Aggression and Violent Behavior 40 (2018) 119–127

Contents lists available at ScienceDirect

Aggression and Violent Behavior

journal homepage: www.elsevier.com/locate/aggviobeh

Motivational interviewing for enhancing engagement in Intimate Partner Violence (IPV) treatment: A review of the literature

Sara Soleymani, Eileen Britt*, Mark Wallace-Bell

School of Health Sciences, University of Canterbury, Christchurch 8140, New Zealand

ARTICLE INFO

Keywords:
Motivational interviewing
Engagement
Intimate Partner Violence

ABSTRACT

Client engagement is an essential component in Intimate Partner Violence (IPV) treatment. Engaged clients are more likely to engage with treatment and report a greater degree of treatment satisfaction. Likewise, enhanced engagement is associated with positive treatment outcomes such as session attendance and homework compliance. Only small effect sizes have been reported for reductions in IPV itself, and treatment engagement has been identified as an important factor in this, with studies reporting high rates of non-attendance and drop-out.

This article reviews research on the efficacy of motivational interviewing (MI) as a pre-treatment intervention to promote treatment engagement for men who have been mandated or self-referred to attend Intimate Partner Violence treatment. Although limited in number (n = 5), these studies revealed a significant improvement in the level of engagement, session attendance and homework compliance following MI. Further research to focus on MI for treatment engagement, specifically, rather than MI for behaviour change is needed.

1. Introduction

Intimate Partner Violence (IPV) is an abuse of power perpetrated mainly (but not only), by men against women in a relationship or after separation and is believed to be a means for men to systematically dominate, control, devalue and disempower women (Healey, 2014). It takes a number of forms, but the most commonly acknowledged forms are physical and sexual violence, threats and intimidation, emotional and social abuse, and economic deprivation (Healey, 2014).

Different cultures have different beliefs regarding the importance of the home and the comfort and security that should be found there. However, for many women home is a place of fear and humiliation (Liesl, 2011). The 2010 National Intimate Partner and Sexual Violence Survey (NISVS) demonstrated that about 35.6% of American women have been the victim of IPV in the form of rape, physical violence, or stalking at some point throughout their lives (Murray, Crowe, & Akers, 2016). Another study indicated that one in four women had experienced severe abuse from their intimate partners in the United States (Burge, Katerndahl, Wood, & Becho, 2016). Other surveys indicate that more than 95% of abuse perpetrators are men and between 20% and 25% of adult women have been physically abused by a partner (Carter, 2007). A multi country study (in countries including: Bangladesh, Brazil, Peru, Samoa, Japan, Thailand, United Republic of Tanzania, Serbia, and Ethiopia) with 24,000 women found that 70% of women reported that they had been physically abused; this rate was lower in western society (Schimanski & Hedgecock, 2009). A New Zealand (NZ) replication of this study found that 33.1% of women in Auckland had experienced physical and/or sexual violence by an intimate partner at some point in their lives (Fanslow & Robinson, 2004).

Thus, IPV is a common problem, which also has serious social consequences accompanied with physical and psychological health impacts (Costa, Kaestle, Walker, & Curtis, 2015; Liesl, 2011). Some of the physical consequences for the female recipient of IPV include: gynaecological disorders, injuries and mortality, and sexually transmitted disease (Kazantzis, Flerr, & Long, 2000). Other consequences that occur frequently for the recipients are depression, posttraumatic stress disorders, anxiety, low self-esteem, sleep disturbances, eating disorders, suicidal behaviour, and increased likelihood of substance abuse (Blasco-Ros, Herbert, & Martinez, 2014; Devries, Mak, Bacchus, Child, & Falder, 2013; Fujiwara, Okuyama, Izumi, & Osada, 2010; Orava, McLeod, & Sharpe, 1996; Pico-Alfonso, 2005); Likewise, women who experience IPV may develop feelings such as guilt and they may become socially isolated and emotionally dependent on their abusive partner (Matud, 2005).

As well as negative consequences for the female victim, IPV also affects children who may be present in the home. Children who are exposed to IPV are at increased risk of developing a range of psychological and behavioural problems such as academic problems, depression, anxiety, substances abuse, and aggression (Ghasemi, 2009).

Men as the perpetrator may also experience negative consequences

* Corresponding author.
E-mail addresses: Sara.soleymani@pg.canterbury.ac.nz (S. Soleymani), Eileen.britt@canterbury.ac.nz (E. Britt), Mark.wallace-bell@canterbury.ac.nz (M. Wallace-Bell).

https://doi.org/10.1016/j.avb.2018.05.005
Received 4 May 2017; Received in revised form 28 March 2018; Accepted 2 May 2018
Available online 04 May 2018
1359-1789/

as a result of their behaviour. This includes feeling down, feeling bad about the way they treated their partner, being distracted at work, worrying about their partner leaving the relationship, and being avoided by their children, friends, and relatives. The majority of men have also reported their violent behaviours to negatively impact on their abilities at work (Walker et al., 2010). Given that statistics demonstrate high rates of male assault against female, the focus of this review is on the male perpetrator of IPV in heterosexual relationships.

1.1. Treatment programs

There are now over 40 published studies, five meta-analyses and numerous commentaries on this field of research (e.g., (Babcock, Green, & Robie, 2004; Feder & Wilson, 2005; Gondolf, 2004)). As a whole, these studies offer only modest support for the role of treatment in helping men end abusive behaviours. Some studies have explored the reasons for the small effect size and a number of factors have been found which may account for these reduced outcomes. These factors include: high rates of non-attendance and treatment dropout Brown, O'Leary, and Feldbau (1997); (Cadsky, Hanson, Crawford, & Lalonde, 1996; Chen, Bersani, Myers, & Denton, 1989; Hamberger & Hastings, 1989), low motivation or readiness to change, problems in the establishment of a therapeutic alliance (Taft, Murphy, King, Musser, & DeDeyn, 2003), and limited engagement in treatment activities such as homework assignments (Taft, Murphy, Musser, & Remington, 2004).

The most important reason however for the small effects of IPV treatment seems to be that on average, 50% of the participants never complete treatment; regardless of whether they are court ordered or not (Daly & Pelowski, 2000). Furthermore, research shows that those who do not complete IPV treatment are at greater risk to continue their violent behaviours and assault their partners (Babcock & Steiner, 1999; Bennett, Stoops, Call, & Flett, 2007; Gordon & Moriarty, 2003; Rondeau, Brodeur, Brochu, & Lemire, 2001). For example, one study (C. Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008) found that treatment attrition rate was significantly related to post-offense arrests in which more than twice as many treatment dropouts (39.7%) than completers (17.9%) were rearrested for a general crime during the 13-month study period. Additionally, those who dropped out from treatment were three times more likely (8.1%) than treatment completers (2.8%) to be arrested for an assault-related charge during the study period.

Factors that have been found to lead to drop out are lifestyle instability factors, motivational factors, program and counsellor characteristics, and treatment compatibility factors (Rooney & Hanson, 2001). In particular, low motivation as a reason for drop out and its relationship with reduced outcome has consistently identified in a number of studies (Arias, Arce, & Vilariño, 2013; Brown, Skelton, Perrin, & Skinner, 2016; Eckhardt, Murphy, & Whitaker, 2013; Hardy, Dollahite, Johnson, & Christensen, 2015; Kelley, Bravo, Braitman, Lawless, & Lawrence, 2016; Naughton, McCarthy, & McCarthy, 2015; Rennie, Harris, & Webb, 2014). Thus, because of high attrition rates and the increased chance of recidivism after drop-out from IPV treatments sessions, the need to address motivation, and treatment engagement specifically, in IPV treatment programs is essential.

1.2. Motivational interviewing

Motivational interviewing (MI) is a person-centred approach that aims to resolve ambivalence about behaviour change by strengthening a person's own motivation and commitment to change (Miller & Rollnick, 2012). MI was initially developed to improve adherence to drug and alcohol treatment (Miller & Rollnick, 2012) but has broadened in application beyond the field of addiction to a range of other behaviours, including health behaviour change (Lundahl et al., 2013), offending (Anstissa, Polaschekb, & Wilson, 2011; Crane, Eckhardt, & Schlauch, 2015; Harper & Hardy, 2000; Lincourt, Kuettel, & Bombardier, 2002; McMurran, 2009; Stein et al., 2006; Vasilaki, Hosier, & Cox, 2006), and engagement in treatment (Carroll, Libby, Sheehan, & Hyland, 2001; Dean, Britt, Bell, & Stanley, 2016; Lundahl et al., 2013; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Medley & Powell, 2010; Neighbors, Walker, Roffman, & Mbilinyi, 2008; Seal et al., 2012; Sterrett, Jones, Zalot, & Shook, 2010; Strong et al., 2012; Swartz et al., 2007; Venner & Verney, 2015). Motivational Interviewing can be used as a stand-alone therapy (Brody, 2009; McCambridge & Strang, 2004), as a combination with other treatments with an aim to enhance treatment gains (e.g. CBT) (Balán, Moyers, & Lewis-Fernández, 2013; Merlo et al., 2010; Moyers & Houck, 2011), and finally MI can be used as a pre-treatment intervention (e.g. before CBT) to increase engagement in the treatment (Brennan, 2015; Crane & Eckhardt, 2013; Kistenmacher & Weiss, 2008).

1.3. Motivational interviewing and treatment engagement

Treatment engagement has been found to be related to a number of factors including client characteristics (e.g. attachment style, motivation, and readiness to change), therapist characteristics (e.g. therapists warmth, optimism, and humour), and treatment factors (e.g. motivational enhancement) (Holdsworth, Bowen, Brown, & Howat, 2014a, 2014b). Further research has shown the link between client engagement and successful treatment outcome (Dearing, Barrick, Dermen, & Walitzer, 2005; Dowling & Cosic, 2011; Holdsworth et al., 2014a, 2014b; Schley, Yuen, Fletcher, & Radovini, 2012).

Much of the research on treatment engagement has focused on therapeutic alliance, defined as the agreement between the client and therapist on the goals and tasks of treatment and the therapeutic and affective bond between them (Bordin, 1979). Therapeutic alliance has also been related to completion of IPV treatment and successful cessation of abusive behaviour. For example, Rondeau et al. (2001) using a sample of 286 batterers found that clients' working alliance ratings distinguished treatment completers and dropouts better than a variety of demographic, interpersonal, psychiatric, and relationship status variables (Rondeau et al., 2001). Qualitative studies of successful change in IPV have also shown the importance of overcoming denial and of developing a working relationship with program facilitators (Pandya & Gingerich, 2002; Scott & Wolfe, 2000; Silvergleid & Mankowski, 2006). For example, (Scott & Wolfe, 2003) found that men who denied problems with abuse and distrusted their counsellors showed less positive change in empathy, communication, and abusive behaviour over intervention than men who began with greater readiness to engage in treatment.

Given the association of therapeutic alliance to positive outcomes, a viable strategy for improving the success of IPV treatment may be to tailor treatment to maximize clients' agreement with the goals of intervention and trust in their therapists, as well as developing strategies that specifically address the perpetrator's motivation to engage in treatment. Motivational interviewing (Miller & Rollnick, 2002) may be a useful approach to promoting treatment engagement in IPV treatment as it has been found to increase treatment engagement (Baker & Hambridge, 2002; Dean et al., 2016), reduce dropout (Roberto, José Ramón, & Cristina, 2004) and improve outcomes among clients who are reluctant to attend treatment and/or change their behaviour (Chlebowy et al., 2015; Lewis-Fernández et al., 2013; Lincourt et al., 2002).

Zuckoff, Swartz, and Grote (2015) have noted the distinction between MI for treatment engagement and MI for behaviour change. He recommended that MI for treatment engagement should include not only consideration of motivation for changing the behaviour under consideration (i.e., changing the risky or unhealthy behaviour), but also should include consideration of additional factors that might influence engagement in treatment as a way of changing the particular behaviour. Zuckoff et al. (2015) identified these as practical (e.g., cost, access, time); symptom (e.g., low energy, anxiety) barriers; negative perception of the proposed treatment (e.g., too long or demanding); negative past