported abuse when directly questioned. Furthermore, when partners were asked individually to complete a self-report instrument describing specific forms of aggressive behavior, 60% reported at least one instance of violence in the past year. Ehrensaft and Vivian (1996) found that the most common reasons that couples seeking couple therapy did not report violence at intake were that violence was not considered a problem, that the acts of violence were infrequent, or that violence was perceived as a secondary concern that would be resolved once primary relationship problems were resolved (Holtzworth-Munroe et al., 2002).

These findings suggest that in order to increase the likelihood of detecting intimate partner violence, use of structured and multimethod assessment procedures is needed. A reliable self-report instrument that assesses a range of violent behaviors should be administered to

all couples seeking therapy. Disclosure of abuse is likely to be facilitated if partners complete self-report instruments separately and in privacy. The Conflict Tactics Scale–Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), the most widely used self-report measure of couple violence, asks individuals to report specific forms of physical violence, psychological aggression, sexual coercion, and injury perpetrated by both oneself and one's partner in the past year as well as during the course of the relationship. Given the high rate of psychological abuse in distressed couples and the fact that it may precede the development of physical abuse, a number of self-report measures have been developed that assess psychological aggression more extensively than the single CTS2 subscale. Examples of such measures include the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001) and the Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999). Self-report instruments that assess psychological and physical aggression, as well as other risk factors associated with violence, are listed in Table 1.

In addition, it is recommended that separate interviews be conducted with each partner so that both partners may feel safe in honestly discussing the circumstances that surround any and all instances of violence reported on the self-report instruments. Topics to be covered include but are not limited to the precipitants leading up to each incident, the sequence of behaviors once the incident has begun and whether such a sequence is typical of violent episodes in the couple relationship, severity of violence including any injuries sustained, what events followed

TABLE 1. SELF-REPORT MEASURES RECOMMENDED FOR CONJOINT TREATMENT OF IPV

Treatment Issue	Measure
Relationship functioning	Dyadic Adjustment Scale (DAS; Spanier, 1976) Communication Patterns Questionnaire (CPQ; Christensen, 1987, 1988)
Psychological abuse	Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001) Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999)
Physical abuse	Conflict Tactics Scale–Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996)
Individual psychological functioning	Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) Trauma Symptom Inventory (TSI; Briere, 1995) Michigan Alcohol Screening Test (MAST; Selzer, 1971)
Affective functioning	Spielberger State-Trait Anger Expression Inventory (Spielberger, 1996)
Cognitions about relationships	Marital Attitude Survey (MAS; Pretzer, Epstein, & Fleming, 1991) Styles of Conflict Inventory (SCI; Metz, 1993)
Gender roles	Provider Roles Inventory (Perry-Jenkins & Crouter, 1990) Who Does What Questionnaire (Cowan & Cowan, 1988)

the violence, potential lethality of the incident to partners, and whether the police or other outside parties were summoned as a result of the incident (Holtzworth-Munroe et al., 2002; Rathus & Feindler, 2004).

Deciding on the Appropriateness of Conjoint Treatment

Conjoint treatment is recommended if the level of violence is low to moderate and if neither partner is perceived to be in imminent danger of physical harm (Holtzworth-Munroe et al., 2002). Such approaches are most suitable for those couples who acknowledge that abuse is a problem, are willing to work toward having an abuse-free relationship, and are committed to staying together. In addition, the female partner must feel safe living with her partner and participating in conjoint treatment as well as comfortable being honest in the presence of her partner.

If it is determined that conjoint treatment is inappropriate, separate individual therapy is recommended, and both partners should be provided with referrals to other sources of help (Holtzworth-Munroe et al., 2002). For female partners, referrals to support groups for battered women and advocacy services may be warranted, as a woman in a violent relationship is often not able to consider other options until she has obtained adequate support and resources (e.g., housing, legal system involvement and protection, child care) to ensure her safety and well-being (Holtzworth-Munroe et al., 2002). Although the effectiveness of gender-specific treatment programs continues to be under question, such programs are recommended for males who use violence against their partners, given the lack of alternatives that are effective in reducing and eliminating male-perpetrated violence.

Crisis Management

Reports of severe or frequent violence necessitate immediate assessment of the potential lethality of the situation (Holtzworth-Munroe et al., 2002). If a couple experiences a violent incident between them, the therapist immediately gives them additional sessions for crisis intervention to stabilize their relationship and control the violence. Based on their response to the crisis intervention and each partner's appraisal of risk for further violence, as assessed during individual interviews, the therapist must decide whether the couple has achieved a level of control and low risk that warrants continuation of conjoint treatment. If a couple is judged to be still at notable risk for violence, it is recommended that the therapist discuss alternate treatment options with them (i.e., separate individual therapy), initiate safety planning to prevent imminent physical harm (e.g., physical separation of partners, removal of weapons from the home), and have both partners agree to a no-violence contract that can be monitored as often as needed to maintain the safety of both partners (Rathus & Feindler, 2004).

Conjoint Approaches Targeting Psychological and Physical Aggression

Recently, a number of conjoint approaches have been developed that target physically and psychologically aggressive behavior between partners directly and also are designed to enhance the quality of the couple's relationship. The following are descriptions of research evaluating the effectiveness of several conjoint approaches to the treatment of abusive behavior. Across all programs, couples in which either or both partners have exhibited psychologically and/or physically abusive behavior but (a) do not engage in battering or severe violence and (b) desire to improve

their relationships and remain together were the focus of treatment. As two of the programs use a couples' group format rather than individual couple therapy, we have included a more detailed description of our own conjoint program, which we believe most closely resembles the type of individual couple format used most commonly by therapists.

Couple Group Approaches

The Physical Aggression Couples Treatment (PACT) program (Heyman & Neidig, 1997; Heyman & Schlee, 2003; O'Leary, Heyman, & Neidig, 1999) is delivered to groups of couples who are experiencing psychological and physical aggression but not severe violence characteristic of battering. PACT is a cognitive-behavioral approach that focuses on reducing current aggressive behavior and preventing future violence, and its goals include educating couples about the patterns of violence in close relationships and about alternatives to IPV, increasing personal responsibility for the use of violence, reducing and ultimately eliminating IPV through anger management and conflict resolution skill training, and increasing relationship satisfaction and positive couple interactions through communication and problem-solving skill training.

PACT was compared to gender-specific treatment in a longitudinal investigation of its efficacy in reducing and eliminating IPV (O'Leary et al., 1999). At posttreatment, husbands and wives who completed the PACT program reported significantly higher marital adjustment scores than at pretreatment. In addition, husbands scored lower on measures of both psychological and physical aggression at posttreatment. Furthermore, husbands reported significant increases in taking responsibility for their violence as well as significant decreases in blaming their wives for their own use of violence. Similarly, wives reported significant decreases in self-blame and taking responsibility for their husbands' use of aggression. One-year follow-up results indicated that husbands' use of physical aggression was significantly reduced, according to both husbands' and wives' reports. Husbands also demonstrated significant decreases in their use of psychological aggression. In addition, both husbands and wives reported significant increases in marital satisfaction at the one-year follow-up. Contrary to the investigators' hypothesis that PACT would be more effective than gender-specific treatment, however, the two treatments were found to be equally effective on the outcome measures. Furthermore, although there were significant reductions in intensity and frequency of aggression, use of violence was not eliminated as a result of treatment; in fact, the cessation rate was 26% at the one-year follow-up for the PACT program.

Stith et al. (2004) evaluated multicouple and individual couple versions of an integrative therapy approach that had an overall solution-focused theoretical framework and found that males in the multicouple condition but not the individual couple condition had a significantly lower IPV recidivism rate than the no-treatment control group at six months posttreatment. At two years posttreatment, males in the individual couple condition were significantly less likely to recidivate than those in the no-treatment comparison group, and there was a trend for men in the multicouple group to have a lower recidivism rate than those in the no-treatment comparison group. In addition, participants in the multicouple groups but not those in individual couple therapy or no-treatment control group exhibited significantly increased marital satisfaction and lowered aggression, and male partners in only the multicouple group demonstrated significantly lowered acceptance of wife battering following treatment. As was true with PACT, Stith et al.'s (2004) study demonstrated that conjoint treatment of mild to moderate IPV using structured, time-limited interventions is highly feasible.

Couples Abuse Prevention Program (CAPP)

The Couples Abuse Prevention Program (CAPP; Epstein et al., 2005) is a project comparing a structured cognitive-behavioral conjoint treatment with treatment as usual (various systems-theory approaches to couple therapy) focused on identifying and reducing risk factors for psychological and physical abuse. It is intended for couples who have shown evidence of psychological aggression and/or mild to moderate physical aggression but no physically damaging abuse or evidence of risk for such abuse. The cognitive-behavioral model in CAPP focuses on enhancing the quality of the couple's relationship and reducing risk factors for IPV described earlier through psychoeducation about abusive behavior and its negative consequences, increasing partners' use of effective anger management skills during conflicts, improving the couple's communication and problem-solving skills, helping the couple recover from any past trauma and broken trust (e.g., any past aggressive behavior or abandonment issues within the relationship), and increasing partners' mutual support and shared positive activities. To date, the cognitive-behavioral and usual treatment protocols of CAPP have been implemented within the outpatient couple and family therapy clinic at the University of Maryland, College Park, which serves an ethnically and socioeconomically diverse local community adjacent to Washington, DC, and is the clinical training setting for a nationally accredited master's level marriage and family therapy training program. Graduate student therapists who are supervised weekly by faculty deliver the treatments.

CAPP Assessment Procedures

Couples are not recruited from the community for CAPP; rather, all couples who seek therapy at the Family Service Center clinic at the university are routinely screened for IPV through a multimodal assessment. First, all persons who call the clinic seeking conjoint couple therapy are screened briefly over the phone for areas that concern them regarding their relationship as well as for substance use, psychological abuse, and physical abuse. Callers who report severe abuse are given community referrals for gender-specific treatment, shelters, and so forth, as appropriate, because the Family Service Center does not provide those services. All couples who are not screened out are scheduled for an in-person assessment session. During this assessment session, the couple initially is interviewed together by a team of co-therapists about their presenting problems and goals for treatment.

The members of the couple also are interviewed separately about their own and their partner's use of alcohol and drugs; past and current treatment of substance use; and the social, legal, and occupational problems due to either partner's use of substances. During the individual interviews, each person also is asked about incidents of IPV as well as whether he or she feels safe living with the partner and safe participating in couple therapy with the partner. While they are in separate rooms, both partners are asked to independently complete a battery of self-report questionnaires that assess the following: demographic information (e.g., age, ethnicity, income, relationship history), relationship distress, communication behaviors, forms of psychologically and physically abusive behavior by self and by one's partner, and psychopathology symptoms (e.g., depression, anxiety, trauma symptoms). It may take the couple up to two hours to complete this portion of the assessment procedure.

Couples who report mild to moderate physical abuse (not resulting in injury), psychological aggression, comfort with conjoint treatment, and a desire to stay together and improve the quality of their relationship are told about an ongoing project for couples who have experienced problems with anger control and conflict management and that they are eligible to participate in the program. They are told that participation in the program involves agreeing to be assigned randomly to one of two forms of couple therapy, each of which is an established approach to helping couples improve their ability to resolve conflicts in their relationships.

One of the two options is usual treatment at the Family Service Center, which involves a variety of systems-theory oriented approaches to couple therapy (e.g., emotionally focused, solution-focused, narrative) that are widely used forms of treatment. In the usual treatment at the clinic, couples are assigned to therapists during weekly staffing meetings, and they receive their therapists' preferred systemic model of conjoint treatment. The other option in CAPP, also staffed during weekly meetings, is a structured cognitive-behavioral protocol designed to improve anger management and communication skills, reduce problematic ways of responding to conflict, and build relationship strengths.

Separate individual treatment for abuse is recommended for those high-risk couples in which one or both partners report sustaining injuries as a result of IPV that required medical attention, feel unsafe or afraid living with and/or spending time with their partner, or report active untreated substance abuse/dependence that may exacerbate the risk for violence. In addition, for those couples at high risk for violence, resource information is provided, including but not limited to crisis line phone numbers, shelter locations, abuser counseling services, and legal system resources (e.g., for instituting protection orders).

Those couples who are eligible and interested in participating in CAPP return to the clinic for a second day of assessment. The two partners individually complete additional questionnaires assessing conflict-related cognitions, anger expression, trust, and aspects of couple behavioral interaction. In addition, the couple is videotaped as they conduct a 10-minute discussion of an area of their relationship (e.g., finances, trust) that they have identified as a source of moderate disagreement. The taped interaction provides observational data on the couple's use of several forms of constructive and destructive communication behaviors, which are coded with the global form of the Marital Interaction Coding System (MICS-G; Weiss & Tolman, 1990). Similar assessment sessions are conducted at the conclusion of 10 usual treatment (UT) or cognitive-behavioral therapy (CBT) sessions as well as at a 4-month follow-up assessment point.

Cognitive-Behavioral Couple Treatment Protocol

The CAPP cognitive-behavioral couple treatment has components that focus on psychoeducation about abuse and its consequences, promotion of personal responsibility for one's behavior toward one's partner, training in anger management and stress reduction techniques, training in communication and problem-solving skills, use of cognitive restructuring techniques to modify negative attributions and beliefs that foster psychological and physical abuse, strategies for relationship recovery from prior domestic abuse, and enhancement of positive couple interactions that serve to both reduce risk for abuse and increase each partner's satisfaction with the relationship. The interventions draw on established cognitive-behavioral procedures for individuals and couples (Baucom & Epstein, 1990; Deffenbacher, 1996; Epstein & Baucom, 2002; Heyman & Neidig, 1997; Holtzworth-Munroe et al., 2002). The protocol consists of 10 weekly 90-minute treatment sessions conducted over approximately a 3- to 4 1/2-month period. The following is a brief overview of the content of the sessions.

Session 1. During the first session, the couple is presented an overview of the cognitive-behavioral treatment program and the structure of the sessions (e.g., review of homework that was set at the previous meeting). A relationship history is taken, including relationship strengths as well as presenting problems that will be foci of treatment. In addition, the couple completes a no-violence contract (including a commitment to reduce verbal aggression). The co-therapists coach the couple in devising an initial written set of goals for therapy, and the therapists stress that the primary goal of CAPP for all participants is having an abuse-free relationship. For homework, the couple is asked to review their treatment goals, revise them if they wish, and bring the list to the following session.

Session 2. During the second session, the couple's initial list of therapy goals is refined, and development of cognitive and behavioral skills that will contribute to the achievement of therapy goals is integrated into the overall treatment plan. Couples receive psychoeducation about the difference between the content and process of couple interactions, with an emphasis on the differential impacts of constructive versus destructive ways of expressing thoughts and emotions. Therapists "socialize" the couple into the cognitive-behavioral theoretical framework by using examples from the couple's own relationship to illustrate the influences of behavioral responses, cognitions, and affect on relationship quality.

In addition, the couple is taught cognitive and behavioral strategies for anger management, including but not limited to self-soothing procedures, time-outs, and cognitive restructuring of anger-eliciting thoughts (Epstein & Baucom, 2002; Heyman & Neidig, 1997). The couple is given additional psychoeducation about the consequences of constructive versus destructive forms of communication and is taught strategies for effective conflict containment (e.g., making a conciliatory statement rather than reciprocating a negative message from one's partner). The couple is instructed to practice anger management strategies between sessions for homework.

Sessions 3 and 4. Expressive and listening skills (Baucom & Epstein, 1990; Epstein & Baucom, 2002; Rathus & Sanderson, 1999) are taught and practiced in both sessions. The couple begins practicing the skills with relatively benign topics, and as they progress the significance of the topics increases so that they are able to practice the skills with topics involving moderate to severe conflict. Therapists use Epstein and Baucom's (2002) text on cognitive behavioral couple therapy as a guide for communication skills training procedures. In addition, the couple is given psychoeducation about the role of cognitions in anger arousal, psychological aggression, and violence. Partners are taught to identify cognitions associated with aggressive behavior, including negative attributions about each other's intentions, positive expectancies about the consequences and so-called rightness of aggression, and idiosyncratic gender role beliefs regarding dominance in relationships (Epstein & Baucom, 2002; Heyman & Neidig, 1997). They are instructed in the use of cognitive restructuring techniques to challenge these cognitions and counteract negative thinking, using Epstein and Baucom's (2002) detailed guidelines for such cognitive interventions. During these sessions, the homework emphasizes additional practice of communication skills as well as continued use of anger management techniques.

Sessions 5 through 7. Beginning with the fifth session, the couple is taught problem-solving skills (Baucom & Epstein, 1990; Epstein & Baucom, 2002; Rathus & Sanderson, 1999) for resolving conflict without abuse. Partners are coached in combining communication and problem-solving skills and in applying those skills to increasingly conflictual topics. An emphasis is placed on applying these skills to the partners' areas of concern about their relationship; thus, the CAPP cognitive-behavioral protocol is structured to a considerable extent but is flexible and tailored to each couple's presenting concerns. The therapists use specific instructions, modeling of problem-solving behaviors, and coaching of the couple as they practice problem solving during sessions. The major problem-solving steps that are taught include behavioral problem clarification/definition, collaborative brainstorming of potential solutions, evaluating the pros and cons of each possible solution, negotiation and selection of a trial solution, and implementation and evaluation of the solution.

In addition, the couple continues to work on identifying and modifying negative cognitions that interfere with problem-solving. Furthermore, the therapists guide them in exploring other factors that may be barriers to their use of appropriate problem-solving skills (e.g., a belief that compromising is a sign of weakness). Using procedures similar to those used to build the couple's communication skills in previous sessions, the therapists systematically apply the guidelines on problem solving detailed by Epstein and Baucom (2002). Epstein and Baucom's (2002) text is also used as a guide for

therapists in their identification and modification of partners' negative cognitions that interfere with problem solving. Each session concludes with plans for the couple's homework for the next week and renewed commitment to use their anger management skills whenever needed.

Sessions 8 through 10. In the final sessions of the protocol, the couple's continued application of communication and problem-solving skills is supplemented by relationship recovery and enhancement strategies. The therapists emphasize that recovery from traumatic events, including past domestic violence, tends to be a gradual process and that it is important that both members of the couple exercise patience as they work together for the common good of the relationship. Therapists encourage formerly abusive partners to be empathic and supportive when the recipient of prior abuse continues to exhibit trauma symptoms (e.g., startle and anxiety responses, defensive withdrawal) and to assist their partner appropriately in efforts to cope with the symptoms more effectively. Themes of acknowledging past mistakes, assuming personal responsibility for one's past hurtful actions, avoiding blaming and criticizing one's partner for relationship problems, forgiveness, and committing oneself to personal change are stressed. Couples are encouraged to balance acknowledging past mistakes with taking an accepting stance toward one's partner for past negative behavior in order to facilitate reconciliation and decrease the likelihood of engaging in retaliatory behavior (for detailed discussions on forgiveness in couple therapy, see Gordon & Baucom, 1998, and Gordon et al., in this journal issue).

The therapists discuss with the couple the importance of balancing efforts toward eliminating abuse with efforts to enhance the positive qualities of their relationship. A goal of cognitive-behavioral couple therapy is to help them increase the proportion of positive activities and sharing, develop greater mutual support, increase affection and intimacy, and increase their ability to work as a team in setting and working toward goals. Guided behavior change strategies (e.g., agreements to engage in mutually pleasurable activities together) are employed to help couples shift the overall frequency of positive behaviors and help partners remember to maintain these behaviors on an ongoing basis. Partners are also encouraged to take individual responsibility for seeking ways to improve the relationship.

Given that a history of overcontrolling behavior by abusive individuals is common, the therapists assist each couple in achieving a balance between togetherness and autonomy. Building on previous sessions, the therapists coach the couple in using their expressive, listening, and problem-solving skills to address areas of disagreement and to devise mutually acceptable ways of enhancing their relationship. The 10th session also focuses on summarizing the couple's progress toward the goals they set at the beginning of treatment as well as on relapse prevention through planning how they will continue to apply the skills that they have learned. Maintenance and enhancement of treatment gains are emphasized.

Research on CAPP

In the CAPP project, the cognitive-behavioral couple therapy (CBCT) intervention has been compared in a pilot study to treatment as usual (UT) for their effects on reducing psychological and physical aggression and in improving couple and individual functioning (Epstein et al., 2005). As noted earlier, the UT condition includes utilization of various family systems models (e.g., emotionally focused, structural, strategic, solution-focused, narrative) to make partners aware of problematic interaction patterns in their relationship and assist them in developing constructive patterns that decrease risk of IPV. Across both treatment conditions, couples attend 10 90-minute sessions, no-violence contracts are written and enforced, and treatment is focused on reducing systemic patterns that contribute to IPV. Additionally, partners in both treatment conditions completed the following measures at pre- and posttreatment: the Dyadic Adjustment Scale (DAS; Spanier, 1976) as a measure of relationship satisfaction; the Conflict Tactics Scale–Revised (CTS2; Straus et al., 1996) as a measure of physical aggression; the Multidimensional Measure of Emotional Abuse

(MMEA; Murphy & Hoover, 2001) as a measure of psychological abuse; and the MICS-G (Weiss & Tolman, 1990), an observational measure of positive and negative communication between partners, as described earlier. The pilot study included no waiting-list control group because of the ethical issue of leaving couples who are at risk for further abuse untreated and based on Baucom, Hahlweg, and Kuschel's (2003) conclusion from a review of prior outcome studies that such control groups are not needed given the strong body of evidence that couple interventions consistently produce improvements, whereas untreated couples remain stable or deteriorate.

As noted earlier, all couples eligible to participate in the study were randomly assigned to either the CBCT or UT treatment condition. Of those couples eligible to participate, 47.5% agreed to participate and completed the pilot study. The final sample consisted of 17 couples in the CBCT condition and 21 couples in the UT condition. Across both treatment conditions, the majority of couples (more than 50%) identified as White and approximately one-third were African American. The majority of couples were either married or living together and had completed some college. Pairwise *t*-tests were used to examine changes within treatment modalities from pretreatment to posttreatment. Analyses of covariance were used to compare CBCT versus UT group differences on both self-report and observational measures at posttreatment, controlling for pretreatment levels.

Epstein et al. (2005) found that the CBCT treatment produced a significant increase in relationship satisfaction for males and a trend toward an increase for females on the DAS. The UT condition resulted in significant increases in relationship satisfaction for both males and females, and there were no differences between CBCT and UT modalities at posttreatment. In regard to participants' reports of psychological aggression by their partner on the MMEA, (1) both CBCT and UT resulted in significant decreases in partner hostile withdrawal (e.g., withholding emotional contact in a hostile fashion) by both males and females; (2) CBCT produced trends ($p < .10$) toward less denigration (e.g., humiliating behaviors) by partner for both males and females, whereas UT produced significant decreases in denigration by both sexes; and (3) CBCT produced no changes in domination/intimidation (e.g., threats of physical aggression) by partner, whereas UT produced a significant decrease by males, reported by females. The posttreatment levels of all forms of psychological aggression (controlling for pretreatment levels) did not differ between the CBCT and UT treatment modalities.

For observed communication coded by trained raters from couple discussions, the CBCT intervention produced significant decreases in negative communication by both males and females, whereas UT produced no change, and for males there was significantly less negative communication at posttreatment for CBCT participants than for UT participants. In addition, CBCT produced a trend ($p < .10$) toward an increase in positive communication for males, whereas UT produced no change in positive communication. Overall, findings indicated that although improvements in relationship functioning were different across treatment modalities, both CBCT and UT were effective in reducing psychological aggression. Neither CBCT nor UT, however, resulted in any significant changes in partners' use of physical aggression posttreatment. The lack of change in reported physical aggression may be due to low rates of partner physical aggression (less than 2 mildly to moderately aggressive behaviors perpetrated in the past 4 months at both pre- and posttreatment) by couples in both treatment conditions. The selection criteria used to exclude highly physically abusive couples who could be at risk in conjoint treatment resulted in a sample of couples with limited physical aggression that could be reduced through the interventions.

Conclusions

Existing findings of outcome studies, including the evaluation of our CAPP project, indicate that conjoint approaches are appropriate and effective in reducing abusive behavior in couple relationships in which partners have exhibited psychological and/or mild to moderate physical abuse. Clinicians must use detailed multimethod assessment procedures, however, before deciding if conjoint treatment is safe and appropriate. Given that couples presenting for therapy rarely report physical violence as a presenting issue, but more than half of all couples seeking treatment have experienced abuse, integration of abuse assessment into one's clinical practice is both necessary and ethical. Although further research is needed, current findings suggest that cognitive-behavioral interventions as well as other systemically oriented forms of couple therapy can be effective in decreasing negative communication behaviors associated with IPV, decreasing psychological and physical aggression, and increasing relationship satisfaction. Overall, conjoint approaches that specifically target abusive behavior, conduct an assessment that offers partners ample opportunities to reveal fears and abusive experiences privately, address relevant risk factors, and incorporate anger management and communication and problem-solving skills will be helpful to those couples who are experiencing abuse within their relationships.

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