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Couples Therapy and Intimate Partner Violence: Considerations, Assessment, and Treatment Modalities

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Intimate partner violence (IPV) is a prevalent health concern among couples, and many couples who seek out couples therapy have experienced IPV in their current relationship. Mental health professionals who work with couples will likely work with couples where IPV is occurring in the relationship. This article aims to help mental health professionals by providing an overview of IPV and risk markers associated with IPV. This article offers a background on assessing for IPV when working with couples and highlights the importance of in-depth and well-rounded assessment for IPV, as couples-based treatment approaches are not appropriate for all couples. We emphasize that couples therapy is not recommended when couples are experiencing intimate terrorism, a form of IPV that is characterized by 1 partner using violence against the other as a means to intimidate, control, and gain power of their partner, in addition to providing factors that would suggest couples therapy would be beneficial. The article provides information on some potential treatment modalities for couples who are not experiencing intimate terrorism in their relationship. Case examples are provided to give mental health professionals examples of what assessment and working with IPV may look like in their practice.

Clinical Impact Statement
This article focuses on providing an overview of couples treatment for intimate partner violence, including safety and assessment considerations, as well as an overview of evidence-based models for further review. This article highlights the need for safety, structure, and assessment for appropriate fit before initiating couples treatment for intimate partner violence.

Keywords: intimate partner violence, therapy, couples treatment, assessment

Intimate partner violence (IPV) is a pervasive public health problem that warrants the attention of therapists and mental health professionals. It is estimated that 37% of women and 30% of men in the United States have experienced IPV victimization in their lifetime (Smith et al., 2017). Undoubtedly, mental health professionals will work with someone impacted by IPV in some way during their career. IPV can be defined as causing physical, emotional, or sexual harm against one's current or former intimate partner. Physical IPV can include acts such as pushing, kicking, shoving, hitting, biting, and strangulation (Straus et al., 1996). Psychological IPV can consist of threats, insults, yelling at one's partner, and breaking the belongings of the partner. Sexual IPV can be defined as forcing one's partner to have sexual contact without their consent, which can consist of using coercion, threats, and physical harm. IPV can also include financial abuse, stalking, or coercive control tactics. There are a host of negative outcomes related to IPV victimization, many of which a victim may seek mental health services to address, making this a population that therapists and clinicians will likely work with during their career.

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IPV victimization has been linked to physical health consequences, such as injury, digestive issues, gynecological issues, back and abdominal pain, and central nervous system issues (Campbell et al., 2002; Hewitt et al., 2011). IPV victimization is also associated with many mental health symptoms, such as anxiety, depression, posttraumatic stress symptoms, suicidal ideation, substance use, and stress (Bosch et al., 2017; Cavanaugh et al., 2011; Spencer et al., 2019). With the high prevalence of individuals experiencing IPV in their relationships, coupled with the negative consequences associated with IPV, it is pertinent that mental health professionals treating couples develop sufficient knowledge base to identify and treat IPV when it is appropriate and safe to do so.

Prevalence of IPV

Although IPV victimization is highly prevalent in the population in general (Smith et al., 2017), it is also important to acknowledge that some individuals are at higher risk than others. Approximately 47% of both men and women in the U.S. have experienced psychological IPV (Smith et al., 2017), but some differences emerge when looking at other types of IPV. Approximately 32% of women and 28% of men have experienced physical IPV, but when we look at severe forms of physical IPV, those statistics change to 23.2% of women and 14% of men (Smith et al., 2017). Intimate partner homicide, arguably the most extreme form of IPV, is gendered in nature, where approximately 39% of homicides committed against women, while 3% of homicides committed against men in the U.S. were committed by a former or current intimate partner (Catalano, 2013). Additionally, 16% of women and 7% of men have experienced sexual IPV, and approximately 10% of women and 2% of men have experienced stalking by a current or former intimate partner (Smith et al., 2017). Although both men and women are victims of IPV, women are more likely to experience sexual IPV, severe physical IPV, intimate partner homicide, and stalking in their lifetime compared to men.

In addition to gender differences, individuals who belong to a racial/ethnic minority group are at a higher risk of experiencing IPV victimization. For example, approximately 54% of multiracial women and 44% of Black women report experiencing sexual IPV, physical IPV, or stalking in their lifetime, whereas this is reported by 35% of White women (Black et al., 2011). For American Indian/Alaskan Native women, approximately 56% have experienced physical IPV, 66% have experienced psychological IPV, and 49% have been stalked (Rosay, 2016). In addition to women who are racial minorities, women who are sexual minorities are at a higher risk of IPV victimization as well. Breiding and colleagues (2014) found that while 35% of women who identified as heterosexual experienced some form of IPV in their lifetime, women who identified as bisexual (61.1%) or as lesbian (43.8%) experienced higher rates of lifetime IPV victimization. Additionally, one study found that in their sample, 23% of cisgender participants experienced IPV victimization, whereas 31% of transgender participants experienced IPV in their lifetime (Langenderfer-Magruder et al., 2016). IPV can impact individuals of all backgrounds, genders, races, or sexual orientations, but it is important to note that women, racial minorities, gender minorities, and sexual minorities are at an increased risk of IPV victimization.

Risk Markers for IPV

Couples may present in therapy specifically to reduce IPV in their relationship, whereas others may be experiencing IPV in the relationship but my not bring it up directly to the therapist. There have been a variety of systematic and meta-analytic reviews that have examined risk markers for IPV perpetration and victimization. It is important for mental health professionals working with couples to have a background in risk markers for IPV perpetration and victimization. We use the term risk marker because research has not established a causal relationship between IPV and risk variables.

A meta-analysis on risk markers for physical IPV perpetration (Spencer et al., 2022) identified top risk markers for IPV perpetration for both men and women and found the strongest risk markers for IPV perpetration were related to the intimate relationship itself, particularly other forms for IPV perpetration and victimization in the relationship (Spencer et al., 2022). This finding highlights that multiple forms of IPV are often co-occurring in relationships, and couples may be experiencing bilateral forms of IPV, where both partners are simultaneously perpetrators and victims (Krebs et al., 2011). Research has also identified that risk markers to be more or less associated with IPV based on

victim's and perpetrator's gender (Spencer et al., 2022), race (Kelly et al., 2022), or sexuality (Kimmes et al., 2019).

Other research has focused specifically on risk markers associated with future IPV perpetration or reperpetration, such as previous history of violence, mental illness, and substance use, in attempt to better predict violence (Sheridan et al., 2007). These markers align with exclusion criteria in some couple-based treatment approaches (Stith et al., 2011) and highlight that although risk of future violence cannot be fully eliminated, couples-based treatment approaches are only to be utilized when risk of continued violence is low.

Why Work With Couples Experiencing IPV?

Many initial treatment approaches used to eliminate IPV have been perpetrator-focused and executed in individual or group settings, created with the intention of treating court-ordered males. Research examining the effectiveness of these batterer intervention programs (BIPs) have found mixed results (Arias et al., 2013; Cheng et al., 2021; Eckhardt et al., 2013). In some cases, negative impacts, like further exposure to or support of other perpetrators abusive behaviors or beliefs, of these programs have been identified (Edleson & Tolman, 1992). Perpetrators participating in these programs, or individuals who have been legally mandated to attend therapy, would likely not be a fit for conjoint treatment due to the nature of violence that would prompt such circumstance. Many state guidelines explicitly prohibiting couples therapy during court ordered IPV treatment (Stith et al., 2011).

As criticism for BIPs have grown, attempts to treat IPV has expanded in several ways, particularly the idea of treating violent couples conjointly. Stith and colleagues (2011) argued the relevance of this approach through a systemic lens with the underlying belief that, "violence can end, relationships can be improved, and women and men both can be empowered through the careful application of conjoint couples' treatment" (Stith et al., 2011, p. 10). A systemic approach aims to create change within the couple dynamic through increasing the perpetrators sense of responsibility and decreasing vulnerability of the victim, allowing for new dynamics to be developed within the relationship.

As couple-based treatment approaches have been developed and tested, results have challenged early assumptions regarding treatment of IPV. For example, a common barrier to couple-based approaches has been fear of putting the victim in further danger, but research has indicated that victims are not at higher risk of IPV when receiving couple's treatment addressing the violence (Dunford, 2000; O'Leary et al., 1999; Stith et al., 2004). When examining effectiveness of couple-based approaches, a meta-analysis conducted by Karakurt and colleagues (2016) found that conjoint treatment for violence couples can successfully reduce/eliminate IPV, particularly for couple's experiencing situational violence.

Research suggests mental health providers may be unknowingly working with couples experiencing IPV in their relationship. Between 36% and 58% of couples seeking couples therapy/counseling have experienced IPV in the current relationship (Jose & O'Leary, 2009). While clients may not present with IPV as their main issue in couples' treatment, there is a chance that IPV may still be an issue for the couple. The couple may choose to stay together after a violent incident, which includes the victim, and treatment can be beneficial to preventing future violence.

However, couples therapy, or conjoint treatment, is not a suitable approach for all couples experiencing IPV, which makes assessment an integral part of determining potential treatment modalities when working with IPV. In addition to client fit, it is important for mental health providers to consider their own comfort level working with couples with a history of violence and their own knowledge of established treatment programs and relevant protocol to safely execute treatment. Mental health professionals who have not immersed themselves in an IPV specific treatment modality risk missing necessary assessment and treatment considerations. Additionally, seeking supervision from a mental health professional who has experience working with IPV may be warranted.

Assessment

While previous research has highlighted positive results when treating IPV systemically, there are serious considerations mental health professionals need to examine prior to conjoint treatment targeting IPV. Taking precautions and implementing a thorough assessment to ensure couples treatment is appropriate will aid in protecting the victim, which is the priority. There is no "one size fits all" approach to treating violence, and conjoint treatment is not a suitable treatment approach for all

couples experiencing IPV in their relationship. This makes it critical to provide in-depth assessment prior to starting conjoint treatment. There are circumstances, discussed in following section, that could make couples treatment in cases of IPV inappropriate and potentially dangerous. General assessment can assist mental health professionals in identifying whether a couple is a good fit for couple-based treatment, and to match the treatment approach to the couple's needs. The following sections summarize assessment tools used in conjoint treatment of couples with IPV (see Table 1).

Assessment Considerations

Type of Violence

When deciding fit for conjoint treatment, it is important to recognize that couple based IPV approaches have only been found to be effective with couple's experiencing situational violence and not intimate partner terrorism. This framework is based on Michael Johnson's (2010) typologies for IPV, which identifies the two of the most common forms of IPV within this framework: situational couple violence and intimate terrorism. Situational IPV involves "low-level" acts of violence (e.g., shouting, pushing, shoving) that are not used to control or dominate one's partner. Situational couple violence often occurs in the context of an argument or disagreement and can be related to a lack of anger management skills, a lack of conflict resolution skills, or a lack of healthy communication strategies. Additionally, situational couple violence can be bidirectional (both partners exhibiting violent behaviors toward one another), and one partner is not fearful of the other partner (Johnson, 2010).

The second typology of importance is intimate terrorism. Intimate terrorism involves one partner committing acts of violence against the other partner as means to control and dominate the other partner (Johnson, 2010). This type of violence involves fear, more severe acts of violence (e.g., severe physical abuse, such as strangulation, coercive control tactics, and constant emotional abuse), and consists of one partner perpetrating the abuse, and the other partner being victimized. Power and control tactics are seen in relationships where intimate terrorism is present (Johnson & Leone, 2005). Situations in which intimate terrorism are occurring are absolutely not appropriate for couples' treatment and could increase the level of danger the partner is in.

Assessing for IPV Separately

In order to obtain more information about the context in which IPV occurs, it is critical to assess each member both separately and privately" ($2). This approach minimizes any apprehension or fear of angering the perpetrator and can set the stage for more detailed and candid reporting from the victim. It is essential to ensure that both partners feel safe and have maximum opportunities for disclosure of violence, and associated relationship dynamics (Horst et al., 2017; Stith et al., 2011). If either partner does not feel safe, the couple would not be appropriate for conjoint treatment.

It is also important to ensure that both partners' accounts IPV within the relationship are similar/

Table 1
Recommended Assessment Tools for Couple-Based IPV Treatment

Area	Measures
Violence	CTS2 (Straus et al., 1996; cited by Hamel, 2005; O'Leary & Cohen, 2007; Stith et al., 2011)
	Danger assessment (Campbell et al., 2009; cited by Hamel, 2005)
Relationship satisfaction	Kansas Marital Satisfaction Scale (Nichols et al., 1983; Stith et al., 2011)
	ECR (Brennan et al., 1998; cited by Hamel, 2005)
	DAS (Spanier, 1989; cited by O'Leary & Cohen, 2007)
Mental health	SCL-90-R (Derogatis & Melisaratos, 1983; Stith et al., 2011)
	PCL-R (Hart et al., 1992; cited by Hamel, 2005; Taft, 2016)
	CAPS (Blake et al., 1995; cited by Taft, 2016)
Substance use	AUDIT (Babor et al., 2001(cited by Stith et al., 2011)
	DAST (Skinner, 1982; cited by Stith et al., 2011; Taft, 2016)
Child abuse	CTSPC- family behaviors (Straus et al., 1998; cited by Hamel, 2005)
	Child Abuse Potential Inventory (Milner, 1994; cited by Hamel, 2005)

Note. IPV = intimate partner violence; CTS2 = Revised Conflict Tactics Scale; ECR = Experiences in Close Relationships; DAS = Dyadic Adjustment Scale; SCL-90-R = Symptom Checklist-90-Revised; PCL-R = Psychopathy Checklist Revised; CAPS = Clinician-Administered PTSD Scale for DSM-5; AUDIT = Alcohol Use Disorders Identification Test; DAST = Drug Abuse Screening Test; CTSPC = Conflict Tactics Scale Parent-Child.

congruent. If there are significant discrepancies in accounts of violence (e.g., one partner reports the other hit them more than twenty times, and the other partner states they only hit them one time) then the couple would not be appropriate for couples' treatment, as it may suggest an inability of the perpetrator to be accountable. A lack of accountability in the context of coercive threat to the victim may lead to significant risk of harm occurring in the context of a couple therapy. A joint commitment to safety is a necessary precondition of conjoint treatment (Stith et al., 2011).

Relationship Commitment

A main aspect in couple-based approaches is improving the overall quality and dynamics within the relationship, which makes relationship commitment a key factor (Hamel, 2005; Stith et al., 2011). If one or both partners reports desire to end the relationship or is questioning commitment, couple-based treatment would not be a good fit. For previously violent couples who are splitting up but remaining coparents, the program "No Kids in the Middle", described below, would work best (Van Lawick & Visser, 2015).

Substance Use

There is a well-established link between substance use and IPV demonstrated in several meta-analyses (Cafferky et al., 2018; Foran & O'Leary, 2008; Gilchrist et al., 2019), and it's been argued that substance use can, depending on other factors like environment or mood, increase severity and frequency of violence (Hamel, 2005). When assessing violence, it is necessary to explore how substance use impacts experiences of violence (Hamel, 2005; Potter-Efron, 2007). In most conjoint programs, substance abuse is seen as a separate issue that needs to be treated before conjoint IPV treatment can begin (Stith et al., 2011). If one partner is experiencing substance abuse, Behavioral Couples Therapy (BCT), originally a dyadic treatment for substance abuse found successful in reducing IPV (O'Farrell et al., 1999; O'Farrell et al., 2004), may be a good fit for simultaneously addressing substance abuse and violence, and is discussed more below.

Mental Health

Similar to substance use, there is an established association between mental health and IPV (Spencer et al., 2019). Although most couple-based approaches do not exclude individuals struggling with mental health from participating, assessment of mental health, along with its impact on violence is necessary. It is also important to consider how certain diagnoses, particularly personality disorders like narcissism, antisocial, and borderline, are associated with more severe violence (Hamel, 2005). For couples where one or more partner is struggling with severe mental health problems, conjoint treatment may not be a fit, and stabilization may need to happen before couple-based work can begin.

Protection of Children from Physical and Emotional Harm

Because of the correlation between IPV and child abuse (Appel & Holden, 1998), it is essential when assessing intimate partner relationship and violence to also assess parent/child relationship and violence (Hamel, 2005; Thomas, 2007). Mental health professionals need to be aware of their state reporting requirements related to child abuse and children witnessing parental violence and be prepared to determine if reporting is warranted. There aren't explicit recommendations for situations where both child abuse and IPV are present, and in these situations, any treatment will likely need to be considered on a case-by-case basis.

It is well-established that IPV among parents or caregivers can have a destructive impact on children's well-being. A meta-analysis found children exposed to IPV are susceptible to physical and mental health problems, conduct and behavioral problems, increased delinquency, crime, and victimization (Artz et al., 2014). Treatment for children exposed to IPV typically fall into four categories: counseling/therapy, crisis/outreach, parenting, and multicomponent intervention programs (Rizo et al., 2011), and some programs have shown promising results (Graham-Bermann et al., 2007; Graham-Bermann et al., 2015). When working with couples who have children, therapists should be prepared to make appropriate referrals for children needing further assessment or treatment.

Access to Guns

A recent meta-analysis examining risk factors for intimate partner homicide (IPH), which can be considered the most extreme form of IPV, found that the strongest risk factor for IPH was the perpetrator's direct access to a gun (Spencer & Stith, 2020). The perpetrator's direct access to a gun increased the likelihood of a homicide occurring by over 1,000% when comparing cases of IPH and

cases of IPV. This finding warrants serious attention from mental health professionals working with couples experiencing IPV in their relationship. It is considered best practice to assess for access to weapons/guns when working with clients expressing suicidal ideation (Simon, 2007) and research findings suggest that gun removal is successful in reducing gun suicides (Swanson, 2019). We highly suggest that when working with couples experiencing IPV in their relationship, or when working with a victim of IPV (whether the relationship has ended or not), it is just as important to assess whether the perpetrator (or both partners if the violence is bilateral) has direct access to a firearm. If a couple presenting for treatment of IPV report having a gun, it would be valuable to create a plan to securely remove and store the gun outside of the home to promote safety.

Commitment to Ending Violence

Another key component in working with partner conjointly is both partner's motivation and commitment to end violence. In Stith and colleagues' (2011) approach, prior to beginning therapy, mental health professionals encourage partners to sign a "no-violence" contract where both partners agree to cessation of violence in the relationship while attending therapy. If one or both partners refuse to sign such a contract, couples therapy is not recommended, as this likely indicates lack of commitment to ending violence (Stith et al., 2011). A no violence contract, although not legally binding, allows for clear expectations and boundaries regarding IPV and treatment and can give insight on partner's willingness to effectively engage in treatment.

Referral

If throughout the assessment process, conjoint treatment is deemed not a fit for a couple, mental health professionals need to have potential referral sources for both victims (e.g., shelters, victim services) and perpetrators (e.g., BIPs). These referral sources should be community or state based and should not be limited to IPV related resources but also substance abuse, mental health, or other practitioners more appropriate for the couple's issues. For couple's nearing fit for conjoint treatment, initial individual work prior to beginning conjoint treatment may be beneficial and promote fit or increase clarity of treatment needs.

Assessment: Case Example

Daniel and Emily came to couples therapy to improve their relationship overall. They did not come to therapy to specifically address violence in their relationship. Prior to beginning the session, the therapist had each partner fill out assessments, the CTS2 (Straus et al., 1996) and DAS (Spanier, 1989). During the first session, the therapist separated Daniel and Emily to assess for safety, violence, and commitment to the relationship. The therapist started the conversation by normalizing conflict in the relationship by stating, "There can be conflicts in all relationships, so I just want to ask a few questions about how you and Emily handle conflict in the relationship." Instead of vaguely asking if the couple experiences violence in the relationship, the therapist asked direct questions about specific acts (e.g., yelling, pushing, shoving, striking) and if they have occurred in the relationship, acknowledging any violence reported in the CTS2 assessment.

The therapist first asked about yelling, and Daniel stated that the couple would argue, and at times they would have verbal arguments where they would yell at one another. The therapist asked Daniel what the verbal arguments in the relationship looked like and began to ask specific questions to gain further details about the verbal conflicts (e.g., "do these verbal arguments ever escalate to where one of you push or shove each other?"). Daniel appeared to be agitated with the questioning and asked the therapist about why this was important to discuss. The therapist remained calm and told Daniel that it would help the therapist understand the relationship and the conflicts that the couple was experiencing. Throughout the discussion, Daniel reported that the couple would only yell at one another on occasion. He stated that they never physically harmed one another. Daniel did tell the therapist that it seemed that their verbal conflicts were becoming more frequent. The therapist asked if the verbal conflicts were escalating in severity, and he reported that they were not. Daniel told the therapist that he was not afraid of his partner, felt safe in the relationship, and was committed to improving the relationship.

Next, the therapist met with Emily individually. The therapist asked what conflict looked like in the relationship and asked specific questions about specific acts, as they had done with Daniel. Emily told the therapist that their arguments have been "getting worse and worse" lately. The therapist asked

Emily what was happening during these arguments that made it feel like the arguments were getting worse. Emily told the therapist that Daniel had become "very scary" recently. The therapist asked Emily what Daniel was doing that was scary. Emily told the therapist that Daniel was becoming aggressive. The therapist began to ask Emily about specific acts of physical aggression and learned that Daniel had slapped Emily multiple times, had pushed her on the floor, threatened to harm her physically, and strangled her during one of their most recent arguments. Emily asked the therapist, "you're not going to report him to the police, are you?" The therapist explained to Emily that in the state they live in, violence between two adults does not require a report, so Daniel would not be reported unless Emily wanted to file a police report. Emily did not want to file a report and stated that she was relieved because she would feel unsafe if Daniel knew she disclosed what happened. Because of the differing reports of violence, the severity of violence, and Emily's fear, the therapist explained to Emily that couples treatment would not be a good fit. The therapist provided Emily with local victim advocacy resources and recommended individual therapy for both Daniel and Emily. When the therapist met with Daniel and Emily together after their individual meetings, the therapist did not share Emily's report of violence with Daniel. However, the therapist told both partners that they recommended individual therapy for each partner at this time and thought that they would have better results with an individual approach.

Research-Based Couple Treatment Modalities for IPV

The following sections include 4 couple-based approaches to treating IPV with existing research: Domestic Violence-Focused Couples Therapy (a general treatment approach), Behavioral Couples Therapy (for couple experiencing substance abuse and IPV), Creating Healthy Relationships Program (for low-income parents experiencing violence), and No Kids in the Middle (for high conflict coparents). This section aims introduce these modalities, provide resources to engage further, and review existing research supporting them. Table 2 identifies various key components and interventions used in the following approaches to facilitate relational change and eliminate violence.

Domestic Violence-Focused Couples Therapy (DVFCT)

Domestic Violence-Focused Couples Therapy (DVFCT) is an 18-session program that aims to end violence (psychological, physical, and sexual), build conflict resolution skills, and enhance couple relationships for couples who choose to stay together or who have shared custody of their children (Stith et al., 2011). DVFCT is typically provided by cotherapists and can be in a single-couple or multicouple format. Couples included in treatment are carefully screened using various violence, substance use, depression, and relationship satisfaction measures. Stith and colleagues (2011) recommend exclusion from the program in situations of severe violence or stark differences in reports of violence, untreated substance abuse, lack of relational commitment, and potential for violence escalation.

The program is solution-focused oriented (De Shazer, 1985), centered on building existing strengths and developing nonviolent conflict resolution skills. The first 6 sections consist of honoring the problem, defining the miracle, providing information related to IPV, practicing mindfulness, safety planning and negotiated time-out, and exploring the role substance use. To promote safety of couples in these initial sessions, couples should either be separated (or put in gender-specific groups if a multicouple format is implemented), or therapists should include pre- and postsession check-ins to assess for safety and provide support (Stith et al., 2011). One particularly helpful intervention for safety can be teaching the "negotiated time-out" technique. The "negotiated time-out" can empower both partners during conflict and consists of teaching the couple to identify their own internal signals of distress and anger and when they need to step away from the situation. When a partner is able to recognize this, they can call for a time-out, and they can signal a hand gesture that signifies a time-out is needed or that the couple had come up with together in session. The couple can then separate for an agreed upon amount of time. During the time-out, the couple can utilize strategies to calm down that were also discussed in session. Lastly, the partner of initiated the time-out can then return to their partner to finish the conversation they were having originally without escalated conflict.

For the remaining 12 sessions of the program, focus is shifted to conjoint work with the couple and the process moves from therapist directed to client directed. The goal of treatment moves from

Table 2
Key Components and Interventions Used in Couple-Based IPV Treatments

Model	Key components and interventions
Domestic violence-focused couples therapy (DVFCT; Stith et al., 2011)	Establishing safety and developing a healthy image of relationships • honoring the problem • defining the miracle • providing information related to IPV • practicing mindfulness • safety planning • negotiated time-out • exploring the role substance use Monitoring risk and enhancing safety within one's unique relationship • miracle question • exception questions • agency questions • scaling questions • modeling a future- and success-oriented view
Behavioral couples therapy (BCT; O'Farrell & Schein, 2011; O'Farrell & Fals-Stewart, 2012)	Substance-focused interventions • create a daily recovery contract • daily trust discussions • consistent substance screenings • progress recorded calendar • participating in other activities that aid recovery Relationship-focused interventions • catching your partner doing something nice • participating in shared rewarding activities • increasing caring acts • developing listening skills • learning to expressing feelings directly • negotiating changes • engaging in planned communication sessions
Creating healthy relationships program (CHRP; Bradley et al., 2011; Cleary Bradley & Gottman, 2012).	• managing stress • managing conflict • establishing connections in the family with partners and children • creating shared meaning • maintaining intimacy
No kids in the middle (Van Lawick & Visser, 2015)	Reduce destructive parental conflict and limit harm to children • keep the child in mind • work in groups • stop the legal processes • make free space for interactions • creative presentation ceremonies • reach out to network

Note. IPV = intimate partner violence.

establishing safety and developing a healthy image of relationships to monitoring risk and enhancing safety within one's unique relationship. This is done through various solution-oriented techniques, including the miracle question (e.g., asking the clients to explore how things would look if a "miracle" occurred and the problems in their relationship were no longer there), exception questions, agency questions, scaling questions, and therapists modeling a future- and success-oriented view. Sessions in this stage still begin and end with individual (or gender-specific group) check ins.

Research examining the effectiveness of DVFCT, done by creators of the model, found that marital aggression perpetrated by both males and females was significantly lower at their six-month follow up compared to their pretest (Stith et al., 2004). In addition to changes in marital aggression, couples also reported higher levels of disapproval of violence in relationships and higher levels of marital satisfaction. But these differences were only significant for couples participating in a multigroup format. The following resource may be of interest for those wanting to learn more about

DVFCT: Couples Therapy for Domestic Violence: Finding Safe Solutions (Stith et al., 2011).

Behavioral Couples Therapy (BCT)

Behavioral Couples Therapy (BCT) is an evidence-based dyadic treatment for alcohol and drug abuse (O'Farrell & Schein, 2011). Although created to address substance abuse, BCT has been found to effectively reduce IPV in couples (O'Farrell et al., 1999; O'Farrell et al., 2004), which is likely related to the well-established comorbidity and interaction of substance use and IPV (Cafferky et al., 2018). BCT typically encompasses 12–20 conjoint sessions with the individual experiencing substance abuse and their partner and may be done in addition to individual counseling. O'Farrell and colleagues (2004) note that BCT is not a good fit for partners who are both abusing substances or experiencing severe violence. The program is behavior oriented and entails two parts: substance-focused interventions and relationship-focused interventions.

Initial work centers on the substance-focused interventions and aims to build support for abstinent living. Couples create a daily recovery contract which encompasses daily trust discussions, consistent substance screenings, a progress recorded calendar, and participating in other activities that aid recovery (ex. medication, other activities; O'Farrell & Fals-Stewart, 2000). When attendance and abstinence stabilize, focus shifts to enhancing relationship functioning.

Relationship-focused interventions focus around two main objectives, increasing positive interactions and enhancing communication skills. Positive interactions are achieved through interventions like catching your partner doing something nice, participating in shared rewarding activities and increasing caring acts. Communication skills are enhanced through developing listening skills, learning to expressing feelings directly and negotiate changes, and engaging in planned communication sessions (O'Farrell, 2000). Overall, relationship focused interventions aim to enhance communication and connection between partners to aid the substance abusing partner in establishing new and healthy behaviors.

Research studies examining BCT's effectiveness in reducing violence, done by creators of the model, have found consistent findings of its success. In O'Farrell and colleagues (1999) first study, they found 61% of couples reported violence at the pretest and only 19% of couples reported violence at a two-year follow up. A follow up study mirrored prior findings of BCT's success lowering levels of violence among partners where one is abusing substances, in addition to highlighting the influence of the recovery process on this relationship (O'Farrell et al., 2004). The following resource may be of interest for those wanting to learn more about BCT: *Behavioral Couples Therapy for Alcoholism and Drug Abuse* (O'Farrell & Fals-Stewart, 2012).

Creating Healthy Relationships Program (CHRP)

Creating Healthy Relationships Program (CHRP) is a psycho-educational program designed to reduce IPV in low-income and situationally violent couples with children. CHRP is based on sound relationship theory, which highlights 7 key domains to creating a healthy relationship, including building love maps, sharing fondness and admiration, turning toward, positive perspective, managing conflict, making dreams come true, and creating shared meaning (Bradley et al., 2011). CHRP consists of twenty-two two-hour sessions with a group of couples delivered by female and male cofacilitators (Cleary Bradley & Gottman, 2012). The program aims to increase skills related to fostering a strong relationship and navigating conflict.

Each session of CHRP begins with a video of a mock couple navigating the topic of the week. Topics fall under five main themes: managing stress, managing conflict, establishing connections in the family with partners and children, creating shared meaning, and maintaining intimacy. Couples are encouraged to discuss relevance and reactions to the videos, which is then followed with facilitators providing educational material on the topic. Sessions are ended with a skills component, where couples are encouraged to actively practice skills being explored.

Research examining CHRP's effectiveness has been done by the creators, Cleary Bradley and Gottman (2012), who found positive impacts of the program. Couples were found to experience a reduction in IPV via increased relationship skills. In addition to examining IPV, Bradley and colleagues (2011) also found positive changes in levels of relationship satisfaction and conflict. The following Gottman and/or Bradley articles may be of

interest for those wanting to learn more about CHRP: "Reducing Situational Violence in Low-Income Couples by Fostering Healthy Relationships" (Bradley et al., 2011) and "Supporting Healthy Relationships in Low-Income, Violent Couples: Reducing Conflict and Strengthening Relationship Skills and Satisfaction" (Cleary Bradley & Gottman, 2012). A limitation of this approach is the lack of instruction manual or related book, but these articles offer insight to the approach and relate it to Gottman's general couple's-based treatment.

No Kids in the Middle

"No Kids in the Middle" is a multifamily approach developed by Van Lawick and Visser (2015). Although this program isn't focused on working with couples who want to stay together after IPV, it is still an important treatment modality to note when exploring potential treatment options for couples who have experienced IPV. The program was developed to reduce destructive parental conflict and limit its damaging impact on children in high conflict divorced families. Treatment consists of two intake sessions, a network information session, and eight 2-hour parent treatment sessions with corresponding children's sessions. Six key principals are utilized throughout treatment: keep the child in mind, work in groups, stop the legal processes, make free space for interactions, creative presentation ceremonies, and reach out to network. These principals ultimately aim to enhance engagement and communication between parents, their children, the professionals who work with the family, and the social networks of both parents.

Work with parents does not aim for reconciliation of parents, but instead focuses on understanding and accepting one another's differences with increased capacity to navigate challenges. This is done through increasing awareness of triggers, enhancing conflict de-escalation skills, and engaging social networks. It is important that work with children is done simultaneously so children see their parents' taking ownership of the issue and working together (Van Lawick & Visser, 2015). The group for children is not directive but instead gives opportunity for artistic expression of their experience with opportunity to share creations with parents, in addition to creating space to connect with other children.

Research studying "No Kids in the Middle's" effectiveness at reducing harmful conflict among parents has found successful initial results. In a qualitative study, parents reported decrease in frequency and intensity of conflicts, which increased their capacity to navigate problems and positive coparenting (Visser et al., 2020). Parent reports mirrored child reports of lessened parental conflict. The following resource may be of interest for those wanting to learn more about "No Kids in the Middle": Group Therapy for High-Conflict Divorce: The "No Kids in the Middle" Intervention Program (Visser & Van Lawick, 2021).

Common Factors of IPV Treatment

A commonality in these approaches is the influence of context of violence on treatment. Of the four approaches, one is a more general approach (Stith et al., 2011), yet it has an intensive screening process and is relatively selective about who participates, and the other three approaches (Bradley et al., 2011; O'Farrell et al., 1999; Van Lawick & Visser, 2015) work within unique contexts of violent couples. This suggests that relating treatment to the couple's context of violence is an important approach when deciding what treatment modality may be appropriate when working with couples who have experienced IPV in their current or former relationship.

Although these programs tailor their treatment to their relevant audience, there are still several common themes within these treatment approaches. Some common factors among all or most of the programs include establishing safety or stabilization in initial stages of treatment, emphasis on skills and behaviors, and enhancing skills related to conflict management and relationship satisfaction. These themes align with well-established risk markers associated with IPV perpetration, such as low relationship satisfaction, verbal arguments, stress, and emotional dysregulation (Spencer et al., 2022).

Call for Research on Couple-Based Approaches

As the described treatment approaches have been developed and empirically supported, additional approaches continue to build off these programs and be developed. Several other treatment programs have been created that have mirrored aspects of these approaches (O'Leary & Cohen, 2007). New programs have been developed using various theories or lenses like Emotion-Focused Therapy (Slootmaeckers & Migerode, 2020) or

Gender-Inclusivity (Hamel, 2005). Although these programs are based on existing research or evidence-based programs, there is no research validating their effectiveness with IPV couples. Existing research supports the use of couple-based approaches but future research is needed to examine these programs the additional insight and treatment perspective they can offer.

Experiences of IPV been found to be impacted by contextual factors, like race, sexuality, and culture (Malley-Morrison & Hines, 2004), yet there is limited recognition for these factors in the described treatment modalities and limited research examining how these factors impact treatment outcomes for couples. Stith and colleagues (2020), recognizing this need, created three international adaptations for their approach, DVFCT, and an examination on how this was done was provided in the article. The adapted protocols in Iran and Colombia yielded positive results, while the adapted protocol in Finland had not been tested at the time of publication.

It is necessary to address power imbalance in the relationship, being intentional to not reinforce existing unacknowledged gender differences based on culturally reinforced stereotypes of gender and power. Knudson-Martin (2013) break down this process in their articles, identifying four key components of establishing mutual support: shared relational responsibility, mutual vulnerability, mutual attunement, and shared influence. Further research is needed to support these adaptations. Additionally, there is a larger need to examine how contextual factors impact couple-based treatment of IPV and how to account and accommodate for these differences.

IPV is a prevalent issue causing intrapersonal and interpersonal distress for perpetrators, victims, and those around them, leading it to be a relevant issue for mental health professionals. This article aimed to highlight the value of conjoint treatment in efforts to reduce/eliminate IPV, in addition to exploring assessment considerations and introducing treatment modalities. It is necessary to highlight again that couples therapy is not a suitable treatment for all couples experiencing IPV in their relationship. It is necessary for the therapist to thoroughly assess for IPV and ensure that both partners feel safe in the relationship and safe discussing acts of violence. It is necessary that the therapists assess whether the couple is experiencing intimate terrorism or situational couples' violence. In cases where intimate terrorism is present, couples therapy is not a suitable treatment option. In cases where situational couple violence is present, therapists can utilize researched treatment modalities. If a therapist is concerned about working with a couple where IPV is present or doesn't have the necessary background or training in treatment approaches, we strongly suggest that the therapist refers the couple to a mental health professional who specializes in working with IPV.

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