VNIVERSITAT DE VALÈNCIA

Programas de intervención con hombres penados por violencia de género: el enfoque motivacional como aproximación para mejorar su eficacia

TESIS DOCTORAL

Doctorado en Investigación en Psicología

Presentada por Faraj Abu-elbar Santirso

Dirigida por Dra. Marisol Lila Murillo
Dr. Enrique Gracia Fuster

Valencia, Octubre 2020

AGRADECIMIENTOS

Concluida esta larga travesía es momento de echar la vista atrás y agradecer a las personas que me han acompañado. Quiero dar las gracias en primer lugar a mis directores, Marisol y Enrique. Marisol fue mi profesora durante la carrera. Ya entonces me dejó impresionado con sus lecciones, su gancho para transmitir ideas y atraer a su audiencia. Como directora de tesis es todavía mejor. Gracias por todas tus correcciones y por los mensajes de ánimo que acompañaban a cada comentario. Enrique, gracias por haber confiado en mí, por todas las correcciones y reuniones, enseñándome la artesanía que hay detrás de hilvanar ideas y evidencias para dar lugar a una aportación científica de calidad. Además, tu empeño en buscar que la evidencia científica esté detrás de la intervención y la docencia ha calado en mí y seguro, en los que me sucederán. Despierta poderosamente mi admiración la capacidad de Marisol y Enrique para haber puesto en marcha el programa Contexto. Un programa de intervención que lleva mejorando la vida de las personas y de la sociedad en su conjunto más de una década. Traspasar las fronteras del conocimiento y crear los mecanismos para que esta evidencia afecte de forma directa a la vida de las personas, es extraordinario. En lo personal, durante estos años no han sido pocas las veces en las que me he visto superado por circunstancias y siempre habéis estado ahí, apoyándome y animándome a continuar. Me siento infinitamente agradecido de haberos tenido como directores.

Quiero agradecer especialmente a mis compañeras de doctorado, Miriam, Manu y Vivi. Hemos pasado muchas horas preparando docencia, viajando a congresos, escribiendo artículos y celebrando éxitos. He aprendido mucho de vosotras, y este sendero tantas veces laberíntico, ha sido mucho más fácil de recorrer con vosotras al lado.

Quiero agradecer al equipo de personas que hacen posible que el programa Contexto funcione, en especial a la subdirectora del programa, Elena, llena de vitalidad y

siempre dispuesta a echarnos un cable con una sonrisa, y a todo el equipo, Aritz, Alba, Vicente, Raquel, Mavi, Manu Roldán, Sara, Javier, María, Adriá, Mónica, Paula, Manuela… Gracias a las personas que están, a las que estuvieron y a las que estarán.

A mis compañeras doctorandas de estos últimos años, Arabella y Sara. Seguid trabajando duro, y disfrutad de este pedazo de equipo que tenéis.

A Gail Gilchrist y a los miembros de su equipo, muchísimas gracias por darme la oportunidad de formarme con vosotras y hacerme sentir uno más del equipo.

Darle las gracias a Sergio, el silbador errante, por su ayuda para gestionar el temido POD y por los divertidos cafés.

A Estefanía, Sofía y Jessica por acompañarme en los primeros pasos en el mundo de la investigación.

Quiero dar las gracias a mi mejor amigo, Alan, por estar ahí siempre que lo he necesitado, por las escapadas a algún oasis a ver las estrellas y a sentir que estamos vivos. Me siento muy agradecido de tener a un amigo como tú.

A mis colegas, Rubén, Maby, Fran, Leah, David, Fran Gilabert, Paula, Paul, Héctor, Pepe, Sara, Adrián y Delmiro. Gracias.

A María Ascensión López y Auxi Javaloyes, por su humanidad, su profesionalidad y su entrega. A Esther Lorente y Beatriz García, por enseñarme a poner las cosas en sus respectivas cajas.

A Lasky y Miko, por haberme querido y quererme tanto, como yo a vosotros.

Quiero dar las gracias a Paz, Vidal, Beatriz y Benjamín. Pedro Muñoz ha sido mi segunda casa en estos años, y es que así me habéis hecho sentir.

A mis hermanas, Aisha y Laila por confiar en mí y apoyarme. Sois un ejemplo a seguir para mí. A mis sobrinas Iara, Jairo, Nora y Emma. Algún día estaré en vuestras tesis.

Ahora es el turno de agradecer a la persona que más admiro, mi madre. Quiero agradecerte habernos inculcado el interés por la literatura, la música, el cine, la ciencia… Nuestra casa siempre ha estado llena de libros porque tú los traías, de tus canciones, porque tú las cantabas, de tus historias y de tu falar asturianu. Te debo la vida y, si de algunas cosas de mí mismo puedo sentirme orgulloso, son un reflejo tuyo, gracias mamá.

Por último, quiero agradecer esta tesis a la persona más importante en mi vida, Irene, que me ha acompañado todos estos años. He tenido el privilegio de poder vivir este trayecto en paralelo contigo, compartiendo las alegrías y los muchos desafíos que hacer un doctorado representa. Desde la estancia en Londres hasta la barra de las canteras. Gracias por apoyarme e inspirarme para ser mejor persona cada día.

ÍNDICE

Listado de abreviaturas		9
Abstract		11
Resumen		13
Capítulo 1	Introducción general	15
	1. Programas de intervención con maltratadores	17
	2. Estrategias motivacionales: incrementando la efectividad de los programas de intervención con maltratadores	25
	3. Alianza terapéutica y conductas proterapéuticas	26
Capítulo 2	Objetivos	29
Capítulo 3	Método	33
	1. Revisión sistemática de la eficacia de las estrategias motivacionales en programas de intervención con maltratadores	35
	2. Validación de una escala observacional de alianza terapéutica	37
	3. RCT: efectos de la intervención con estrategias motivacionales en la alianza terapéutica y la conducta proterapéutica de una muestra de maltratadores	42
Capítulo 4	Estudio 1. Motivational strategies in interventions for intimate partner violence offenders: a systematic review and meta-analysis of randomized controlled trials	49
	1. Introduction	51
	2. Method	54
	3. Results	56
	4. Trial Author's findings and conclusions	71
	5. Meta-analysis	73
	6. Discussion	76
	7. References	82
	Estudio 2. Validation of the working alliance inventory-observer short version with male intimate partner violence offenders	99
	1. Introduction	101
	2. Method	104
	3. Results	109
	4. Discussion	113
	5. References	117
	6. Appendix	125
	Estudio 3. Motivational strategies, working alliance, and protherapeutic behaviors in batterer intervention programs: a randomized controlled trial	127
	1. Introduction	129
	2. Method	133
	3. Results	137
	4. Discussion	144
	5. References	147
Capítulo 5	Discusión general	159
	1. Discusión general	161
	2. Implicaciones prácticas	171
	3. Limitaciones generales	172
	4. Líneas de investigación futuras	173
	5. Conclusiones generales	174
	6. General conclusions	174
Financiación		175
Referencias		177

LISTADO DE ABREVIATURAS

BIP = Batterer Intervention Program

CBT = Cognitive Behavioral Therapy

CG = Control Group

CTS-2 = Conflict Tactics Scales Revised

IG = Intervention Group

IMP = Individualized Motivational Plan

IPV = Intimate Partner Violence

MCTS = Modified Conflict Tactics Scale

MI = Motivational Interviewing

MIT = Motivational Interviewing Techniques

MMEA = Multidimensional Measure of Emotional Abuse

PENN = Pennsylvania Helping Alliance Rating Scale

RCT = Randomized Controlled Trial

SBIP = Standard Batterer Intervention Program

SUD = Substance Use Disorder

TLFB-AM = The Time Line Follow Back-Aggression Module

TTM = Transtheoretical Model of behavioral change

VTAS = Vanderbilt Therapeutic Alliance Scale

WAI = Working Alliance Inventory

WAI-O = Working Alliance Inventory Observer Version

WAI-O-S = Working Alliance Inventory Observer Short Version

WAI-P = Working Alliance Inventory Patient Version

WAI-S = Working Alliance Inventory Short Form

WAI-T = Working Alliance Inventory Therapist Version

ABSTRACT

Intimate partner violence (IPV) against women is a widespread public health problem with serious consequences on victims' physical and psychological health, their children, and the wider society. IPV offender intervention programs are one of the main treatment approaches aimed at preventing further violence. Meta-analyses focused on the effectiveness of IPV offender intervention programs have shown small effect sizes. Consequently, new approaches have been proposed as a way to increase their effectiveness, among which motivational strategies stand out. The aim of the present doctoral thesis was to analyze the effect of the inclusion of motivational strategies on the effectiveness of IPV intervention programs, both in proximal outcomes (i.e, working alliance and pro-therapeutic behavior) and in final outcomes (i.e., reduction of recidivism, intervention dose, and dropout). To this end, three studies were carried out. The first study evaluated the effectiveness of motivational strategies in reducing physical and psychological violence, dropout, intervention dose and recidivism by means of a systematic review with meta-analysis of the existing randomized controlled trials in the literature. The second study analyzed the psychometric properties of an observational scale of working alliance, considering its relationships with other variables (i.e, pro-therapeutic behaviors) with a sample of IPV offenders, as a previous step for the third study. The third study compared the effects of an intervention with motivational strategies versus an intervention without such strategies on the working alliance and pro-therapeutic behaviors of IPV offenders, using the scale validated in the second study, among other instruments. Taking together, the results of this doctoral thesis highlight the benefits of including motivational strategies in IPV offender programs in order to improve the adherence to the intervention, the reduction of dropout, and key processes of the intervention such as working alliance and pro-therapeutic behaviors. Specifically, the

inclusion of motivational strategies throughout the intervention program could favor the stabilization of these benefits in the long term as opposed to the sporadic use of these strategies. Compared to a more coercive approach, motivational strategies may help batterers overcome their ambivalence towards change by helping them find their own reasons for change and facilitating the achievement of their goals, and ultimately increasing the effectiveness of IPV offender programs. These findings go beyond previous research in this field, and could favor the optimizations of intervention protocols in this population.

Keywords: Batterer intervention programs; Motivational strategies; Working alliance; Protherapeutic behaviors.

RESUMEN

La violencia de género es un problema de salud pública de proporciones epidémicas con serias consecuencias para la salud física y psicológica de las víctimas, sus hijos y la sociedad en su conjunto. Una de las aproximaciones para responder a esta problemática son los programas de intervención con maltratadores. Los meta-análisis que se han llevado a cabo para evaluar la eficacia de estos programas han mostrado tamaños del efecto pequeños. Debido a ello, se han propuesto nuevos acercamientos como vía para incrementar su eficacia, entre los que destacan las estrategias motivacionales. El objetivo de la presente tesis doctoral fue analizar el efecto de la inclusión de estrategias motivacionales sobre la eficacia de los programas de intervención con maltratadores, tanto en variables de proceso (i.e., alianza terapéutica y conducta pro-terapéutica) como en variables finales (i.e., reducción de la reincidencia, dosis de intervención y abandono del programa de intervención). Para ello, se realizaron tres estudios. El primer estudio evaluó la eficacia de las estrategias motivacionales en la reducción de la violencia física y psicológica, el abandono de la intervención, la dosis de intervención recibida y la reincidencia, mediante una revisión sistemática con meta-análisis de los ensayos controlados aleatorizados existentes en la literatura. El segundo estudio analizó las propiedades psicométricas de una escala observacional de alianza terapéutica, considerando sus relaciones con otras variables (i.e., conductas pro-terapéuticas) con una muestra de maltratadores, como paso previo para la realización del tercer estudio. El tercer estudio comparó los efectos de una intervención con estrategias motivacionales frente a una intervención sin dichas estrategias sobre la alianza terapéutica y las conductas pro-terapéuticas de maltratadores, empleando la escala validada en el segundo estudio, entre otros instrumentos. Considerados conjuntamente, los resultados de la presente tesis doctoral ponen de manifiesto los beneficios de la inclusión de estrategias motivacionales

en programas de intervención con maltratadores en la adherencia de la intervención, la reducción del abandono de ésta y procesos clave de la intervención como son la alianza terapéutica y las conductas pro-terapéuticas. En concreto, la inclusión de estrategias motivacionales a lo largo de todo el programa de intervención podría favorecer la estabilización de estos beneficios a largo plazo frente al uso de estrategias motivacionales de forma puntual. En comparación con un enfoque más coercitivo, las estrategias motivacionales podrían ayudar a los maltratadores a superar su ambivalencia hacia el cambio, ayudándoles a encontrar sus propias razones para cambiar y facilitando la consecución de sus objetivos y, en última instancia, incrementando la eficacia de los programas de intervención con maltratadores. Estos hallazgos suponen un avance respecto a la investigación previa en este campo, y podrían favorecer la optimización de protocolos de intervención en esta población.

Palabras clave: Programas de intervención con maltratadores; Estrategias motivacionales; Alianza terapéutica; Conductas proterapéuticas.

CAPÍTULO 1

Introducción general

1. Programas de intervención con maltratadores

La violencia de género en las relaciones de pareja es un problema de salud pública de proporciones epidémicas con serias consecuencias a corto y largo plazo para la salud física y psicológica de las víctimas, sus hijos y la sociedad en su conjunto (Campbell, 2002; Ellsberg et al., 2008; Guedes et al., 2016; Okuda et al., 2011; Vilariño et al., 2018; Organización Mundial de la Salud, 2013). A nivel global, la Organización Mundial de la Salud (2013) indica que un 30% de las mujeres que han tenido una pareja han sido víctimas de violencia física o sexual en algún momento de sus vidas, siendo esta prevalencia algo menor en los países con altos niveles de desarrollo económico (23.2%). En Europa, esta prevalencia se sitúa alrededor del 25.4% (Devries et al., 2013; Organización Mundial de la Salud, 2013). Así, un reciente estudio ha mostrado que el 22% de mujeres de los 28 países de la Unión Europea han sido víctimas de violencia física o sexual por parte de su pareja desde los 15 años, con una prevalencia entre países del 13 al 32% (Agencia de los Derechos Fundamentales de la Unión Europea, 2014). La alta prevalencia de esta problemática y su impacto social y económico justifica el desarrollo de estrategias de prevención y de intervención eficaces con el objetivo de proporcionar una respuesta global, que tenga en cuenta los factores sociales y culturales que están detrás de la misma (Organización Mundial de la Salud, 2005).

Los programas de prevención e intervención de la violencia contra la mujer en las relaciones de pareja han evolucionado desde una perspectiva centrada en la víctima a otra que incluye, a su vez, la intervención con el agresor (Stover, 2005). Así, los primeros programas de intervención con maltratadores surgen en los años 70 (Barner y Cartney, 2011; Jennings, 1987; Mankowski et al., 2002; Pleck, 2004). En esa década, la violencia contra la pareja se contemplaba como una variante del conflicto marital cuyo tratamiento estaba orientado a la terapia de pareja y la necesidad de una mayor asunción de

responsabilidad dentro del sistema familiar (Mankowski et al., 2002). Es a partir de la década de los 80 cuando el impulso de los movimientos de mujeres aumenta la concienciación de la sociedad acerca de la violencia de pareja como un problema de primer orden (Schecter, 1982).

Los programas de intervención con maltratadores comparten el objetivo de reducir los niveles de violencia en las relaciones de pareja y proteger a las víctimas (Cheng et al., 2019; Eckhardt et al., 2013). La necesidad de intervenir con el agresor se sustenta en factores como los siguientes: a) la protección de la víctima actual, ya que un alto porcentaje de mujeres continúan manteniendo una relación con el agresor tras la denuncia (Snyder y Scheer, 1981; Gondolf, 1987); b) la protección de las futuras parejas del agresor (Gondolf, 1987); c) la protección de los hijos e hijas, atendiendo a la vinculación que se ha descrito entre la violencia de pareja y el maltrato infantil (Rada, 2014; Casanueva et al., 2009; Hamby et al., 2010) y a la transmisión intergeneracional de la violencia de pareja (Franklin y Kercher, 2012; Kerley et al., 2010; Kwong et al., 2003; Whitfield et al., 2003); y d) los efectos negativos que tiene la encarcelación del agresor sobre la víctima y los hijos e hijas en términos de reducción de recursos o estigma social (Davis y Taylor, 1999).

Los programas de intervención con maltratadores presentan una considerable variabilidad respecto a métodos de intervención y acercamientos empleados (Eckhardt et al., 2013). En las revisiones sistemáticas acerca de la eficacia de estos programas (Arce et al., 2020; Babcock et al., 2004; Cheng et al., 2019; Eckhardt et al., 2013; Feder y Wilson, 2005) encontramos predominantemente dos modelos, los modelos psicoterapéuticos cognitivo-conductuales (e.g., Browne et al., 1997) y el modelo Duluth o intervención psicoeducacional feminista, basada en el poder y el control (e.g., Pence y Paymar, 1993). En menor medida, también encontramos otros modelos como el modelo

educacional, el modelo psicodinámico o intervención grupal no estructurada, el modelo de riesgos, necesidades y responsabilidad o el modelo holístico (Arias et al., 2013; Babcock et al., 2004; Cheng et al., 2019).

Desde los modelos cognitivo-conductuales se considera que la violencia es un comportamiento aprendido y que, del mismo modo, patrones de conducta no violentos pueden ser aprendidos (Adams, 1989). Según este modelo, los maltratadores presentan pensamientos distorsionados sobre ellos mismos, su pareja y la utilidad de la violencia en los conflictos (Banks et al., 2013). Estos enfoques terapéuticos incluyen factores que se han asociado con la violencia de pareja en la investigación empírica (Eckhardt et al., 2013). Entre estos factores, encontramos los déficits en las habilidades sociales, la impulsividad o las distorsiones cognitivas (Bazargan-Hejazi et al., 2014; Grigorian et al., 2020; Romero-Martinez et al., 2019; Schumacher et al., 2001). Entre las técnicas empleadas, se encuentran el reconocimiento de las ventajas y los inconvenientes del patrón de conducta violenta, las técnicas de control de la ira (e.g., técnicas de relajación y tiempo fuera), el entrenamiento en habilidades sociales (e.g., asertividad), las tareas para realizar en casa, la potenciación de la autoestima positiva o el reconocimiento y sustitución de actitudes y valores hacia la violencia contra las mujeres (Bowen, 2011; Mennicke et al., 2015).

El modelo Duluth o intervención feminista basada en el control y el poder se basa en los aspectos históricos y culturales de la violencia que respaldan la percepción del derecho del hombre de controlar las acciones, pensamientos y sentimientos de su pareja (Pence y Paymar, 1993). Desde esta perspectiva, el objetivo de la intervención es que el participante se responsabilice de su conducta violenta (Mankowski et al. 2002). Para ello, la intervención se centra en señalar las motivaciones de poder y control que hay detrás de los episodios de maltrato, utilizando herramientas como la rueda de poder y control, para

ilustrar que la violencia es parte de un patrón de comportamiento que incluye la intimidación, el aislamiento o el abuso económico, entre otros (Pence y Paymar, 1993). Se pretende que los hombres asuman la responsabilidad de su conducta violenta y modifiquen sus conductas destructivas y autoritarias descritas en la rueda de poder y control por conductas descritas en la rueda de la igualdad que les conduzcan a mantener relaciones sanas e igualitarias (Mankowski et al., 2002). Los temas que se tratan son los siguientes: no violencia, comportamiento no amenazante, respeto, confianza y apoyo, honestidad y responsabilidad, respeto sexual, relación de pareja, y negociación y justicia (Pence y Paymar, 1993). Dentro de este modelo se llevan a cabo actividades para definir y comprender los aspectos históricos y culturales de la violencia de pareja, definir y comprender las tácticas de control y poder, resolución de problemas y habilidades de comunicación, estrategias alternativas a la violencia, manejo de la ira, y asunción de responsabilidad de la propia conducta (Feder y Dugan, 2002; Haggård et al., 2017; Taylor et al., 2001).

El modelo educacional tiene como principal objetivo favorecer la toma de responsabilidad en las propias acciones a través de la definición y explicación de la violencia de pareja, el recorrido histórico de la violencia contra las mujeres y la opresión y el abuso de poder al que se han visto y se ven sometidas, la socialización de los hombres en nuestra sociedad o los efectos que la violencia de pareja tiene sobre los menores (Labriola et al., 2008; Palmer et al., 1992). La mayoría de los programas educacionales incorporan técnicas cognitivo-conductuales como ejercicios para desarrollar habilidades sociales o el manejo de la ira, denominándose psicoeducacionales, una definición frecuentemente utilizada en la descripción de los programas de intervención con maltratadores (Babcock et al., 2004).

El modelo psicodinámico o intervención grupal no estructurada defiende que la mejor forma de superar la conducta violenta es recibir apoyo por parte del grupo y, para ello, se centra en favorecer e incrementar una expresión emocional directa y responsable (Browne, et al., 1997; Morrel et al., 2003; Scher et al., 1987). En la intervención grupal no estructurada son los miembros del grupo los que determinan los temas a tratar, mientras que la persona encargada del grupo se dirige a este en vez de a los individuos y estimula las interacciones de ayuda mutua que se dan en el grupo (Jennning, 1987).

El modelo de riesgos, necesidades y responsabilidad está dirigido a maltratadores que presentan un riesgo moderado o alto de reincidir en la conducta violenta y, por tanto, requieren una intervención intensiva (Andrews et al., 2011). El principio de riesgo presenta dos partes. Por una parte, puede considerarse la probabilidad de involucrarse en una conducta criminal, siendo posible calcular esta probabilidad a partir de un conjunto de factores como las características o la conducta criminal previa (Polascheck, 2012). Por otra parte, implica que el nivel de riesgo del participante debe ser evaluado previamente para tomar decisiones sobre su intervención y que, niveles de riesgo moderado o alto requieren intervenciones intensivas (Andrews et al., 1990). El principio de necesidad hace referencia a los objetivos de cambio, características dinámicas y circunstancias de los participantes, cuya modificación produce reducciones en la reincidencia (Andrews et al., 1990). Por último, el principio de receptividad describe cómo se lleva a cabo la intervención de manera que involucre a los participantes y les ayude a cambiar (Ogloff y Davis, 2004). Dentro de este modelo, se utilizan estrategias como vincular a los participantes con los recursos comunitarios para la búsqueda de empleo, el tratamiento de adicciones o los servicios de salud mental. También se emplean técnicas cognitivo-conductuales para modificar las cogniciones que están detrás de la conducta de abuso (Scott et al., 2015).

Los modelos holísticos no sólo abordan los factores directamente relacionados con la violencia contra la mujer en las relaciones de pareja, sino también factores relacionados con el estilo de vida del agresor que pueden contribuir a su conducta violenta (i.e., desempleo, falta de recursos, bajo nivel educativo, falta de habilidades parentales, consumo de drogas) (Maxwell, 2005). Para ello, se realizan sesiones de orientación laboral, habilidades parentales y sesiones de intervención en abuso de sustancias, en su caso. Los participantes se someten a evaluaciones regulares de consumo de sustancias y se supervisa que mantienen un empleo (Pitts et al., 2009).

Cabe destacar que la clasificación de los programas de intervención es orientativa, ya que los programas de intervención a menudo incorporan estrategias de varios acercamientos (Babcock et al., 2004; Eckhardt et al., 2013). Así, programas basados en el modelo cognitivo-conductual pueden, a su vez, trabajar las actitudes patriarcales y los programas basados en el modelo Duluth pueden centrarse en los aspectos aprendidos y reforzadores de la conducta violenta (Babcock et al., 2004). Es notable que la mayoría de los programas de intervención y guías que regulan la intervención con maltratadores apoyan los presupuestos centrales de la perspectiva feminista respecto a la etiología de la violencia de pareja y la forma de intervenir (Maiuro y Eberle, 2008).

Los meta-análisis que se han llevado a cabo para evaluar la eficacia de los programas de intervención con maltratadores han mostrado tamaños del efecto pequeños (Arce et al., 2020; Arias et al., 2013; Babcock et al., 2004; Cheng et al., 2019; Feder y Wilson, 2005). En concreto, Babcock et al. (2004) analizaron 22 estudios que incluían un grupo control formado por participantes que abandonaron la intervención o que no recibieron el tratamiento y emplearon información de las víctimas o registros policiales como medida de la reincidencia. Los programas presentaron efectos significativos en la reducción de la reincidencia oficial, con un tamaño del efecto pequeño, tanto en el caso

de estudios experimentales como de estudios cuasi-experimentales (Babcock et al., 2004). En cuanto a la reincidencia informada por la víctima, se encontraron reducciones significativas en los estudios cuasi-experimentales, con un tamaño del efecto pequeño, pero no así en los estudios experimentales (Babcock et al., 2004). Feder y Wilson (2005) evaluaron la eficacia de 10 estudios con maltratadores que asistían por mandato judicial a la intervención y que incluían un grupo control (libertad condicional, no intervención o participantes que abandonaron la intervención). Empleando datos de informes policiales, los estudios experimentales mostraron reducciones significativas de la reincidencia con un tamaño del efecto medio (Feder y Wilson, 2005). En cuanto a los estudios cuasi-experimentales, aquellos con un grupo control que no había recibido la intervención no presentaron diferencias significativas, mientras que los que incluyeron hombres que habían abandonado la intervención como grupo control mostraron diferencias significativas con un tamaño del efecto medio (Feder y Wilson, 2005). No se encontraron diferencias significativas en la reincidencia informada por las víctimas (Feder y Wilson, 2005). Arias et al. (2013) analizaron 19 estudios de programas de intervención con maltratadores en los que se evaluaba la reincidencia por medio de informes oficiales o de la víctima, encontrando una reducción no significativa de la reincidencia. Cheng et al. (2019) analizaron 14 estudios en los que se incluía un grupo control (libertad condicional, no intervención o participantes que abandonaron la intervención), hallando una reducción no significativa de la reincidencia informada por la víctima y una reducción significativa de la reincidencia evaluada mediante datos de informes policiales, con un tamaño del efecto pequeño. Si desglosamos este último resultado en función del diseño del estudio, encontramos que la reducción de la reincidencia fue significativa en los estudios cuasi-experimentales, pero no en los experimentales. Arce et al. (2020) analizaron 25 estudios sin grupo control, cuasi-experimentales y experimentales, evaluando la reincidencia

informada por los informes policiales, encontrando una reducción significativa con un tamaño del efecto medio. En cambio, no se encontraron estas diferencias en la reincidencia informada por la víctima.

Los estudios mencionados anteriormente no están exentos de críticas debido a factores como el grupo control utilizado o cuestiones metodológicas de los meta-análisis, entre otros (Dobash y Dobash, 2000; Gondolf, 2004). Respecto al grupo control utilizado, algunos estudios incluyen a hombres en libertad condicional como grupo control, y esto puede conllevar ciertos riesgos, ya que las medidas de vigilancia, sanciones y tratamientos aplicados por la administración a estos hombres son variables (Gondolf, 2004). Otros estudios incluyen hombres que han abandonado prematuramente el programa como grupo control, y como grupo experimental únicamente a aquellos que han finalizado la intervención. No obstante, teniendo en cuenta que los hombres que abandonan la intervención presentan mayor probabilidad de reincidir (Bowen et al., 2005; Lila et al., 2019), esto implica comparar a los participantes más motivados con los menos motivados (Davis y Taylor, 1999) y puede sobreestimar la eficacia de la intervención (Arias et al., 2013; Bowen, 2011). Una de las vías para superar esta limitación es realizar un análisis por intención de tratar, es decir, realizar la comparación con los hombres que se han asignado inicialmente a cada grupo independientemente de la dosis de intervención que hayan recibido (Piantadosi, 2017). Respecto a las cuestiones metodológicas de los meta-análisis, cabe destacar que la forma de establecer el tamaño del efecto como pequeño, medio o grande (Cohen, 1988) podría minusvalorar el impacto real de una intervención (Gondolf, 2004).

2. Estrategias motivacionales: incrementando la efectividad de los programas de intervención con maltratadores

Debido al pequeño tamaño del efecto encontrado en los programas de intervención con maltratadores, se han propuesto nuevos acercamientos como vía para incrementar su eficacia, entre los que destacan las estrategias motivacionales (Babcock et al., 2016; Feder y Wilson, 2005). Estas estrategias se están integrando progresivamente en los programas de intervención con maltratadores con resultados prometedores (Babcock et al., 2004; Eckhardt et al., 2013; Lee et al., 2004; Lila et al., 2018; Morrel et al., 2003; Musser et al., 2008; Saunders, 2008; Scott et al., 2011; Taft et al., 2001).

Entre las estrategias motivacionales, destacan los modelos de intervención basados en los estadios de cambio o el modelo transteórico del cambio (Prochaska y DiClemente, 1983; Prochaska et al., 1992), las técnicas de entrevista motivacional (Miller y Rollnick, 2002) y las técnicas de retención (Taft et al., 2003; Taft y Murphy, 2007). Los modelos de intervención basados en los estadios de cambio o el modelo transteórico del cambio (Prochaska y DiClemente, 1983; Prochaska et al., 1992) subraya que los individuos atraviesan una serie de estadios a la hora de prepararse, conseguir y mantener un cambio de conducta (Prochaska y Velicer, 1997). Por su parte, las técnicas de entrevista motivacional (Miller y Rollnick, 2002) asumen que los participantes llegan a la intervención con diferentes niveles de preparación para el cambio y se centran en movilizar la motivación intrínseca de los participantes (Murphy y Maiuro, 2009). Las técnicas de retención se centran en mantener a los participantes en la intervención (e.g., llamadas telefónicas para informar de las citas y/o tras una falta de asistencia a una sesión de intervención) (Taft et al., 2003; Taft y Murphy, 2007).

Estas estrategias motivacionales comparten el propósito común de facilitar la alianza terapéutica, por lo que podrían reducir la resistencia a la intervención de los

participantes e incrementar su motivación para el cambio (Stuart et al., 2007). Del mismo modo, estas estrategias podrían aumentar la probabilidad de que se produzcan conductas pro-terapéuticas dentro del grupo, mejorando así el clima grupal en las intervenciones (Musser et al., 2008; Rondeau et al., 2001; Semiatin et al., 2013; Taft et al., 2003). Por este motivo, en la presente tesis doctoral nos centraremos en dos variables relevantes en la eficacia de la intervención: la alianza terapéutica y las conductas pro-terapéuticas.

3. Alianza terapéutica y conductas proterapéuticas

El concepto de alianza terapéutica tiene su origen en la terapia psicoanalítica (Taft y Murphy, 2007). Freud (1913, 1966) señaló la importancia de que el terapeuta mostrara una actitud de apertura, entendimiento e interés por el paciente para poder entablar una relación de confianza y aprecio entre ambos. Bordin (1979) planteó la primera definición operativa de la alianza terapéutica, definiendo tres componentes: a) 'objetivo', consistente en el acuerdo entre paciente y terapeuta en los objetivos que esperan alcanzar con la intervención; b) 'tarea', componente referido a la colaboración y la aceptación por parte del paciente de las tareas que el terapeuta plantea para alcanzar el objetivo propuesto; y c) 'vínculo', consistente en la calidad de la relación paciente-terapeuta en términos de aprecio o confianza mutua. Diferentes meta-análisis han indicado que la alianza terapéutica es uno de los mejores predictores de los resultados de la psicoterapia, encontrándose una robusta, aunque moderada, relación entre la alianza terapéutica y los cambios alcanzados durante la intervención (Del Re et al., 2012; Horvath y Symonds, 1991; Martin et al., 2000; Sharf et al., 2010). Esta relación entre la alianza terapéutica y los resultados de la intervención también se ha observado en la intervención con maltratadores (Brown y O´Leary, 2000; Miles-McLean et al., 2019; Musser et al., 2008; Semiatin et al., 2013; Taft et al., 2003, 2004; Walling et al., 2012).

Para evaluar la alianza terapéutica se han desarrollado numerosos instrumentos, siendo el *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989) uno de los más extensamente empleados (Hill & Lambert, 2004). Este instrumento evalúa las tres dimensiones de la alianza propuestas por Bordin (1979) (i. e., objetivo, tarea y vínculo) y presenta varias versiones para medir la alianza desde diferentes perspectivas: terapeuta (WAI-T), paciente (WAI-P) y observador (WAI-O) (Andrade-González y Fernández-Liria, 2015). Se han desarrollado versiones abreviadas de este instrumento como el *Working Alliance Inventory Short Form* (WAI-S; Tracey y Kokotovic, 1989), con diferentes versiones en función del evaluador como el *Working Alliance Inventory-Observer Short versión* (WAI-O-S; Tichenor y Hill, 1989).

Otra de las variables relacionadas con la eficacia de los programas de intervenciones con maltratadores son las conductas pro-terapéuticas. Las conductas pro-terapéuticas o contra-terapéuticas son las verbalizaciones de los participantes durante el grupo dirigidas a promover o impedir que un participante cese en su conducta violenta (Semiatin et al., 2013). Las conductas pro-terapéuticas durante la intervención con maltratadores se han relacionado con reducciones en la violencia física y psicológica informada por la víctima seis meses después de la intervención (Semiatin et al., 2013).

El *Observational Coding of Protherapeutic Group Behavior* (Semiatin et al., 2013) es un instrumento diseñado para evaluar las conductas pro-terapéuticas de forma observacional durante los grupos de intervención. Presenta tres dimensiones: (a) reconocimiento o negación de la responsabilidad: verbalizaciones de los participantes relacionadas con la asunción o negación de la conducta violenta, las consecuencias de la misma, y la necesidad de un cambio personal para no cometer actos abusivos en el futuro; b) rol del participante: verbalizaciones interpersonales que ocurren durante el grupo y son relevantes para el cambio, diferenciándose cuatro roles comportamentales a lo largo de

dos ejes: confrontación vs. confirmación, y el progreso positivo vs. progreso negativo; y c) valor del grupo: verbalizaciones relacionadas con el valor percibido de la intervención y el grupo (Semiatin et al., 2013).

CAPÍTULO 2

Objetivos

1. Objetivos

El objetivo general de esta tesis doctoral es analizar el efecto de la inclusión de estrategias motivacionales en la eficacia de los programas de intervención con maltratadores, tanto en variables de proceso como la alianza terapéutica o la conducta pro-terapéutica, como en variables finales como la reducción de la reincidencia, la dosis de intervención o abandono del programa de intervención. Los objetivos específicos son los siguientes:

Objetivo 1. Evaluar la eficacia de las estrategias motivacionales en programas de intervención con maltratadores en la reducción de la violencia física y psicológica, el abandono de la intervención, la dosis de intervención recibida y la reincidencia, mediante una revisión sistemática con meta-análisis. Este objetivo se desarrollará en el estudio 1:

- Santirso, F. A., Gilchrist, G., Lila., M., & Gracia, E. (2020). Motivational strategies in interventions for intimate partner violence offenders: a systematic review and meta-analysis of randomized controlled trials. *Psychosocial Intervention, 29*(3), 175-190. https://doi.org/10.5093/pi2020a13

Objetivo 2. Validar una escala observacional de alianza terapéutica con una muestra de maltratadores. El propósito del estudio 2 es responder a este objetivo:

- Santirso, F. A., Martín-Fernández, M., Lila, M., Gracia, E., & Terreros, E. (2018). Validation of the working alliance inventory–observer short version with male intimate partner violence offenders. *International Journal of Clinical and Health Psychology, 18,* 152-161. https://doi.org/10.1016/j.ijchp.2018.02.003

Objetivo 3. Comparar los efectos de una intervención con estrategias motivacionales frente a una intervención sin dichas estrategias en la alianza terapéutica y las conductas pro-terapéuticas de los maltratadores. Para ello, se empleará la escala validada en el

estudio 2, entre otros instrumentos. El estudio 3 se centrará en este objetivo, mediante un ensayo controlado aleatorizado (RCT):

- Santirso, F. A., Lila, M., & Gracia, E. (2020). Motivational strategies, working alliance, and protherapeutic behaviors in batterer intervention programs: a randomized controlled trial. *European Journal of Psychology Applied to Legal Context*, *12*(2), 77-84. https://doi.org/10.5093/ejpalc2020a7

CAPÍTULO 3

Método

En este capítulo se presenta la metodología empleada en los diferentes estudios de la presente tesis doctoral.

1. Revisión sistemática de la eficacia de las estrategias motivacionales en programas de intervención con maltratadores

Para llevar a cabo la revisión sistemática con meta-análisis se siguieron las recomendaciones PRISMA (*Preferred Reporting Items for Systematic Reviews and Meta-Analyses;* Moher et al., 2009) y se procedió a su registro en PROSPERO (*International Prospective Register of Systematic Reviews; PROSPERO 018: CRD42018110107).* Se realizó una búsqueda sistemática de la literatura en las siguientes bases de datos: Cochrane Collaboration, MEDLINE, EMBASE, PsycINFO y CINAHL. El período de búsqueda fue desde 1983 hasta agosto de 2018; se tomó como punto de partida 1983, ya que es cuando se realiza la primera publicación acerca de la entrevista motivacional (Miller, 1983). La estrategia de búsqueda combinaba términos relacionados con RCTs, programas de intervención con maltratadores y estrategias motivacionales.

1.1. Criterios de inclusión

Se incluyeron los estudios que cumplieron las siguientes condiciones: a) fueron publicados entre 1983 y 2018; b) la muestra estaba compuesta por adultos; c) la muestra incluía hombres; y d) eran RCTs. No se aplicaron restricciones lingüísticas. Inicialmente, GG y FS evaluaron de forma independiente si los artículos cumplían los criterios de inclusión a través de la lectura del título y el resumen. Posteriormente, los artículos pre-seleccionados fueron evaluados a partir de la su lectura completa por GG y FS. Los desacuerdos fueron solucionados mediante discusión y consenso con revisores adicionales (EG y ML).

1.2. Extracción de datos

FS y GG extrajeron de forma independiente los resultados de los estudios siguiendo las recomendaciones (TIDIeR; *Template for Intervention Description and Replication* (Hoffmann et al., 2014). Específicamente, se extrajo información acerca de los objetivos, materiales y procedimientos seguidos, proveedores de la intervención, frecuencia y duración de la intervención, formato de la intervención, entorno de intervención y modificaciones realizadas. Además, se recopilaron los resultados obtenidos en cada uno de los estudios. Los datos introducidos en las tablas fueron verificados por revisores adicionales (EG y ML) y las diferencias fueron resueltas a través de discusión.

1.3. Evaluación de la calidad metodológica

La calidad metodológica de los estudios se evaluó empleando el *Cochrane Risk of Bias tool* (Higgins et al., 2011). Con esta escala, dos revisores (FS y GG) evaluaron los siguientes dominios: a) sesgo de selección; b) sesgo de realización; c) sesgo de detección; d) sesgo de desgaste; y e) sesgo de notificación. Los desacuerdos se resolvieron mediante discusión con revisores adicionales (EG y ML).

1.4. Análisis de datos

La principal medida empleada fue la *standarized mean difference* (SMD) y el *odds ratio* (OR) en función de la naturaleza de la variable (continua o dicotómica, respectivamente). En cada RCT, se recuperaron o se calcularon los intervalos de confianza al 95% para cada resultado evaluado (Bland y Altman, 2000). La introducción de datos y los análisis estadísticos se realizaron mediante el *Review Manager Software*, versión 5.3. En aquellos estudios que presentaban datos de varios periodos de seguimiento de los participantes, se incluyeron en el meta-análisis los datos del periodo de seguimiento

más largo. Se calculó el grado de heterogeneidad (I^2) para comprobar si los RCTs incluidos en el meta-análisis eran consistentes entre sí. Los valores de I^2 se interpretaron de la siguiente manera: $I^2 \leq 25\%$: baja heterogeneidad; I^2 entre 50% y 75%: moderada heterogeneidad; $I^2 \geq 75\%$: alta heterogeneidad (Higgins et al., 2003).

2. Validación de una escala observacional de alianza terapéutica

2.1. Participantes

La muestra estaba formada por 140 hombres que habían ejercido violencia de género y habían sido remitidos judicialmente a realizar un programa de intervención, el programa Contexto, que se realiza en la Universitat de València. Los hombres habían sido condenados a menos de dos años de prisión, no presentaban anteceden penales, y su pena de prisión estaba suspendida con la condición de asistir al programa de intervención. Los criterios de inclusión fueron: a) no presentar trastornos mentales graves; b) no presentar una adicción grave al alcohol u otras drogas; y c) firmar el consentimiento informado. La media de edad fue de 40.26 años (*DT* = 11.66, rango 18-76). Respecto al nivel educativo de los participantes, el 50.7% contaba con estudios elementales finalizados, el 34.3% con estudios secundarios o formación profesional, el 10% con estudios universitarios y el 5% restante no había sido escolarizado. En cuanto al estado civil de los participantes, el 37.5% eran solteros, el 39.3% divorciados o separados, y el 24.3% casados o en una relación sentimental. Respecto a la nacionalidad, el 70% eran españoles, el 12.7% latinoamericanos, el 8.5% de otros países europeos, el 7.8% africanos y el 0.7% asiáticos. Los ingresos medios anuales por unidad familiar oscilaban entre los 6000 y los 12000 euros.

2.2. Procedimiento

Todos los participantes fueron asignados a un grupo de intervención. El número de participantes por grupo osciló entre 8 y 12 participantes. Una vez iniciado el grupo, no se aceptó la inclusión de más participantes. Cada grupo fue dirigido por dos coordinadores. La intervención consistió en 32 sesiones grupales semanales, en las que se realizó una intervención cognitivo-conductual, incluyendo perspectiva de género, siendo esta la intervención estándar para maltratadores (Eckhardt et al., 2013; Ferrer-Perez et al., 2016). Los participantes fueron informados de la naturaleza y el propósito de la investigación y de que su participación o no en el estudio no afectaría a su situación legal, firmaron un consentimiento informado, y se aseguró la confidencialidad. Se realizaron un total de 14 grupos de intervención. Las sesiones grupales de intervención fueron grabadas en vídeo, y se evaluó una de las últimas sesiones de intervención de cada grupo. Cuatro ayudantes de investigación evaluaron las grabaciones, analizando la alianza terapéutica y las conductas pro-terapéuticas. Estos evaluadores habían realizado una formación previa en la que evaluaron la misma sesión de forma independiente hasta alcanzar un nivel aceptable de acuerdo (i.e., no diferir en más de un punto en cada ítem evaluado). Cada vídeo analizado tuvo una duración de dos horas, que fueron divididas en 24 segmentos. La codificación observacional de la alianza terapéutica y de la conducta proterapéutica se realizó puntuando intervalos de vídeo de cinco minutos, y se calculó la puntuación media para cada participante. El estadio de cambio y la motivación para el cambio fueron evaluados al final de la intervención, ya que la literatura previa muestra que estas medidas se relacionan positivamente con la deseabilidad social al inicio de la intervención, pero no al final (Begun et al., 2003). Los datos de todos los participantes se recogieron de acuerdo con el protocolo del Comité Ético de la Universitat de València.

2.3. Instrumentos

Working Alliance Inventory Shortened Observer-rated version (WAI-O-S; Tichenor y Hill, 1989). Esta escala observacional evalúa la alianza terapéutica y está compuesta por 12 ítems (e.g., "el participante siente que el terapeuta le valora como persona", "participante y terapeuta están trabajando metas consensuadas de mutuo acuerdo"). Los evaluadores respondieron mediante una escala tipo Likert de 7 puntos que oscilaba entre 0 (*evidencia concluyente en contra*) y 7 (*evidencia concluyente a favor*).

Observational Coding of Protherapeutic Group Behavior (Semiatin et al., 2013). Este instrumento evalúa las conductas pro-terapéuticas de los participantes a través de sus verbalizaciones. Está compuesto por tres ítems que se corresponden con las siguientes conductas pro-terapéuticas: a) negación/reconocimiento de la conducta/asunción de responsabilidad: verbalizaciones relacionadas con el reconocimiento o la negación de la responsabilidad de la conducta violenta, las consecuencias de este comportamiento y la necesidad de un cambio personal para evitar cometer actos abusivos en el futuro; b) rol comportamental del participante: conductas interpersonales que ocurren en el grupo y son relevantes para el cambio. Se distinguen cuatro roles comportamentales a través de dos dimensiones: confrontación vs confirmación y progreso positivo vs progreso negativo; c) valoración del grupo: verbalizaciones relacionadas con la percepción del grupo y del programa de intervención. Los evaluadores respondieron en una escala Likert de 5 puntos que oscilaba entre 1 (*evidencia concluyente en contra*) y 5 (*evidencia concluyente a favor*).

Estadio de cambio. Los coordinadores evaluaron el estadio de cambio de los participantes siguiendo la clasificación de Prochaska et al. (1992), atendiendo a las entrevistas motivacionales, los autoinformes y la evaluación directa. Los estadios de cambio se evaluaron como 1 (*precontemplación*), 2 (*contemplación*), 3 (*preparación*), 4 (*acción*) y

5 (*mantenimiento)* (para un procedimiento similar, ver Scott (2004) y Carbajosa et al., (2017).

Motivación para el cambio. Los terapeutas evaluaron la motivación para el cambio de cada participante mediante un ítem que oscilaba entre 1 (*baja*) y 5 (*alta*).

2.4. Análisis de datos

Para evaluar las características psicométricas del instrumento WAI-O-S se llevaron a cabo los siguientes análisis. Primero, se evaluó el acuerdo y la fiabilidad inter-evaluadores calculando el *intraclass correlation coefficient* (*ICC*). La media de la escala *ICC* se estimó utilizando un *random two-way ANOVA model*, ya que cada evaluador evaluaba a cada participante ($ICC_{(2,k)}$). Este estadístico considera a los evaluadores como una variable de efecto aleatorio, y, por tanto, representa a una muestra aleatoria dentro de una amplia población de evaluadores (i.e, evaluadores entrenados). Los valores iguales o superiores a 0.70 de este estadístico son indicativos de una buena consistencia interna. Se obtuvieron los estadísticos descriptivos y las correlaciones ítem-total para todos los ítems.

Para evaluar la estructura latente del WAI-O-S, se llevó a cabo un análisis factorial confirmatorio Bayesiano (CFA). Este acercamiento ha mostrado mejores resultados con muestras pequeñas y variables observadas asimétricas que la estimación clásica de máxima verosimilitud en el análisis factorial confirmatorio (Lee y Song, 2004). El modelo Bayesiano de ecuaciones estructurales es un marco emergente de CFA que ha demostrado ser adecuado para las distribuciones asimétricas de las estimaciones de los parámetros, y que también permite que probar estructuras latentes complejas (Muthén y Asparouhov, 2012). Dado el limitado tamaño de la muestra en este estudio, y las potenciales ventajas de la estimación Bayesiana, se siguió este acercamiento metodológico para probar la estructura latente del WAI-O-S.

Se compararon cinco modelos latentes de diferente complejidad para obtener el mejor ajuste de los datos. El primer modelo fue un modelo unidimensional en el cuál todos los ítems cargaban en un único factor. El segundo modelo, basado en los hallazgos de Andrusyna et al. (2001) y Falkenström et al. (2015), fue un modelo oblicuo de dos dimensiones, que establecía un factor para la dimensión original de *vínculo,* y un segundo factor para los ítems de *objetivo* y *tarea.* El tercero fue un modelo oblicuo de tres dimensiones que planteaba un factor para cada una de las dimensiones originales (Munder et al., 2010). El cuarto y quinto modelo eran generalizaciones del segundo y tercero, en las cuales un factor de segundo orden denominada *alianza general*, explicaba la relación entre los factores de primer orden de cada modelo. Por tanto, el cuarto modelo establecía un modelo de segundo orden considerando las dimensiones del segundo modelo como factores de primer orden, mientras el quinto modelo consideraba las tres dimensiones del tercer modelo como factores de primer orden.

Todos los modelos fueron estimados con el algoritmo *MCMC*, estableciendo 4 cadenas y 20000 iteraciones. Las primeras 10000 iteraciones se desecharon. El modelo de convergencia se evaluó con el *potential scale reduction factor (PSR)*, considerando valores de *PSR* de 1.05 o inferiores como indicadores de una buena convergencia (Gelman, et al., 2014). Sin embargo, Asparpuhov y Muthén (2010), informaron de que la mayoría de modelos suelen alcanzar la convergencia con valores de *PSR* comprendidos entre 1.05 y 1.10, por lo que consideramos que los valores de PSR de 1.10 o inferiores son indicativos de una convergencia aceptable. Los parámetros del modelo se estimaron utilizando el método *expected a posteriori (EAP).* Para delimitar la credibilidad de los intervalos de los parámetros, se obtuvo la *SD* posterior para cada parámetro. Para evaluar el ajuste del modelo se obtuvo el *Deviance Information Criterion (DIC), y el* Bayesian Information Criterion *(BIC).* Además, en este estudio se calculó la corrección del *DIC*,

tal y como plantean algunos autores (*DICc*; Ando, 2011). *DICc* penaliza con mayor severidad que *DIC* los modelos con un gran número de parámetros. Todos estos criterios son índices de significado comparativo, por tanto, el modelo con los menores datos de *DIC, DICc* y *BIC* fue considerado como el de mejor ajuste a los datos.

Por último, para evaluar la validez de criterio, las puntuaciones factoriales del WAI-O-S se correlacionaron con las conductas pro-terapéuticas, estadios de cambio, y motivación para el cambio. Cuando ambas variables se consideraron continuas (i.e, con cinco o más categorías) se emplearon las correlaciones de Pearson. Cuando al menos una de las variables se consideró ordinal, se emplearon las correlaciones de Spearman. Los análisis descriptivos, de fiabilidad y validez de los instrumentos se realizaron en el paquete estadístico *R* y la librería *psych* de *R.* El CFA Bayesiano se realizó con Mplus 7.1 (Muthén y Muthén, 2010).

3. RCT: efectos de la intervención con estrategias motivacionales en la alianza terapéutica y la conducta proterapéutica de una muestra de maltratadores

3.1. Participantes

La muestra estaba formada por 153 hombres que habían ejercido violencia de género y habían sido remitidos judicialmente a realizar un programa de intervención. Los hombres habían sido condenados a menos de dos años de prisión, no presentaban anteceden penales, y su pena de prisión estaba suspendida con la condición de asistir al programa de intervención. Los criterios de inclusión fueron: a) tener una edad de 18 años o superior; b) no presentar trastornos mentales graves; c) no presentar una adicción grave al alcohol u otras drogas; y d) firmar el consentimiento informado. La media de edad fue de 40.73 años (*DT* = 11.99, rango 18-78). Respecto al nivel educativo de los participantes, el 51.0% contaba con estudios elementales finalizados, el 31.5% con estudios secundarios

o formación profesional, el 11.1% con estudios universitarios y el 6.4% restante no había sido escolarizado. En cuanto al estado civil de los participantes, el 33.3% eran solteros, el 42.5% divorciados o separados, y el 24.2% casados o en una relación sentimental. Respecto a la nacionalidad, el 71.7% eran españoles, el 11.2% latinoamericanos, el 8.6% de otros países europeos, el 7.2% africanos y el 1.3% asiáticos. Los ingresos medios anuales por unidad familiar oscilaban entre los 6000 y los 12000 euros.

3.2. Procedimiento

Se informó a los participantes de que su participación o no en el estudio no afectaría a su situación legal y, por tanto, no tendría consecuencias legales. Se aseguró la confidencialidad, con la única excepción de situaciones que pusieran el riesgo al participante o a otras personas. Todos los participantes firmaron un consentimiento informado.

Los participantes fueron asignados aleatoriamente a una de dos condiciones: programa estándar de intervención con maltratadores (SBIP) y programa estándar de intervención con maltratadores + plan motivacional individualizado (SBIP + IMP). La condición SBIP consistió en 35 sesiones semanales de intervención cognitivo-conductual en formato grupal. La intervención se dividió en seis módulos con los siguientes objetivos principales: a) primer módulo: construir un clima de confianza y establecer las normas de funcionamiento del grupo; b) segundo módulo: introducir los conceptos básicos de violencia en las relaciones de pareja y abordar la asunción de responsabilidad; c) tercer módulo: entrenar técnicas de control emocional y reestructuración cognitiva; d) cuarto módulo: concienciar acerca de las consecuencias que la violencia en las relaciones de pareja tiene para las víctimas y desarrollar la empatía y habilidades de comunicación positiva en las relaciones de pareja; e) quinto módulo: discutir acerca de las actitudes sexistas, los roles de género y la igualdad de género; y f) sexto módulo: consolidar los

aprendizajes y prevenir recaídas. Durante la SBIP, se aplicaron numerosas técnicas (i.e., dinámicas de grupo, *role-playing*, entrenamiento en reestructuración cognitiva o control emocional). La condición SBIP + IMP englobó la misma intervención estándar cognitivo-conductual, añadiendo el plan motivacional individualizado. Dicho plan consistió en: a) cinco entrevistas motivacionales, de las cuales tres se llevaron a cabo durante la fase de la evaluación para reducir la resistencia de los participantes a la intervención y establecer los objetivos personales de cada participante, una se llevó a cabo a mitad de la intervención para monitorizar los progresos, y la última se realizó hacia el final de la intervención para evaluar los objetivos alcanzados; b) tres sesiones grupales realizadas al inicio, a la mitad y al final de la intervención, en las que los participantes compartieron sus objetivos personales, explicaron sus progresos al grupo, y recibieron retroalimentación, apoyo y consejo de los coordinadores y del resto de participantes; c) seguimiento y refuerzo de los objetivos de los participantes por parte de los coordinadores en cada sesión grupal a lo largo de la intervención; y d) técnicas de retención como llamadas telefónicas a los participantes cuando no asistían a una sesión. El plan motivacional individualizado también implicaba que los coordinadores adoptaran una actitud motivacional y empática a lo largo de la intervención, creando un clima de aceptación y utilizando la confrontación únicamente cuando era absolutamente necesario.

En ambas condiciones, la intervención se realizó en formato grupal. Cada grupo de intervención estaba conformado por entre 10 y 12 hombres, y fue dirigido por dos coordinadores. Una vez iniciado el grupo, no se aceptó a más participantes. En las dos condiciones, los coordinadores fueron psicólogos con al menos dos años de experiencia en intervención con maltratadores. Los coordinadores recibieron aproximadamente 25 horas de formación en su condición de intervención, siendo ciegos a dicha condición. Cada pareja de coordinadores intervino exclusivamente en una condición de intervención.

Los coordinadores de cada condición fueron supervisados de forma independiente una vez cada dos semanas. Las sesiones de supervisión se focalizaron en el protocolo de adherencia a la intervención, el manejo del grupo, el progreso de los participantes y la preparación de futuras sesiones. Para asegurar la adherencia al protocolo, se utilizaron manuales de intervención para cada condición (Lila et al., 2018).

Cuatro asistentes de investigación ciegos a los objetivos e hipótesis del estudio, codificaron las grabaciones de las sesiones. La alianza terapéutica y las conductas pro-terapéuticas fueron evaluadas en dos ocasiones: al inicio de la intervención (sesiones 3-7) y al final de la intervención (sesiones 24-28). Estos evaluadores previamente habían realizado una formación en la que evaluaron la misma sesión de forma independiente hasta alcanzar un nivel aceptable de acuerdo (i.e., no diferir en más de un punto en cada ítem evaluado). Cada vídeo analizado tuvo una duración de 2 horas, que fueron divididas en 24 segmentos de 5 minutos. Se calculó la puntuación media de los segmentos en alianza terapéutica y conductas pro-terapéuticas para cada participante.

3.3. Instrumentos

Working Alliance Inventory Shortened Observer-rated version (WAI-O-S; Tichenor & Hill, 1989). Se utilizó la versión validada en castellano en el estudio 2 de la presente tesis doctoral. Esta escala observacional evalúa la alianza terapéutica general y dos componentes de ésta (acuerdo y vínculo). Los ítems y la escala de respuesta del instrumento han sido descritos anteriormente. En este estudio, la escala mostró una alta consistencia interna, con valores alfa de Cronbach de 0.97 y 0.92 para las mediciones al inicio y al final de la intervención, respectivamente.

Observational Coding of Protherapeutic Group Behavior (Semiatin et al., 2013). Este instrumento ha sido descrito en el apartado anterior de la presente tesis doctoral. En este

estudio, se evaluó la fiabilidad inter-jueces del instrumento a través de la evaluación de los mismos participantes. La correlación agrupada de las medias de las puntuaciones de los tres evaluadores (*r*) fue de 0.53, n = 30, $p = 0.011$.

3.4. Análisis de datos

Se realizaron pruebas chi-cuadrado y pruebas t para muestras independientes para variables categóricas y continuas, respectivamente, con la finalidad de analizar si los participantes que recibieron la condición SBIP + IMP y aquellos que recibieron la condición SBIP eran equivalentes en el momento de la asignación a las condiciones experimentales. Para evaluar las diferencias en función del momento y del grupo en alianza terapéutica y conductas pro-terapéuticas, se llevaron a cabo ANOVAs de medidas repetidas, incluyendo la alianza terapéutica y las conductas pro-terapéuticas como factores intra-sujetos, y el grupo de intervención (SBIP + IMP o SBIP) como factor inter-sujetos. Cuando un factor fue significativo en los ANOVAs anteriores, se utilizó Bonferroni como prueba a posteriori. Todos los análisis estadísticos se realizaron empleando el *software* SPSS 26.0, considerando como significativa una $p < 0.05$.

CAPÍTULO 4

Estudios

ESTUDIO 1

Motivational strategies in interventions for intimate partner violence offenders: a systematic review and meta-analysis of randomized controlled trials[1]

[1] Published in: Santirso, F. A., Gilchrist, G., Lila, M., & Gracia, E. (2020). Motivational strategies in interventions for intimate partner violence offenders: a systematic review and meta-analysis of randomized controlled trials. *Psychosocial Intervention*, *29*(3), 175-190. https://doi.org/10.5093/pi2020a13

1. Introduction

Intimate partner violence (IPV) against women is a widespread public health problem with serious consequences on victims' physical and psychological health, their children, and the wider society (Campbell, 2002; Ellsberg et al., 2008; Gracia, Rodríguez et al., 2020; Guedes et al., 2016; Martín-Fernández et al., 2019, 2020; Okuda et al., 2011; Vilariño et al., 2018; World Health Organization, 2013). Given the importance and complex nature of IPV, prevention and intervention strategies need to be targeted at different levels (i.e., individual, relational, contextual, and socio-cultural levels; Gracia, 2014; Gracia et al., 2008; Gracia, Lila, et al., 2020; Heise, 2011; Jewkes, 2002; Jewkes et al., 2015; World Health Organization, 2002). IPV offender intervention programs are one of the main treatment approaches aimed at preventing further violence (Cannon et al., 2016; Price & Rosenbaum, 2009; Voith et al., 2018). However, meta-analyses focused on the effectiveness of IPV offender intervention programs have shown small effect sizes (Arias et al., 2013; Babcock et al., 2004; Cheng et al., 2019; Eckhardt et al., 2013; Feder & Wilson, 2005; Gondolf, 2004; Smedslund et al., 2011).

Research has identified a number of factors explaining the modest effectiveness of IPV offender intervention programs. High levels of attrition, low motivation to change, lack of acceptance of responsibility, low working alliance, and limited engagement in treatment activities are among these factors (Gerlock, 2001; Martín-Fernández, Gracia, Marco, et al., 2018; Saunders, 2008; Stuart et al., 2007). Levels of attrition are high in IPV offender intervention programs, ranging from 15% to 58% (Babcock et al., 2004; Bennett et al., 2007; Daly & Pelowski, 2000; Feder & Wilson, 2005; Jewell & Wormith, 2010; Olver et al., 2011; Rondeau et al., 2001). This is an important concern and challenge for the reduction and prevention of IPV, since program dropout is associated with higher recidivism rates (Bennett et al., 2007; Chen et al., 1989; Coulter & VandeWeerd, 2009;

Dutton et al., 1997; Gondolf, 2000; Taft et al., 2001). Additionally, IPV offenders typically show low levels of motivation to change at the intake phases of IPV offender programs (Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017; Carbajosa, Catalá-Miñana, Lila, Gracia, et al., 2017; Crane et al., 2015; Zalmanowitz et al., 2013). This is an important issue, because IPV offenders in the most advanced stages of change are more likely to complete the treatment (Eckhardt et al., 2004; Levesque et al., 2000; Scott, 2004; Scott & Wolf, 2003). Furthermore, IPV offenders are characterized by their tendency to deny and minimize their violent behavior, as well as to blame the victims (Heckert & Gondolf, 2000; Henning & Holdford, 2006; Lila et al., 2014; Martín-Fernández, Gracia, & Lila, 2018). A large number of IPV offenders are court-mandated to attend these intervention programs instead of receiving a custodial sentence (Eckhardt et al., 2013; Price & Rosenbaum, 2009). Consequently, they may not be purely voluntary and self-motivated participants to attend, as they are 'forced' to undergo an intervention that they often feel is useless or unfair (Eckhardt et al., 2013; Lila et al., 2018; Stuart et al., 2007). Finally, some studies have suggested that IPV offender intervention programs often use confrontational approaches that can limit the development of positive treatment processes, such as working alliance and engagement in treatment activities, limiting the effectiveness of the intervention (Murphy & Baxter, 1997; Taft et al., 2003).

Several authors point out that the inclusion of motivational strategies, such as stages-of- change-based treatments, strengths-based treatments, motivational interviewing, and retention techniques, could overcome some of these limitations, increasing the effectiveness of interventions for IPV offenders (Babcock et al., 2016; Feder & Wilson, 2005). Thus, motivational strategies, with proven evidence among other populations resistant to change (such as people with alcohol and drug disorders), are increasingly being incorporated into IPV offender intervention programs with promising

results (Babcock et al., 2004; Eckhardt et al., 2013; Lee et al., 2004; Morrel et al., 2003; Musser et al., 2008; Saunders, 2008; Scott et al., 2011; Taft et al., 2001). The 'stages of change' model, or the Transtheoretical Model of behavioral change (TTM; Prochaska & DiClemente, 1982; Prochaska et al., 1992), emphasizes that individuals proceed through a series of stages in preparing for, accomplishing, and maintaining behavior change (Prochaska & Velicer, 1997). Closely related to TTM, the Motivational Interviewing Techniques (MITs; Miller & Rollnick, 2002) assumes that participants arrive at interventions at different levels of readiness to change and focus on mobilizing a client's intrinsic motivation (Murphy & Maiuro, 2009). Finally, retention techniques (e.g., telephone calls about appointments and after missed sessions) are focused on maintaining participants within the intervention program (Taft & Murphy, 2007; Taft et al., 2003).

This body of research suggests potential benefits of incorporating motivational strategies into interventions for IPV offenders to increase its effectiveness. Therefore, the aim of this review was to rigorously assess the effectiveness of interventions for IPV offenders that includes motivational strategies in reducing physical and psychological IPV, treatment dropout, official recidivism to IPV offending (e.g., rearrests, police records), and in increasing intervention attendance dose. Only randomized controlled trial studies (RCTs) were included to obtain a precise effect size and to prevent possible confounding factors, as well as to ensure the replicability of the results (Ioannidis, 2015). RCTs are the gold standard for making comparisons between different interventions (Lilienfeld et al., 2018), since they afford enhanced control over different causes of spurious therapeutic efficacy, such as regression to the mean, spontaneous remission, or selection bias (Lilienfeld et al., 2014). As far as we are aware, this is the first systematic review and meta-analysis focusing on the effectiveness of motivational strategies in interventions for IPV offenders that has considered evidence only from RCTs.

2. Method

This systematic review and meta-analysis were undertaken in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations (Moher et al., 2009) and registered with the International Prospective Register of Systematic Reviews (PROSPERO 018: CRD42018110107).

2.1 Search strategy

A systematic search of the literature was carried out in Cochrane Collaboration, MEDLINE, EMBASE, PsycINFO and CINAHL, covering the period from 1983 to August 2018; 1983 was selected as the start date for the search as this was when first publication about motivational interviewing was published (Miller, 1983). The search strategy included combining terms for randomized controlled trials, IPV interventions, and motivational strategies (see Appendix). Given the different nomenclatures used for IPV and motivational strategies, we first carried out a thesaurus search from Cochrane Collaboration, CINAHL, PsycINFO, Emtree terms in EMBASE, and Mesh terms in Medline to include all related terms in the search strategy. Search terms used included terms related to intimate partner violence (e.g., abuse, batterer, domestic, dating, and marital) and motivational strategies (e.g., motivational interviewing, motivational enhancement therapy, motivational intervention), and the Cochrane Highly Sensitive Search Strategy (Lefebvre et al., 2011) was used for identifying RCTs. Forward and backward searches of all relevant records were conducted by performing electronic searches for further relevant articles by the first author of any identified study.

2.2 Eligibility

Studies were eligible if (1) they were published during the 1983-2018 period; (2) the sample consisted of adult participants; (3) the sample included men; (4) they were

RCTs; (5) the intervention incorporated motivational strategies; and (6) outcome/s included any IPV behaviors. No language restrictions were applied. Manuscripts were independently assessed for eligibility in two stages. Firstly, GG and FS independently assessed all titles and abstracts against eligibility criteria. Secondly, full-text articles of potentially eligible manuscripts were independently assessed (GG and FS), and disagreements were solved through discussions and consensus with additional reviewers (EG or ML).

2.3 Data Extraction

FS and GG independently extracted data from all included studies by following the Template for Intervention Description and Replication (TIDIeR; Hoffmann et al., 2014). Specifically, information around the intervention approach and goals, materials and procedures followed, intervention providers, frequency and duration of the intervention, delivery mode, setting and modifications made were extracted. In addition, outcome assessments and results were compiled. These data were verified by a third reviewer (EG or ML) and differences resolved through discussion.

2.4 Assessment of Methodological Quality

The methodological quality of trials was assessed using the Cochrane Risk of Bias tool (Higgins et al., 2011): 1) random sequence generation, 2) allocation concealment, 3) blinding of participants and personnel, 4) blinding of outcome assessment, 5) incomplete outcome data, and 6) selective reporting bias. Two authors (FS and GG) independently assessed trials' methodological quality. Disagreements were resolved through discussion with other authors (EG or ML).

2.5 Statistical Analysis

The main summary measures were the standardized mean difference (SMD) and odds ratios (OR) depending on the nature of the variable (continuous or dichotomous). For each RCT, the corresponding 95% CIs for the assessed outcome were retrieved or calculated (Bland & Altman, 2000). Data entry and statistical analysis were carried out using Review Manager Software, version 5.3. When data from more than one follow-up period were reported, data from the latest period were included in the meta-analysis. The degree of heterogeneity (I^2) was calculated to determine whether RCTs included in the meta-analysis were consistent. I^2 of 25% was considered low, 50% moderate, and 75% high (Higgins et al., 2003).

3. Results

3.1 Study Selection

Database searches resulted in 1,132 records and two additional ones were identified through other sources (Figure 1). Following the removal of duplicates, 683 articles were retained for title and abstract screening. In total, 639 abstracts were excluded as they did not meet the eligibility criteria and 44 manuscripts were selected for full text review. Thirty-two manuscripts were excluded because the intervention did not include motivational strategies (n = 15), outcomes of interest were not assessed (n = 6), they were not RCTs (n = 5), the sample was composed exclusively of women (n = 3), or the sample included offenders under the age of 18 (n = 3). The remaining 12 trials (see Table 1) were included in the qualitative synthesis and are marked with an "*" in the References section. Of these, five trials were excluded from the meta-analysis. One trial was excluded because it did not fully report the outcomes of interest (Alexander et al., 2010). The other four trials were excluded from the meta-analysis to favor comparability: two were couples-

based therapy (Bahia 2016; Woodin & O'Leary, 2010), one incorporated motivational strategies in both conditions (Kraanen et al., 2013), and one trial used two different delivery intervention formats for each condition of the same intervention (individual intervention vs. group intervention; Murphy et al., 2017). Therefore, meta-analyses in this study included seven trials.

The 12 trials selected for the narrative review evaluated 1,733 participants, 844 in intervention groups (IG) and 889 in control groups (CG). Only seven trials were included in the meta-analyses, including 989 participants: 488 in intervention groups (IG) and 501 in control groups (CG). Most of the trials were conducted in the USA (n = 10; Alexander et al., 2010; Bahia, 2016; Chermack et al., 2017; Crane & Eckhardt, 2013; Mbilinyi et al., 2011; Murphy et al., 2017; Murphy et al., 2018; Schumacher et al., 2011; Stuart et al., 2013; Woodin & O'Leary, 2010), one in the Netherlands (Kraanen et al.,2013), and one in Spain (Lila et al., 2018).

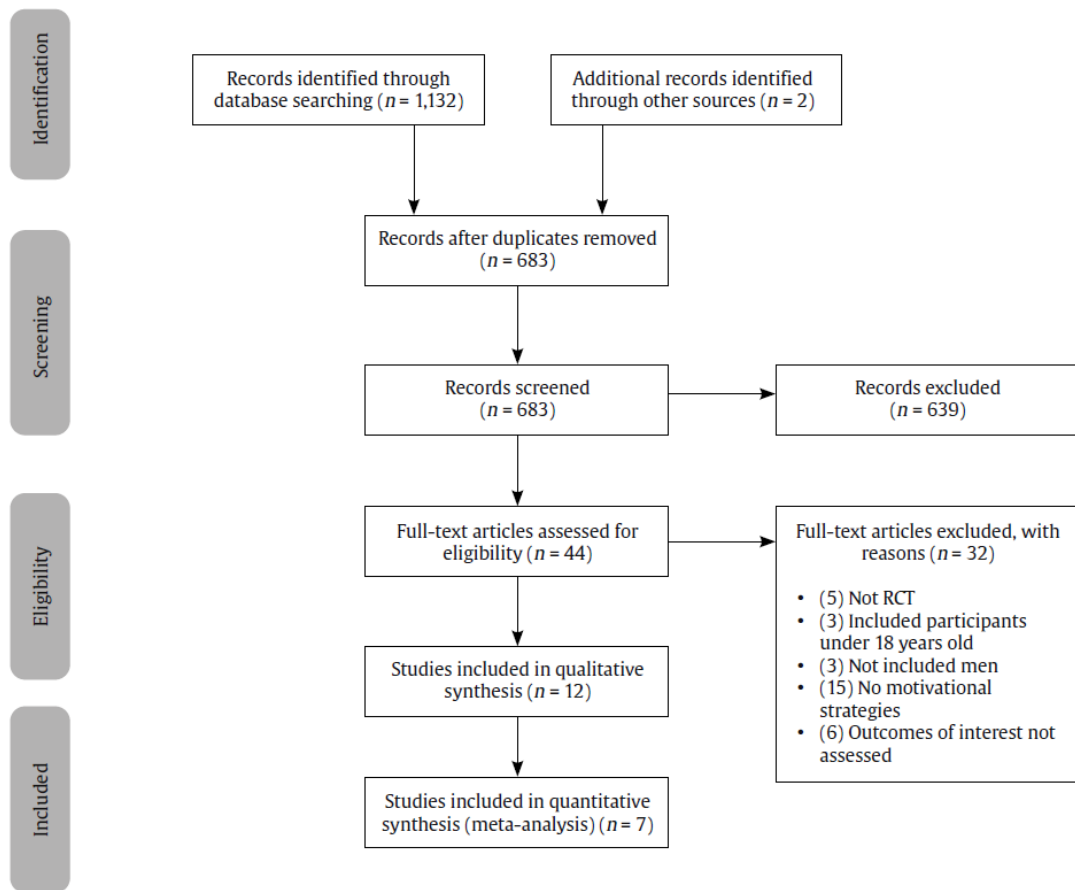


Figure 1. Flowchart.

Table 1. *Summary of trials*

Author Country Recruited Population Sample Size (N) IG vs. CG Mean Age year (SD) (% of men)	% Court referred	Intervention delivery setting /staff	Motivational intervention			Standard intervention		Length of follow-up and period assessed	Outcomes	Results
			Intervention group/s	**Type of motivational strategy delivered**	**Number of sessions**	**Control intervention**	**Number of sessions**			
Alexander et al. (2010) USA 528 Adult IPV perpetrators IG: 247 Age 35.61 (9.35) CG: 281 Age 34.61 (9.65) (100%)	96.1%	Community-based domestic violence agency / Masters-level mental health professionals	Stage of Change Treatment Format (*n* = 247)	Group therapy. Stage of change treatment format. Integrated MI techniques throughout the intervention	26 total sessions: 14 sessions target experiential change processes stage and 12 sessions focused on behavioral change processes	CBT and gender reeducation group format (*n* = 281)	26 sessions	Perpetrator post intervention (asked for previous 6-months) and victim 12- months post intervention (asked for previous 6-months)	1.IPV victim and self-perpetrator report measured by CTS-2	The IG significantly reduced the number of partner´s reports of physical (but not psychological) aggression at 12-month follow-up. No difference between groups for participant IPV report.
Bahia (2016) USA 72 Adults/ 36 heterosexual couples (50%) one or both partners engaged in alcohol or other drug use within the past three months IG: 36 Age: 23 (2.78) (19%) CG:36 Age: 24.36 (2.96) (81%)	0%	Family center clinic / Clinical and counselling psychology graduate students	The Relationship Check-Up (*n* = 36)	MI couple sessions and structural feedback about the relationship	3 total sessions: 1 session semi-structured interview with the couple 1 session video observation 1 feedback session with the couple	Assessment visit (*n* = 36)	1 session	3-weeks post intervention (asked for previous 24 hours)	1.Psychological IPV victim and self-report measured by MCTS	No significant difference between groups in psychological IPV victim and self-report.
Chermack et al. (2017) USA 119 Adult patients in SUD treatment reporting past-year IPV IG: 57 CG: 62 Age: 35.3 (10.8) (70%)	0%	SUD facility/ master-level therapists trained in social work or psychology	Integrated Violence Prevention Treatment (*n* = 57)	MI-CBT individual sessions and personalized feedback targeting IPV and SUD	6 total sessions. Session 1: MI principles. Sessions 2-6: Primarily skills-focused CBT-based content + MI principles	Psycho-educational individual sessions targeting SUD (only the initial sessions included some content on anger management) (*n* = 62)	6 sessions	6-months post intervention (asked for previous 3-months)	1.Physical IPV self-report measured by TLFB-AM	Significant reductions between post and pre-intervention for IPV perpetration in both groups.

Table 1 (cont.)

Author Country Recruited Population Sample Size (N) IG vs. CG Mean Age year (SD) (% of men)	**% Court referred**	**Intervention delivery setting /staff**	**Motivational intervention**			**Standard intervention**		**Length of follow-up and period assessed**	**Outcomes**	**Results**
			Intervention group/s	**Type of motivational strategy delivered**	**Number of sessions**	**Control intervention**	**Number of sessions**			
Crane & Eckhardt (2013) USA 82 Adult male IPV perpetrators IG: 48 Age: 34 (11.8) CG: 34 Age: 33.9 (12) (100%)	100%	Community-based domestic violence agency/ advanced clinical psychology graduate	Single-session brief motivational enhancement (*n* = 48)	MI individual session + standardized change plan worksheet	27 total sessions 1 session MI + 26 sessions IPV offender program	Unrelated computer task + BIP (*n* = 34)	27 total sessions 1 session computer task + 26 sessions IPV offender program	6-months post intervention	1.Session attendance 2. Dropout 3.Official recidivism	IG participants attended more sessions than CG (IG = 12.2 (1.5); CG = 8.3 (1.8)) Significantly less dropout in IG (27.1% in the IG and 50% in the CG). No significant difference in official recidivism between groups (25% in the IG and 39.4% of participants in the CG).
Kraanen et al. (2013) Netherlands 52 Adult male/female in SUD treatment reported at least 7 acts of physical IPV in the past year IG: 27 Age 34.85 (9.87) (70%) CG: 25 Age 37.08 (8.87) (68%)	0%	SUD facility / female social workers with extensive experience in substance abuse counseling	Individual CBT-MI, and MI addressed SUD and IPV (*n* = 27)	Integrated MI techniques throughout the intervention Diary register cards of substance abuse and IPV behaviors Wordbook containing psycho-education and weekly assignments	16 total sessions	Individual CBT-MI targeting predominantly SUD only one session focused on IPV (*n* = 25)	16 sessions	Post-Intervention (asked for previous 8-weeks)	1.IPV self-report measured by CTS-2 2. Session attendance 4. Dropout	Significant reductions between post and pre-intervention for IPV perpetration in both groups. No significant difference between groups in intervention dose (IG = 9.25 (6.54); CG = 8.68 (5.59)) and dropout (59.3% in the IG and 68% in the CG).
Lila et al. (2018) Spain 160 IPV offenders IG: 80 Age: 46.36 (10.81) CG: 80 Age: 40.95 (12.29) (100%)	100%	Community-based domestic violence agency/ Psychologists (at least one year of experience with BIPs)	SBIP (CBT and gender reeducation) + individualized motivational plan (*n* = 80)	Integrated MI techniques throughout the intervention Retention techniques	35 total sessions: 5 individual MI, 3 group sessions to share goals and receive feedback and support, 27 CBT and gender reeducation group format	CBT and gender reeducation group format (*n* = 80)	35 sessions	IPV self-report post-intervention (asked for previous 6-months) Official recidivism 6-months post-intervention	1. IPV self-report measured by CTS-2 2.Session attendance 3. Dropout 4. Official recidivism	IG participants reported significantly lower physical violence at post-intervention. Significant difference between groups in intervention dose (IG = 27.01 (9.08); CG = 23.77 (8.06)) but not in dropout (IG = 20%; CG = 26.25%) or official recidivism (IG = 8.33%; CG = 8.75%).

Table 1 (cont.)

Author Country Recruited Population Sample Size (N) IG vs. CG Mean Age year (SD) (% of men)	**% Court referred**	**Intervention delivery setting /staff**	**Motivational intervention**			**Standard intervention**		**Length of follow-up and period assessed**	**Outcomes**	**Results**
			Intervention group/s	**Type of motivational strategy delivered**	**Number of sessions**	**Control intervention**	**Number of sessions**			
Mbilinyi et al. (2011) USA N = 124 Adult with recent IPV and SUD behaviours IG:58 CG: 66 Age: 39.4 from 18 to 67 (100%)	0%	Community + phone/mail / Master level and bachelor level counsellors	Telephone-delivered motivational enhancement therapy (*n* = 58)	60- to 90- telephone MI focused on IPV and SUD and personal feedback report by mail	1 session	Psycho-educational materials via mail related to IPV and SUD (*n* = 66)	0 sessions	30 days post-intervention (asked for previous 30 days)	1.IPV self-report measured by CTS-2 2.Session attendance 3.Substance Abuse 4.Perceived norms for IPV and drinking	IG participants reported significantly less psychological and physical + injurious violence at follow-up. Greater session attendance to a voluntary interview in IG (IG = 41.38%; CG = 27.27)
Murphy et al. (2017) USA N = 42 IPV offenders IG: 21 Age 36.86 (7.12) CG: 21 Age 31.90 (6.07) (100%)	90.5%	Community-based domestic violence agency / Doctoral clinical psychologists, doctoral students in clinical psychology and master level clinical psychologists	Individual CBT-psycho-educational-MI sessions (*n* = 21)	Integrated MI techniques throughout the intervention	20 weekly individual 1-hr sessions CBT and psycho-educational	CBT and psycho-educational group format (*n* = 21)	20 group weekly 2-hr sessions	IPV victim and self-report 6-months post-intervention. Official recidivism (1 year from the date of first intake)	1. IPV victim and self-perpetrator report measured by CTS-2 2.Emotional abuse measured by MMEA 3. Official recidivism 3. Session attendance 4. Dropout	Partners reported significantly less psychological violence and emotional abuse in CG. Significantly greater session attendance in IG (IG = 19.62 (3.61); CG = 12.19 (9.12)) and significantly fewer dropout in IG (IG = 10%; CG = 28%). No significant difference in official recidivism (IG = 19%, CG = 5%).
Murphy et al. (2018) USA N = 228 Adult IPV offenders in SUD treatment IG: 110 Age 33.25 (9.33) CG: 118 Age: 34.40 (11) (100%)	96%	Community-based domestic violence agency / doctoral-level clinical psychologist, doctoral students in clinical psychology, marriage and family therapist, and social workers	Individual motivational enhancement therapy + IPV offender program (*n* = 110)	Integrated MI techniques throughout the sessions and structural feedback	Total number of sessions: n.s. 4 sessions focused on SUD and IPV + n.s IPV offender program	Individual psycho-educational sessions (videos regarding SUD and IPV, brief test on the content of the video, written educational handouts, and 10 minutes to ask questions or discuss related personal concerns + IPV offender program (*n* = 118)	Total number of sessions: n.s. 4 video sessions + n.s IPV offender program	12-months post-intervention (asked for previous 12-months)	1.Physical IPV self-report measured by TLFB-AM 2. Session attendance 3. Dropout	Significant reductions between baseline and follow-up for physical IPV in both groups. No significant difference between groups in session attendance (IG = 3.71 (0.95); CG = 3.55 (1.17)) and dropout (IG = 5.71%; CG = 8.18%)

Table 1 (cont.)

Author Country Recruited Population Sample Size (N) IG vs. CG Mean Age year (SD) (% of men)	**% Court referred**	**Intervention delivery setting /staff**	**Motivational intervention**			**Standard intervention**		**Length of follow-up and period assessed**	**Outcomes**	**Results**
			Intervention group/s	**Type of motivational strategy delivered**	**Number of sessions**	**Control intervention**	**Number of sessions**			
Schumacher et al. (2011) USA N = 24 IPV offenders with SUD (100%) IG: 12 Age: 32.3 (8.2) CG: 12 Age: 31.8 (10.2)	0%	SUD facility / doctoral-level therapists	Individual motivational enhancement style intervention + list of community resources for IPV treatment (*n* = 11)	MI session and objective feedback	1 session: 90 minutes MI focused on concrete a plan to make a change in one or more behaviors	List of community resources for IPV treatment (*n* = 12)	0 sessions	6-months post-intervention	1. IPV victim and self-perpetrator report measured by CTS-2	No significant difference between groups in IPV self and victim report.
Stuart et al. (2013) USA N = 252 IPV offenders with hazardous drinking IG: 123 Age: 31.5 (9.6) CG: 129 Age: 31.6 (9.9) (100%)	98%	Community-based domestic violence agency / Doctoral-level therapists	Brief Alcohol Intervention + CBT and gender reeducation group format (*n* = 123)	MI individual session and feedback Letter reviewing MI session and encouraging participants to maintain their commitment to change	41 total sessions 1 MI session + 40 CBT gender reeducation group format	CBT and gender reeducation group format (*n* = 129)	40 sessions CBT and gender reeducati on group format	12-months after baseline (asked for previous 6-months) Official recidivism 12-months after baseline	1.IPV self-report measured by CTS-2 2. Official recidivism	IG participants significantly reported less severe psychological aggression and fewer injuries to partners at 3- and 6-month follow-up. No significant difference in official recidivism (IG = 13.8%; GC = 13.1%).
Woodin & O'Leary (2010) USA N = 100 /50 couples with at least one act of male-to-female physical aggression IG: 25 CG: 25 Age: 19.96 (1.34) (50%)	0%	University/ advanced graduate in Clinical Psychology	Motivational Feedback (*n* = 50 / 25 couples)	45 minutes MI couple session and personal feedback with each member of the couple and couple format in the last 15 minutes	1 session	10-minute individual non-motivational session. Brief written feedback about their overall relationship adjustment and verbal definitions of the components of relationship adjustment	1 session	9-months (asked for previous 3-months)	1. IPV self-report CTS-2 (completed by both partners)	IG participants significantly reduced physical IPV self-report.

Note. CBT = cognitive behavioral therapy; CG = control group; CTS-2 = Revised Conflicts Tactics Scale; IG = intervention group; IPV = intimate partner violence; MMEA = Multidimensional Measure of Emotional Abuse; MCTS = Modified Conflict Tactics Scale; MI = motivational interviewing; n.s = not specified; SUD = substance use disorder; TLFB-AM = The Time Line Follow Back-Aggression Module.

3.2 Quality and Publication Bias Assessment

A summary of authors' judgements about each risk of bias item for each included trial is described in Figure 2. Six trials (50%) met at least three criteria. None of the trials satisfied all criteria. Concerning random sequence generation, nine of 12 trials (75%) described a random component in the sequence generation. In one trial (8.3%) assignation was constrained by IPV offenders' work schedules (Alexander et al., 2010), so its risk of bias was considered high. Knowledge of allocation concealment was not properly described except for two trials that reported a suitable method to conceal allocation (Kraanen et al., 2013; Stuart et al., 2013). Four trials (33.3%) reported no or incomplete blinding of participants and personnel (Alexander et al., 2010; Bahia, 2016; Murphy et al., 2018; Woodin & O'Leary et al., 2010). In the remaining eight trials (66.7%), the blinding of participants and personnel scores indicate that the risk is unclear due to inadequate description. Three trials (25%) ensured blinding of outcome assessment (Alexander et al., 2010; Murphy et al., 2018), or the outcome measurement was not likely to be influenced by lack of blinding (Crane & Eckhardt, 2013). Two trials reported no blinding of outcome assessment (Bahia, 2016; Woodin & O'Leary, 2010). The information provided was insufficient to assess detection bias of the remaining seven trials (58.3%). An intention-to-treat analysis was used in eight trials (66.7%; Chermack et al. 2017; Crane & Eckhardt, 2013; Kraanen et al. 2013; Lila et al., 2018; Murphy et al., 2017; Murphy et al., 2018; Stuart et al. 2013; Woodin & O'Leary, 2010). Regarding selective reporting, two trials (16.6%) were assessed as high risk because one or more outcomes of interest in the review were incompletely reported and, consequently, they could not be entered in the meta-analysis (Alexander et al., 2010; Woodin & O'Leary, 2010). In four trials (33.3%), information available was insufficient to judge the reporting bias (Bahia, 2016; Chermack et al., 2017; Kraanen et al., 2013; Murphy et al., 2018).

	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)
Alexander et al. (2010)	−	?	−	+	?	−
Bahia (2016)	+	?	−	−	?	?
Chermack et al. (2017)	?	?	?	?	+	?
Crane & Eckhardt (2013)	+	?	?	+	+	+
Kraanen et al. (2013)	+	+	?	?	+	?
Lila et al. (2018)	+	?	?	?	+	+
Mbilinyi et al. (2011)	+	?	?	?	?	+
Murphy et al. (2017)	+	?	?	?	+	+
Murphy et al. (2018)	+	?	−	+	+	?
Schumacher et al. (2011)	+	?	?	?	?	+
Stuart et al. (2013)	+	+	?	?	+	+
Woodin & O´Leary (2010)	?	?	−	−	+	−

Figure 2. Risk of bias for included trials.

3.3 Qualitative Analysis

The majority of trials recruited exclusively male IPV offenders (eight trials, 66.7%; Alexander et al., 2010; Crane & Eckhardt, 2013; Lila et al., 2018; Mbilinyi et al., 2011; Murphy et al., 2017; Murphy et al., 2018; Schumacher et al., 2011; Stuart et al., 2013). Four trials (33.3%) recruited both male and female IPV offenders, including 50% male (Bahia, 2016; Woodin & O'Leary, 2010), 69.2% male (Kraanen et al., 2013), and 70% male (Chermack et al., 2017). In seven trials (58.3%) participants also met criteria for substance use disorder (SUD; Bahia 2016; Chermack et al., 2017; Kraanen et al., 2013; Mbilinyi et al., 2011; Murphy et al., 2018; Schumacher et al., 2011; Stuart et al., 2013).

Half of the reviewed trials included court-referred participants, ranging from 90.5% to 100% of the sample (Alexander et al., 2010; Crane & Eckhardt, 2013; Lila et al., 2018; Murphy et al., 2017; Murphy et al., 2018; Stuart et al., 2013), while the other half included only "voluntary" participants who had not been court-mandated (Bahia 2016; Chermack et al., 2017; Kraanen et al., 2013; Mbilinyi et al., 2011; Schumacher et al., 2011; Woodin & O'Leary, 2010).

The intervention delivery setting was: community-based domestic violence agencies (Alexander et al., 2010; Crane & Eckhardt, 2013; Murphy et al., 2017; Murphy et al., 2018; Stuart et al. 2013), substance abuse facilities (Chermack et al. 2017; Kraanen et al., 2013; Schumacher et al., 2011), family center clinic (Bahia, 2016), university (Lila et al., 2018; Woodin & O'Leary, 2010), and community + phone/ mail (Mbilinyi et al., 2011). In five trials (41.7%), the intervention was delivered by graduate-level professionals, either psychologists (Bahia 2016; Crane & Eckhardt, 2013; Lila et al., 2018; Woodin & O'Leary, 2010) or social workers (Kraanen et al., 2013). In two trials (16.7%), master-level mental health professionals delivered the intervention (Alexander et al., 2010; Chermack et al., 2017). In one study (8.3%) both graduate and master

counsellors delivered the intervention (Mbilinyi et al., 2011). In four trials (33.3%) the intervention was conducted by doctoral-level professionals, either clinical psychologists (Murphy et al., 2017; Murphy et al., 2018) or therapists (without specifying background; Schumacher et al., 2011; Stuart et al., 2013).

The content of the intervention in seven (58.3%) trials exclusively addressed IPV (Alexander et al., 2010; Bahia, 2016; Crane & Eckhardt, 2013; Lila et al., 2018; Murphy et al., 2017; Schumacher et al., 2011; Woodin & O'Leary, 2010) and five interventions (41.7%) targeted both IPV and SUD (Chermack et al., 2017; Kraanen et al., 2013; Mbilinyi et al., 2011; Murphy et al., 2018; Stuart et al., 2013). Five interventions for IPV offenders were delivered to individuals (Chermack et al., 2017; Kraanen et al., 2013; Mbilinyi et al., 2011; Murphy et al., 2018; Schumacher et al., 2011), four were delivered to groups (33.3%; Alexander et al., 2010; Crane & Eckhardt, 2013; Lila et al., 2018; Stuart et al., 2013), and two (16.7%) were couples-based interventions (Bahia, 2016; Woodin & O'Leary, 2010). In one trial (8.3%; Murphy et al., 2017) the motivational intervention was delivered individually to the intervention group and the standard intervention was delivered to the control group in a group format.

Multiple motivational strategies were used in the RCTs. MITs (Miller & Rollnick, 2002) were included in all RCTs, most of them incorporating a personalized feedback to participants about their behaviors of interest (Bahia, 2016; Chermack et al., 2017; Mbilinyi et al., 2011; Murphy et al., 2018; Schumacher et al., 2011; Stuart et al., 2013; Woodin & O'Leary, 2010). Alexander et al. (2010) carried out an intervention based on stages of change, in which the first 14 sessions where focused on precontemplation and contemplation stages with an approach based on experiential change processes activities, and the following 12 sessions focused on advanced stages of change based on behavioral change process. Bahia (2016) delivered a couple-based intervention consisting of a semi-

structured interview to identify areas of strength and strain in the relationship and build rapport, a couple video observation task, and a feedback session. Chermack et al. (2017) implemented six individual motivational interview-cognitive behavioral therapy (MI-CBT) sessions, with the first session focusing on MITs and enhancing motivation to change, and the remaining sessions being primarily skills-focused. Crane and Eckhardt (2013) carried out a single individual MI prior to entry into the IPV offender intervention program, and a standardized worksheet to reflect the change plan at the end of the interview. Kraanen et al. (2013) integrated MITs over the 16 sessions of the program and implemented diary register cards of SUD and IPV behaviors, as well as a workbook containing psychoeducation and weekly assignments. Lila et al. (2018) implemented five individual MI and three group sessions where participants shared their goals, and retention strategies and participants' personal goals were reinforced throughout the program. Mbilinyi et al. (2011) conducted a single telephone MI and a personal feedback report by mail. Murphy et al. (2017) delivered 20 individual CBT-psycho-educational-MI sessions. Murphy et al. (2018) carried out four MIs prior to entry into the IPV offender program and included a personalized assessment feedback. Schumacher et al. (2011) implemented a MI session and provided a list of community resources for IPV treatment. Stuart et al. (2013) carried out a MI session prior to entering the program and delivered feedback letters reviewing the MI session. Finally, Woodin and O'Leary (2010) proposed a MI couple session divided into three parts: with the couple, with each member of the couple (in which they received personal feedback), and finally with the couple again.

We found a high heterogeneity in terms of duration of the intervention. Six (50.0%) trials were long-term programs (Alexander et al., 2019; Crane & Eckhardt, 2013; Kraanen et al., 2013; Lila et al., 2018; Murphy et al., 2017; Stuart et al., 2013), with the number of sessions ranging from 16 (Kraanen et al., 2013) to 40 (Stuart et al., 2013). Three (25.0%)

were short-term programs (Bahia, 2016; Chermack et al., 2017; Murphy et al., 2018), with the number of sessions ranging from three (Bahia, 2016) to six (Chermack et al., 2017). Finally, three interventions (25.0%) were carried out in a single session (Mbilinyi et al., 2011; Schumacher et al., 2011; Woodin & O'Leary, 2010).

Regarding control groups, three trials (25%) compared IPV intervention programs with added motivational strategies against those without motivational strategies. Among them, the approach used was CBT and gender re-education group format (Alexander et al., 2010; Lila et al., 2018), and CBT and psycho-educational format (Murphy et al., 2017). Three trials (25%) compared pre-entry IPV offender program interventions that include motivational strategies against those comprised by non-motivational strategies, such as unrelated computer tasks (Crane & Eckhardt, 2013), no intervention (Stuart et al., 2013), or four individual psycho-educational sessions focused on IPV and SUD, written educational handouts, and 10 minutes to ask questions or discuss related personal concerns (Murphy et al., 2018). In two trials (16.7%) the control group was composed of interventions focused predominantly on SUD (Chermack et al., 2017; Kraanen et al., 2013). Two trials (16.7%) based control interventions on providing prevention materials; Schumacher et al. (2011) offered a list of community resources for IPV treatment, and Mbilinyi et al. (2011) sent psycho-educational materials via mail. In Woodin and O'Leary's (2010) trial each partner in the control group received 10-minutes of non-motivational feedback sessions and a brief written feedback about overall relationship adjustment. In Bahia's (2016) trial, couples in the control group received an assessment session only.

Among trials comparing interventions of more than one session per condition, most (87.5%) included the same number of sessions in both groups (Alexander et al., 2010; Chermack et al., 2017; Crane & Eckhardt, 2013; Kraanen et al., 2013; Lila et al.,

2018; Murphy et al., 2017; Murphy et al., 2018), except for Stuart et al. (2013), where the number of sessions was lower in the control intervention than in the motivational intervention.

There was considerable heterogeneity across RCTs in the duration of time participants who were followed-up. The follow-up varied depending on the outcome considered. In two trials, the baseline/first intake was considered the reference point for reporting the follow-up time period; specifically, the follow-up was up to 12 months after the date of first intake (Murphy et al., 2017), and 12 months after baseline (Stuart et al., 2013). All other trials considered post-intervention as the starting point, with a follow-up time period from immediately post intervention (Kraanen et al., 2013), three weeks post intervention (Bahia, 2016), one-month post intervention (Mbilinyi et al., 2011), six months post intervention (Chermack et al., 2017); Crane & Eckhardt, 2013; Lila et al., 2018; Schumacher et al., 2011), nine months post intervention (Woodin & O'Leary, 2010), and 12 months post intervention (Alexander et al., 2010; Murphy et al., 2018). Regarding the assessment period participants were asked about, the most frequent was whether any of the IPV behaviors had occurred in the last 3 months (Chermack et al, 2017; Murphy et al. 2018; Stuart et al. 2013; Woodin & O'Leary, 2010). Two trials (16.7%) asked for reports of exceptionally short periods of time, such as Mbilinyi et al. (2011), who asked for the previous 30 days, and Bahia (2016), who asked for the past 24 hours.

Regarding the main outcomes analyzed in RCTs, physical IPV was assessed in all trials except in Bahia's (2016) and in Crane and Eckhardt's (2013) studies. All trials used the Conflict Tactics Scales-Revised (CTS-2; Straus et al., 1996) or tools based on the same scale (Chermack et al., 2017; Murphy et al., 2018). These tools were semi-structured

interviews to identify specific days in which physical assault and injurious behaviors occurred.

Psychological IPV was assessed in nine RCTs (75.0%; Alexander et al. 2010; Bahia, 2016; Kraanen et al., 2013; Lila et al. 2018; Mbilinyi et al., 2011; Murphy et al., 2017; Stuart et al., 2013; Schumacher et al., 2011; Woodin & O'Leary, 2010). All trials used CTS-2 except for Bahia (2016), who used an alternative tool based on the same scale. Only one study included the Multidimensional Measure of Emotional Abuse (MMEA; Murphy et al., 1999) to measure emotional abuse (Murphy et al., 2017). Only two trials (16.7%; Alexander et al., 2010; Murphy et al., 2017) obtained victim reports about both physical and psychological IPV. Injuries resulting from IPV were assessed in three RCTs (25.0%; Kraanen et al., 2013; Murphy et al., 2017; Stuart et al., 2013) using the CTS-2. Dropout and intervention doses were assessed in five trials (41.7%; Crane & Eckhardt, 2013; Kraanen et al., 2013; Lila et al., 2018; Murphy et al., 2017; Murphy et al., 2018).

Official recidivism (i.e., rearrests, police records) was assessed in four trials (33.3%; Crane & Eckhardt, 2013; Lila et al., 2018; Murphy et al., 2017; Stuart et al., 2013). In three trials, IPV specific recidivism was assessed (Lila et al., 2018; Stuart et al., 2013; Murphy et al., 2017). However, Crane and Eckhardt (2013) were unable to assess IPV-specific recidivism due to the low rate of IPV events, and therefore considered any new police record as recidivism (including IPV and non IPV events). The follow-up assessment period for official recidivism varied across RCTs. Crane and Eckhardt (2013) collected recidivism data six months after the first pre-intervention session, Lila et al. (2018) six months after completing the intervention, Stuart et al. (2013) twelve months following the baseline assessment, and Murphy et al. (2017) twelve months from the date of first intake.

4. Trial Authors' Findings and Conclusions

Integrated motivational strategies throughout IPV offender intervention program. Alexander et al. (2010) found a significant reduction for the motivational intervention group in the number of partner reports of physical violence 12 months post intervention ($p < .01$), but not in psychological violence. No differences in participant self-reported violence during follow-up were found (Alexander et al., 2010). Chermack et al. (2017) found a significant reduction in total violence reported by participants in both conditions at 6-month follow-up compared with the baseline. Kraanen et al. (2013) found a significant reduction in IPV perpetration in participants in both treatment conditions after the intervention. Those in the motivational intervention group received a higher mean intervention dose (mean ± *SD*: IG = 9.25 ± 6.54, CG = 8.68 ± 5.59, $p = .89$) and a lower proportion of intervention dropout was reported (IG = 59.3%, CG = 68%, $p = .51$), but these differences were not statistically significant (Kraanen et al., 2013). Lila et al. (2018) reported significant reductions in physical violence at post-treatment in the motivational group ($p < .05$). Moreover, participants from the motivational group received a significantly higher mean intervention dose (mean ± SD: IG = 27.01 ± 9.08, CG = 23.77 ± 8.06, $p < .01$) and a lower proportion dropped out of the intervention (IG = 20%, CG = 26.25%, $p = .15$) and official recidivism at 6 month post intervention (IG = 8.33%, CG = 8.75%, $p = .64$) (Lila et al., 2018). Murphy et al. (2017) showed less psychological and emotional violence reported by partners six months after the intervention in participants from control intervention (CBT and psychoeducational 20 group weekly 2-hour sessions). A lower proportion of participants in the motivational group dropped out of the intervention (IG = 10%, CG = 28%, $p = .03$) and received a significant higher mean intervention dose (mean ± SD: IG = 19.62 ± 3.61, CG = 12.19 ± 9.12, $p = .001$) (Murphy et al., 2017). There were no significant differences in official

recidivism at 12 month from the date of first intake between motivational and control groups (IG = 19%, CG = 5%) (Murphy et al., 2017).

Motivational intervention prior to entry in IPV offender program. Crane & Eckhardt (2013) found that participants in the motivational intervention received a non-statistically significant higher mean intervention dose (mean ± SD: IG = 8.34 ± 9.89, CG = 12.24 ± 10.18, p = .09) and a significantly lower proportion dropped out of the intervention than those from the control group (IG = 27.1%, CG = 50%, p = .04). Moreover, motivational intervention participants showed a reduction in official recidivism at 6 months post intervention (IG = 25%, CG = 39.4%), although this difference did not reach statistical significance. Similarly, Stuart et al. (2013) found that those in motivational intervention reported less severe psychological violence and fewer injuries to partners at three and six-month follow-up (for all, p < .04). However, there were no significant differences between groups in physical IPV and official recidivism at 12 months following the baseline (IG = 13.8%, CG = 13.1%) (Stuart et al., 2013). Murphy et al. (2018) showed that both groups had a significant reduction in physical violence from baseline through 12-month follow-up. Those in the motivational intervention group received a higher mean intervention dose (mean ± SD: IG = 3.71 ± 0.95, CG = 3.55 ± 1.17, p = .27) and a lower proportion dropped out than those from the control group (IG = 5.71%, CG = 8.18%, p = .31), but these differences were not statistically significant (Murphy et al., 2018).

Single session interventions. Mbilinyi et al. (2011) reported a significant reduction in psychological and physical plus injurious violence for participants in the motivational intervention group. In addition, these participants showed higher attendance to a voluntary interview (IG = 41.38%, CG = 27.27) (Mbilinyi et al., 2011). Schumacher et

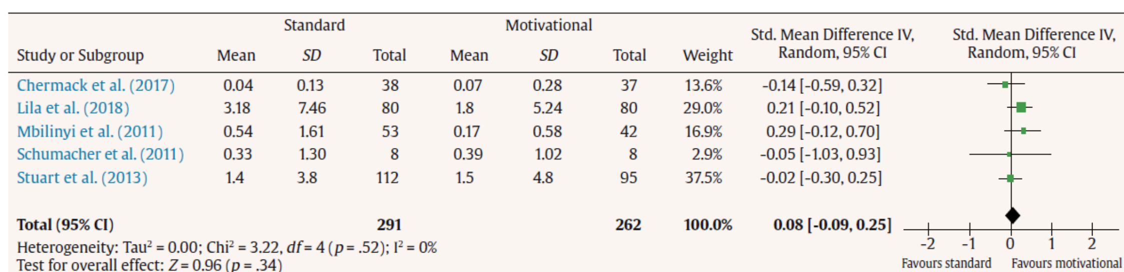
al. (2011) found no differences in IPV reported by victims or self-reported by offenders between groups.

Couple-based interventions. Bahia et al. (2016) reported no significant differences in psychological violence reported by victims or self-reported by offenders between groups. Woodin and O'Leary (2010) found a significant reduction in self-reported IPV in the motivational group.

5. Meta-analysis

The main outcomes analyzed in the meta-analysis were physical and psychological IPV, intervention dropout, intervention dose, and official recidivism. Injuries resulting from IPV were not included in the meta-analysis as only one trial measured this outcome (Stuart et al., 2013). Results for the outcomes analyzed are showed in Figures 3-7.

Physical IPV. Data from trials carried out by Murphy et al. (2018) and Woodin and O'Leary (2010) could not be included in the meta-analysis due to the lack of data for comparison (means and standard deviations were not reported in the manuscript). The meta-analysis with self-reported physical IPV as outcome included 553 participants from five trials (Chermack et al., 2017; Lila et al., 2018; Mbilinyi et al., 2011; Schumacher et al., 2011; Stuart et al., 2013). It is worth noting that Mbilinyi et al. (2011) included results of self-reported physical and injurious IPV combined, so in the present meta-analysis this measure was considered as an indicator of physical violence. Only Alexander et al. (2010) examined victim-reported physical IPV, so this outcome was not included in the meta-analysis. IPV offenders allocated to receive motivational interventions showed a nonsignificant reduction in the occurrence of physical IPV compared to those allocated to control interventions (SMD = 0.08, 95% CI [-0.09, 0.25]) (Figure 3). Heterogeneity was low ($I^2 = 0\%$). Consequently, no further analysis of the heterogeneity was conducted.

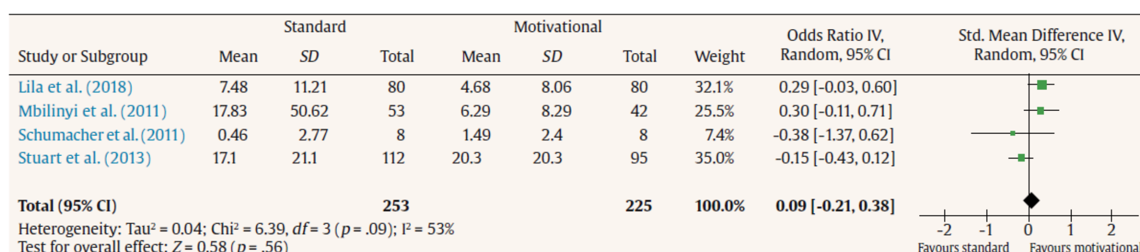


Study or Subgroup	Standard Mean	Standard *SD*	Standard Total	Motivational Mean	Motivational *SD*	Motivational Total	Weight	Std. Mean Difference IV, Random, 95% CI
Chermack et al. (2017)	0.04	0.13	38	0.07	0.28	37	13.6%	-0.14 [-0.59, 0.32]
Lila et al. (2018)	3.18	7.46	80	1.8	5.24	80	29.0%	0.21 [-0.10, 0.52]
Mbilinyi et al. (2011)	0.54	1.61	53	0.17	0.58	42	16.9%	0.29 [-0.12, 0.70]
Schumacher et al. (2011)	0.33	1.30	8	0.39	1.02	8	2.9%	-0.05 [-1.03, 0.93]
Stuart et al. (2013)	1.4	3.8	112	1.5	4.8	95	37.5%	-0.02 [-0.30, 0.25]
Total (95% CI)			**291**			**262**	**100.0%**	**0.08 [-0.09, 0.25]**

Heterogeneity: Tau² = 0.00; Chi² = 3.22, *df* = 4 (*p* = .52); I² = 0%
Test for overall effect: *Z* = 0.96 (*p* = .34)

Figure 3. Self-reported physical IPV.

Psychological IPV. Four trials with a total of 478 participants (Lila et al., 2018; Mbilinyi et al., 2011; Schumacher et al., 2011; Stuart et al., 2013) were included in the meta-analysis with self-reported psychological IPV as the outcome. Only one trial examined victim-reported psychological IPV (Alexander et al., 2010), so this outcome was not included in the meta-analysis. IPV offenders allocated to receive motivational interventions showed no difference in psychological IPV occurrence compared to those allocated to interventions without motivational strategies (SMD = 0.09, 95% CI [-0.21, 0.38]) (Figure 4). Moderate heterogeneity (I^2 = 53%) was reported. No further analysis of heterogeneity was conducted.



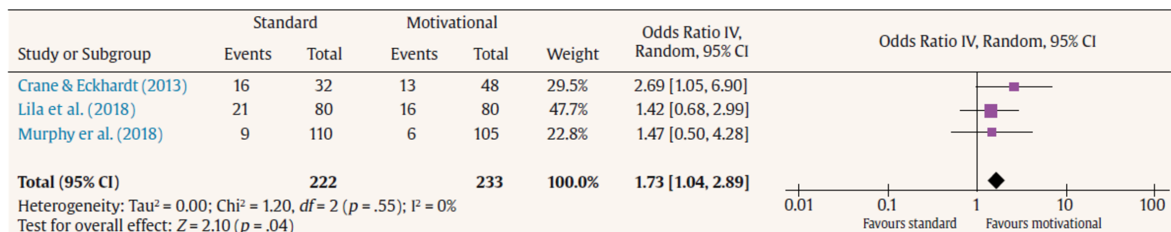
Study or Subgroup	Standard Mean	Standard *SD*	Standard Total	Motivational Mean	Motivational *SD*	Motivational Total	Weight	Odds Ratio IV, Random, 95% CI
Lila et al. (2018)	7.48	11.21	80	4.68	8.06	80	32.1%	0.29 [-0.03, 0.60]
Mbilinyi et al. (2011)	17.83	50.62	53	6.29	8.29	42	25.5%	0.30 [-0.11, 0.71]
Schumacher et al. (2011)	0.46	2.77	8	1.49	2.4	8	7.4%	-0.38 [-1.37, 0.62]
Stuart et al. (2013)	17.1	21.1	112	20.3	20.3	95	35.0%	-0.15 [-0.43, 0.12]
Total (95% CI)			**253**			**225**	**100.0%**	**0.09 [-0.21, 0.38]**

Heterogeneity: Tau² = 0.04; Chi² = 6.39, *df* = 3 (*p* = .09); I² = 53%
Test for overall effect: *Z* = 0.58 (*p* = .56)

Figure 4. Self-reported psychological IPV.

Dropout. Three trials with a total of 455 participants were included in the meta-analysis with intervention dropout as outcome (Crane & Eckhardt, 2013; Lila et al., 2018;

Murphy et al., 2018). IPV offenders receiving motivational interventions were significantly more likely to complete the intervention, compared to interventions without motivational strategies (*OR* = 1.73, 95% CI [1.04, 2.89]) (Figure 5). Heterogeneity was low (I^2 = 0%).

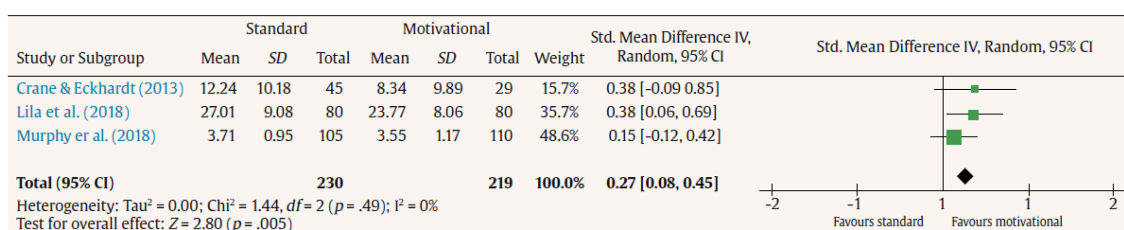


Study or Subgroup	Standard Events	Standard Total	Motivational Events	Motivational Total	Weight	Odds Ratio IV, Random, 95% CI
Crane & Eckhardt (2013)	16	32	13	48	29.5%	2.69 [1.05, 6.90]
Lila et al. (2018)	21	80	16	80	47.7%	1.42 [0.68, 2.99]
Murphy er al. (2018)	9	110	6	105	22.8%	1.47 [0.50, 4.28]
Total (95% CI)		**222**		**233**	**100.0%**	**1.73 [1.04, 2.89]**

Heterogeneity: Tau² = 0.00; Chi² = 1.20, *df* = 2 (*p* = .55); I² = 0%
Test for overall effect: *Z* = 2.10 (*p* = .04)

Figure 5. Dropout.

Intervention dose. Three trials with a total of 449 participants were entered into the meta-analysis with intervention dose as an outcome (Crane & Eckhardt, 2013; Lila et al. 2018; Murphy et al., 2018). IPV offenders allocated to receiving motivational interventions significantly attended a higher number of sessions than those allocated to interventions without motivational strategies (SMD = 0.27, 95% CI [0.08, 0.45]) (Figure 6). Heterogeneity was low (I^2 = 0%).



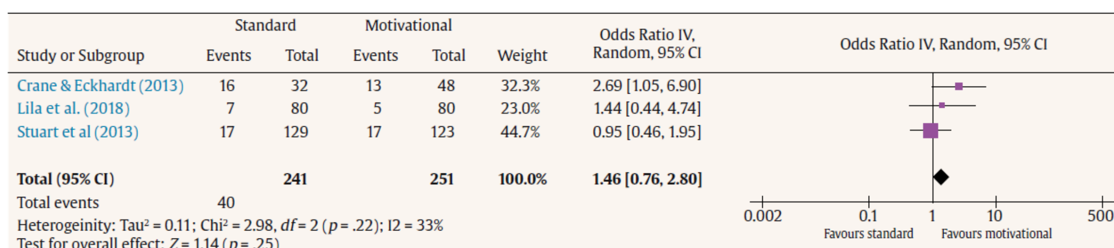
Study or Subgroup	Standard Mean	Standard *SD*	Standard Total	Motivational Mean	Motivational *SD*	Motivational Total	Weight	Std. Mean Difference IV, Random, 95% CI
Crane & Eckhardt (2013)	12.24	10.18	45	8.34	9.89	29	15.7%	0.38 [-0.09 0.85]
Lila et al. (2018)	27.01	9.08	80	23.77	8.06	80	35.7%	0.38 [0.06, 0.69]
Murphy er al. (2018)	3.71	0.95	105	3.55	1.17	110	48.6%	0.15 [-0.12, 0.42]
Total (95% CI)			**230**			**219**	**100.0%**	**0.27 [0.08, 0.45]**

Heterogeneity: Tau² = 0.00; Chi² = 1.44, *df* = 2 (*p* = .49); I² = 0%
Test for overall effect: *Z* = 2.80 (*p* = .005)

Figure 6. Intervention dose.

Official recidivism. Three trials with a total of 492 participants were included in the meta-analysis with official recidivism (i.e., rearrests, police records) as outcome

(Crane & Eckhardt, 2013; Lila et al., 2018; Stuart et al., 2013). In the motivational intervention, 35 participants out of 251 (13.9%) were rearrested on one or more occasions at follow-up, compared with 40 participants out of 241 (16.6%) in the intervention without motivational strategies. Evidence favored motivational interventions, although not significantly (*OR* = 1.46, 95% CI [0.76, 2.80]) (Figure 7). Heterogeneity was low (I^2 = 33%), so no further analysis of heterogeneity was conducted.



Study or Subgroup	Standard Events	Standard Total	Motivational Events	Motivational Total	Weight	Odds Ratio IV, Random, 95% CI
Crane & Eckhardt (2013)	16	32	13	48	32.3%	2.69 [1.05, 6.90]
Lila et al. (2018)	7	80	5	80	23.0%	1.44 [0.44, 4.74]
Stuart et al (2013)	17	129	17	123	44.7%	0.95 [0.46, 1.95]
Total (95% CI)		**241**		**251**	**100.0%**	**1.46 [0.76, 2.80]**
Total events	40					

Heterogeinity: Tau² = 0.11; Chi² = 2.98, *df* = 2 (*p* = .22); I2 = 33%
Test for overall effect: *Z* = 1.14 (*p* = .25)

Figure 7. Official recidivism.

6. Discussion

A systematic review and meta-analysis of the effectiveness of motivational strategies in interventions for IPV offenders was conducted. Different outcomes were compared (i.e., self-reported physical and psychological IPV, dropout, intervention dose and official recidivism). Twelve trials were included in the qualitative analysis and seven trials in the meta-analysis.

Results from the meta-analysis indicated that interventions for IPV offenders that included motivational strategies were significantly more effective in reducing dropout and increasing intervention dose than interventions without motivational strategies. For official recidivism and self-reported physical and psychological IPV, evidence favored motivational interventions, although results did not reach statistical significance.

Concerning dropout and intervention dose, all analyzed trials found greater reductions in dropout and increases in the number of intervention sessions attended among offenders participating in motivational interventions compared to those in interventions without motivational strategies (Crane & Eckhardt, 2013; Lila et al., 2018; Murphy et al., 2018). Intervention dropout rate was 15.02% in interventions that included motivational strategies versus 20.72% in interventions without these strategies. This means that dropout rate was 1.73 times greater amongst interventions for IPV offenders without motivational strategies compared to those that included them.

It is noteworthy that lower dropout in motivational intervention groups was also found in Crane and Eckhardt's (2013) trial, that incorporated only a single motivational interviewing session prior to the delivery of a standard IPV offender program. However, in Crane and Eckhardt's (2013) study, improvements in initial treatment compliance in the motivational condition tended to dissipate over time. It is possible that interventions with more motivational strategies could lead to more durable gains, suggesting that the majority of trials with integrated motivational strategies delivered throughout the duration of the intervention program maintained these effects with large follow-up periods of at least six months (Alexander et al., 2010; Chermack et al., 2017; Kraanen et al., 2013; Lila et al., 2018; Murphy et al., 2017). Lundahl et al. (2010) conducted a systematic review of the effectiveness of motivational interviewing on SUD, gambling, health-related behaviors, and engagement in treatment and found similar results, that is, the greater the dose of motivational strategies received, the better the outcomes. This body of evidence highlights the importance of incorporating motivational strategies to significantly increase treatment compliance among IPV offenders (Miller & Rollnick, 2002; Musser et al., 2008; Soleymani et al., 2018). These findings have important practical implications, especially considering high dropout rates in IPV offender programs and the link between

dropout and higher rates of recidivism reported (Jewell & Wormith, 2010; Lila et al., 2020; Lila et al., 2019; Olver et al., 2011; Stoops et al., 2010). For example, Lila et al. (2019) analyzed official recidivism from an IPV offender program and found that dropout was the most predictive variable of official recidivism.

Regarding official recidivism, two trials in the current meta-analysis favored motivational intervention (Crane & Eckhardt, 2013; Lila et al., 2018), and one trial reported inconclusive evidence (Stuart et al., 2013). Considering these three trials, the rate of recidivism was 1.46 times greater in IPV offenders from standard interventions compared to those from motivational interventions, although results did not reach statistical significance. One possible explanation for this result could be the low level of official recidivism rates among participants in both conditions. Of the 492 participants analyzed, only 75 were rearrested on one or more occasions at follow-up. Arrests are low base-rate events limiting the power of our analysis. Police reports as an index of IPV recidivism could be also problematic and may not appropriately reflect reality. Many acts of IPV do not result in law enforcement intervention and, therefore, are likely to greatly underestimate IPV actual frequency (Velonis et al., 2016). As Babcock et al. (2004) pointed out, official reports could be inaccurate and some crimes may not appear on criminal records (e.g., crimes committed outside of the state or local jurisdiction, violence incidents in which adjudication was deferred), and there is a certain disparity in which types of crimes research considered as recidivism. For example, in our meta-analysis, three trials considered only IPV-specific new police records (Lila et al. 2018; Murphy et al., 2017; Stuart et al., 2013), while another (Crane & Eckhardt et al., 2013) considered any new police report. Nevertheless, arrest records are the most objective data available on IPV recidivism and the most commonly used objective recidivism measure (Babcock et al., 2004; Gondolf, 2004; López-Ossorio et al., 2016). Despite the lack of statistical

significance in official recidivism results in this meta-analysis, the role of motivational strategies in lowering attrition and recidivism has been stressed in previous systematic reviews on IPV offender programs' effectiveness (Babcock et al., 2004; Eckhardt et al., 2013).

Regarding physical IPV reported by offenders, the meta-analysis indicates that two trials favored motivational intervention (Mbilinyi et al., 2011; Lila et al., 2018), two trials favored control intervention (Chermack et al., 2017; Schumacher et al., 2011), and one trial showed inconclusive evidence (Stuart et al., 2013). Two trials favored motivational intervention (Lila et al., 2018; Mbilinyi et al, 2011) on psychological IPV reported by offenders, and two trials favored control intervention (Schumacher et al., 2011; Stuart et al., 2013). Overall, although reduction in psychological IPV was in the expected direction across all included studies, the difference was not large enough to be significant. Reliance on self-reported perpetrators IPV behavior still presents complex issues (Babcock et al. 2004). Despite the fact that the use of reliable and well-validated instruments and the guarantee of confidentiality reduces the risk of biased data (Babor et al., 2000), the court-mandated nature of some IPV offender programs may cause participants to associate program staff with probation personnel and to adapt their responses accordingly (Crane & Eckhardt et al., 2013). In our meta-analysis, the percentage of court ordered participants in the sample measuring outcomes for physical and psychological IPV were 60% and 73%, respectively. Previous studies showed that such participants were more likely to minimize the severity of assaults than their victims (Heckert & Gondolf, 2000). In fact, Alexander et al. (2010) found that motivational interventions favor a significant reduction in the number of partner reports of physical violence, but not a significant reduction in self-reported violence.

Finally, based on this systematic review and meta-analyses, the following recommendations for future trials can be made. Longer follow-up periods are necessary to appropriate assess persistence of change (Alexander et al., 2010; Soleymani et al., 2018). Also, it is important to accurately report follow-up start point. For example, some trials used the date of first intake or baseline assessment as the start of the follow-up period. However, there may be a substantial delay between the in-take and the actual initiation of the intervention program. Using post treatment as reference point could help improve comparability of study results. A clear definition of dropout criteria is also important. Indicating the number of participants who leave the program before it ends (i.e., dropout) provides more accurate information than, for example, stablishing a pre-defined percentage of participation as criteria. Additionally, one way to strengthen overall validity of IPV offender program outcomes would be data triangulation, such as using information from perpetrators, current or ex-partners, and police records (Heckert & Gondolf, 2000).

This review is not without limitations. We have only considered RCTs in our study. Although it is a strength of our study to use the gold standard to evaluate interventions effectiveness (Lilienfeld et al., 2018), we are aware of difficulties of and downsides to the use of RCT in the field of IPV offender treatment (Lilley-Walker et al., 2018), what explain in part the low number of RCTs found. Relatedly, the low number of studies included in the meta-analysis implies that the results should be considered with caution. Also, the outcomes considered (men's self-reported physical and psychological IPV or official recidivism) to report change in behavior or effectiveness could raise concerns about whether we are measuring IPV offender treatment 'success' too narrowly without accurately reflecting relevant changes in any controlling or coercive behaviors, repeating victimization, or whether women/children feel safer (Arbach & Bobbio, 2018; Dobash et

al., 1999; Hester & Westmarland, 2005). Also, self-report measures of physical and psychological IPV can be vulnerable to participants' distortions and social desirability biases (Eckhardt et al., 2012; Gracia et al., 2015; Santirso et al., 2018). In addition, methodology of studies presented considerable heterogeneity in terms of duration, intervention format, follow-up duration, or methods used to evaluate outcomes. Finally, some studies included mixed samples of men and women and court referred and non-court referred participants, without reporting disaggregated data. This may have influenced results.

Despite these limitations, this review points to the potential benefits of integrating motivational strategies into IPV offender programs to increase intervention adherence and reduce dropout. Also, sustained integration of motivational strategies throughout the delivery of IPV intervention program could lead to more substantial gains than the use of a single session motivational strategy, increasing long-term effects of these programs (Lila et al., 2018; Santirso et al., 2020). Additionally, matching the appropriate intervention with participants' readiness to change could help to improve the effectiveness of these programs (Begun et al., 2003; Eckhardt et al., 2004; Levesque et al., 2008). Alexander et al. (2010) and Murphy et al. (2017) illustrated that participants who are less ready to change at intake were more likely to benefit from interventions that included motivational strategies. Also, therapists who use motivational strategies tend to minimize their confrontational style, develop a more collaborative therapeutic alliance, and find less resistance from participants (Alexander et al., 2010; Stuart et al., 2007). In contrast to a more coercive approach, motivational strategies may help IPV offenders to overcome ambivalence about change, helping them to find their own reasons to change and promoting offenders efficacy in obtaining their goals and, more generally, increasing IPV offender program effectiveness.

7. References

References with an asterisk refer to articles included in the meta-analysis.

*Alexander, P. C., Morris, E., Tracy, A., & Frye, A. (2010). Stages of change and the group treatment of batterers: A randomized clinical trial. *Violence and Victims*, *25*(5), 571-587. https://doi.org/10.1891/0886-6708.25.5.571

Arbach, K., & Bobbio, A. (2018). Intimate partner violence risk assessment in community health facilities: A multisite longitudinal study. *Psychosocial Intervention*, *27*(2), 105-112. https://doi.org/10.5093/pi2018a13

Arias, E., Arce, R., & Vilariño, M. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial Intervention*, *22*(2), 153-160. https://doi.org/10.5093/in2013a18

Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., Cantos, A., Hamel, J., Kelly, D., Jordan, C., Lehmann, P., Leisring, P. A., Murphy, C., O'Leary, K. D., Bannon, S., Salis, K. L., & Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence based standards in the united states. *Partner Abuse*, *7*(4), 355-460. https://doi.org/10.1891/1946-6560.7.4.355

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, *23*(8), 1023-1053. https://doi.org/10.1016/j.cpr.2002.07.001

Babor, T. F., Steinberg, K., Anton, R. A. Y., & Del Boca, F. (2000). Talk is cheap: Measuring drinking outcomes in clinical trials. *Journal of Studies on Alcohol*, *61*, 55-63. https://doi.org/10.15288/jsa.2000.61.55

Bahia, H. K. (2016). *Effects of the relationship check up on early adults' romantic relationship adjustment and substance use: A pilot study* (Doctoral dissertation). http://hdl.handle.net/1794/22261

Begun, A. L., Murphy, C., Bolt, D., Weinstein, B., Strodthoff, T., Short, L, & Shelley, G. (2003). Characteristics of the Safe at Home instrument for assessing readiness to change intimate partner violence. *Research on Social Work Practice*, *13*(1), 80-107. https://doi.org/10.1177/1049731502238758

Bennett, L. W., Stoops, C., Call, C., & Flett, H. (2007). Program completion and re-arrest in a batterer intervention system. *Research on Social Work Practice*, *17*(1), 42-54. https://doi.org/10.1177/1049731506293729

Bland, J. M., & Altman, D. G. (2000). Statistics notes: The odds ratio. *British Medical Journal*, *320*, 1468. https://doi.org/10.1136/bmj.320.7247.1468

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331-1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Cannon, C., Hamel, J., Buttell, F., & Ferreira, R. (2016). A survey of domestic violence perpetrator programs in the united states and Canada: Findings and implications for policy and intervention. *Partner Abuse*, *7*(3), 226-276. https://doi.org/10.1891/1946-6560.7.3.226

Carbajosa, P., Catalá-Miñana, A., Lila, M., & Gracia, E. (2017). Differences in treatment adherence, program completion, and recidivism among batterer subtypes. *The European Journal of Psychology Applied to Legal Context*, *9*(2), 93-101. https://doi.org/10.1016/j.ejpal.2017.04.001

Carbajosa, P., Catalá-Miñana, A., Lila, M., Gracia, E., & Boira, S. (2017). Responsive versus treatment-resistant perpetrators in batterer intervention programs: Personal characteristics and stages of change. *Psychiatry, Psychology and Law*, *24*(6), 936-950. https://doi.org/10.1080/13218719.2017.1347933

Chen, H. T., Bersani, C., Myers, S. C., & Denton, R. (1989). Evaluating the effectiveness of a court sponsored abuser treatment program. *Journal of Family Violence*, *4*, 309-322. https://doi.org/10.1007/BF00978573

Cheng, S. Y., Davis, M., Jonson-Reid, M., & Yaeger, L. (2019). Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma, Violence, & Abuse*, 1-16. https://doi.org/10.1177/1524838019865927

*Chermack, S. T., Bonar, E. E., Ilgen, M. A., Walton, M. A., Cunningham, R. M., Booth, B. M., & Blow, F. C. (2017). Developing an integrated violence prevention for men and women in treatment for substance use disorders. *Journal of Interpersonal Violence*, *32*, 581-603. https://doi. org/10.1177/0886260515586369

Coulter, M., & VandeWeerd, C. (2009). Reducing domestic violence and other criminal recidivism: Effectiveness of a multilevel batterers intervention program. *Violence and Victims*, *24*(2), 139-152. https://doi.org/10.1891/0886-6708.24.2.139

*Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology*, *60*(2), 180-187. https://doi. org/10.1037/a0032178

Crane, C. A., Schlauch, R. C., & Eckhardt, C. I. (2015). Dyadic violence and readiness to change among male intimate partner violence offenders. *Criminal Behaviour and Mental Health*, *25*(4), 287-298. https://doi.org/10.1002/cbm.1977

Daly, J. E., & Pelowski, S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims*, *15*(2), 137-160. https://doi.org/10.1891/0886- 6708.15.2.137

Dobash, R. P., Dobash, R. E., Cavanagh, K., & Lewis, R. (1999). A research evaluation of British programmes for violent men. *Journal of Social Policy*, *28*(2), 205-233. https://doi.org/10.1017/S0047279499005589

Dutton, D. G., Bodnarchuk, M., Kropp, R., Hart, S. D., & Ogloff, J. R. (1997). Wife assault treatment and criminal recidivism: An 11-year followup. International *Journal of Offender Therapy and Comparative Criminology*, *41*, 9-23. https://doi.org/10.1177/0306624X9704100102

Eckhardt, C. I., Babcock, J., & Homack, S. (2004). Partner assaultive men and the stages and processes of change. *Journal of Family Violence*, *19*, 81-93. https://doi.org/10.1023/B:JOFV.0000019839.98858.5c

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, *4*(2), 196-231. https://doi.org/10.1891/1946-6560.4.2.196

Eckhardt, C. I., Samper, R., Suhr, L., & Holtzworth-Munroe, A. (2012). Implicit attitudes toward violence among male perpetrators of intimate partner violence: A preliminary investigation. *Journal of Interpersonal Violence*, *27*, 471-491. https://doi.org/10.1177/0886260511421677

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & García-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study.

The Lancet, *371*(9619), 1165-1172. https://doi.org/10.1016/S0140-6736(08)60522-X

Feder, L., & Wilson, D. B. (2005). A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior? *Journal of Experimental Criminology*, *1*, 239-262. https://doi.org/10.1007/s11292-005-1179-0

Gerlock, A. A. (2001). A profile of who completes and who drops out of domestic violence rehabilitation. *Issues in Mental Health Nursing*, *22*(4), 379-400. https://doi.org/10.1080/01612840116997

Gondolf, E. W. (2000). A 30-month follow-up of court-referred batterers in four cities. *International Journal of Offender Therapy and Comparative Criminology*, *44*, 111-128. https://doi.org/10.1177/0306624X00441010

Gondolf, E. W. (2004). Evaluating batterer counseling programs: A difficult task showing some effects and implications. *Aggression and Violent Behavior*, *9*(6), 605-631. https://doi.org/10.1016/j.avb.2003.06.001

Gracia, E. (2014). Intimate partner violence against women and victim-blaming attitudes among Europeans. *Bulletin of the World Health Organization*, *92*, 380-381. https://doi.org/10.2471/BLT.13.131391

Gracia, E., Garcia, F., & Lila, M. (2008). Police involvement in cases of intimate partner violence against women: The influence of perceived severity and personal responsibility. *Violence Against Women*, 14, 697-714. https://doi.org/10.1177/1077801208317288

Gracia, E., Lila, M., & Santirso, F. A. (2020). Attitudes toward intimate partner violence against women in the European Union: A systematic review. European *Psychologist*, *25*, 104-121. https://doi.org/10.1027/1016-9040/a000392

Gracia, E., Rodriguez, C. M., & Lila, M. (2015). Preliminary evaluation of an analog procedure to assess acceptability of intimate partner violence against women: The Partner Violence Acceptability Movie Task. *Frontiers in Psychology*, *6*, 1567. https://doi.org/10.3389/fpsyg.2015.01567

Gracia, E., Rodriguez, C. M., Martín-Fernández, M., & Lila, M. (2020). Acceptability of family violence: Underlying ties between intimate partner violence and child abuse. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260517707310

Guedes, A., Bott, S., Garcia-Moreno, C., & Colombini, M. (2016). Bridging the gaps: A global review of intersections of violence against women and violence against children. *Global Health Action*, *9*(1), 1-15. https://doi.org/10.3402/gha.v9.31516

Heckert, D. A., & Gondolf, E. W. (2000). Assessing assault self-reports by batterer program participants and their partners. *Journal of Family Violence*, *15*, 181-197. https://doi.org/10.1023/A:1007594928605

Heise, L. L. (2011). *What works to prevent partner violence: An evidence overview*. http://strive.lshtm.ac.uk/resources/what-works-preventpartner- violence-evidence-overview

Henning, K., & Holdford, R. (2006). Minimization, denial, and victim blaming by batterers: How much does the truth matter? *Criminal Justice and Behavior*, *33*, 110-130. https://doi.org/10.1177/0093854805282322

Hester, M., & Westmarland, N. (2005). *Tackling domestic violence: Effective interventions and approaches.* London, Home Office Research, Development and Statistics Directorate.

Higgins, J. P., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D, Savovic, J., Schulz, K. F., Weeks, L., & Sterne, J. A. C. (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *British Medical Journal*, *343*, 1-9. https://doi.org/10.1136/bmj.d5928

Higgins, J. P., Thompson, S. G., Deeks, J. J., & Altman, D. G. (2003). Measuring inconsistency in meta-analyses. *British Medical Journal*, *327*, 557-560. https://doi.org/10.1136/bmj.327.7414.557

Hoffmann, T., Glasziou, P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D., Barbour, V., Macdonald, H., Johnston, M., Lamb, S., Dixon-Woods, M., McCulloch, P., Wyatt, J., Chan, A., & Michie, S. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *British Medical Journal*, *348:g*1687. https://doi.org/10.1136/bmj.g1687

Ioannidis, J. A. (2015). Contradicted and initially stronger effects in highly cited clinical research. *Journal of the American Medical Association*, *294*(2), 218-228. https://doi.org/10.1001/jama.294.2.218

Jewell, L. M., & Wormith J. S. (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers: A meta-analysis. *Criminal Justice and Behavior*, *37*, 1086-1113. https://doi.org/10.1177/0093854810376815

Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet*, *359*, 1423-1429. https://doi.org/10.1016/S0140-6736(02)08357-5

Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls. *The Lancet*, *385*, 1580-1589. https://doi.org/10.1016/S0140-6736(14)61683-4

*Kraanen, F. L., Vedel, E., Scholing, A., & Emmelkamp, P. M. (2013). The comparative effectiveness of integrated treatment for substance abuse and partner violence (I-StoP) and substance abuse treatment alone: A randomized controlled trial. *BMC Psychiatry*, *13*, 1-14. https://doi.org/10.1186/1471-244X-13-189

Lee, M. Y., Uken, A., & Sebold, J. (2004). Accountability for change: Solution focused treatment with domestic violence offenders. *Families in Society*, *85*, 463-476. https://doi.org/10.1606/1044-3894.1832

Lefebvre, C., Manheimer E., & Glanville, J. (2011). Chapter 6: Searching for studies. In J. P. T. Higgins & S. Green (Eds.), *Cochrane handbook for systematic reviews of interventions* (Version 5.1.0, updated March 2011). Cochrane. https://training.cochrane.org/handbook

Levesque, D. A., Gelles, R. J., & Velicer, W. F. (2000). Development and validation of a stages of change measure for men in batterer treatment. *Cognitive Therapy and Research*, *24*, 175-199. https://doi.org/10.1023/A:1005446025201

Levesque, D. A., Velicer, W. F., Castle, P. H., & Greene, R. N. (2008). Resistance among domestic violence offenders: Measurement development and initial validation. *Violence Against Women*, *14*, 158-184. https://doi. org/10.1177/1077801207312397

*Lila, M., Gracia, E., & Catalá-Miñana, A. (2018). Individualized motivational plans in batterer intervention programs: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *86*(4), 309-320. https://doi.org/10.1037/ccp0000291

Lila, M., Gracia, E., & Catalá-Miñana, A. (2020). More Likely to dropout, but what if they don't? Partner violence offenders with alcohol abuse problems completing batterer intervention programs. *Journal of Interpersonal Violence*, *35*(9-10), 1958-1981. https://doi.org/10.1177/0886260517699952

Lila, M., Martín-Fernández, M., Gracia, E., López-Ossorio, J. J., & González, J. L. (2019). Identifying key predictors of recidivism among offenders attending a batterer intervention program: A survival analysis. *Psychosocial Intervention*, *28*(3), 157-167. https://doi.org/10.5093/pi2019a19

Lila, M., Oliver, A., Catalá-Miñana, A., Galiana, L., & Gracia, E. (2014). The intimate partner violence responsibility attribution scale (IPVRAS). *The European Journal of Psychology Applied to Legal Context*, *6*(1), 29-36. https://doi.org/10.5093/ejpalc2014a4

Lilienfeld, S. O., McKay, D., & Hollon, S. D. (2018). Why randomized controlled trials of psychological treatments are still essential. *The Lancet Psychiatry*, *5*(7), 536-538. https://doi.org/10.1016/S2215-0366(18)30045-2

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. *Perspectives on Psychological Science*, *9*(4), 355-387. https://doi.org/10.1177/1745691614535216

Lilley-Walker, S. J., Hester, M., & Turner, W. (2018). Evaluation of European domestic violence perpetrator programmes: Toward a model for designing and reporting

evaluations related to perpetrator treatment interventions. *International Journal of Offender Therapy and Comparative Criminology*, *62*(4), 868-884. https://doi.org/10.1177/0306624X16673853

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137-160. https://doi.org/10.1177/1049731509347850

López-Ossorio, J. J., González-Álvarez, J. L., & Andrés-Pueyo, A. (2016). Eficacia predictiva de la valoración policial del riesgo de la violencia de género. *Psychosocial Intervention*, *25*(1), 1-7. https://doi.org/10.1016/j.psi.2015.10.002

Martín-Fernández, M., Gracia, E., & Lila, M. (2018). Assessing victimblaming attitudes in cases of intimate partner violence against women: Development and validation of the VB-IPVAW scale. *Psychosocial Intervention*, *27*(3), 133-143. https://doi.org/10.5093/pi2018a18

Martín-Fernández, M., Gracia, E., & Lila, M. (2019). Psychological intimate partner violence against women in the European Union: A crossnational invariance study. *BMC Public Health*, *19*, 1739. https://doi.org/10.1186/s12889-019-7998-0

Martín-Fernández, M., Gracia, E., & Lila, M. (2020). Ensuring the comparability of cross-national survey data on intimate partner violence against women: A cross-sectional, population-based study in the European Union. *BMJ Open*, *10*, e032231. https://doi.org/10.1136/bmjopen-2019-032231

Martín-Fernández, M., Gracia, E., Marco, M., Vargas, V., Santirso, F. A., & Lila, M. (2018). Measuring acceptability of intimate partner violence against women: Development and validation of the A-IPVAW scale. *European Journal of*

Psychology Applied to Legal Context, *10*(1), 26-34. https://doi.org/10.5093/ejpalc2018a3

*Mbilinyi, L. F., Neighbors, C., Walker, D. D., Roffman, R. A., Zegree, J., Edleson, J., & O'Rourke, A. (2011). A telephone intervention for substance-using adult male perpetrators of intimate partner violence. *Research on Social Work Practice*, *21*(1), 43-56. https://doi.org/10.1177/1049731509359008

Miller, W. R. (1983) Motivational interviewing with problem drinkers. *Behavioural and Cognitive Psychotherapy*, *11*, 147-172. https://doi.org/10.1017/S0141347300006583

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive behavior* (2nd ed.). Guilford Press.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, *151*(4), 264-269. https://doi.org/10.7326/0003-4819-151-4-200908180-00135

Morrel, T. M., Elliott, J. D., Murphy, C. M., & Taft, C. T. (2003). Cognitive behavioral and supportive group treatments for partner-violent men. *Behavior Therapy*, *34*(1), 77-95. https://doi.org/10.1016/S0005-7894(03)80023-0

Murphy, C. M., & Baxter, V. A. (1997). Motivating batterer to change in the treatment context. *Journal of Interpersonal Violence*, *12*(4), 607-619. https://doi.org/10.1177/088626097012004009

Murphy, C. M., Hoover, S. A., & Taft, C. (1999, November). *The multidimensional measure of emotional abuse: Factor structure and subscale validity. Presented at*

the annual meeting of the Association for the Advancement of Behavior Therapy, Toronto, Ontario, Canada.

*Murphy, C. M., Eckhardt, C. I., Clifford, J. M., Lamotte, A. D., & Meis, L. A. (2017). Individual versus group cognitive-behavioral therapy for partnerviolent men: A preliminary randomized trial. *Journal of Interpersonal Violence*, 1-23. https://doi.org/10.1177/0886260517705666

Murphy, C. M., & Maiuro, R. D. (2009). *Motivational interviewing and stages of change in intimate partner violence.* Springer Publishing Company.

*Murphy, C. M., Ting, L. A., Jordan, L. C., Musser, P. H., Winters, J. J., Poole, G. M., & Pitts, S. C. (2018). A randomized clinical trial of motivational enhancement therapy for alcohol problems in partner violent men. *Journal of Substance Abuse Treatment*, *89*(1), 11-19. https://doi. org/10.1016/j.jsat.2018.03.004

Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims*, *23*(5), 539-557. https://doi.org/10.1891/0886-6708.23.5.539

Okuda, M., Olfson, M., Hasin, D., Grant, B. F., Lin, K., & Blanco, C. (2011). Mental health of victims of intimate partner violence: Results from a national epidemiologic survey. *Psychiatric Services*, *62*(8), 959-962. https://doi.org/10.1176/appi.ps.62.8.959

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, *79*(1), 6-21. https://doi.org/10.1037/a0022200

Price, B. J., & Rosenbaum, A. (2009). Batterer intervention programs: A report from the field. *Violence and Victims*, *24*(6), 757-770. https://doi.org/10.1891/0886-6708.24.6.757

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice*, *19*(3), 276–288. https://doi.org/10.1037/h0088437

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*(9), 1102-1114. https://doi.org/10.1037/0003-066X.47.9.1102

Prochaska, J.O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion*, *12*(1), 38-48. https://doi.org/10.4278/0890-1171-12.1.38

Rondeau, G., Brodeur., N., Brochu, S., & Lemire, G. (2001). Dropout and completion of treatment among spouse abusers. *Violence and Victims*, *16*(2), 127-143. https://doi.org/10.1891/0886-6708.16.2.127

Santirso, F. A., Lila, M. & Gracia, E. (2020). Motivational strategies, working alliance, and protherapeutic behaviors in batterer intervention programs: A randomized controlled trial. *European Journal of Psychology Applied to Legal Context*, *12*(2), 77-84. https://doi.org/10.5093/ejpalc2020a7

Santirso, F. A., Martín-Fernández, M., Lila, M., Gracia, E., & Terreros, E. (2018). Validation of the Working Alliance Inventory-Observer Short Version with male intimate partner violence offenders. *International Journal of Clinical and Health Psychology*, *18*(2), 152-161. https://doi.org/10.1016/j.ijchp.2018.02.003

Saunders, D. G. (2008). Group interventions for men who batter: A summary of program descriptions and research. *Violence and Victims*, *23*(2), 156-172. https://doi.org/10.1891/0886-6708.23.2.156

*Schumacher, J. A., Coffey, S. F., Stasiewicz, P. R., Murphy, C. M., Leonard, K. E., & Fals-Stewart, W. (2011). Development of a brief motivational enhancement intervention for intimate partner violence in alcohol treatment settings. *Journal of Aggression, Maltreatment & Trauma*, *20*(2), 103-127. https://doi.org/10.1080/10926771.2011.546749

Scott, K. L. (2004). Stage of change as a predictor of attrition among men in a batterer treatment program. *Journal of Family Violence*, *19*(1), 37-47. https://doi.org/10.1023/B:JOFV.0000011581.01231.1e

Scott, K., King, C., McGinn, H., & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence*, *26*(2), 139-149. https://doi.org/10.1007/s10896-010-9353-1

Scott, K. L., & Wolf, D. A. (2003). Readiness to change as a predictor of outcome in batterer treatment. *Journal of Consulting and Clinical Psychology*, *71*(5), 879-889. https://doi.org/10.1037/0022-006X.71.5.879

Smedslund, G., Dalsbø, T. K., Steiro, A., Winsvold, A., & Clench-Aas, J. (2011). Cognitive behavioural therapy for men who physically abuse their female partner. *Cochrane Database of Systematic Reviews*, *2*(2), 1–33. https://doi.org/10.1002/14651858.CD006048.pub2

Soleymani, S., Britt, E., & Wallace-Bell, M. (2018). Motivational interviewing for enhancing engagement in intimate partner violence (IPV) treatment: A review of

the literature. *Aggression and Violent Behavior*, *40*, 119-127. https://doi.org/10.1016/j.avb.2018.05.005

Straus, M., Hamby, S., Boney-McCoy, S., & Sugarman, D. (1996). The Revised Conflict Tactics Scales (CTS-2). *Journal of Family Issues*, *17*(3), 283–316. https://doi.org/10.1177/019251396017003001

Stoops, C., Bennett, L., & Vincent, N. (2010). Development and predictive ability of a behavior-based typology of men who batter. *Journal of Family Violence, 25*(3), 325-335. https://doi.org/10.1007/s10896-009-9294-8

*Stuart, G. L., Shorey, R. C., Moore, T. M., Ramsey, S. E., Kahler, C. W., O'farrell, T. J., Strong, D., Temple, J. R., & Monti, P. M. (2013). Randomized clinical trial examining the incremental efficacy of a 90-minute motivational alcohol intervention as an adjunct to standard batterer intervention for men. *Addiction*, *108*(8), 1376-1384. https://doi.org/10.1111/add.12142

Stuart, G. L., Temple, J. R., & Moore, T. M. (2007). Improving batterer intervention programs through theory-based research. *Journal of the American Medical Association*, *298*(5), 560-562. https://doi.org/10.1001/jama.298.5.560

Taft, C., & Murphy, C. M. (2007). The working alliance in intervention for partner violence perpetrators: Recent research and theory. *Journal of Family Violence*, *22*(1), 11-18. https://doi.org/10.1007/s10896-006-9053-z

Taft, C. T., Murphy, C. M., Elliott, J. D., & Morrel, T. M. (2001). Attendance-enhancing procedures in group counseling for domestic abusers. Journal of Counseling Psychology, 48(1), 51-60. https://doi.org/10.1037/0022-0167.48.1.51

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, *71*(4), 812-820. https://doi.org/10.1037/0022-006X.71.4.812

Velonis, A. J., Cheff, R., Finn, D., Davloor, W., & O'Campo, P. (2016). Searching for the mechanisms of change: a protocol for a realist review of batterer treatment programmes. *BMJ Open*, *6*:e010173. https://doi.org/10.1136/bmjopen-2015-010173

Vilariño, M., Amado, B. G., Vázquez, M. J., & Arce, R. (2018). Psychological harm in women victims of intimate partner violence: Epidemiology and quantification of injury in mental health markers. *Psychosocial Intervention*, *27*(3), 145-152. https://doi.org/10.5093/pi2018a23

Voith, L. A., Logan-Greene, P., Strodthoff, T., & Bender, A. E. (2018). A paradigm shift in batterer intervention programming: A need to address unresolved trauma. *Trauma, Violence, & Abuse*, *19*(1)1-15. https://doi.org/10.1177/1524838018791268

*Woodin, E. M., & O'Leary, K. D. (2010). A brief motivational intervention for physically aggressive dating couples. *Prevention Science*, *11*(4), 371-383. https://doi.org/10.1007/s11121-010-0176-3

World Health Organization. (2002). *Understanding and addressing violence against women*. https://www.who.int/reproductivehealth/topics/violence/vaw_series/en

World Health Organization. (2013*). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner*

sexual violence. https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

Zalmanowitz, S. J., Babins-Wagner, R., Rodger, S., Corbett, B. A., & Leschied, A. (2013). The association of readiness to change and motivational interviewing with treatment outcomes in males involved in domestic violence group therapy. *Journal of Interpersonal Violence*, *28*(5), 956-974. https://doi.org/10.1177/0886260512459381

ESTUDIO 2

Validation of the working alliance inventory-observer short version with male intimate partner violence offenders [1]

[1] Published in: Santirso, F. A., Martín-Fernández, M., Lila, M., Gracia, E., & Terreros, E. (2018). Validation of the working alliance inventory–observer short version with male intimate partner violence offenders. *International Journal of Clinical and Health Psychology, 18*(2), 152-161. https://doi.org/10.1016/j.ijchp.2018.02.003

1. Introduction

The working alliance is one of the most extensively studied constructs in psychotherapy research (Del Re, Flükiger, Horvath, Symonds, & Wampold, 2012; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). According to Bordin (1979), the working alliance is a collaborative feature of the therapy, composed of three elements: (1) agreement between patient and therapist on the objectives that they aspire to achieve with the treatment, (2) the patient's acceptance and collaboration in the tasks the therapist proposes during therapy to address their problem, and (3) the quality of the patient-therapist bond in terms of mutual trust, appreciation, etc. Several meta-analyses show that the working alliance is one of the best predictors of the results of psychotherapy, indicating that there is a robust although moderate relationship between the working alliance and the indicators of change during treatment (Del Re et al., 2012; Horvath & Symonds, 1991; Martin et al.,2000).

A number of instruments have been developed to measure the working alliance, including the Pennsylvania Helping Alliance Rating Scale (PENN; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The latter is one of the most widely used instruments (Andrade-González & Fernández-Liria, 2015) and evaluates the three theoretical dimensions proposed in 1979 by Bordin (i.e., objective, task, and bond). The WAI (Horvath & Greenberg, 1989) presents three different versions to measure the working alliance from different perspectives: the therapist (WAI-T), the patient (WAI-P) and the observer (WAI-O) versions. Tracey and Kokotovic (1989) developed an abbreviated version of the scale composed of12 items, the Working Alliance Inventory Short Form (WAI-S).

This abbreviated version was adapted for evaluation by an external observer by Tichenor and Hill (1989): The Working Alliance Inventory-Observer Short version (WAI-O-S). Regarding the WAI factorial structure, research using different versions of this scale (Busseri & Tyler, 2003; Horvath & Greenberg, 1989; Munder, Wilmers, Leonhart, Linster, & Barth, 2010; Tracey & Kokotovic, 1989) tends to support the three-factor structure proposed by Bordin (1979), with some of these studies reporting a high correlation between the 'task' and 'goal' dimensions (Busseri & Tyler, 2003; Horvath & Greenberg, 1989). However, other studies favor a two-factor structure, grouping the 'task' and 'goal' dimensions into a single dimension (Andrusyna, Tang, DeRubeis, & Luborsky, 2001).

Measuring Working Alliance in Batterers'Intervention Programs (BIPs)

The various meta-analyses on the effectiveness of BIPs indicate limited effect sizes of these intervention programs (e.g., Arias, Arce, & Vilariño, 2013; Babcock, Green, & Robie, 2004). A number of new intervention strategies are now being implemented in BIPs with evidence to support their effectiveness among resistant populations (Alexander, Morris, Tracy, & Frye, 2010; Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017; Lila, Gracia, & Catalá-Miñana, 2018; Musser, Semiatin, Taft, & Murphy, 2008; Vargas, Lila, & Catalá-Miñana, 2015). Among these strategies are motivational interviewing, stages of change or strengths-based approaches, and some studies applying them to offenders attending BIPs have consistently showed their ability to promote positive changes, such as acceptance and adherence to the intervention process and lower levels of post-treatment recidivism (Crane, & Eckhardt, 2013; Llor-Esteban, García-Jiménez, Ruiz-Hernández, & Godoy-Fernández, 2016; López-Ossorio, Álvarez, Pascual, García, & Buela-Casal, 2017; López-Ossorio, González-Álvarez, & Andrés-Pueyo, 2016). These new intervention strategies share the idea that the working alliance is a key

element to increase 'users' motivation, adherence to treatment, and active participation in BIPs. Improving the working alliance can increase participants' perception that the therapist is concerned about their progress. The working alliance is also associated with a higher motivation to participate and complete the intervention program, reducing dropout and recidivism rates (Babcock et al., 2004; Brown & O'Leary, 2000; Semiatin, Murphy, & Elliot, 2013; Taft, Murphy, Musser, & Remington, 2004). Several studies have analyzed the relationship between the working alliance and the results of BIPs (Brown & O'Leary, 2000; Semiatin et al., 2013; Taft et al., 2004). These studies suggest that the working alliance is associated with protherapeutic group behaviors, motivation to change, and stage of change.

Given the importance of this construct for the effectiveness of BIPs, the availability of psychometrically sound observational measures would clearly improve the evaluation of the working alliance in such intervention programs. Men who attend this type of program tend to minimize or deny the violent acts for which they have been convicted (Lila, Oliver, Catalá-Miñana, Galiana, & Gracia, 2014). Assessing the working alliance among BIP participants using self-reported measures is particularly problematic, as social desirability, deception, minimization, and denial are common in this population (Gracia, Rodriguez, & Lila, 2015). Observational measures can overcome these limitations. However, such measures have not so far been used to assess the working alliance in BIPs. In the present study, we aim to address this gap in the literature by validating the WAI-O-S scale (Tichenor & Hill, 1989) with a sample of intimate partner violence (IPV) offenders court-mandated to a community-based BIP. As far as we know, only one study has analyzed the working alliance with observational measures in a group treatment for husband-on-wife spouse abuse (Brown & O'Leary, 2000). It is important to note that in this study the couples attended the treatment on a voluntary basis, while in the present

study we analyze the working alliance using an observational measure with men who have been court-mandated to a BIP. The objectives of the present study are: (1) to assess the psychometric properties and factor structure of the WAI-O-S scale with a sample of men convicted of IPV attending a BIP; (2) to analyze the criterion-related validity of this measure by studying the association between the working alliance and a set of variables relevant for BIP intervention processes: protherapeutic group behavior, motivation to change, and stage of change (Brown & O'Leary, 2000; Carbajosa, Catalá-Miñana, Lila, Gracia, & Boira, 2017; Semiatin et al., 2013; Taft et al., 2004).

2. Method

2.1 Participants

The sample consisted of 140 men who were convicted for IPV and court-mandated to a community-based BIP, the Contexto Program, conducted at the University of Valencia. These offenders had been sentenced to less than two years in prison, had no previous criminal record, and their sentence was suspended on the condition that they attended this community-based intervention program. The criteria for inclusion in this study were: (a) not having a serious mental disorder, (b) not having a serious addiction to alcohol or other substances, and (c) signing an informed consent form. The mean age was 40.26 years (SD = 11.66, range 18-76); 50.7% had completed primary or elementary studies, 34.3% had completed high school or vocational training, 10% university studies, and 5% had no schooling;35.7% were single, 39.3% divorced or separated, and 24.3% married or in a relationship. The majority, 70%, were Spanish, 12.7% were Latin-American, 8.5% from other European countries, 7.8% African, and 0.7% Asian. The median family household income was between 6,000 and 12,000 euros.

2.2 Procedure

All participants were assigned to an intervention group. The number of participants per group ranged from 8-12 participants and once started, no more participants were allowed. Two therapists conducted each group. The intervention consisted of 32 weekly group sessions of a cognitive-behavioral intervention including the gender perspective, which is the standard intervention with IPV offenders (Eckhardt et al., 2013; Ferrer-Perez, Ferreiro-Basurto, Navarro-Guzmán, & Bosch-Fiol, 2016). Participants were informed about the nature and purpose of the research, completed a written consent form, and were told that neither participation nor refusal would affect their legal situation. Confidentiality was ensured. The group intervention sessions were recorded on video (there were a total of 14 intervention groups), and one session at the end of each group intervention was evaluated. Four trained research assistants assessed the recorded sessions. Raters previously underwent training during which they assessed the same recorded session separately until they reached an acceptable level of agreement (i.e., not differing by more than one point on each assessed item). Each analyzed video had a recording time of two hours divided into24 segments. For the observational coding (i.e., working alliance and protherapeutic group behaviors), scores for 5-minute video intervals were used, and averaged for each participant. Stage of change and motivation to change were evaluated at the end of the intervention, as research has found that this measures are positively related to social desirability at the beginning of the intervention, but not at the end (Begun et al., 2003). All participants' data were collected in accordance with the University of Valencia Ethics Committee approved procedures.

2.3 Instruments

Working Alliance Inventory Shortened Observer-rated version (WAI-O-S; Tichenor & Hill, 1989). This observational scale evaluates the working alliance and is

composed of 12 items (e.g., ‘‘the participant feels that the therapist appreciates him as a person’’, ‘‘the participant and therapist are working on mutually agreed upon goals’’). Raters responded on a 7-point Likert-type scale ranging from 0 (*conclusive evidence against*) to 7 (*conclusive evidence in favor*). See Appendix.

Observational Coding of Protherapeutic Group Behavior (Semiatin et al., 2013). This instrument evaluates participants’ protherapeutic group behaviors by focusing on their verbalizations. It consists of three items that correspond to the following pro-therapeutic behaviors: (a)Denial/acknowledgment of behavior/responsibility: participants’ verbalizations related to recognition or denial of their responsibility for their violent behavior, the consequences of this behavior, and the need for personal change to avoid committing abusive acts in the future; (b) Client role behavior: interpersonal behaviors that occur in the group and are relevant for change. Four types of behavioral roles can be distinguished along two dimensions: confrontation vs. confirmation, and positive progress vs. negative progress;(c) Group value: participants’ verbalizations related to the perception of the group, and the treatment program. Raters responded on a 5-point Likert-type scale ranging from 1(*conclusive evidence against*) to 5 (*conclusive evidence in favor*).

Stage of change. Based on individual interviews, self-reports, and direct observations, therapists rated each participant’s stage of change following the classification of Prochaska, DiClement and Norcross (1992). The stages of change are rated as 1 (*precontemplation*), 2 (*contemplation*), 3 (*preparation*), 4 (*action*), and 5 (*maintenance*). For a similar procedure, see Scott (2004) and Carbajosa et al. (2017a).

Motivation to change. The therapists evaluated the motivation to change of each participant on a single item ranging from 1 (*low*) to 5 (*high*).

2.4 Data analysis

The following analyses were carried out to assess the psychometric properties of the WAI-O-S. First, inter-rater agreement and reliability were evaluated by computing the intraclass correlation coefficient (ICC). The average scale ICC was estimated using a random two-way ANOVA model, since all raters evaluated each participant (ICC $_{(2,\,k)}$). This statistic treated raters as a random effect variable, rep-resenting a random sample of a larger population of raters (i.e., trained observers). Reliability was also measured in terms of internal consistency with Cronbach's alpha and the McDonal's omega. Values of this statistics equal to or higher than .70 were indicative of good internal consistency. Descriptive statistics and corrected item-total correlations were then obtained for all items.

To test the latent structure underlying the WAI-O-S, a Bayesian confirmatory factor analysis approach was used (CFA). This approach has been shown to perform better in small samples and with skewed observed variables than the classical maximum likelihood estimation in confirmatory factor analysis (Lee & Song, 2004). Bayesian Structural Equation Modeling is an emergent CFA framework that has proved to be well-suited to skewed distributions of parameter estimates, and it also allows complex latent structures to be tested (Muthén & Asparouhov, 2012). Given the limited size of the sample in this study, and the potential advantages of the Bayesian estimation, this methodological approach was followed to test the latent structure of the WAI-O-S.

Five models of different latent complexity were compared in order to obtain the best fit to the data (see Figure 1). The first (1a) was a one-dimensional model in which all items load onto a single factor. The second(1b), based on the findings of Andrusyna et al. (2001) and Falkenström, Hatcher, and Holmqvist (2015), was an oblique two-dimensional model that set one factor for the original Bond dimension, and a second

factor for the Goal and Task items. The third (1c) was an oblique three-dimensional model which posited one factor for each of the original dimensions (i.e., Task, Goal, and Bond; Munder, Wilmers, Leonharet, Linster, & Barth, 2010). The fourth (1d) and fifth(1e) models were generalizations of the second and third ones, in which a second-order factor, called General working alliance, accounted for the relation between the first order factors of each model. Hence the fourth model (1d) set a second-order model considering the two dimensions of the second model as the first-order factors, whereas the fifth (1e) model considered the three dimensions of the third model as first-order factors.

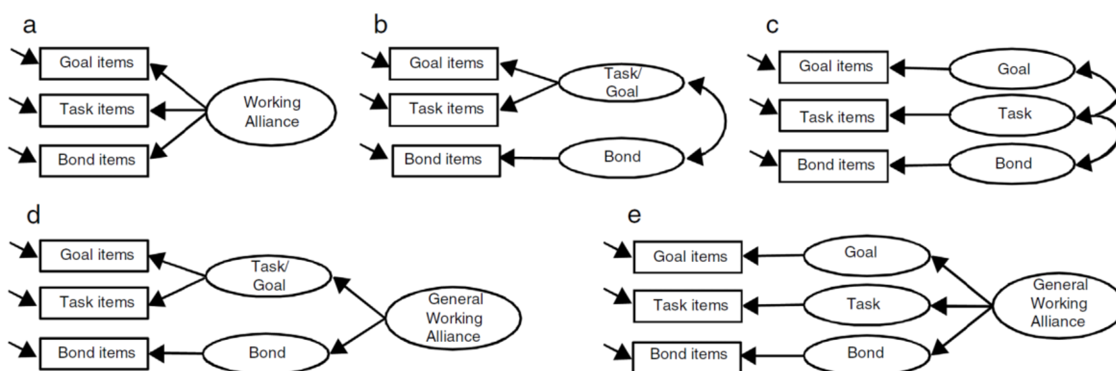


Figure 1. CFA tested models.

All models were estimated with the MCMC algorithm, setting 4 chains and 20,000 iterations. The first 10,000iterations were discarded as a burn-in period. Model convergence was assessed with the potential scale reduction factor (PSR), considering PSR values of 1.05 or lower as indicative of good convergence (Gelman, Carlin, Stern, & Rubin, 2014). Asparouhov and Muthén (2010) reported, however, that most models usually reach convergence with PSR values between 1.05 and 1.10, hence we considered PSR values of 1.10 or lower as indicative of acceptable convergence. Model parameters were estimated using the expected a posteriori (EAP) method. To delimit the credible intervals of the parameters, posterior SD for each parameter was also obtained. The

Deviance Information Criterion (DIC), and the Bayesian Information Criterion (BIC) were obtained to evaluate model fit. The DIC correction proposed by several authors was also computed in this study (DIC_C; Ando, 2011). DICC penalized more severely than DIC models with a high number of parameters. These criteria are indices of comparative meaning, and, thus, the model with the lowest DIC, DIC_C and BIC values has the best fit.

Finally, to test criterion-related validity, the WAI-O-S factorial scores were correlated to the variables protherapeutic group behavior, stage of change, and motivation to change. Pearson correlations were used when both correlated variables were considered continuous (i.e., with five or more categories). When at least one of the variables was considered ordinal, Spearman correlations were used instead. Descriptive, reliability, and validity tests were carried out with the statistical package R and the psych library for R. Bayesian CFA analyses were performed with Mplus 7.1 (Muthén & Muthén, 2010).

3. Results

3.1 Reliability and descriptive analyses

The effect of different raters assessing the same participants was first evaluated. The ICC $_{(2,\ k)}$ for the average of the four raters' measures was .82, F (10, 30) = 9.3, $p <$ .001, indicating an excellent level of inter-rater agreement and reliability. The internal consistency of the WAI-O-S was also high (Cronbach's alpha = .96; McDonald's omega = .98).

Item descriptives and item-total corrected correlation are displayed in Table 1. Items 4 and 10 were removed from the scale as they lowered the Cronbach's alpha and the McDonald's omega, they presented low item-total corrected correlations, and, moreover, they were highly correlated. Item scores were centered on 4, the mid-point of the scale, and slightly displaced to the right, reflecting the small differences between the

mean and the median and the low standard deviation values. Some items (5, 7, and12) presented a strong positive skewness and almost all of them showed high kurtosis values, resulting in a leptokurtic distribution of the item scores. Regarding the item-total corrected correlations, all the remaining items showed a very strong relation with the rest of the test.

Table 1. Item descriptives

	M	*SD*	*Mdn*	*Min*	*Max*	*Skew*	*Kurtosis*	$r_{item\text{-}total}$
Item 1	4.24	0.23	4.21	3.75	4.91	0.60(.02)	0.32(.02)	0.80
Item 2	4.19	0.21	4.17	3.67	4.88	0.41(.02)	0.14(.02)	0.79
Item 3	4.22	0.24	4.21	3.46	4.91	0.32(.02)	0.64(.02)	0.81
Item 5	4.14	0.21	4.05	3.50	4.88	1.06(.02)	2.35(.02)	0.81
Item 6	4.16	0.22	4.08	3.83	4.88	1.38(.02)	1.63(.02)	0.92
Item 7	4.15	0.23	4.08	3.17	4.88	0.04(.02)	3.04(.02)	0.78
Item 8	4.15	0.24	4.08	3.22	4.91	0.65(.02)	2.85(.02)	0.85
Item 9	4.16	0.23	4.06	3.42	4.88	0.78(.02)	1.30(.02)	0.90
Item 11	4.13	0.21	4.04	3.75	4.88	1.47(.02)	1.98(.02)	0.91
Item 12	4.13	0.21	4.05	3.79	4.88	1.79(.02)	3.14(.02)	0.85

Note. *M* = Mean, *SD* = Standard Deviation, *Mdn* = Median, *Min* = Minimum, *Max* = Maximum, $r_{item\text{-}total}$ = item-total corrected correlation. In brackets: the standard error for the *skew* and *kurtosis* statistics.

3.2 Confirmatory factor analysis

Fit indices are shown in Table 2. Both DIC progressions are clear: modeling working alliance as a second-order factor improved the model fit to the data as compared to the two and three first-order factor models. Although there were no differences between the one-, two-, and three-factor first-order models, when the second-order factor was taken into account, the model with two first-order factors and a second-order factor (General working alliance) showed a better fit to the data. BIC values, however, suggest that the two-factor model is the latent structure with the best fit to the data. Given that two out of three indices found that the second-order model with two first-order factors best fit-ted the data, and since this model had lower DIC, DIC_C, and BIC values than the

other second-order model, we decided to keep the second-order with two first-order factors model as the latent structure of the WAI-O-S. All models reached convergence adequately, below the usual cut-off for the PSR factor.

Table 2. Bayesian CFA fit indices

Model	PSR	DIC	DICc	*pD*	BIC
One Factor	1.00	-1363.11	-1333.78	29.33	-1283.35
Two Factors	1.01	-1377.33	-1344.71	32.62	-1299.95
Three Factors	1.01	-1377.88	-1345.09	32.79	-1292.99
2nd Order – Two Factors	1.08	-1385.46	-1358.01	27.45	-1295.44
2nd Order – Three Factors	1.09	-1381.87	-1354.52	27.35	-1288.22

Note. PSR = parameter scale reduction factor, DIC = deviance information criterion, DIC_C = corrected deviance information criterion, *pD* = estimated number of parameters, BIC = Bayesian information criterion.

Regarding the selected model (Figure 2), the WAI-O-S Bond items group on a first-order factor, and thus we kept the same name. The remaining Goal and Task items, however, group on a single first-order factor, which we named Agreement, as suggested by Andrusyna et al. (2001). All items loaded positively on the first-order factors, with standardized loadings above .80 in almost all cases. More-over, both first-order factors contributed equally to the second-order factor, with high standardized loadings. Posterior standard deviations for the standardized loadings were on average low, implying an accurate estimation of these parameters.

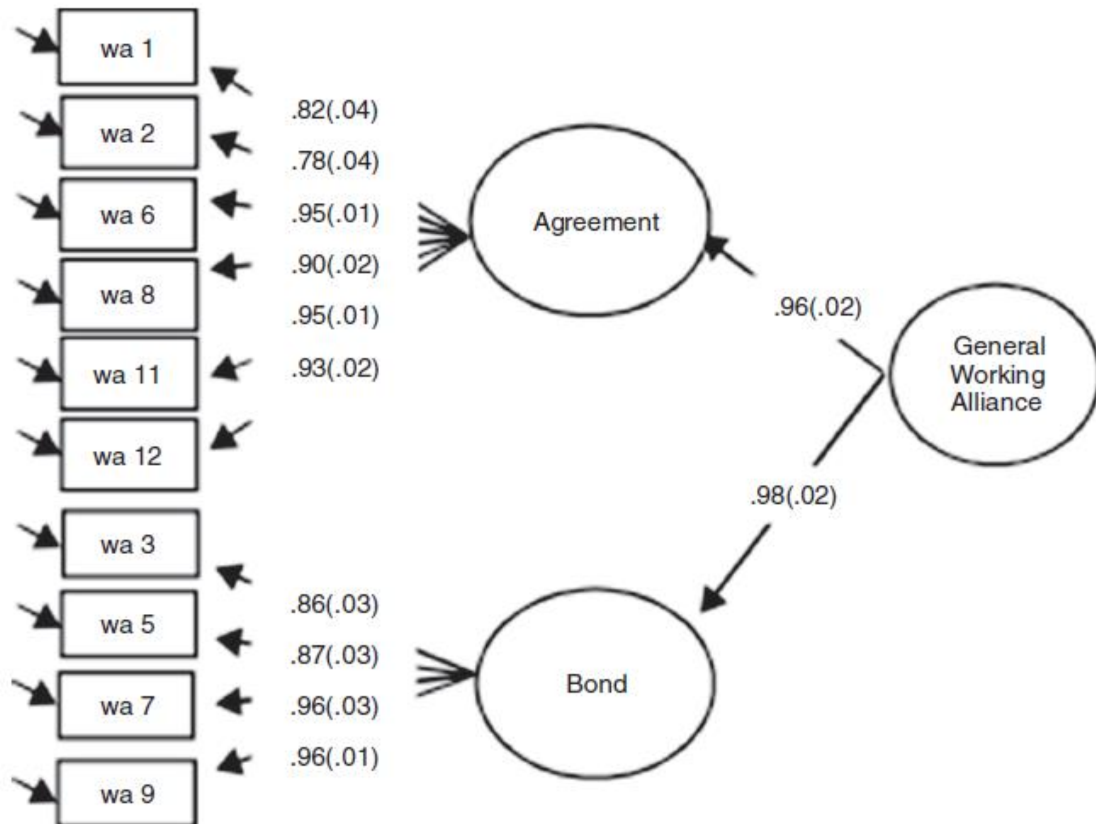


Figure 2. CFA second order model with standardized item loadings.

3.3 Criterion-related validity

Criterion-related validity was assessed by means of the correlation of various constructs that have been related to the working alliance in multiple studies on IPV. Both two first-order factors (i.e., Bond and Agreement) and the second-order factor (i.e., General working alliance) were significantly and positively associated with the protherapeutic group behavior, stage of change, and motivation to change. Statistics of these associations are shown in Table 3.

Table 3. Criterion-related validity

	Agreement (Task/Goal)	Bond	General Alliance
Protherapeutic Group Behavior	*r* = 0.69**	*r* = 0.73**	*r* = 0.73**
Stage of Change	*r* = .29**	*r = 0.17**	*r* = 0.25*
Motivation to Change	*r = .33***	*r* = 0.22*	*r* = 0.29**

Note. *$p < .05$, **$p < .01$

4. Discussion

Results from this study showed that the WAI-O-S could be used to assess the working alliance through external observers in interventional settings. In particular, among the male batterers attending BIPs, this instrument has showed to be an accurate and consistent approach to evaluate the relationships between the therapists and the offenders. Its factorial structure with this sample supports the grouping of Bordin's (1979) three original factors (i.e., Objective, Task and Bond), into two first-order factors (i.e., Bond and Agreement). We also found a second-order factor (i.e., General working alliance) explaining the relationship between the first-order factors. In addition, our findings showed high correlations between the WAI-O-S scores and a set of relevant variables in the evaluation of BIPs' success with IPV offenders, providing evidence of criterion-related validity.

Results showed an excellent level of inter-rater agreement according to Cicchetti's cut-offs (1994). In our study, we obtained values of agreement superior to those obtained by Andrusyna et al. (2001), Brown and O'Leary (2000) and Strunk, Brotman and DeRubeis (2010), and similar to those obtained by Tichenor and Hill (1989). The discrepancies between our results and other studies could be due to differences in the coding procedure used. The above-mentioned studies scored the working alliance through a single measurement for the entire session. In our study, to evaluate the working alliance

we divided the session into 24 segments. Another divergence between our study and that of Andrusyna et al. (2001) is the number of raters. We used four raters in this study, compared to two raters in Andrusyna et al. (2001), which could have given rise to the different results obtained in the two studies.

Regarding the reliability of the WAI-O-S, using both Cronbach's alpha and McDonald's omega, our measure showed high levels of internal consistency. These results are similar to those obtained in previous studies (Tichenor & Hill, 1989). It should be noted that items 4 and 10 were removed from our scale in order to improve the accuracy of the instrument and meet the CFA assumptions of item independence. Andrusyna et al. (2001) also obtained a low item-total correlation with these items. However, in our study, after removing items 4 and 10, we obtained a high item-total correlation.

The factor structure of WAI-O-S indicated that grouping the three original factors into two first-order factors (i.e., Bond and Agreement), and a second-order factor (i.e., General working alliance) improved the model fit to the data. This implies that a second-order factor of General working alliance explains the relationship between the Bond and Agreement factors better than a simple correlation. Thus, the working alliance can be measured as a general second-order factor encompassing the Bond and Agreement items of the WAI-O-S, in which both Bond and Agreement factors have almost the same relevance.

Previous studies using the observational version of the questionnaire with patients in cognitive-behavioral treatment found a latent structure of two independent factors, an Agreement/confidence factor and a Relation-ship factor (Andrusyna et al., 2001). Other researchers validating the client version of the inventory and using a Bayesian approach have proposed a two-factor structure (Falkenström et al., 2015); whereas other authors

have proposed three-factor structures (Munder et al., 2010) using the client version. The study by Andrusyna et al. (2001) is the most comparable to our study as it uses the same version of the questionnaire. However, it should be noted that our study differs from that of Andrusyna et al. (2001) in the study sample and in the methodology, since we used a Bayesian approach, which is more suitable for small sample sizes with skewed and kurtotic observed variables (Lee &Song, 2004). On the other hand, contrary to other studies, we have found that the working alliance could be assessed as a second-order factor model rather than as a factorial model with correlated factors.

Regarding the criterion-related validity of the scale, both the two first-order factors (i.e., Bond and Agreement)and the second-order factor (i.e., General working alliance) were significantly associated with a set of relevant variables in variables in the evaluation of the effectiveness of BIPs. Thus, we found a positive association between the working alliance and protherapeutic group behaviors (Semiatin et al., 2013). This suggests that when there is agreement between the therapist and the participants on the intervention goals and tasks, and there is an adequate bond between them, the participants are more likely to assume their responsibility, adequately value peer change initiatives, and make positive group verbalizations (Lila, Gracia, & Murgui, 2013). Another variable that was positively associated with the working alliance was motivation to change, in line with other studies with IPV offenders (Carbajosa et al., 2017a; Taft et al., 2004). These results have also been found in other populations with alcohol addiction, where motivation to change was one of the most reliable predictors of the working alliance evaluated by the client and the therapist (Catalá-Miñana, Lila, & Oliver, 2013; Connors et al., 2000; Lila, Gracia, & Catalá-Miñana, 2017). In this regard, our results suggest that a positive bond and agreement on the goals and tasks of the intervention between therapists and participants could facilitate offenders' motivation to change. Previous studies have

proposed that the working alliance between the participant and the therapist is not only able to modify their cognitive processing but also their actions and affective state (Brown & O'Leary, 2000; Romero-Martínez, Lila, & Moya-Albiol, 2016). In this regard, Brown and O'Leary (2000) found that the working alliance, observationally assessed, was related to a decrease in psychological and physical aggression. Finally, we found a positive and significant association between stage of change and the therapeutic alliance. Using patients' and therapists' measures, Taft et al. (2004) found a similar association between the stage of change and the working alliance.

The main implication of this study is that the WAI-O-S is a psychometrically sound instrument that can be used to assess the working alliance in intervention programs using external raters. To this end, intervention practitioners could compute the scores of the Agreement and Bond factors (see DiStefano, Zhu, & Mindrila, 2009) and then obtain the General working alliance by summing the participants' scores on the first order factors (i.e., Agreement and Bond). The working alliance could thus be monitored during the different stages of the intervention, allowing researchers and practitioners to assess the impact of the relationship between the therapists and the participants of the program in other relevant intervention outcomes.

This study is not without limitations. First, the sample consisted of men convicted of IPV that were court-mandated to a community-based BIP in Spain. Therefore, results could not be extrapolated to other populations, such as offenders in prison, self-referred men, or other cultural groups (Boira, Carbajosa, & Méndez, 2016; Lila, Gracia, Catalá-Miñana, Santirso, & Romero-Martínez, 2016; Vargas et al.,2015). Second, although the Bayesian approach allowed us to test the internal structure of the scale, further research is needed with larger sample sizes to replicate and test the fit of the proposed model to new data. Third, in order to establish whether the inter-rater agreement and reliability of

the WAI-O-S could be generalized, it is necessary to explore the concordance of the raters' evaluations using this instrument in other intervention settings. Finally, future research would benefit from exploring the relationships of the WAI-O-S with other BIPs' relevant outcomes such us recidivism and dropout rates.

Despite these limitations, given that the working alliance is key in intervention programs with offenders and, in particular, with highly resistant populations such as participants in BIPs, the availability of an observational measure of this construct such as the WAI-O-S can provide a useful tool to overcome self-report measurement limitations such as social desirability, deception, and denial among this population.

5. References

Alexander, P. C., Morris, E., Tracy, A., & Frye, A. (2010). Stages of change and the group treatment of batterers: A randomized clinical trial. *Violence and Victims*, *25*, 571-587. http://dx.doi.org/10.1891/0886-6708.25.5.571

Ando, T. (2011). Predictive Bayesian model selection. *American Journal of Mathematical and Management Sciences*, *31*, 13-38. http://dx.doi.org/10.1080/01966324.2011.10737798

Andrade-González, N., & Fernández-Liria, A. (2015). Spanish adaptation of the Working Alliance Inventory (WAI) Psychometric properties of the patient and therapist forms (WAI-P and WAI-T). *Anales de Psicología*, *31*, 524-533. http://dx.doi.org/10.6018/analesps.31.2.177961

Andrusyna, T. P., Tang, T. Z., DeRubeis, R. J., & Luborsky, L. (2001). The factor structure of the Working Alliance Inventoryin cognitive-behavioral therapy. *The Journal of Psychotherapy Practice and Research*, *10*, 173-178.

Asparouhov, T., & Muthén, B. (2010). *Bayesian analysis using Mplus: Technical implementation*. Retrieved from: http://statmodel2.com/download/Bayes3.pdf.

Arias, E., Arce, R., & Vilariño, M. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial Intervention*, *22*, 153-160. http://dx.doi.org/10.5093/in2013a18

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A metaanalytic review of domestic violence treatment. *Clinical Psychology Review*, *23*, 1023-1053.http://dx.doi.org/10.1016/j.cpr.2002.07.001

Begun, A. L., Murphy, C., Bolt, D., Weinstein, B., Strodthoff, T., Short, L., & Shelley, G. (2003). Characteristics of the Safe at Home instrument for assessing readiness to change intimate partner violence. *Research on Social Work Practice*, *13*, 80-107. http://dx.doi.org/10.1177/1049731502238758

Boira, S., Carbajosa, P., & Méndez, R. (2016). Fear, conformity and silence. Intimate partner violence in rural areas of Ecuador. *Psychosocial Intervention*, *25*, 9-17. http://dx.doi.org/10.1016/j.psi.2015.07.008

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, *16*, 252-260. https://doi.org/10.1037/h0085885

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, *68*,340-345. http://dx.doi.org/10.1037/0022-006X.68.2.340

Busseri, M. A., & Tyler, J. D. (2003). Interchangeability of the Working Alliance Inventory and Working Alliance Inventory Short Form. *Psychological Assessment*, *15*, 193-197. http://dx.doi.org/10.1037/1040-3590.15.2.193

Carbajosa, P., Catalá-Miñana, A., Lila, M., & Gracia, E. (2017). Differences in treatment adherence, program completion, and recidivism among batterer subtypes. *The European Journal of Psychology Applied to Legal Context*, *9*, 93-101. http://dx.doi.org/10.1016/j.ejpal.2017.04.001

Carbajosa, P., Catalá-Miñana, A., Lila, M., Gracia, E., & Boira, S. (2017). Responsive versus treatment-resistant perpetrators in batterer intervention programs: Personal characteristics and stages of change. *Psychiatry, Psychology and Law*, *24*, 936-950. http://dx.doi.org/10.1080/13218719.2017.1347933

Catalá-Miñana, A., Lila, M., & Oliver, A. (2013). Consumo de alcohol en hombres penados por violencia contra la pareja: factores individuales y contextuales. *Adicciones*, 25, 19-28.

Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment*, *6*, 284-290. http://dx.doi.org/10.1037/1040-3590.6.4.284

Connors, G. J., DiClemente, C. C., Dermen, K. H., Kadden, R., Carroll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*,*61*, 139-149. http://dx.doi.org/10.15288/jsa.2000.61.139

Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology*, *60*, 180-187. http://dx.doi.org/10.1037/a0032178

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology*, *32*, 642-649.http://dx.doi.org/10.1016/j.cpr.2012.07.002

DiStefano, C., Zhu, M., & Mindrila, D. (2009). Understanding and using factor scores: Considerations for the applied researcher. *Practical Assessment*, *14*, 1---11. https://doi.org/10.7275/da8t-4g52

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effective-ness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, *4*, 196-231. http://dx.doi.org/10.1891/1946-6560.4.2.196

Falkenström, F., Hatcher, R. L., & Holmqvist, R. (2015). Confirmatory factor analysis of the patient version of the Working Alliance Inventory-Short Form Revised. *Assessment*, *22*, 581-593. http://dx.doi.org/10.1177/1073191114552472

Ferrer-Perez, V. A., Ferreiro-Basurto, V., Navarro-Guzmán, C., & Bosch-Fiol, E. (2016). Batterer intervention programs in Spain: The professionals' perspective. *Psychosocial Intervention*, *25*,159-168. http://dx.doi.org/10.1016/j.psi.2016.06.001

Gelman, A., Carlin, J. B., Stern, H. S., & Rubin, D. B. (2014). *Bayesian data analysis* (2) Boca Raton, FL, USA: Chapman &Hall/CRC.

Gracia, E., Rodriguez, C. M., & Lila, M. (2015). Preliminary evaluation of an analog procedure to assess acceptability of intimate partner violence against women: The Partner Violence Acceptability Movie Task. *Frontiers in Psychology*, *6*, 1567. http://dx.doi.org/10.3389/fpsyg.2015.01567Hartley,

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance:Its relationship to outcome in brief psychotherapy. In J. Masling(Ed.), *Empirical studies of psychoanalytical theories* (1) (pp.1-38). Hillsdale, NJ: Analytical Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*, 223-233. http://dx.doi.org/10.1037/0022-0167.36.2.223

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139-149. http://dx.doi.org/10.1037/0022-0167.38.2.139

Lee, S. Y., & Song, X. Y. (2004). Evaluation of the Bayesian and maximum likelihood approaches in analyzing structural equation models with small sample sizes. *Multivariate Behavioral Research*, *39*, 653-686. http://dx.doi.org/10.1207/s15327906mbr3904_4

Lila, M., Gracia, E., & Catalá-Miñana, A. (2017). More likely to dropout, but what if they don't? Partner violence offenders with alcohol abuse problems completing batterer intervention programs. *Journal of Interpersonal Violence*. http://dx.doi.org/10.1177/0886260517699952

Lila, M., Gracia, E., & Catalá-Miñana, A. (2018). Individualized Motivational Plans in batterer intervention programs: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*. http://dx.doi.org/10.1037/ccp0000291

Lila, M., Gracia, E., Catalá-Miñana, A., Santirso, F. A., & Romero-Martínez, Á. (2016). Alcohol abuse in Latin American immigrants participating in intervention programs for abusers: The importance of adherence to treatment. *Universitas Psychologica*, *15*,1-16. http://dx.doi.org/10.11144/Javeriana.upsy15-4.caai

Lila, M., Gracia, E., & Murgui, S. (2013). Psychological adjustment and victim-blaming among intimate partner violence offenders: The role of social support and stressful life events. *The European Journal of Psychology Applied to Legal Context*, *5*, 147-153. http://dx.doi.org/10.5093/ejpalc2013a4

Lila, M., Oliver, A., Catalá-Miñana, A., Galiana, L., & Gracia, E. (2014). The intimate partner violence responsibility attribution scale (IPVRAS*). The European Journal of Psychology Applied to Legal Context*, 6, 29-36. http://dx.doi.org/10.5093/ejpalc2014a4

Llor-Esteban, B., García-Jiménez, J. J., Ruiz-Hernández, J. A., & Godoy-Fernández, C. (2016). Profile of partner aggressors as a function of risk of recidivism. *International Journal of Clinical and Health Psychology*, *16*, 39-46. http://dx.doi.org/10.1016/j.ijchp.2015.05.004

López-Ossorio, J. J., Álvarez, J. L. G., Pascual, S. B., García, L. F., & Buela-Casal, G. (2017). Risk factors related to intimate partner violence police recidivism in Spain. *International Journal of Clinical and Health Psychology*, *17*, 107-119. http://dx.doi.org/10.1016/j.ijchp.2016.12.001

López-Ossorio, J. J., González-Álvarez, J. L., & Andrés-Pueyo, A. (2016). Predictive effectiveness of the police risk assessment in intimate partner violence. *Psychosocial Intervention*, *25*, 1-7. http://dx.doi.org/10.1016/j.psi.2015.10.002

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., &Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy. A counting signs vs. a global rating method. *The Journal of Nervous and Mental Disorders*, *171*,480-491.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438-450. http://dx.doi.org/10.1037/0022-006X.68.3.438

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., &Barth, J. (2010). Working Alliance Inventory-Short Revised(WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology and Psychotherapy*, *17*, 231-239. https://doi.org/10.1002/cpp.658

Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims*, *23*, 539-557. http://dx.doi.org/10.1891/0886-6708.23.5.539

Muthén, B., & Asparouhov, T. (2012). Bayesian structural equation modeling: A more flexible representation of substantive theory. *Psychological Methods*, *17*, 313-335. https://doi.org/10.1037/a0026802

Muthén, L. K., & Muthén, B. O. (2010). Mplus User's Guide. USA, Los Angeles: Muthén & Muthén.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*, 102-114. http://dx.doi.org/10.1037/0003-066X.47.9.1102

Romero-Martínez, Á., Lila, M., & Moya-Albiol, L. (2016). Testosterone and attention deficits as possible mechanisms underlying impaired emotion recognition in intimate partner violence perpetrators. *The European Journal of Psychology Applied to Legal Context*, *8*, 57-62. http://dx.doi.org/10.1016/j.ejpal.2016.01.001

Scott, K. L. (2004). Stage of change as a predictor of attrition among men in a batterer treatment program. *Journal of Family Violence*, *19*, 37-47. http://dx.doi.org/10.1023/B:JOFV.0000011581.01231.1e

Semiatin, J., Murphy, C., & Elliot, J. (2013). Observed behavior during group treatment for partner-violent men: Acceptance of responsibility and promotion of change. *Psychology of Violence*, *3*, 126-139. http://dx.doi.org/10.1037/a0029846

Strunk, D. R., Brotman, M. A., & DeRubeis, R. J. (2010). The process of change in cognitive therapy for depression: Predictors of early inter-session symptom gains. *Behaviour Research and Therapy*, *7*, 599-606. http://dx.doi.org/10.1016/j.brat.2010.03.011

Taft, C. T., Murphy, C. M., Musser, P. H., & Remington, N. A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, *72*, 349-354. http://dx.doi.org/10.1037/0022-006X.72.2.349

Tichenor, V., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy*, *26*, 195-199. https://doi.org/10.1037/h0085419

Tracey, T., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 207---210. http://dx.doi.org/10.1037/1040-3590.1.3.207

Vargas, V., Lila, M., & Catalá-Miñana, A. (2015). Do cultural differences influence batterer intervention program outcomes? A study with Spanish and Latin American offenders. *Psychosocial Intervention*, *24*, 41-47. http://dx.doi.org/10.1016/j.psi.2015.03.001

6. Appendix

Item 1	Existe acuerdo sobre las medidas adoptadas para ayudar a mejorar la situación del participante
Item 2	Hay acuerdo sobre la utilidad de la actividad actual en la intervención
Item 3	Hay una simpatía recíproca entre el participante y el terapeuta
Item 5	El participante siente confianza en la habilidad del terapeuta para ayudarle
Item 6	Participante y terapeuta están trabajando metas consensuadas de mutuo acuerdo
Item 7	El participante siente que el terapeuta le valora como persona
Item 8	Hay acuerdo sobre lo que es importante trabajar para el participante
Item 9	Hay confianza mutua entre el participante y el terapeuta
Item 11	El participante y el terapeuta han establecido una buena comprensión de los cambios que podrían ser buenos para el participante
Item 12	El participante cree que la forma en la que están trabajando su problema es correcta

Estudio 3

Motivational strategies, working alliance, and protherapeutic behaviors in batterer intervention programs: a randomized controlled trial[1]

[1] Published in: Santirso, F. A., Lila, M., & Gracia, E. (2020). Motivational strategies, working alliance, and protherapeutic behaviors in batterer intervention programs: a randomized controlled trial. *European Journal of Psychology Applied to Legal Context*, *12*(2), 77-84. https://doi.org/10.5093/ejpalc2020a7

1. Introduction

Several meta-analyses conducted to evaluate the effectiveness of batterer intervention programs (BIPs) have indicated that the effect size of these interventions on reducing recidivism tends to be small (Arce et al., 2020; Babcock et al., 2004; Cheng et al., 2019; Eckhardt et al., 2013; Feder & Wilson, 2005; Smedslund et al., 2011). This limited success of BIPs in reducing recidivism has been attributed to different factors such as low treatment compliance and high dropout rates (Bennett et al., 2007; Daly & Pelowski, 2000; Jewell & Wormith, 2010; Lila et al., 2019; Olver et al., 2011), lack of motivation for change (Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017; Carbajosa, Catalá-Miñana, Lila, Gracia, et al., 2017; Crane et al., 2015; Eckhardt et al., 2008; Zalmanowitz et al., 2013), problems in building the working alliance (Cadsky et al., 1996; DiGiuseppe et al., 1994; Murphy & Baxter, 1997; Taft et al., 2004), and poor engagement in program activities (Musser et al., 2008; Taft et al., 2003).

Motivational strategies are one of the approaches to overcome these limitations and, consequently, to improve the effectiveness of BIPs (Babcock et al., 2016; Feder & Wilson, 2005; Santirso et al., 2020). Among the motivational strategies included in BIPs are, for example, interventions based on the ‘stage of change’ approach (Alexander et al., 2010), retention techniques (Mbilinyi et al., 2011; Musser et al., 2008; Taft et al., 2001), or motivational interviewing (Alexander et al., 2010; Crane & Eckhardt, 2013; Kistenmacher & Weiss, 2008; Lila et al., 2018; Mbilinyi et al., 201; Murphy et al., 2017; Musser et al., 2008; Scott et al., 2011; Woodin & O’Leary, 2010). A growing body of research reports promise results regarding the effectiveness of BIPs incorporating motivational strategies, in terms of decreasing intimate partner violence recidivism and levels of dropout (Alexander et al., 2010; Crane & Eckhardt, 2013; Lila et al., 2018; Mbilinyi et al., 2011; Murphy et al., 2017; Scott et al., 2011; Taft et al., 2001; Woodin &

O'Leary, 2013) and increasing intervention attendance, homework compliance, and stage of change level (Crane & Eckhardt, 2013; Kistenmacher & Weiss, 2008; Lila et al., 2018; Murphy et al., 2017; Musser et al., 2008; Taft et al., 2001).

Motivational strategies aim to build a strong facilitator-participant working alliance that helps to reduce participants' intervention resistance and increase motivation for change (Stuart et al., 2007). Also, these strategies are likely to promote protherapeutic behaviors among participants, thus leading to an improved group climate in BIPs (Brown & O'Leary, 2000; Musser et al., 2008; Rondeau et al., 2001; Semiatin et al., 2013; Taft et al., 2003; Taft et al., 2004).

The working alliance, according to Bordin (1979), consists of three components: facilitator-participant agreement on the intervention goals, participants' acceptance of and collaboration with the tasks proposed by facilitators to address participants' problems, and facilitator-participant emotional bond. The working alliance has been related to physical and psychological IPV reduction. For example, using observers' scores, Brown and O'Leary (2000) found that the working alliance in the first sessions of a voluntary couple intervention on IPV was associated with significant reductions of physical and psychological violence at the end of the intervention. In a court-mandated group intervention to prevent IPV, Taft et al. (2003) found that the therapeutic alliance reported by the therapist was also related with significant reductions of physical and psychological violence at six-month follow-up.

As for protherapeutic behaviors in the context of BIPs, Semiatin et al. (2013) defined them in terms of participants' verbalizations indicating: a) acknowledgment of personal responsibility and the need for personal change to avoid future violent behavior; b) participants' role behavior facilitating positive changes of other group members; and c) participants' verbalizations indicating a positive perception of both the group and the

intervention program. These protherapeutic behaviors have been related to a significant reduction of physical and psychological IPV reported by victims at six-month follow-up (Semiatin et al., 2013).

However, despite the importance of these key intervention processes, little research has been conducted to assess the effectiveness of motivational strategies on increasing participant facilitator working alliance and participants' protherapeutic behavior in BIPs.

The Present Study

The main aim of the present study was to examine whether adding motivational strategies to a standard BIP increases participant facilitator working alliance and participants' protherapeutic behaviors. To this end, a randomized controlled trial was conducted, comparing a standard BIP (control group) with an experimental condition in which an individualized motivational plan was added to the standard BIP as a motivational strategy (IMP; Lila et al., 2018; Romero-Martínez et al., 2019). The IMP is based on several approaches aimed at increasing intervention compliance in BIPs that have proved their effectiveness in different settings: motivational interviewing (Miller & Rollnick, 2002), stages of change approach (Prochaska & DiClemente, 1982; Prochaska et al., 1992), solution-focused brief therapy (DeShazer & Berg, 1997), and the Good Lives model (Langlands et al., 2009; Ward, 2002). The main components of the IMP are: (1) five individual motivational interviews, of which three were conducted during the evaluation phase to reduce participants' resistance to the intervention and establish participants' personal goals, one was conducted in the middle of the program to monitor their progress, and the last one was conducted around the end of the program to assess their achievements; (2) three group sessions, where participants share their personal goals, explain their progress to the group, and receive feedback, support, and advice from facilitators and other group participants (these group sessions are conducted at the

beginning, middle, and end of the program); (3) facilitators follow-up and reinforcement of participants' goals in every weekly group session throughout the intervention; and (4) retention techniques, such as phone calls when participants miss a group session. The IMP also implies that facilitators adopt an empathic and motivational attitude throughout the intervention, creating a climate of acceptance and using confrontation only when it becomes absolutely necessary.

As far as we know, the only previous experimental study analyzing whether motivational strategies increase working alliance and protherapeutic behaviors in BIP participants was conducted by Musser et al. (2008). In their study, groups receiving two motivational interviewing sessions as a pretreatment intervention were compared to control groups (i.e., intake as usual, without motivational interviewing). These researchers observed in the experimental group an increase in protherapeutic behaviors (i.e., verbalizations of responsibility for abusive behavior and group intervention usefulness) and higher working alliance late in intervention rated by therapists.

The present study pulls ahead previous research in two relevant issues, one related to the implementation of motivational strategies and the other related to the assessment of both protherapeutic behaviors and working alliance. First, in our study the motivational strategy was delivered throughout the BIP and not only as pretreatment intervention. We expected that the higher the exposure to motivational strategies the more positive the effect on the working alliance and protherapeutic behaviors. Second, we used a systematic observational methodology conducted by external observers to assess both protherapeutic behaviors and the working alliance. This methodological approach addressed impression management and social desirability issues when using offenders' self-reports, as well as potential biases in facilitators' self-reports or observations (Bennett, 2007; Gracia et al., 2015; Juarros-Basterrechea et al., 2018; Santirso et al., 2018; Weber et al., 2019).

2. Method

2.1 Participants

The sample consisted of 153 males convicted of intimate partner violence against women and court-mandated to a community based BIP. Offenders had been sentenced to less than a two-year term in prison, did not have previous criminal records, and their sentence was suspended on the condition that they attended the intervention. Eligibility criteria for this study were the following: (a) men over 18 years of age, (b) who had no severe psychological disorder, (c) had no severe substance abuse problems, and (d) had signed an informed consent form. Mean age was 40.73 years (*SD* = 11.99, range: 18-78). The sample consisted primarily of Spanish (71.7%, *n* = 110), Latin American (*n* = 17, 11.2%), European (other than Spanish, *n* = 13, 8.6%), African (*n* = 11, 7.2%), and Asian (*n* = 2, 1.3%) males. Regarding educational level, 6.4% had no education, 51% had primary education, 31.5% had secondary education, and 11.1% had university education. As for marital status, 33.3% were single (*n* = 51), 32.7% were divorced (*n* = 50), 24.2% were married or in a relationship (*n* = 37), and 9.8% were separated (*n* = 15). On average, annual family household income was between €6,000 and €12,000. About half of the participants were unemployed 45.1% (*n* = 69) at the time of the initial assessment.

2.2 Intervention Conditions

Standard batterer intervention program (SBIP). This condition consisted of 35 weekly group sessions of a standard cognitive-behavioral intervention. It was divided into six modules with the following main aims: a) first module: to build a climate of trust and establish norms for the group to function; b) second module: to introduce the IPV basic concepts and address attribution of responsibility; c) third module: to train in cognitive emotion management techniques and cognitive restructuring; d) fourth module: to develop awareness of IPV consequences on victims, empathy, and positive

communication skills in intimate relationships; e) fifth module: to discuss sexist attitudes, gender roles, and gender equality; and f) sixth module: to consolidate learning objectives and prevent relapse. Several techniques were applied during the SBIP (i.e., group dynamics, role-playing, monitored exercises, and training in cognitive restructuring or emotion management skills). Closed-ended groups in both conditions ranged from 10 to 12 men per group and were led by two facilitators.

Standard batterer intervention program plus individualized motivational plan (SBIP + IMP). The experimental condition consisted of the same standard cognitive-behavioral intervention with the addition of the IMP (see description above).

Facilitators training and intervention adherence. Facilitators were psychologists with at least two years' experience in BIPs. They received approximately 25 hours of training in their respective intervention condition. Facilitators were blind to the intervention condition. Each pair of facilitators intervened exclusively on one intervention condition. Facilitators for each condition were supervised independently once every two weeks. Supervision sessions focused on adherence to treatment protocol, group management, participants' progress, and preparation of future sessions. To ensure the content of and adherence to the protocol, written intervention manuals for each condition were used (Lila et al., 2018).

Randomization. Participants assessed for eligibility came through the penitentiary system (N = 181). Twenty-eight men were excluded, mainly for not attending the first meeting (see Figure 1). A random number generator was used to allocate participants to the SBIP or the SBIP + IMP condition. Fourteen intervention groups were established, seven for the SBIP + IMP condition (n = 74) and seven for the SBIP condition (n = 79). Figure 1 provides the description of participant flow from recruitment to study completion.

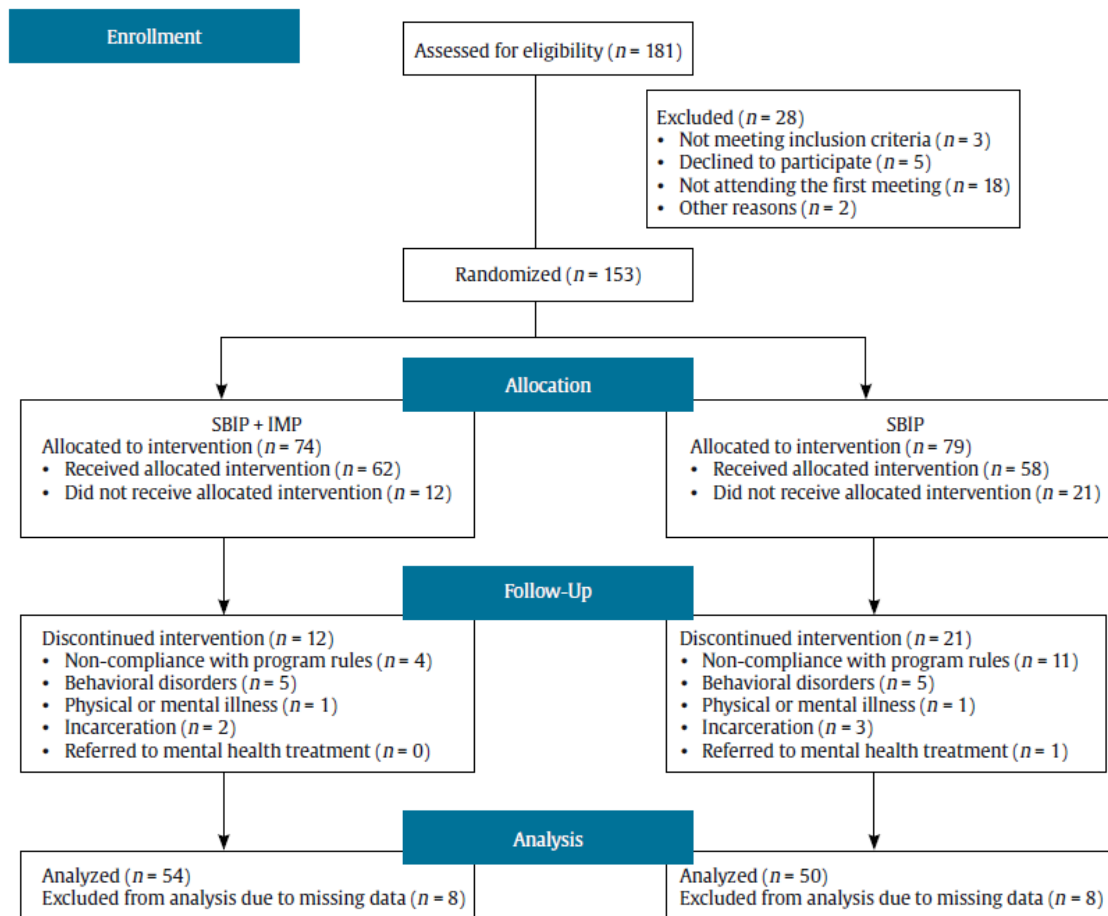


Figure 1. Flow diagram.

2.3 Procedure

Participants were clearly told that refusing to participate in the study would not affect their legal situation and would have no legal consequences. Confidentiality was assured, with the sole exception of situations that could pose a risk to participants or other people. Participants who agreed to take part in this study completed a written consent form and were randomly assigned to the SBIP + IMP or SBIP condition. Four independent trained graduate research assistants, who were blind to the objectives and hypotheses of the study, coded videotaped sessions. Working alliance and protherapeutic group behaviors were assessed twice: early in intervention (sessions 3-7) and late in intervention (sessions 24-28). Raters previously underwent training in which they

assessed the same recorded session separately until they reached an acceptable level of agreement (i.e., not differing by more than one point on each assessed item). Two-hour recorded intervention sessions were divided into 24 five-minute intervals. Each participant received an average rating across session intervals on working alliance and protherapeutic group behaviors.

2.4 Measures

Working Alliance Inventory-Observer short version (WAI-O-S; Tichenor & Hill, 1989; Spanish version by Santirso et al., 2018). This observational scale assesses both general working alliance, and two components of working alliance (i.e., agreement and bond). The WAI-O-S contains 12 items (e.g., "There is a mutual liking between participant and facilitator", "There is agreement on what is important for the participant to work on"). Raters responded on a 7-point Likert-type scale ranging from 0 (*conclusive evidence against*) to 7 (*conclusive evidence in favor*). The scale had adequate internal consistency in this study with Cronbach's alpha equal to .97 and .92 for early and late in intervention measures, respectively. In a previous study with a sample of male IPV offenders, results showed an excellent level of inter-rater agreement and significant correlations with other indicators of intervention effectiveness (e.g., stage of change, motivation to change, and protherapeutic group behaviors; see Santirso et al., 2018).

Observational coding of protherapeutic group behavior (Semiatin et al., 2013). This observational tool assesses protherapeutic behaviors of group participants through their verbalizations. It is a 3-item measure of the following protherapeutic behaviors: (a) responsibility for abuse—participants' verbalizations related to assuming vs. denying responsibility for their abusive actions, consequences of these actions, and the need for a personal change to avoid committing abusive acts in the future; (b) participant role behavior—interpersonal behaviors within the group that promote or hinder change by

other participants; the coding system addressed four types of participant role behavior along two axes, confirmation vs. confrontation and negative progress vs. positive progress; and (c) group value—participant verbalizations related to the perceived value of the group and the intervention in general. Raters assessed each of the protherapeutic behaviors on a 5-point Likert type scale ranging from 1 (*conclusive evidence against*) to 5 (*conclusive evidence in favor*). The effect of different raters assessing the same participants was evaluated. Pooled reliability correlation (r) across the three coded variables for averaged session ratings was .53, $n = 30$, $p = .011$.

2.5 Statistical Analyses

To analyze whether participants who received SBIP + IMP and participants who received SBIP were equivalent at the time of allocation, chi-square and independent t-tests were conducted for categorical and continuous variables, respectively. To assess 'time' and 'group' differences in working alliance and protherapeutic behavior, we carried out repeated measures ANOVAs, with working alliance and protherapeutic group behaviors (early and late in intervention) as between-subject factors, and 'intervention group' (SBIP + IMP or SBIP) as the within-subject factor. When a factor was significant in previous ANOVAs, Bonferroni tests were performed. All statistical analyses were conducted using SPSS 26.0, and two tailed tests with p set to .05 were considered as significant.

3. Results

3.1 Baseline Characteristics

Table 1 contains information on sociodemographic characteristics by treatment condition. The results showed that randomization was satisfactory. No pretreatment characteristics significantly distinguished SBIP + IMP and SBIP groups.

Table 1. Baseline characteristics of participants in each intervention condition (n = 153)

Variables	SBIP + IMP[a] (*n* = 74)			SBIP[b] (*n* = 79)				
	M	*SD*	%	*M*	*SD*	%	*t*	χ^2
Age	*39.39*	*11.66*		*41.99*	*12.23*		*1.34*	
Income[c]	4.31	2.53		4.00	2.12		-0.83	
Origin								.44
Spain			69.9			73.4		
Latin American			12.3			10.1		
Europe (excluding Spain)			9.6			7.6		
Africa			6.8			7.6		
Asia			1.4			1.3		
Education								
No Education			2.7			10.1		4.46
Primary			50.0			51.9		
Secondary			36.5			26.6		
University			10.8			11.4		
Marital status								4.59
Married or with partner			18.9			29.1		
Single			36.5			30.4		
Separated			6.8			12.7		
Divorced			37.8			27.8		
Unemployment			50.0			40.5		1.39

Note. All comparisons were not significant at ≤.05.
[a] SBIP + IMPAP = Standarized Batterer Intervention Program Plus Individualized Motivational Plan; [b]SBIP: Standarized Batterer Intervention Program; [c] Annual income: 1 = < €1,800, 2 = €1,800-€3,600, 3 = €3,600-€6,000, 4 = €6,000-€12,000, 5 = €12,000-18,000, 6 = €18,000-€24,000, 7 = €24,000-€30,000, 8 = €30,000-€36,000, 9 = €36,000-€60,000, 10 = €60,000-€90,000, 11 = €90,000-€120,000, and 12 = €120,000.

3.2 Observational Ratings of Working Alliance and Protherapeutic Group Behaviors

There was a significant effect of 'time' on general working alliance, and on the agreement and bond subscales, $F(1, 102) = 15.30$, $p = .0001$, $\eta^2 = .13$; $F(1, 102) = 15.65$, $p = .0001$, $\eta^2 = .13$; $F(1,102) = 12.49$, $p = .001$, $\eta^2 = .11$, respectively, with higher scores later in intervention than early in intervention in the total sample (see Table 2). A

significant effect of 'group' was also found on general working alliance, and on agreement and bond subscales, $F(1, 102) = 12.50$, $p = .001$, $\eta^2 = .11$; $F(1, 102) = 9.77$, $p = .002$, $\eta^2 = .09$; $F(1, 102) = 16.63$, $p = .0001$, $\eta^2 = .14$, respectively. Size effects were moderate to large (Cohen, 1988). Participants who received SBIP + IMP intervention showed higher general working alliance than those who received SBIP intervention, regardless of intervention moment (see Table 2 and Figure 2). No other significant effects were found on working alliance.

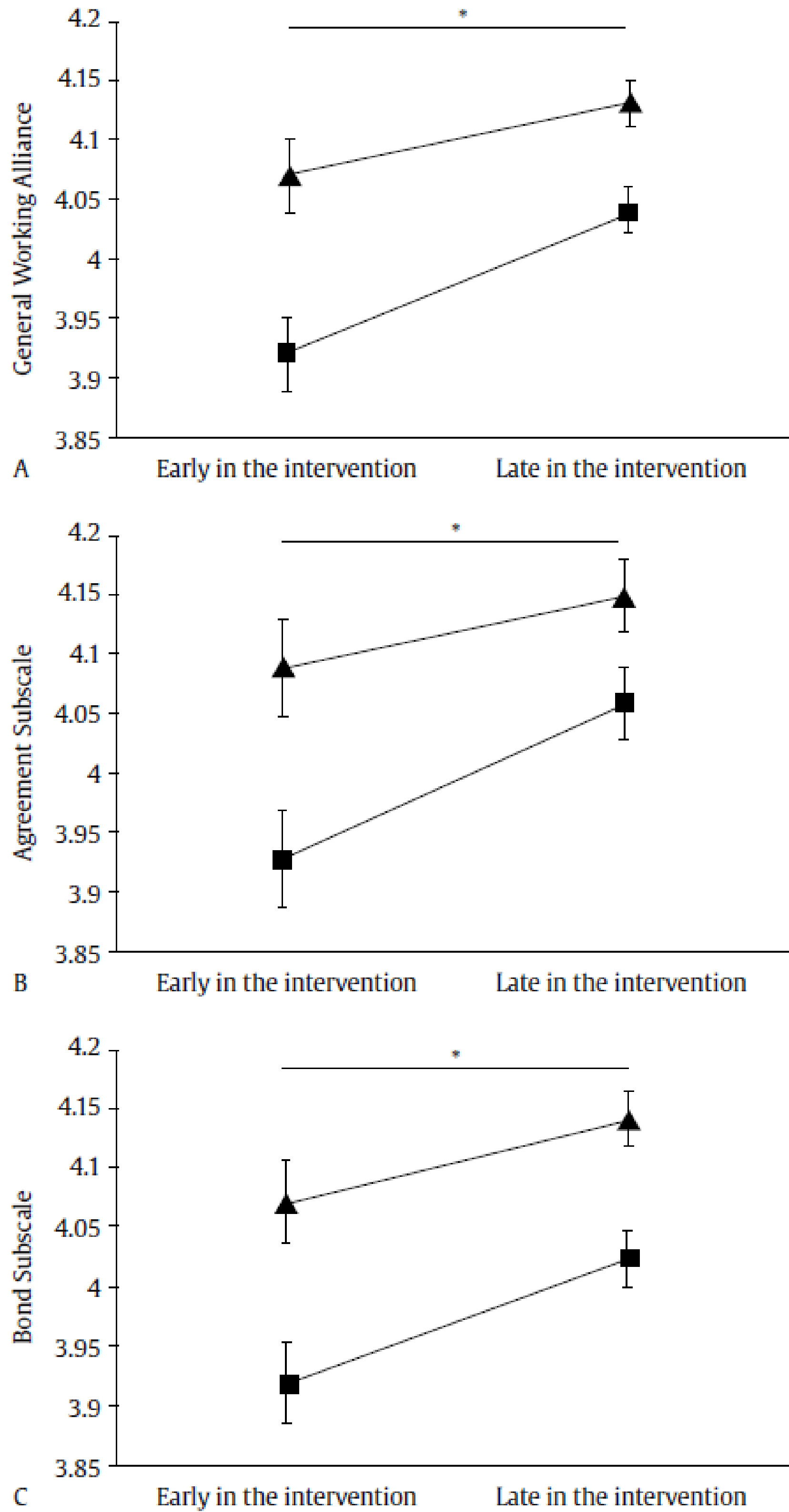


Figure 2. Working Alliance Scores Early in Intervention and Late in intervention in SBIP+IMP group (represented by triangles) and SBIP group (represented by squares). a) General working alliance; b) Agreement subscale; c) Bond subscale. * Effect of group (SBIP + IMP or SBIP) ($p < 0.05$).

Additionally, a significant effect of 'time' was found on responsibility for abuse, participant role behavior, and group value scores, $F(1, 102) = 12.81$, $p = .001$, $\eta^2 = .11$; $F(1, 102) = 7.00$, $p = .009$, $\eta^2 = .06$; $F(1, 102) = 13.20$, $p = .0001$, $\eta^2 = .12$, respectively, with higher scores late in intervention compared to early in intervention in the total sample (see Table 2). Moreover, a significant 'group' effect was found on responsibility for abuse, participant role behavior and group value scores, $F(1, 102) = 13.92$, $p = .0001$, $\eta^2 = .12$; $F(1, 102) = 10.63$, $p = .002$, $\eta^2 = .09$, $F(1, 102) = 20.85$, $p = .0001$, $\eta^2 = .17$, respectively, with participants who received SBIP + IMP having higher scores (see Figure 3). Size effects were moderate to large (Cohen, 1988). Furthermore, a significant 'time * group' effect was found on responsibility for abuse and participant role behavior scores, F(1, 102) = 5.23, $p = .02$, η2 = .05; $F(1, 102) = 7.31$, $p = .008$, η2 = .07, respectively (see Table 2 and Figure 3). Specifically, participants who received SBIP + IMP intervention showed higher responsibility for abuse early ($p = .001$) and late in intervention ($p = .013$) than those who received SBIP. Additionally, participants who received SBIP + IMP condition had significantly higher participant role behavior scores ($p = .002$) and tended to show higher participant role behaviors scores late in treatment than those who received SBIP only ($p = .067$). Finally, responsibility for abuse and participant role behaviors significantly increased throughout intervention in participants who received SBIP (for all, $p < .0001$), but not in those in SBIP + IMP condition (for all, $p > .35$).

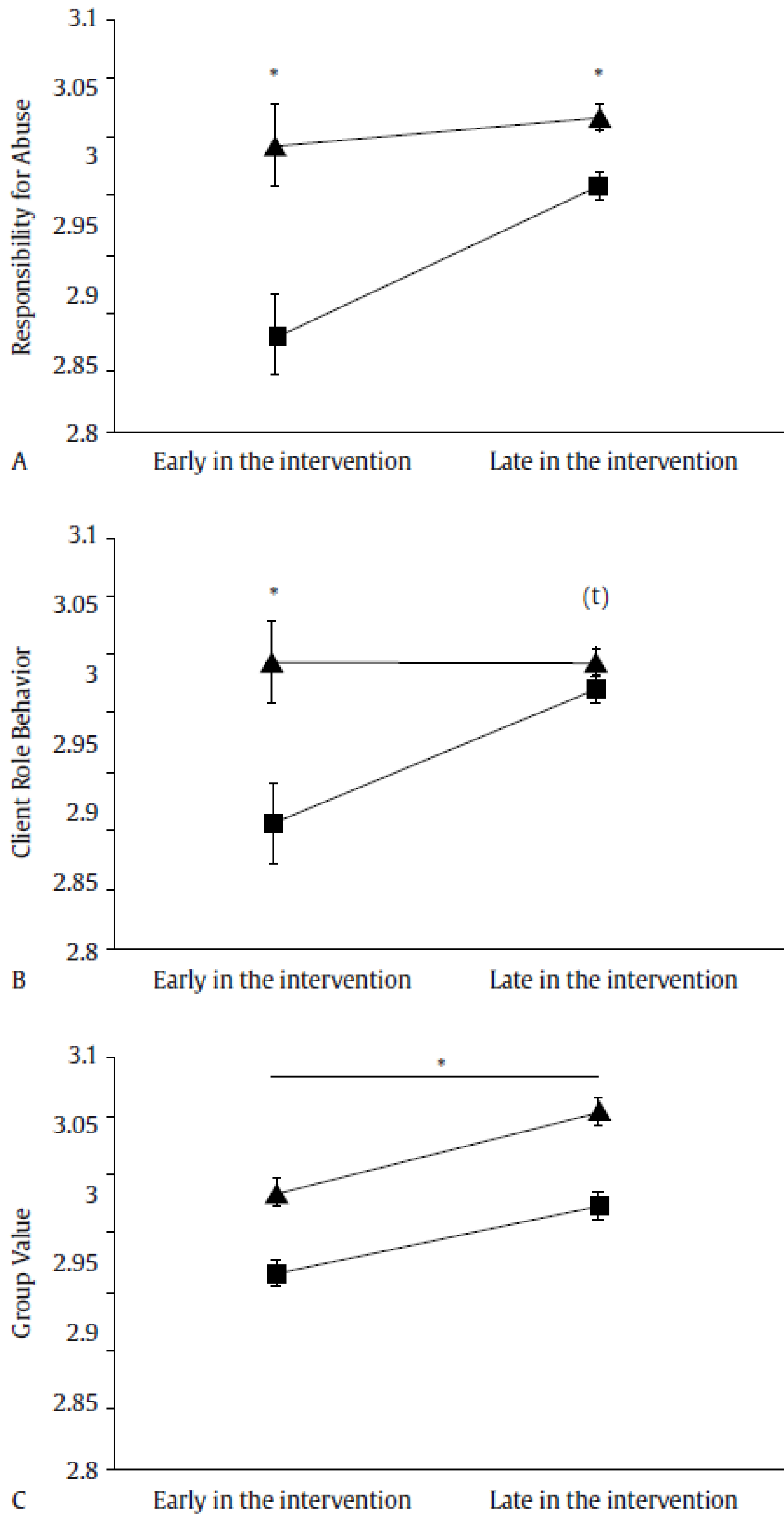


Figure 3. Protherapeutic Group Behavior Early in Intervention and Late in Intervention in SBIP+IMP group (represented by triangles) and SBIP group (represented by squares). a) Responsibility for abuse; b) Participant role behavior; c) Group value. * Effect of group (SBIP + IMP or SBIP) ($p < 0.05$). * Effect of 'time*group' ($p < 0.05$). (t) Effect of 'time*group' ($p = 0.067$).

Table 2. Descriptive statistics and 2x2 measures ANOVAs for completers sample (*n* = 104)

	Early in intervention		Late in intervention		Time		Group		Time * Group	
	[a] SBIP + IMP (n = 54)	[b]SBIP (*n* = 50)	[a] SBIP + IMP (n = 54)	[b]SBIP (*n* = 50)						
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*F*	$\eta 2_p$	*F*	$\eta 2_p$	*F*	$\eta 2_p$
General working alliance	4.07 (0.03)	3.92 (0.03)	4.13 (0.02)	4.04 (0.02)	13.66***	0.12	11.95***	0.10	2.03	0.02
Agreement	4.09 (0.04)	3.93 (0.04)	4.15 (0.03)	4.06 (0.03)	13.21***	0.11	9.32***	0.08	2.67	0.03
Bond	4.04 (0.03)	3.91 (0.03)	4.10 (0.02)	4.00 (0.02)	12.04***	0.11	16.20***	0.14	0.85	0.01
Responsibility for abuse	3.01 (0.03)	2.87 (0.03)	3.03 (0.01)	2.98 (0.01)	11.69***	0.10	13.23***	0.11	5.35*	0.05
Participant role behavior	3.01 (0.03)	2.89 (0.03)	3.01 (0.01)	2.99 (0.01)	7.26***	0.07	9.83***	0.09	7.19***	0.07
Group value	3.00 (0.01)	2.94 (0.01)	3.06 (0.01)	2.99 (0.01)	13.36***	0.12	21.20***	0.17	0.00	0.00

Note. * ≤ .05; ** ≤ .01; *** ≤ .001; [a] SBIP + IMP = Standarized Batterer Intervention Program Plus Individualized Motivational Plan; [b]SBIP = Standarized Batterer Intervention Program

4. Discussion

Working alliance and protherapeutic behaviors are key intervention processes to improve BIP effectiveness. Motivational strategies can contribute to build a strong working alliance and promote protherapeutic behaviors. However, little rigorous research has been conducted to assess the effectiveness of motivational strategies to increase working alliance and participants' protherapeutic behavior in BIPs. The randomized controlled trial conducted in this study showed that adding motivational strategies to a standard BIP increases participant-facilitator working alliance and participants' protherapeutic behaviors.

Our results showed that both general working alliance and scores on the agreement and bond subscales increased significantly over the course of the intervention in both intervention conditions, and was significantly higher in the SBIP + IMP intervention condition (both early and late in intervention). The results indicate that using an IMP helps to establish an agreement between IPV offenders and facilitators on BIPs' objectives and tasks. Reaching this agreement is a challenge in BIPs, as IPV offenders tend to minimize or fail to recognize acts of violence for which they have been convicted (Flinck & Paavilainen, 2008; Lila, Oliver, Catalá-Miñana, & Conchell, 2014; Martín-Fernández et al., 2018; Murphy & Maiuro, 2009; Weber et al., 2019). For example, they do not recognize that their anger is problematic, and tend to attribute responsibility for their abusive actions to their partner or the legal system, believing that they have been treated unfairly and that they are the main aggrieved party (DiGiuseppe et al., 1994; Murphy & Maiuro, 2009; Vitoria-Estruch et al., 2017). In addition, most of these men are court referred or enter intervention as a result of external pressure (Daly & Pelowski, 2000; Velonis et al., 2016). Motivational strategies seem to overcome some of these difficulties by establishing a collaborative environment and helping participants to

establish self-determined goals through the exploration of potential benefits of change (Lee et al., 2014; Miller & Rollnick, 2002). Regarding bond, Safran and Muran (2000) stressed the importance of participants' trust in facilitators' ability to help them throughout the intervention. Among the basic intervention principles of motivational strategies, such as the IMP, is the acceptance of participant resistance as part of the change process (Murphy & Maiuro, 2009). This attitude of accepting resistance and supporting participants' self-efficacy facilitates and strengthens the bond between a facilitator and a participant.

As for protherapeutic behaviors, our results showed that assumption of responsibility was significantly higher in the SBIP + IMP intervention condition (both early and late in intervention). Participants in the SBIP + IMP condition recognized more frequently within the group their responsibility for the violence, its consequences on people around them, and the need to make personal changes to avoid committing abusive acts in the future. Non-confrontational, non-judgmental, and empathetic listening qualities of motivational strategies may explain this increase in participants' assumption of responsibility (Musser et al., 2008; Taft & Murphy, 2007). In fact, the framework of motivational interviewing is that participants feel accepted despite the presence of some unacceptable behaviors (Murphy & Maiuro, 2009). Concerning early in intervention participant role behavior, offenders in the SBIP + IMP intervention condition showed significantly greater efforts to help other members of the group to change and to assume responsibility for their behavior. For example, participants in the SBIP + IMP group more frequently confronted other group members' comments about avoiding responsibility by blaming their partner or the legal system, or reinforced assumptions of responsibility of other group members (Gracia, 2014; Henning & Holdford, 2006; Lila, Oliver, Catalá-Miñana, Galiana, et al., 2014; Martín-Fernández et al., 2018). Regarding group value,

participants in the SBIP + IMP intervention condition were more likely to make positive assessments of the group, and the intervention in general, both early and late in intervention.

The results of our study highlight the importance of using motivational strategies in order to increase their impact on both participant-facilitator working alliance and participants' protherapeutic behaviors. Our study pulls ahead previous research on the importance of motivational strategies to increase the effectiveness of BIPs (Musser et al., 2008) at least in three aspects.

First, in our study, motivational strategies were implemented throughout the intervention program. Other studies tend to implement motivational strategies only at pre-intervention stage. However, as our results showed, a more extensive implementation of motivational strategies can lead to more long-lasting gains (Crane & Eckhardt, 2013; Musser et al., 2008; Santirso et al., 2020; Stuart et al., 2013). This idea is also supported by research on other behavior change interventions. For example, a systematic review of the effectiveness of motivational interviewing on substance abuse, gambling, health-related behaviors, and engagement in intervention showed a positive association between the motivational intervention dose and its efficacy (Lundahl et al., 2010). Second, in our study we assess both protherapeutic behaviors and working alliance using a systematic observational methodology conducted by external observers. This methodological approach allows researchers to address important limitations that arise when using offenders' selfreports (i.e., impression management or social desirability). This approach also overcomes potential biases in facilitators' reports (Bennett, 2007; Gracia et al., 2015; Santirso et al., 2018). For example, previous research reports different results depending on the source of information, such as participants or facilitators (Musser et al., 2008). Third, facilitators used in our study were psychologists with at least two years' experience

in managing BIPs. Facilitators' experience can be a major factor in the implementation quality of motivational strategies (Hamel et al., in press).

As for limitations, although manuals for each condition were used to ensure the content of and adherence to the protocol, and facilitators were regularly supervised, the IMP protocol was not quantitatively rated by an external observer. Also, this study was conducted with IPV offenders court-mandated to a community based BIP. This could limit the generalizability of our results to other population samples such as men attending voluntary programs, men imprisoned for IPV, women who have committed IPV, or individuals with severe substance abuse problems or psychological disorders. Despite these limitations, this is the first RCT evaluating the effectiveness of a motivational strategy implemented throughout the intervention program—IMP—on the participant facilitator working alliance and participants' protherapeutic behaviors. Our findings have important practical implications, as our results clearly showed that a motivational strategy tool such as the IMP improves key intervention processes (i.e., working alliance and protherapeutic behaviors) in BIPs, therefore increasing their effectiveness.

5. References

Alexander, P. C., Morris, E., Tracy, A., & Frye, A. (2010). Stages of change and the group treatment of batterers: A randomized clinical trial. *Violence and Victims*, *25*, 571-587. https://doi.org/10.1891/0886-6708.25.5.571

Arce, R., Arias, E., Novo, M., & Fariña, F. (2020). Are interventions with batterer effectives? A meta-analytical review. *Psychosocial Intervention*. Advance online. https://doi.org/10.5093/pi2020a11

Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R. Cantos, A., Hamel, J., Kelly, D., Jordan, C., Lehmann, P., Leisring, P. A., Murphy, C.,

O'Leary, K. D., Bannon, S., Salis, K. L., & Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence based standards in the United States. *Partner Abuse*, *7*, 355-460. https://doi.org/10.1891/1946-6560.7.4.355

Bennett, L. W., Stoops, C., Call, C., & Flett, H. (2007). Program completion and re-arrest in a batterer intervention system. *Research on Social Work Practice*, *17*, 42-54. https://doi.org/10.1177/1049731506293729

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: *Theory, Research and Practice*, *16*, 252-260. https://doi.org/10.1037/h0085885

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, *68*, 340-345. https://doi. org/10.1037//0022-006x.68.2.340

Cadsky, O., Hanson, R. K., Crawford, M., & Lalonde, C. (1996). Attrition from a male batterer treatment program: Client-treatment congruence and lifestyle instability. *Violence and Victims*, *11*, 51-64. https://doi. org/10.1891/0886-6708.11.1.51

Carbajosa, P., Catalá-Miñana, A., Lila, M., & Gracia, E. (2017). Differences in treatment adherence, program completion, and recidivism among batterer subtypes. *The European Journal of Psychology Applied to Legal Context*, *9*, 93-101. https://doi.org/10.1016/j.ejpal.2017.04.001

Carbajosa, P., Catalá-Miñana, A., Lila, M., Gracia, E., & Boira, S. (2017). Responsive versus treatment-resistant perpetrators in batterer intervention programs: Personal characteristics and stages of change. *Psychiatry, Psychology and Law*, *24*, 936-950. https://doi.org/10.1080/13218719.2017.1347933

Cheng, S. Y., Davis, M., Jonson-Reid, M., & Yaeger, L. (2019). Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma, Violence, & Abuse*, 1-16. https://doi.org/10.1177/1524838019865927

Cohen, J. (1988*). Statistical power analysis for the behavioral sciences* (2nd ed). Erlbaum.

Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology*, *60*, 180-187. https://doi.org/10.1037/ a0032178

Crane, C. A., Schlauch, R. C., & Eckhardt, C. I. (2015). Dyadic violence and readiness to change among male intimate partner violence offenders. *Criminal Behaviour and Mental Health*, *25*, 287-298. https://doi.org/10.1002/cbm.1977

Daly, J. E., & Pelowski, S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims*, *15*, 137-160. https://doi.org/10.1891/0886- 6708.15.2.137

De Shazer, S., & Berg, I. K. (1997). 'What works?' Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy*, *19*, 121-124. https://doi.org/10.1111/1467-6427.00043

DiGiuseppe, R., Tafrate, R., & Eckhardt, C. (1994). Critical issues in the treatment of anger. *Cognitive and Behavioral Practice*, *1*, 111-132. https://doi.org/10.1016/S1077-7229(05)80089-6

Eckhardt, C., Holtzworth-Munroe, A., Norlander, B., Sibley, A., & Cahill, M. (2008). Readiness to change, partner violence subtypes, and treatment outcomes among

men in treatment for partner assault. *Violence and Victims*, *23*, 446-475. https://doi.org/10.1891/0886-6708.23.4.446

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, *4*, 196-231. https://doi.org/10.1891/1946-6560.4.2.196

Feder, L., & Wilson, D. B. (2005). A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior? *Journal of Experimental Criminology*, *1*, 239-262. https://doi.org/10.1007/s11292-005-1179-0

Flinck, A., & Paavilainen, E. (2008). Violent behavior of men in their intimate relationships, as they experience it. *American Journal of Men's Health*, *2*, 244-253. https://doi.org/10.1177/1557988308321674

Gracia, E. (2014). Intimate partner violence against women and victim blaming attitudes among Europeans. *Bulletin of the World Health Organization*, *92*, 380-381. https://doi.org/10.2471/BLT.13.131391

Gracia, E., Rodriguez, C. M., & Lila, M. (2015). Preliminary evaluation of an analog procedure to assess acceptability of intimate partner violence against women: The partner violence acceptability movie task. *Frontiers in Psychology*, *6*, 1567. https://doi.org/10.3389/fpsyg.2015.01567

Hamel, J., Cannon, C., Buttell, F., & Ferreira, R. (in press). A survey of IPV perpetrator treatment providers: Ready for evidence-based practice? *Partner Abuse*.

Henning, K., & Holdford, R. (2006). Minimization, denial, and victim blaming by batterers: How much does the truth matter? *Criminal Justice and Behavior*, *33*, 110-130. https://doi.org/10.1177/0093854805282322

Jewell, L. M., & Wormith J. S. (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers: A meta-analysis. *Criminal Justice and Behavior*, *37*, 1086-1113. https:// doi.org/10.1177/0093854810376815

Juarros-Basterrechea, J., Herrero, J., Fernández-Suárez, A., Pérez, B., & Rodríguez-Díaz, F. J. (2018). Are generalist batterers different from generally extra-family violent men? A study among imprisoned male violent offenders. *European Journal of Psychology Applied to Legal Context*, *10*, 8-14. https://doi.org/10.5093/ejpalc2018a1

Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence and Victims*, *23*, 558-570. https://doi.org/10.1891/0886- 6708.23.5.558

Langlands, R. L., Ward, T., & Gilchrist, E. (2009). Applying the Good Lives Model to male perpetrators of domestic violence. *Behaviour Change*, *26*, 113-129. https://doi.org/10.1375/bech.26.2.113

Lee, M. Y., Uken, A., & Sebold, J. (2014). Self-determined goals and treatment of domestic violence offenders: What if we leave it up to them? *Partner Abuse*, *5*, 239-258. http://doi.org/10.1891/1946-6560.5.3.239

Lila, M., Gracia, E., & Catalá-Miñana, A. (2018). Individualized motivational plans in batterer intervention programs: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *86*, 309-320. http://doi.org/10.1037/ccp0000291

Lila, M., Martín-Fernández, M., Gracia, E., López-Ossorio, J. J., & González, J. L. (2019). Identifying key predictors of recidivism among offenders attending a batterer intervention program: A survival analysis. *Psychosocial Intervention*, *28*, 157-167. https://doi.org/10.5093/pi2019a19

Lila, M., Oliver, A., Catalá-Miñana, A., & Conchell, R. (2014). Recidivism risk reduction assessment in batterer intervention programs: A key indicator for program efficacy evaluation. *Psychosocial Intervention*, *23*, 217-223. https://doi.org/10.1016/j.psi.2014.11.001

Lila, M., Oliver, A., Catalá-Miñana, A., Galiana, L., & Gracia, E. (2014). The Intimate Partner Violence Responsibility Attribution Scale (IPVRAS). *European Journal of Psychology Applied to Legal Context*, *6*, 29-36. https://doi.org/10.5093/ejpalc2014a4

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*, 137-160. https://doi.org/10.1177/1049731509347850

Martín-Fernández, M., Gracia, E., & Lila, M. (2018). Assessing victim blaming attitudes in cases of intimate partner violence against women: Development and validation of the VB-IPVAW scale. *Psychosocial Intervention*, *27*, 133-143. https://doi.org/10.5093/pi2018a18

Martín-Fernández, M., Gracia, E., Marco, M., Vargas, V., Santirso, F. A., & Lila, M. (2018). Measuring acceptability of intimate partner violence against women: Development and validation of the A-IPVAW scale. *European Journal of*

Psychology Applied to Legal Context, *10*, 26-34. https://doi.org/10.5093/ejpalc2018a3

Mbilinyi, L. F., Neighbors, C., Walker, D. D., Roffman, R. A., Zegree, J., Edleson, J., & O´Rourke, A. (2011). A telephone intervention for substance-using adult male perpetrators of intimate partner violence. *Research on Social Work Practice*, *21*, 43-56. https://doi.org/10.1177/1049731509359008

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. Guilford.

Murphy, C. M., & Baxter, V. A. (1997). Motivating batterer to change in the treatment context. *Journal of Interpersonal Violence*, *12*, 607-619. https://doi.org/10.1177/088626097012004009

Murphy, C. M., Eckhardt, C. I., Clifford, J. M., Lamotte, A. D., & Meis, L. A. (2017). Individual versus group cognitive-behavioral therapy for partner violent men: A preliminary randomized trial. *Journal of Interpersonal Violence*, 1-23. https://doi.org/10.1177/0886260517705666

Murphy C. M., & Maiuro R. D. (2009). *Motivational interviewing and stages of change in intimate partner violence*. Springer Publishing Company.

Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims*, *23*, 539-557. https://doi.org/10.1891/0886-6708.23.5.539

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, *79*, 6-21. https://doi.org/10.1037/a0022200

Prochaska, J. O, & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, *19*, 276-288. https://doi.org/10.1037/h0088437

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*, 1102-1114. https://doi.org/10.1037//0003- 066x.47.9.1102

Romero-Martínez, Á., Lila, M., Gracia, E., & Moya-Albiol, L. (2019). Improving empathy with motivational strategies in batterer intervention programmes: Results of a randomized controlled trial. *British Journal of Clinical Psychology*, *58*, 125-139. https://doi.org/10.1111/bjc.12204

Rondeau, G., Brodeur, N., Brochu, S., & Lemire, G. (2001). Dropout and completion of treatment among spouse abusers. *Violence and Victims*, *16*, 127-143. https://doi.org/10.1891/0886-6708.16.2.127

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. Journal of Clinical Psychology, 56, 233-243. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<233::AID-JCLP9>3.0.CO;2-3

Santirso, F. A., Gilchrist, G., Lila, M. & Gracia, E. (2020). Motivational strategies for intimate partner violence offender treatment: A systematic review and meta-analysis of randomized controlled trials. *Psychosocial Intervention*, *29*. https://doi.org.10.5093/pi2020a13

Santirso, F. A., Martín-Fernández, M., Lila, M., Gracia, E., & Terreros, E. (2018). Validation of the working alliance inventory-observer short version with male

intimate partner violence offenders. *International Journal of Clinical and Health Psychology*, *18*, 152-161. https://doi.org/10.1016/j.ijchp.2018.02.003

Scott, K., King, C., McGinn, H., & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence*, *26*, 139-149. https://doi.org/10.1007/s10896-010- 9353-1

Semiatin, J. N., Murphy, C. M., & Elliott, J. D. (2013). Observed behavior during group treatment for partner-violent men: Acceptance of responsibility and promotion of change. *Psychology of Violence*, *3*, 126-139. https://doi.org/10.1037/a0029846

Smedslund, G., Dalsbø, T. K., Steiro, A., Winsvold, A., & Clench-Aas, J. (2011). Cognitive behavioural therapy for men who physically abuse their female partner. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD006048.pub2

Stuart, G. L., Shorey, R. C., Moore, T. M., Ramsey, S. E., Kahler, C. W., O'Farrell, T. J., Strong, D. R., Temple, J. R., & Monti, P. M. (2013). Randomized clinical trial examining the incremental efficacy of a 90-minute motivational alcohol intervention as an adjunct to standard batterer intervention for men. *Addiction*, *108*, 1376-1384. https://doi.org/10.1111/add.12142

Stuart, G. L., Temple, J., & Moore, T. (2007). Improving batterer intervention programs through theory-based research. *Journal of the American Medical Association*, *298*, 560-562. https://doi.org/10.1001/jama.298.5.560

Taft, C. T. & Murphy, C. M. (2007). The working alliance in intervention for partner violence perpetrators: Recent research and theory. *Journal of Family Violence*, *22*, 11-18. https://doi.org/10.1007/s10896-006-9053-z

Taft, C. T., Murphy, C. M., Elliott, J. D., & Morrel, T. M. (2001). Attendance enhancing procedures in group counselling for domestic abusers. *Journal of Counselling Psychology*, *48*, 151-160. https://doi.org/10.1037/0022-0167.48.1.51

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, *71*, 812-820. https://doi.org/10.1037/0022-006X.71.4.812

Taft, C. T., Murphy, C. M., Musser, P. H., & Remington, N. A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioural therapy for partner-violent men. *Journal of Consulting and Clinical Psychology*, *72*, 349-354. https://doi.org/10.1037/0022-006X.72.2.349

Tichenor, V., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy: Theory, Research, Practice, Training*, *26*, 195-199. https://doi.org/10.1037/h0085419

Velonis, A. J., Cheff, R., Finn, D., Davloor, W., & O'Campo, P. (2016). Searching for the mechanisms of change: A protocol for a realist review of batterer treatment programmes. *BMJ Open*, *6*, 1-9. https://doi.org/10.1136/ bmjopen-2015-010173

Vitoria-Estruch, S., Romero-Martínez, Á., Ruiz-Robledillo, N., Sariñana-González, P., Lila, M., & Moya-Albiol, L. (2017). The role of mental rigidity and alcohol consumption interaction on intimate partner violence: A Spanish study. Journal of *Aggression, Maltreatment & Trauma*, *26*, 664-675. https://doi.org/10.1080/10926771.2017.1300619

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior*, *7*, 513-528. https://doi.org/10.1016/S1359-1789(01)00076-3

Weber, E. N., Taylor, A. R., Cantos, A. L., Amado, B. G., & O'Leary, K. D. (2019). Exploring typology categorizations of male perpetrators: A methodology study. *European Journal of Psychology Applied to Legal Context*, *11*, 93-97. https://doi.org/10.5093/ejpalc2019a5

Woodin, E. M., & O`Leary, K. D. (2010). A brief motivational intervention for physically aggressive dating couples. *Prevention Science*, *11*, 371-383. https://doi.org/10.1007/s11121-010-0176-3

Zalmanowitz, S. J., Babins-Wagner, R., Rodger, S., Corbett, B. A., & Leschied, A. (2013). The association of readiness to change and motivational interviewing with treatment outcomes in males involved in domestic violence group therapy. *Journal of Interpersonal Violence*, *28*, 956-974. https://doi.org/10.1177/0886260512459381

CAPÍTULO 5

Discusión general

1. Discusión general

Los principales resultados de cada estudio han sido discutidos separadamente en capítulos anteriores. En este capítulo se presenta una discusión general de los principales resultados de esta tesis doctoral, sus implicaciones y sus limitaciones, sugiriendo algunas direcciones futuras basadas en los resultados de los diferentes estudios y ofreciendo una conclusión general de la misma.

Los estudios de la presente tesis doctoral exploran el efecto de la inclusión de estrategias motivacionales sobre la eficacia de los programas de intervención con maltratadores, tanto en variables de proceso (i.e., alianza terapéutica y conducta pro-terapéutica) como en variables finales (i.e., reducción de la reincidencia, dosis de intervención y abandono del programa de intervención). Así, el primer estudio evaluó la eficacia de dichas estrategias motivacionales en la reducción de la violencia física y psicológica, el abandono de la intervención, la dosis de intervención recibida y la reincidencia, mediante una revisión sistemática con meta-análisis de los RCTs existentes en la literatura. El segundo estudio analizó las propiedades psicométricas de una escala observacional de alianza terapéutica, considerando sus relaciones con otras variables (i.e., conductas pro-terapéuticas) con una muestra de maltratadores, como paso previo para la realización del tercer estudio. El tercer estudio comparó los efectos de una intervención con estrategias motivacionales frente a una intervención sin dichas estrategias sobre la alianza terapéutica y las conductas pro-terapéuticas de maltratadores, empleando la escala validada en el segundo estudio, entre otros instrumentos.

1.1. Eficacia de las estrategias motivacionales en la intervención con maltratadores: revisión sistemática y meta-análisis de RCTs

En el primer estudio de la tesis se realizó una revisión sistemática con meta-análisis acerca de la eficacia de las estrategias motivacionales en la intervención con maltratadores. Se compararon distintas variables (i.e., violencia física y psicológica autoinformadas, abandono de la intervención, dosis de intervención recibida y reincidencia recogida en registros oficiales). Para ello, se incluyeron 12 RCTs en el análisis cualitativo y siete RCTs en el meta-análisis. Los resultados del meta-análisis mostraron que las intervenciones para maltratadores que incluyeron estrategias motivacionales fueron significativamente más efectivas a la hora de reducir el abandono de la intervención e incrementar la dosis de intervención recibida frente a las intervenciones sin estas estrategias. En cuanto a la reincidencia recogida en registros oficiales y a la violencia física y psicológica auto-informada, se encontraron mejores resultados con las intervenciones que incluían estrategias motivacionales, pero las diferencias no alcanzaron la significación estadística.

Respecto al abandono de la intervención y la dosis de intervención recibida, todos los RCTs analizados encontraron un menor abandono de la intervención y una mayor dosis de intervención recibida en maltratadores sometidos a la intervención motivacional respecto a las intervenciones sin estrategias motivacionales (Crane y Eckhardt, 2013; Lila et al., 2018; Murphy et al., 2018). La ratio de abandono de la intervención fue del 15.02% en intervenciones motivacionales frente a 20.72% en intervenciones sin estrategias motivacionales; es decir, la ratio fue 1.73 veces mayor en intervenciones sin estrategias motivacionales respecto a aquellas que incluían dichas estrategias. Cabe destacar que se halló un menor abandono de la intervención incluso en un estudio que incluyó únicamente una sesión de entrevista motivacional (Crane y Eckhardt, 2013), aunque las mejoras en la

adherencia al tratamiento en la condición motivacional tendieron a disiparse a lo largo del tiempo. Estos resultados sugieren que las intervenciones con más estrategias motivacionales podrían favorecer ganancias más duraderas.

En cuanto a la reincidencia recogida en registros oficiales, en dos RCTs se encontraron evidencias a favor de la intervención motivacional (Crane y Eckhardt, 2013; Lila et al., 2018), y en otro RCT se encontraron evidencias inconcluyentes (Stuart et al., 2013). Considerando estos tres RCTs, la ratio de reincidencia fue 1.46 veces mayor en los hombres de la intervención sin estrategias motivacionales respecto a aquellos sometidos a la intervención motivacional, aunque los resultados no alcanzaron la significación estadística. Una posible explicación para este resultado podría ser los bajos niveles de reincidencia encontrados en ambas condiciones. Así, de los 492 participantes analizados, sólo 75 fueron arrestados en una o más ocasiones durante el seguimiento. Cabe destacar que algunos actos de violencia podrían no aparecer en los registros oficiales, existiendo además cierta disparidad en los tipos de actos de violencia considerados como reincidencia. Por ejemplo, en nuestro meta-análisis, dos estudios consideraron únicamente la violencia contra la mujer en los registros oficiales (Lila et al. 2018; Stuart et al., 2013), mientras que el estudio restante incluyó cualquier tipo de arresto (Crane y Eckhardt et al., 2013). A pesar de la falta de significación estadística en los resultados del meta-análisis relativos a la reincidencia, el papel de las estrategias motivacionales sobre el aumento de la adherencia a la intervención y la reducción de la reincidencia ha sido señalado en previas revisiones sistemáticas (Babcock et al., 2004; Eckhardt et al., 2013).

Respecto a la violencia física contra la pareja informada por los participantes, dos RCTs encontraron evidencias a favor de la intervención motivacional (Mbilinyi et al., 2011; Lila et al., 2018), dos RCTs a favor de la intervención sin estrategias motivacionales

(Chermack et al., 2017; Schumacher et al., 2011), y un RCT encontró evidencias inconcluyentes (Stuart et al., 2013). En cuanto a la violencia psicológica contra la pareja informada por los participantes, dos RCTs encontraron evidencias a favor de la intervención motivacional (Mbilinyi et al., 2011; Lila et al., 2018), y otros dos estudios encontraron evidencias a favor de la intervención sin estrategias motivacionales (Schumacher et al., 2011; Stuart et al., 2013). En su conjunto, aunque se produjo una reducción de violencia física y psicológica en la dirección esperada, la diferencia no alcanzó la significación estadística. La confianza en los autoinformes de violencia física y psicológica continúa siendo un asunto controvertido (Babcock et al. 2004). Aunque se emplearon instrumentos validados y se aseguró la confidencialidad a los participantes, reduciendo así el riesgo de sesgo en los datos (Babor et al., 2000), el hecho de que los participantes asistieran por mandato judicial al programa podría haber favorecido que estos percibieran al personal del programa de intervención como parte del sistema legal y adaptaran sus respuestas en consecuencia (Crane y Eckhardt et al., 2013). En nuestro meta-análisis, un 60% de los participantes de los RCTs que evaluaron violencia física contra la pareja mediante autoinformes asistieron a la intervención por mandato judicial, siendo este porcentaje del 73% en el caso de la violencia psicológica auto-informada. Estos participantes podrían presentar mayor tendencia a minimizar la gravedad de la conducta violenta frente a sus víctimas (Heckert y Gondolf, 2000). De hecho, Alexander et al. (2010) hallaron que la intervención motivacional favoreció una reducción significativa de la violencia física informada por las víctimas, pero no de la violencia informada por los participantes.

1.2. Estrategias motivacionales, alianza terapéutica y conductas proterapéuticas en programas de intervención con maltratadores

La alianza terapéutica y las conductas pro-terapéuticas son clave para incrementar la motivación, la adherencia al tratamiento y la participación en los programas de intervención con maltratadores. Dado que no se disponía de ningún instrumento validado en castellano para evaluar la alianza terapéutica de forma observacional en la intervención con maltratadores, el segundo estudio de la tesis se centró en evaluar las propiedades psicométricas y la estructura factorial del WAI-O-S (Tichenor y Hill, 1989). Por su parte, el tercer estudio analizó los efectos de una intervención con estrategias motivacionales frente a una intervención sin dichas estrategias sobre la alianza terapéutica y las conductas pro-terapéuticas, mediante un RCT, empleando la validación en castellano del WAI-O-S, entre otros instrumentos.

Los resultados del segundo estudio de la tesis mostraron que el WAI-O-S puede ser utilizado para evaluar la alianza terapéutica a través de observadores externos en contextos de intervención. En concreto, con hombres que asistían a un programa de intervención para maltratadores, este instrumento ha demostrado ser preciso y consistente para evaluar las relaciones entre los coordinadores y los participantes. Respecto a la evaluación observacional del WAI-O-S, encontramos un nivel excelente de acuerdo inter-jueces, considerando los puntos de corte establecidos por Cicchetti (1994). De hecho, nuestro nivel de acuerdo inter-jueces fue superior al obtenido por Andrusyna et al. (2001), Brown y O'Leary (2000) y Strunk et al. (2010), y similar al encontrado por Tichenor y Hill (1989). El procedimiento utilizado en la codificación de la alianza terapéutica podría explicar las discrepancias entre estudios. Por ejemplo, en nuestro estudio evaluamos a alianza terapéutica dividiendo la sesión en 24 segmentos, mientras que los estudios anteriores emplearon una única medición de alianza terapéutica para toda la sesión.

En cuanto a la fiabilidad del WAI-O-S, nuestros resultados mostraron niveles altos de consistencia interna considerando conjuntamente el alfa de Cronbach y la omega de McDonald. Estos hallazgos son similares a los encontrados en la versión original del instrumento (Tichenor y Hill, 1989). Es importante destacar que los ítems 4 y 10 fueron eliminados de nuestra escala para mejorar la precisión del instrumento y cumplir los supuestos de independencia de los ítems del CFA. Tras la eliminación de estos ítems, obtuvimos una alta correlación ítem-total.

Respecto a la estructura factorial del WAI-O-S, agrupar los tres factores originales de alianza terapéutica propuestos por Bordin (1979) en dos factores de primer orden (acuerdo y vínculo) mejoró el ajuste del modelo a nuestros datos. A su vez, la relación entre los factores de primer orden se explicó mediante un factor de segundo orden (alianza terapéutica general). Andrusyna et al. (2001), empleando la versión observacional del cuestionario con pacientes sometidos a terapia cognitivo-conductual, encontraron una estructura latente de dos factores independientes: factor de acuerdo/confianza y factor relacional. Cabe destacar que nuestro estudio difiere del estudio de Andrusyna et al. (2001) en la muestra del estudio y en la metodología utilizada.

Respecto a la validez de criterio, nuestros resultados mostraron que los dos factores de primer orden (vínculo y acuerdo) y el factor de segundo orden (alianza terapéutica general) del WAI-O-S se asociaron significativamente con un conjunto de variables relevantes en el éxito de la intervención con maltratadores. Así, encontramos una asociación positiva entre la alianza terapéutica y las conductas pro-terapéuticas (Semiatin et al., 2013). Esto sugiere que, cuando existe acuerdo entre los coordinadores y los participantes en los objetivos y tareas de la intervención, y el vínculo entre ellos es adecuado, los participantes son más propensos a asumir su responsabilidad, apoyar las iniciativas de cambio de otros compañeros y realizar comentarios positivos acerca del

valor del grupo (Lila et al., 2013). Otra de las variables que se asoció positivamente con la alianza terapéutica fue la motivación para el cambio, de acuerdo con otros estudios con maltratadores (Carbajosa et al., 2017; Taft et al., 2004). Estos resultados también se han encontrado en poblaciones con adicción al alcohol, en las que la motivación para el cambio fue uno de los predictores más fiables de la alianza terapéutica evaluada por el cliente y el terapeuta (Catalá-Miñana et al., 2013; Connors et al., 2000; Lila et al., 2017). En este sentido, nuestros hallazgos sugieren que un adecuado vínculo junto con el acuerdo en los objetivos y tareas de la intervención entre coordinadores y participantes podría favorecer la motivación para el cambio de estos últimos. En este sentido, estudios previos han sugerido que la alianza terapéutica entre el participante y el coordinador no sólo es capaz de modificar su procesamiento cognitivo, sino también su estado afectivo y su conducta (Brown y O'Leary, 2000; Romero-Martínez et al., 2016). Por otra parte, encontramos una relación positiva y significativa entre la alianza terapéutica y el estadio de cambio. Taft et al. (2004) encontraron resultados similares, empleando medidas informadas por el participante y el terapeuta.

Dado que la alianza terapéutica es un elemento clave en los programas de intervención con maltratadores y, en general, con poblaciones resistentes a la intervención, la disponibilidad de una medida observacional de este constructo como el WAI-O-S supone una herramienta útil para superar las limitaciones de los autoinformes en lo que respecta a la deseabilidad social, y la tendencia a mentir, negar o minimizar la conducta violenta de esta población.

Las estrategias motivacionales pueden contribuir en la construcción de una alianza terapéutica sólida y promover las conductas pro-terapéuticas en la intervención con maltratadores. Sin embargo, existen escasos estudios que hayan analizado esta relación. Por ese motivo, en el tercer estudio de la tesis realizamos un RCT, comparando una

intervención que incluía estrategias motivacionales (SBIP + IMP) frente a una intervención sin estas estrategias (SBIP) con maltratadores. Los resultados mostraron que la inclusión de estrategias motivacionales en la intervención con maltratadores favorece la alianza terapéutica entre los coordinadores y los participantes, así como las conductas pro-terapéuticas de los participantes.

En concreto, los resultados del tercer estudio de la presente tesis doctoral mostraron que tanto la alianza terapéutica general como las puntuaciones de las subescalas 'acuerdo' y 'vínculo' aumentaron significativamente a lo largo de la intervención en ambas condiciones de intervención, y fueron significativamente superiores en la condición SBIP+ IMP, tanto al inicio como al final de la intervención. Nuestros hallazgos sugieren que la utilización de estrategias motivacionales favorece el establecimiento de acuerdos sobre las tareas y objetivos de la intervención entre los participantes y los coordinadores. Alcanzar estos acuerdos supone un reto en la intervención con maltratadores, debido a su tendencia a no reconocer los actos de violencia por los que han sido condenados (Flinck y Paavilainen, 2018; Lila et al., 2014; Martín-Fernández et al., 2018; Murphy y Maiuro, 2009; Weber et al., 2019). Por ejemplo, habitualmente no reconocen que su ira es problemática, y tienden a atribuir la responsabilidad de sus actos violentos a sus parejas o al sistema legal, defendiendo que han sido tratados de manera injusta (DiGiuseppe et al., 1994; Murphy y Maiuro, 2009; Vitoria-Estruch et al., 2017). Además, como se ha indicado anteriormente, muchos de estos hombres asisten al programa de intervención por mandato judicial o inician la intervención como resultado de presiones externas (Daly y Pelowski, 2000; Velonis et al., 2016). Las estrategias motivacionales podrían superar algunas de estas dificultades mediante el establecimiento de un entorno de colaboración, así como ayudar a los participantes a establecer sus propios objetivos mediante la exploración de los beneficios

potenciales del cambio (Lee et al., 2014; Miller y Rollnick, 2002). Respecto al vínculo, Safran y Muran (2000) destacaron la importancia de que los participantes confíen en la habilidad de los coordinadores para ayudarles a lo largo de la intervención. La aceptación de las resistencias de los participantes como parte del proceso de cambio es uno de los principios básicos de las estrategias motivacionales (Murphy y Maiuro, 2009). Esta actitud de aceptación de las resistencias y de apoyo a la autoeficacia del participante facilita y fortalece el vínculo entre coordinadores y participantes.

En cuanto a las conductas pro-terapéuticas, nuestros hallazgos mostraron que la asunción de responsabilidad fue significativamente mayor en la condición SBIP + IMP tanto al inicio como al final de la intervención. Los participantes de la condición SBIP + IMP reconocieron con mayor frecuencia dentro del grupo su responsabilidad por la conducta violenta ejercida, las consecuencias de esta conducta y la necesidad de un cambio personal para evitar cometer actos violentos en el futuro. Este incremento en la asunción de responsabilidad de los participantes podría explicarse por el carácter no confrontacional, no enjuiciador y de escucha empática de las estrategias motivacionales (Musser et al., 2008; Taft y Murphy, 2007). De hecho, la entrevista motivacional pretende que los participantes se sientan aceptados a pesar de presentar algunas conductas inaceptables (Murphy y Maiuro, 2009). Respecto al rol comportamental al inicio de la intervención, los participantes del grupo SBIP + IMP presentaron significativamente mayores esfuerzos por ayudar a otros miembros del grupo a cambiar y a asumir la responsabilidad de su conducta. Por ejemplo, los participantes del grupo SBIP + IMP confrontaron con mayor frecuencia los comentarios de otros miembros del grupo relacionados con la culpabilización de la víctima o del sistema legal, y reforzaron más frecuentemente la asunción de responsabilidad de otros miembros del grupo (Gracia, 2014; Henning y Holdford, 2006; Lila et al., 2014; Martín-Fernández et al., 2018).

Respecto a la valoración del grupo, los participantes de la condición SBIP + IMP realizaron con mayor frecuencia valoraciones positivas del grupo y de la intervención en general, tanto al inicio como al final de ésta.

Nuestros resultados destacan la importancia de incluir estrategias motivacionales en la intervención con maltratadores a fin de incrementar la alianza terapéutica entre coordinadores y participantes y las conductas pro-terapéuticas grupales. Este estudio supone un avance en la literatura previa en este campo (Musser et al., 2008) al menos en tres aspectos. En primer lugar, en nuestro estudio, las estrategias motivacionales se implementaron a lo largo de todo el programa de intervención, mientras que ha existido una tendencia en la literatura previa a aplicar estas estrategias únicamente antes de la intervención. Sin embargo, como mostró el primer estudio de la presente tesis doctoral, una aplicación más extensa de las estrategias motivacionales puede conducir a ganancias más duraderas. Esta idea también se apoya en la investigación previa sobre otras intervenciones de cambio de comportamiento. Por ejemplo, una revisión sistemática de la eficacia de las entrevistas motivacionales sobre el abuso de sustancias, el juego patológico, los comportamientos relacionados con la salud y la adherencia a la intervención mostró una asociación positiva entre la dosis de intervención motivacional y su eficacia (Lundahl et al., 2010). En segundo lugar, en nuestro estudio evaluamos la alianza terapéutica y las conductas proterapéuticas empleando una metodología observacional mediante observadores externos. Esta aproximación metodológica permite evitar los posibles sesgos en los informes de los coordinadores (Bennet, 2007; Gracia et al., 2015) y superar las limitaciones que tienen los autoinformes con esta población (i.e., deseabilidad social), que han sido descritas en apartados anteriores de la presente tesis. En tercer lugar, los coordinadores de este estudio fueron psicólogos con al menos dos años de experiencia en intervención con maltratadores, y esto podría ser un factor

relevante en la calidad de las estrategias motivacionales implementadas (Hamel et al., *in press*).

2. Implicaciones prácticas

Los resultados de la presente tesis tienen implicaciones prácticas. En primer lugar, nuestros hallazgos suponen un avance respecto a la investigación previa sobre la eficacia de las estrategias motivacionales en los programas de intervención con maltratadores. En concreto, encontramos que la inclusión de estrategias motivacionales favorece una mayor dosis de intervención recibida y un menor abandono de la intervención, y mejora procesos clave de la intervención (i.e., alianza terapéutica y conductas proterapéuticas), incrementando, por tanto, su eficacia. Dado que las altas tasas de abandono de la intervención en maltratadores se han asociado a mayor reincidencia (Jewell y Wormith, 2010; Lila et al., 2019,2020; Olver et al., 2011; Stoops et al., 2010) y la alianza terapéutica y las conductas proterapéuticas se han relacionado con una disminución de la violencia contra la pareja (Brown y O'Leary, 2000; Semiatin et al., 2013), nuestros hallazgos pueden favorecer la optimización de protocolos de intervención en esta población. En segundo lugar, los resultados de la tesis permiten establecer recomendaciones para futuros RCTs en el marco de los programas de intervención con maltratadores. En este sentido, es recomendable establecer períodos de seguimiento de al menos seis meses para evaluar adecuadamente la persistencia de los cambios (Alexander et al., 2010; Soleymani et al., 2018), así como indicar de forma precisa el inicio del período de seguimiento. A su vez, es necesaria una clara definición del criterio de abandono de la intervención, indicando el número de participantes que han abandonado la intervención antes de su finalización en lugar de establecer un porcentaje arbitrario de participación como criterio. Además, una manera de fortalecer la validez de estas intervenciones sería la triangulación de datos, incluyendo información de diferentes fuentes (i.e., autoinformes, informes de las víctimas

y registros oficiales). En tercer lugar, los resultados de nuestra validación han mostrado que el WAI-O-S cuenta con propiedades psicométricas adecuadas, por lo que podría utilizarse para evaluar la alianza terapéutica mediante observadores externos en programas de intervención con maltratadores, permitiendo evaluar el impacto de las relaciones entre el coordinador y el participante sobre otros resultados de la intervención.

3. Limitaciones generales

En esta sección se presentan algunas limitaciones generales que deben ser consideradas para interpretar y generalizar adecuadamente los resultados de esta tesis doctoral.

En primer lugar, en el meta-análisis realizado únicamente se incluyeron RCTs. Aunque este tipo de estudios representan el estándar de calidad para la comparación de la eficacia de diferentes intervenciones (Lilienfeld et al., 2018), su realización en el ámbito de la intervención con maltratadores puede conllevar dificultades (Lilley-Walker et al., 2018), lo que explicaría el bajo número de RCTs encontrados. En segundo lugar, cabe señalar ciertas consideraciones respecto a las medidas utilizadas (i.e., reincidencia recogida en registros oficiales y violencia contra la pareja informada por el agresor). Aunque los arrestos son la medida más objetiva de violencia contra la mujer en las relaciones de pareja y el indicador de reincidencia más utilizado (Babcock et al., 2004; Gondolf, 2004; López-Ossorio et al., 2016), cabe considerar que son eventos de baja frecuencia, lo que podría subestimar la frecuencia de actos de violencia (Velonis et al., 2016), limitando la potencia del meta-análisis en lo que respecta a esta variable. Por otra parte, los autoinformes de violencia física y psicológica contra la pareja pueden estar influenciadas por las distorsiones de los participantes y su deseabilidad social (Eckhardt et al., 2012; Gracia et al., 2015). En tercer lugar, en los estudios 2 y 3 de la presente tesis doctoral, la muestra estaba formada por hombres penados por violencia de pareja que

fueron remitidos por mandato judicial a un programa de intervención en España. Por tanto, los resultados de estos estudios no podrían extrapolarse a otras poblaciones como maltratadores en prisión, hombres que acuden voluntariamente a la intervención u otros grupos culturales (Boira et al., 2016; Lila et al., 2016; Vargas et al., 2015).

4. Líneas de investigación futuras

A partir de los diferentes estudios presentados en esta tesis, se plantean nuevas cuestiones de interés.

En primer lugar, en relación a las limitaciones planteadas en el apartado anterior, sería interesante recoger información de diferentes fuentes para evaluar la eficacia de la intervención sobre la reducción de la violencia contra la mujer en las relaciones de pareja (i.e., autoinformes, informes de las víctimas y registros oficiales). En segundo lugar, nuestros resultados muestran que la inclusión de estrategias motivacionales en la intervención con maltratadores reduce el abandono de la intervención, incrementando la adherencia a la misma, y favorece la alianza terapéutica y las conductas pro-terapéuticas. Futuros estudios deberían explorar si la alianza terapéutica y las conductas pro-terapéuticas median la relación entre el tipo de intervención y los resultados de la intervención (i.e., dosis de intervención recibida, abandono de la intervención, violencia contra la pareja o expareja). Finalmente, aunque en nuestro estudio de validación del WAI-O-S empleamos una aproximación bayesiana para evaluar la estructura externa de la escala. Futuros estudios deberían evaluar el ajuste del modelo a los datos con muestras más amplias.

5. Conclusiones generales

Considerados conjuntamente, los resultados de la presente tesis doctoral ponen de manifiesto los beneficios de la inclusión de estrategias motivacionales en programas de intervención con maltratadores en la adherencia a la intervención, la reducción del abandono de ésta y procesos clave de la intervención como son la alianza terapéutica y las conductas pro-terapéuticas. En concreto, la inclusión de estrategias motivacionales a lo largo de todo el programa de intervención podría favorecer la estabilización de estos beneficios a largo plazo frente al uso de estrategias motivacionales de forma puntual. En comparación con un enfoque más coercitivo, las estrategias motivacionales podrían ayudar a los maltratadores a superar su ambivalencia hacia el cambio, ayudándoles a encontrar sus propias razones para cambiar y facilitando la consecución de sus objetivos y, en última instancia, incrementando la eficacia de los programas de intervención con maltratadores.

6. General conclusions

Taking together, the results of this doctoral thesis highlight the benefits of including motivational strategies in IPV offender programs in order to improve the adherence to the intervention, the reduction of dropout, and key processes of the intervention such as working alliance and pro-therapeutic behaviors. Specifically, the inclusion of motivational strategies throughout the intervention program could favor the stabilization of these benefits in the long term as opposed to the sporadic use of these strategies. Compared to a more coercive approach, motivational strategies may help batterers overcome their ambivalence towards change by helping them find their own reasons for change and facilitating the achievement of their goals, and ultimately increasing the effectiveness of IPV offender programs.

FINANCIACIÓN

El autor de esta Tesis doctoral es beneficiario del programa FPU del Ministerio de Ciencia e Innovación (FPU15/00864).

Los estudios presentados en esta Tesis han sido financiados por el Ministerio de Economía y Competitividad de España (PSI2011-25434 y PSI2010-21334), por el Plan Nacional de drogas del Ministerio de Salud, Consumo y Asuntos Sociales (PND2018/021).

Esta Tesis se ha realizado en el marco de un convenio de colaboración entre la Secretaría General de Instituciones Penitenciarias del Ministerio del Interior y la Universitat de València.

REFERENCES

Adams, D. (1989). Feminist-based interventions for battering men. In L. Caesar, & K. Hamberger (Eds.), *Treating men who batter: theory, practice and programs* (pp. 3–23). Springer. http://www.ncjrs.gov/App/publications/abstract.aspx?ID=121632

Agencia de los Derechos Fundamentales de la Unión Europea. (2014). *Violence against women: an EU-wide survey*. https://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report

Alexander, P. C., Morris, E., Tracy, A., & Frye, A. (2010). Stages of change and the group treatment of batterers: a randomized clinical trial. *Violence and Victims*, *25*(5), 571-587. https://doi.org/10.1891/0886-6708.25.5.571

Ando, T. (2011). Predictive Bayesian model selection. *American Journal of Mathematical and Management Sciences*, *31*(1), 13-38. http://dx.doi.org/10.1080/01966324.2011.10737798

Andrade-González, N., & Fernández-Liria, A. (2015). Spanish adaptation of the Working Alliance Inventory (WAI). Psychometric properties of the patient and therapist forms (WAI-P and WAI-T). *Annals of Psychology*, *31*(2), 524-533. https://doi.org/10.6018/analesps.31.2.177961

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, *17*(1), 19-52. https://doi.org/10.1177/0093854890017001004

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The risk-need responsivity model: Does the Good Lives Model contribute to effective crime prevention? *Criminal*

Justice and Behavior, 38(7), 735–755. https://doi.org/10.1177/0093854811406356

Andrusyna, T. P., Tang, T. Z., DeRubeis, R. J., & Luborsky, L. (2001). The factor structure of the Working Alliance Inventory in cognitive-behavioral therapy. *The Journal of Psychotherapy Practice and Research*, *10*(3), 173-178.

Arce, R., Arias, E., Novo, M., & Fariña, F. (2020). Are interventions with batterers effective? A meta-analytical review. *Psychosocial Intervention, 29*(3), 153-164. https://doi.org/10.5093/pi2020a11

Arias, E., Arce, R., & Vilariño, M. (2013). Batterer intervention programmes: a meta-analytic review of effectiveness. *Psychosocial Intervention*, *22*, 153-160. http://dx.doi.org/10.5093/in2013a18

Asparouhov, T., & Muthén, B. (2010*). Bayesian analysis using Mplus: technical implementation*. http://statmodel2.com/download/Bayes3.pdf

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, *23*(8), 1023-1053. https://doi.org/10.1016/j.cpr.2002.07.001

Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., Cantos, A., Hamel, J., Kelly, D., Jordan, C., & Lehmann, P. (2016). Domestic violence perpetrator programs: a proposal for evidence-based standards in the United States. *Partner Abuse*, *7*(4), 355-460. https://doi.org/10.1891/1946-6560.7.4.355

Babor, T. F., Steinberg, K., Anton, R. A. Y., & Del Boca, F. (2000). Talk is cheap: Measuring drinking outcomes in clinical trials. *Journal of Studies on Alcohol and Drugs*, *61*(1), 55-63. https://doi.org/10.15288/jsa.2000.61.55

Banks, J. C., Kini, S., & Babcock, J. C. (2013). Interventions that work to stop intimate partner violence. In L. A. Craig, T. A. Gannon, & L. Dixon (Eds.), *What works in offender rehabilitation: an evidence-based approach to assessment and treatment*. Wiley. https://onlinelibrary.wiley.com/doi/abs/10.1002/9781118320655#page=179

Barner, J. R., & Carney, M. M. (2011). Interventions for intimate partner violence: a historical review. *Journal of Family Violence*, *26*, 235-244. https://doi.org/10.1007/s10896-011-9359-3

Bazargan-Hejazi, S., Kim, E., Lin, J., Ahmadi, A., Khamesi, M. T., & Teruya, S. (2014). Risk factors associated with different types of intimate partner violence (IPV): an emergency department study. *The Journal of Emergency Medicine*, *47*(6), 710-720. https://doi.org/10.1016/j.jemermed.2014.07.036

Begun, A. L., Murphy, C., Bolt, D., Weinstein, B., Strodthoff, T., Short, L., & Shelley, G. (2003). Characteristics of the Safe at Home instrument for assessing readiness to change intimate partner violence. *Research on Social Work Practice*, *13*(1), 80-107. https://doi.org/10.1177/1049731502238758

Bennett, L. W., Stoops, C., Call, C., & Flett, H. (2007). Program completion and re-arrest in a batterer intervention system. *Research on Social Work Practice*, *17*(1), 42-54. https://doi.org/10.1177/1049731506293729

Bland, J. M., & Altman, D. G. (2000). Statistics notes: the odds ratio. *BMJ*, *320*, 1468. https://doi.org/10.1136/bmj.320.7247.1468

Boira, S., Carbajosa, P., & Méndez, R. (2016). Fear, conformity and silence. Intimate partner violence in rural areas of Ecuador. *Psychosocial Intervention*, *25(1)*, 9-17. http://dx.doi.org/10.1016/j.psi.2015.07.008

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252-260. https://doi.org/10.1037/h0085885

Bowen, E. (2011) *The rehabilitation of partner-violent men.* Wiley-Blackwell. https://onlinelibrary.wiley.com/doi/book/10.1002/9780470978603

Bowen, E., Gilchrist, E. A., & Beech, A. R. (2005). An examination of the impact of community-based rehabilitation on the offending behaviour of male domestic violence offenders and the characteristics associated with recidivism. *Legal and Criminological Psychology*, *10*, 189-209. https://doi.org/10.1348/135532505X36778

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, 68*(2)*,340-345. http://dx.doi.org/10.1037/0022-006X.68.2.340

Brown, P. D., & O'Leary, K. D. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology*, *68*(2), 340-345. https://doi.org/10.10.V7//0022-006X.68 2.340

Browne, K. O., Saunders, D. G., & Staecker, K. M. (1997). Process-psychodynamic groups for men who batter: a brief treatment model. *Families in Society*, *78*(3), 265-271. https://doi.org/10.1606/1044-3894.774

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*, 1331-1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Carbajosa, P., Catalá-Miñana, A., Lila, M., Gracia, E., & Boira, S. (2017). Responsive versus treatment-resistant perpetrators in batterer intervention programs: personal characteristics and stages of change. *Psychiatry, Psychology and Law*, *24*(6), 936-950. https://doi.org/10.1080/13218719.2017.1347933

Casanueva, C., Martin, S. L., & Runyan, D. K. (2009). Repeated reports for child maltreatment among intimate partner violence victims: Findings from the national survey of child and adolescent well-being. *Child Abuse & Neglect*, *33*, 84-93. https://doi.org/10.1016/j.chiabu.2007.04.017

Catalá-Miñana, A., Lila, M., & Oliver, A. (2013). Consumo de alcohol en hombres penados por violencia contra la pareja: factores individuales y contextuales. *Adicciones*, 25, 19-28.

Cheng, S. Y., Davis, M., Jonson-Reid, M., & Yaeger, L. (2019). Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma, Violence, & Abuse*, 1-16. https://doi.org/10.1177/1524838019865927

Chermack, S. T., Bonar, E. E., Ilgen, M. A., Walton, M. A., Cunningham, R. M., Booth, B. M., & Blow, F. C. (2017). Developing an integrated violence prevention for men and women in treatment for substance use disorders. *Journal of Interpersonal Violence*, *32*(4), 581-603. https://doi.org/10.1177/0886260515586369

Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment*, *6*(4), 284-290. http://dx.doi.org/10.1037/1040-3590.6.4.284

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Erlbaum. https://www.utstat.toronto.edu/~brunner/oldclass/378f16/readings/CohenPower.pdf

Connors, G. J., DiClemente, C. C., Dermen, K. H., Kadden, R., Car-roll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*, *61*(1), 139-149. http://dx.doi.org/10.15288/jsa.2000.61.139

Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology*, *60*(2), 180-187. https://doi.org/10.1037/a0032178

Daly, J. E., & Pelowski, S. (2000). Predictors of dropout among men who batter: a review of studies with implications for research and practice. *Violence and Victims*, *15*(2), 137-160. https://doi.org/10.1891/0886-6708.15.2.137

Davis, R. C., & Taylor, B. G. (1999). Does batterer treatment reduce violence? A synthesis of the literature. *Women & Criminal Justice*, *10*(2), 69-93. https://doi.org/10.1300/J012v10n02_05

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: a restricted-maximum likelihood meta-analysis. *Clinical Psychology Review*, *32*, 642-649. https://doi.org/10.1016/j.cpr.2012.07.002

Devries, K. M., Mak, J. Y. T., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, C., Pallitto, T., Vos, T., Abrahams, N., Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science*, *340*, 1527-1528. https://doi.org/10.1126/science.1240937

DiGiuseppe, R., Tafrate, R., & Eckhardt, C. (1994). Critical issues in the treatment of anger. *Cognitive and Behavioral Practice*, *1*(1), 111-132. https://doi.org/10.1016/S1077-7229(05)80089-6

Dobash, R. E., & Dobash, R. P. (2000). Evaluating criminal justice interventions for domestic violence. *Crime & Delinquency*, *46*(2), 252-270. https://doi.org/10.1177/0011128700046002007

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, *4*(2), 196-231. https://doi.org/10.1891/1946-6560.4.2.196

Eckhardt, C. I., Samper, R., Suhr, L., & Holtzworth-Munroe, A. (2012). Implicit attitudes toward violence among male perpetrators of intimate partner violence: a preliminary investigation. *Journal of Interpersonal Violence*, *27*, 471-491. https://doi.org/10.1177/0886260511421677

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & García-Moreno, C. (2008). Intimate partner violence and women´s physical and mental health in the WHO multi-country study on women´s health and domestic violence: an observational study. *The Lancet*, *371*, 1165- 1172. https://doi.org/10.1016/S0140-6736(08)60522-X

Falkenström, F., Hatcher, R. L., & Holmqvist, R. (2015). Confirmatory factor analysis of the patient version of the Working Alliance Inventory-Short Form Revised. *Assessment*, *22*(5),581-593. http://dx.doi.org/10.1177/1073191114552472

Feder, L., & Dugan, L. (2002). A test of the efficacy of court-mandated counseling for domestic violence offenders: The Broward experiment. *Justice Quartely*, *19*(2), 343-375. https://doi.org/10.1080/07418820200095271

Feder, L., & Wilson, D. B. (2005). A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior? *Journal of Experimental Criminology*, *1*, 239-262. https://doi.org/10.1007/s11292-005-1179-0

Ferrer-Perez, V. A., Ferreiro-Basurto, V., Navarro-Guzmán, C. & Bosch-Fiol, E. (2016). Programas de intervención con maltratadores en España: la perspectiva de los/as profesionales. *Psychosocial Intervention*, *25*, 159-168. http://dx.doi.org/10.1016/j.psi.2016.06.001

Flinck, A., & Paavilainen, E. (2008). Violent behavior of men in their intimate relationships, as they experience it. *American Journal of Men's Health*, *2*(3), 244-253. https://doi.org/10.1177/1557988308321674

Franklin, C. A., & Kercher, G. A. (2012). The intergenerational transmission of intimate partner violence: Differentiating correlates in a random community sample. *Journal of Family Violence*, *27*, 187-199. https://doi.org/10.1007/s10896-012-9419-3

Freud, S. (1913/1966). On beginning the treatment. In J. Strachey (Eds.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 123–

144). Hogarth Press. https://www.worldcat.org/title/standard-edition-of-the-complete-psychological-works-of-sigmund-freud/oclc/9091183

Gelman, A., Carlin, J. B., Stern, H. S., Dunson, D. B., Vehtari, A., & Rubin, D. B. (2014). *Bayesian data analysis* (3th ed.). CRC Press. http://www.stat.columbia.edu/~gelman/book/

Gondolf, E. W. (1987). Evaluating programs for men who batter: Problems and prospects. *Journal of Family Violence*, *2*(1), 95-108. https://doi.org/10.1007/BF00976373

Gondolf, E. W. (2004). Evaluating batterer counseling programs: A difficult task showing some effects and implications. *Aggression and Violent Behavior*, *9*(6), 605-631. https://doi.org/10.1016/j.avb.2003.06.001

Gracia, E. (2014). Intimate partner violence against women and victim-blaming attitudes among Europeans. *Bulletin of the World Health Organization*, *92*, 380-381. https://doi.org/10.2471/BLT.13.131391

Gracia, E., Rodriguez, C. M., & Lila, M. (2015). Preliminary evaluation of an analog procedure to assess acceptability of intimate partner violence against women: The partner violence acceptability movie task. *Frontiers in Psychology*, *6*, 1-7. https://doi.org/10.3389/fpsyg.2015.01567

Grigorian, H. L., Brem, M. J., Garner, A., Florimbio, A. R., Wolford-Clevenger, C., & Stuart, G. L. (2020). Alcohol use and problems as a potential mediator of the relationship between emotion dysregulation and intimate partner violence perpetration. *Psychology of Violence*, *10*(1), 91–99. https://doi.org/10.1037/vio0000237

Guedes, A., Bott, S., Garcia-Moreno, C., & Colombini, M. (2016). Bridging the gaps: A global review of intersections of violence against women and violence against children. *Global Health Action*, *9*, 1-15. https://doi.org/10.3402/gha.v9.31516

Haggård, U., Freij, I., Danielsson, M., Wenander, D., & Långström, N. (2017). Effectiveness of the IDAP treatment program for male perpetrators of intimate partner violence: a controlled study of criminal recidivism. *Journal of Interpersonal Violence*, *32*(7), 1027-1043. https://doi.org/10.1177/0886260515586377

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse & Neglect*, *34*, 734-741. https://doi.org/10.1016/j.chiabu.2010.03.001

Hamel, J., Cannon, C., Buttell, F., & Ferreira, R. (in press). A survey of IPV perpetrator treatment providers: Ready for evidence-based practice? *Partner Abuse*. https://domesticviolenceintervention.net/wp-content/uploads/2020/02/Hamel_etal.2019Survey.pdf

Heckert, D. A., & Gondolf, E. W. (2000). Assessing assault self-reports by batterer program participants and their partners. *Journal of Family Violence*, *15*, 181-197. https://doi.org/10.1023/A:1007594928605

Henning, K., & Holdford, R. (2006). Minimization, denial, and victim blaming by batterers: How much does the truth matter? *Criminal Justice and Behavior*, *33*(1), 110-130. https://doi.org/10.1177/0093854805282322

Higgins, J. P., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D., Savovic, J., Schulz, K. F., Weeks, L., & Sterne, J. A. C. (2011). The Cochrane

Collaboration's tool for assessing risk of bias in randomised trials. *BMJ*, *343*, 1-12. https://doi.org/10.1136/bmj.g1687

Higgins, J. P., Thompson, S. G., Deeks, J. J., & Altman, D. G. (2003). Measuring inconsistency in meta-analyses. *BMJ*, *327*, 557-560. https://doi.org/10.1136/bmj.327.7414.557

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84-135). Wiley. https://www.wiley.com/en-us/Bergin+and+Garfield%27s+Handbook+of+Psychotherapy+and+Behavior+Change%2C+6th+Edition-p-9781118038208

Hoffmann, T.C., Glasziou, P.P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D.G., Barbour, V., Macdonald, H., Johnston, M., Lamb, S. E., Dixon-Woods, M., McCulloch, P., Wyatt, J. C., Chan, A., & Michie, S. (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, 348. https://doi.org/10.1136/bmj.g1687

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233. https://doi.org/10.1037/0022-0167.36.2.223

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139-149. https://doi.org/10.1037/0022-0167.38.2.139

Jennings, J. L. (1987). History and issues in the treatment of battering men: A case for unstructured group therapy. *Journal of Family Violence*, *2*(3), 193-213. https://doi.org/10.1007/BF00976539

Jewell, L. M., & Wormith J. S. (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers: A meta-analysis. *Criminal Justice and Behavior*, *37*(10), 1086-1113. https://doi.org/10.1177/0093854810376815

Kerley, K. R., Xu, X., Sirisunyaluck, B., & Alley, J. M. (2010). Exposure to family violence in childhood and intimate partner perpetration or victimization in adulthood: Exploring intergenerational transmission in urban Thailand. *Journal of Family Violence*, *25*, 337-347. https://doi.org/10.1007/s10896-009-9295-7

Kwong, M. J., Bartholomew, K., Henderson, A. J., & Trinke, S. J. (2003). The intergenerational transmission of relationship violence. *Journal of Family Psychology*, *17*(3), 288-301. https://doi.org/10.1037/0893-3200.17.3.288

Labriola, M., Rempel, M., & Davis, R. C. (2008). Do batterer programs reduce recidivism? Results from a randomized trial in the Bronx. *Justice Quarterly*, *25*(2), 252-282. https://doi.org/10.1080/07418820802024945

Lee, M. Y., Uken, A., & Sebold, J. (2004). Accountability for change: Solution-focused treatment with domestic violence offenders. *Families in Society*, *85*(4), 463-476. https://doi.org/10.1177/104438940408500405

Lee, M. Y., Uken, A., & Sebold, J. (2014). Self-determined goals and treatment of domestic violence offenders: What if we leave it up to them? *Partner Abuse*, *5*(3), 239-258. http://doi.org/10.1891/1946-6560.5.3.239

Lee, S. Y., & Song, X. Y. (2004). Evaluation of the Bayesian and maximum likelihood approaches in analyzing structural equation models with small sample sizes. *Multivariate Behavioral Research*, *39*(4), 653-686. http://dx.doi.org/10.1207/s15327906mbr3904_4

Lila, M., Gracia, E., & Catalá-Miñana, A. (2018). Individualized motivational plans in batterer intervention programs: a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *86*(4), 309-320. http://dx.doi.org/10.1037/ccp0000291

Lila, M., Gracia, E., & Catalá-Miñana, A. (2020). More likely to dropout, but what if they don't? Partner violence offenders with alcohol abuse problems completing batterer intervention programs. *Journal of Interpersonal Violence*, *35*(9), 1958-1981. https://doi.org/10.1177/0886260517699952

Lila, M., Gracia, E., & Murgui, S. (2013). Psychological adjustment and victim-blaming among intimate partner violence offenders: the role of social support and stressful life events. *The European Journal of Psychology Applied to Legal Context*, *5*(2), 147-153. http://dx.doi.org/10.5093/ejpalc2013a4

Lila, M., Gracia, E., Catalá-Miñana, A., Santirso, F. A., & Romero-Martínez, Á. (2016). Alcohol abuse in Latin American immigrants participating in intervention programs for abusers: the importance of adherence to treatment. *Universitas Psychologic*a, *15*(4),1-16. http://dx.doi.org/10.11144/Javeriana.upsy15-4.caai

Lila, M., Martín Fernández, M., Gracia, E., López Ossorio, J. J., & González, J. L. (2019). Identifying key predictors of recidivism among offenders attending a batterer intervention program: a survival analysis. *Psychosocial Intervention*, *28*(3), 157-167. https://doi.org/10.5093/pi2019a19

Lila, M., Oliver, A., Catalá-Miñana, A., Galiana, L., & Gracia, E. (2014). The Intimate Partner Violence Responsibility Attribution Scale (IPVRAS). *European Journal of Psychology Applied to Legal Context*, *6*(1), 29-36. https://doi.org/10.5093/ejpalc2014a4

Lilienfeld, S. O., McKay, D., & Hollon, S. D. (2018). Why randomized controlled trials of psychological treatments are still essential. *The Lancet Psychiatry*, *5*(7), 536-538. https://doi.org/10.1016/S2215-0366(18)30045-2

Lilley-Walker, S. J., Hester, M., & Turner, W. (2018). Evaluation of European domestic violence perpetrator programmes: Toward a model for designing and reporting evaluations related to perpetrator treatment interventions. *International Journal of Offender Therapy and Comparative Criminology*, *62*(4), 868-884. https://doi.org/10.1177/0306624X16673853

López-Ossorio, J. J., González-Álvarez, J. L., & Andrés-Pueyo, A. (2016). Eficacia predictiva de la valoración policial del riesgo de la violencia de género. *Psychosocial Intervention*, *25*(1), 1-7. https://doi.org/10.1016/j.psi.2015.10.002

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137-160. https://doi.org/10.1177/1049731509347850

Maiuro, R. D. y Eberle, J. A. (2008). State standards for domestic violence perpetrator treatment: current status, trends, and recommendations. *Violence and Victims*, *23*, 133-155. https://10.1891/0886-6708.23.2.133

Mankowski, E. S., Haaken, J., & Silvergleid, C. S. (2002). Collateral damage: An analysis of the achievements and unintended consequences of batterer intervention

programs and discourse. *Journal of Family Violence*, *17*(2), 167-184. https://doi.org/10.1023/A:1015061517888

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438-450. https://doi.org/10.1037//0022-006X.68.3.438

Martín-Fernández, M., Gracia, E., Marco, M., Vargas, V., Santirso, F. A., & Lila, M. (2018). Measuring acceptability of intimate partner violence against women: Development and validation of the A-IPVAW scale. *European Journal of Psychology Applied to Legal Context*, *10*(1), 26-34. https://doi.org/10.5093/ejpalc2018a3

Maxwell, C. D. (2005). Prosecuting domestic violence. *Criminology & Public Policy*, *4*(3), 527-534. https://doi.org/10.1111/j.1745-9133.2005.00311.x

Mbilinyi, L. F., Neighbors, C., Walker, D. D., Roffman, R. A., Zegree, J., Edleson, J., & O'Rourke, A. (2011). A telephone intervention for substance-using adult male perpetrators of intimate partner violence. *Research on Social Work Practice*, *21*(1), 43-56. https://doi.org/10.1177/1049731509359008

Mennicke, A. M., Tripodi, S. J., Veeh, C. A., Wilke, D. J., & Kennedy, S. C. (2015). Assessing attitude and reincarceration outcomes associated with in-prison domestic violence treatment program completion. *Journal of Offender Rehabilitation*, *54*(7), 465-485. https://doi.org/10.1080/10509674.2015.1076103

Miles-McLean, H. A., LaMotte, A. D., Semiatin, J. N., Farzan-Kashani, J., Torres, S., Poole, G. M., & Murphy, C. M. (2019). PTSD as a predictor of treatment

engagement and recidivism in partner abusive men. *Psychology of Violence*, *9*(1), 39-47. http://dx.doi.org/10.1037/vio0000161

Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*, *11*, 147-172.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). Guilford Press. https://www.guilford.com/books/Motivational-Interviewing/Miller-Rollnick/9781609182274

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Altman, D. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*, *339*, 1-8. https://doi.org/10.1136/bmj.b2535

Morrel, T. M., Elliott, J. D., Murphy, C. M., & Taft, C. T. (2003). Cognitive behavioral and supportive group treatments for partner-violent men. *Behavior Therapy*, *34*, 77-95. https://doi.org/10.1016/S0005-7894(03)80023-0

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., &Barth, J. (2010). Working Alliance Inventory-Short Revised(WAI-SR): psychometric properties in outpatients and inpatients. *Clinical Psychology and Psychotherapy*, *17*(3), 231-239. https://doi.org/10.1002/cpp.658

Murphy, C. M. & Maiuro R. D. (2009). *Motivational interviewing and stages of change in intimate partner violence*. Springer. https://www.springerpub.com/motivational-interviewing-and-stages-of-change-in-intimate-partner-violence-9780826119773.html

Murphy, C. M., Ting, L. A., Jordan, L. C., Musser, P. H., Winters, J. J., Poole, G. M., & Pitts, S. C. (2018). A randomized clinical trial of motivational enhancement therapy for alcohol problems in partner violent men. *Journal of Substance Abuse Treatment*, *89*(1), 11-19. https://doi.org/10.1016/j.jsat.2018.03.004

Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims*, *23*(5), 539-557. https://doi.org/10.1891/0886-6708.23.5.539

Muthén, B., & Asparouhov, T. (2012). Bayesian structuralequation modeling: f more flexible representation of substantive theory. *Psychological Methods*, *17*(3), 313-335. https://doi.org/10.1037/a0026802

Muthén, L. K., & Muthén, B. O. (2010). *Mplus user's guide*. https://www.statmodel.com/download/usersguide/MplusUserGuideVer_8.pdf

Ogloff, J. R. P., & Davis, M. R. (2004). Advances in offender assessment and rehabilitation: Contributions of the risk–needs–responsivity approach. *Psychology, Crime & Law*, *10*(3), 229-242. https://doi.org/10.1080/10683160410001662735

Okuda, M., Olfson, M., Hasin, D., Grant, B. F., Lin, K., & Blanco, C. (2011). Mental health of victims of intimate partner violence: results from a national epidemiologic survey. *Psychiatric Services*, *62*(8), 959–962. http://dx.doi.org/10.1176/appi.ps.62.8.959

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, *79*(1), 6-21. https://doi.org/10.1037/a0022200

Organización mundial de la salud. (2005). *WHO Multi-country study on women's health and domestic violence against women. https://www.who.int/reproductivehealth/publications/violence/9241593512/en/*

Organización mundial de la salud. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

Palmer, S., Brown, R., & Barerra, M. (1992). Group treatment program for abusive husbands. *American Journal of Orthopsychiatry, 62*(2), 276–283. https://doi.org/10.1037/h0079336

Pence, E., & Paymar, M. (1993). *Education groups for men who batter. The Duluth model*. Springer Publishing Company. https://doi.org/10.1891/9780826179913

Piantadosi, S. (2017). *Clinical trials: a methodologic perspective* (3th ed.). Wiley. https://www.wiley.com/en-us/Clinical+Trials%3A+A+Methodologic+Perspective%2C+3rd+Edition-p-9781118959206

Pitts, W. J., Givens, E., & McNeeley, S. (2009). The need for a holistic approach to specialized domestic violence court programming: Evaluating offender rehabilitation needs and recidivism. *Juvenile and Family Court Journal*, *60*(3), 1-21. https://doi.org/10.1111/j.1755-6988.2009.01029.x

Pleck, E. H. (2004). *Domestic tyranny: The making of American social policy against family violence from colonial times to the present*. University of Illinois Press. https://www.press.uillinois.edu/books/catalog/87bwk5bk9780252029127.html

Polaschek, D. L. (2012). An appraisal of the risk–need–responsivity (RNR) model of offender rehabilitation and its application in correctional treatment. *Legal and Criminological Psychology*, *17*(1), 1-17. https://doi.org/10.1111/j.2044-8333.2011.02038.x

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*(3), 390-395. https://doi.org/10.1037/0022-006X.51.3.390

Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion*, *12*(1), 38-48. https://doi.org/10.4278/0890-1171-12.1.38

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist*, *47*(9), 1102-1114.

Rada, C. (2014). Violence against women by male partners and against children within the family: prevalence, associated factors, and intergenerational transmission in Romania, a cross-sectional study. *BMC Public Health*, *14*(1), 1-15. https://doi.org/10.1186/1471-2458-14-129

Romero-Martínez, Á., Lila, M., & Moya-Albiol, L. (2016). Testosterone and attention deficits as possible mechanisms underlying impaired emotion recognition in intimate partner violence perpetrators. *The European Journal of Psychology Applied to Legal Context*, *8*(2), 57-62. http://dx.doi.org/10.1016/j.ejpal.2016.01.001

Romero-Martínez, Á., Lila, M., & Moya-Albiol, L. (2019). The importance of impulsivity and attention switching deficits in perpetrators convicted for intimate partner violence. *Aggressive Behavior*, *45*(2), 129-138. https://doi.org/10.1002/ab.21802

Rondeau, G., Brodeur, N., Brochu, S., & Lemire, G. (2001). Dropout and completion of treatment among spouse abusers. *Violence and Victims*, *16*(2), 127-143. https://doi.org/10.1891/0886-6708.16.2.127

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: diversity and integration. *Journal of Clinical Psychology*, *56*(2), 233-243. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<233::AID-JCLP9>3.0.CO;2-3

Saunders, D. G. (2008). Group interventions for men who batter: A summary of program descriptions and research. *Violence and Victims*, *23*(2), 156-172. https://doi.org/10.1891/0886-6708.23.2.156

Schechter, S. (1982). *Women and male violence: the visions and struggles of the battered women´s movement.* South End Press. https://books.google.es/books/about/Women_and_Male_Violence.html?id=rVQrxDKihxwC&redir_esc=y

Scher, M., & Stevens, M. (1987). Men and violence. *Journal of Counseling & Development*, *65*, 351-355. https://doi.org/10.1002/j.1556-6676.1987.tb00729.x

Schumacher, J. A., Coffey, S. F., Stasiewicz, P. R., Murphy, C. M., Leonard, K. E., & Fals-Stewart, W. (2011). Development of a brief motivational enhancement intervention for intimate partner violence in alcohol treatment settings. *Journal*

of Aggression, Maltreatment & Trauma, *20*(2), 103-127. https://doi.org/10.1080/10926771.2011.546749

Schumacher, J. A., Feldbau-Kohn, S., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behavior*, *6*(2), 281–352. https://doi.org/10.1016/S1359-1789(00)00027-6

Scott, K. L. (2004). Stage of change as a predictor of attrition among men in a batterer treatment program. *Journal of Family Violence*, *19*(1), 37-47. https://doi.org/10.1023/B:JOFV.0000011581.01231.1e

Scott, K., Heslop, L., Kelly, T., & Wiggins, K. (2015). Intervening to prevent repeat offending among moderate-to high-risk domestic violence offenders: a second-responder program for men. *International Journal of Offender Therapy and Co mparative Criminology,* *59*(3), 273-294. https://doi.org/10.1177/0306624X13513709

Scott, K., King, C., McGinn, H., & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence*, *26*, 139-149. https://doi.org/10.1007/s10896-010-9353-1

Semiatin, J. N., Murphy, C. M., & Elliott, J. D. (2013). Observed behavior during group treatment for partner-violent men: Acceptance of responsibility and promotion of change. *Psychology of Violence*, *3*(2), 126-139. https://doi.org/10.1037/a0029846

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: a meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *47*(4), 637-645. https://doi.org/10.1037/a0021175

Snyder, D. K., & Scheer, N. S. (1981). Predicting disposition following brief residence at a shelter for battered women. *American Journal of Community Psychology, 9*(5), 559-566. https://doi.org/10.1007/BF00896476

Soleymani, S., Britt, E., & Wallace-Bell, M. (2018). Motivational interviewing for enhancing engagement in intimate partner violence (IPV) treatment: a review of the literature. *Aggression and Violent Behavior*, *40*, 119-127. https://doi.org/10.1016/j.avb.2018.05.005

Stoops, C., Bennett, L., & Vincent, N. (2010). Development and predictive ability of a behavior-based typology of men who batter. *Journal of Family Violence*, *25*(3), 325-335. https://doi.org/10.1007/s10896-009-9294-8

Stover, C. S. (2005). Domestic violence research: What have we learned and where do we go from here? *Journal of Interpersonal Violence*, *20*(4), 448-454. https://doi.org/10.1177/0886260504267755

Strunk, D. R., Brotman, M. A., & DeRubeis, R. J. (2010). The process of change in cognitive therapy for depression: predictors of early inter-session symptom gains. *Behaviour Research and Therapy*, *48*(7), 599-606. http://dx.doi.org/10.1016/j.brat.2010.03.011

Stuart, G. L., Shorey, R. C., Moore, T. M., Ramsey, S. E., Kahler, C. W., O'farrell, T. J., Strong, D., Temple, J. R., & Monti, P. M. (2013). Randomized clinical trial examining the incremental efficacy of a 90-minute motivational alcohol intervention as an adjunct to standard batterer intervention for men. *Addiction*, *108*(8), 1376-1384. https://doi.org/10.1111/add.12142

Stuart, G. L., Temple, J., & Moore, T. (2007). Improving batterer intervention programs through theory-based research. *Journal of the American Medical Association*, *298*(5), 560-562. https://doi.org/10.1001/ jama.298.5.560

Taft, C. T., & Murphy, C. M. (2007). The working alliance in intervention for partner violence perpetrators: recent research and theory. *Journal of Family Violence*, *22*, 11-18. https://doi.org/10.1007/s10896-006-9053-z

Taft, C. T., Murphy, C. M., Elliott, J. D., & Morrel, T. M. (2001). Attendance-enhancing procedures in group counseling for domestic abusers. *Journal of Counseling Psychology*, *48*(1), 51. https://doi.org/10.1037/0022-0167.48.1.51

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, *71*(4), 812-820. 10.1037/0022-006X.71.4.812

Taft, C. T., Murphy, C. M., Musser, P. H., & Remington, N. A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology*, *72*(2), 349 354. http://dx.doi.org/10.1037/0022-006X.72.2.349

Taylor, B. G., Davis, R. C., & Maxwell, C. D. (2001). The effects of a group batterer treatment program: a randomized experiment in Brooklyn. *Justice Quarterly*, *18*(1), 171-201. https://doi.org/10.1080/07418820100094861

Tichenor, V., & Hill, C. E. (1989). A comparison of six measures of working alliance. *Psychotherapy: Theory, Research, Practice, Training*, *26*(2), 195-199. https://doi.org/10.1037/h0085419

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(3), 207-210. https://doi.org/1040-3590/89/S00.75

Vargas, V., Lila, M., & Catalá-Miñana, A. (2015). Do cultural differences influence batterer intervention program outcomes? A study with Spanish and Latin American offenders. *Psychosocial Intervention*, *24*, 41-47. http://dx.doi.org/10.1016/j.psi.2015.03.001

Velonis, A. J., Cheff, R., Finn, D., Davloor, W., & O'Campo, P. (2016). Searching for the mechanisms of change: a protocol for a realist review of batterer treatment programmes. *BMJ Open*, *6*, 1-9. https://doi.org/10.1136/bmjopen-2015-010173

Vilariño, M., Amado, B. G., Vázquez, M. J., & Arce, R. (2018). Psychological harm in women victims of intimate partner violence: epidemiology and quantification of injury in mental health markers. *Psychosocial Intervention*, *27*(3), 145-152. https://doi.org/10.5093/pi2018a23

Vitoria-Estruch, S., Romero-Martínez, Á., Ruiz-Robledillo, N., Sariñana-González, P., Lila, M., & Moya-Albiol, L. (2017). The role of mental rigidity and alcohol consumption interaction on intimate partner violence: a Spanish study. *Journal of Aggression, Maltreatment & Trauma*, *26*(6), 664-675. https://doi.org/10.1080/10926771.2017.1300619

Walling, S. M., Suvak, M. K., Howard, J. M., Taft, C. T., & Murphy, C. M. (2012). Race/ethnicity as a predictor of change in working alliance during cognitive behavioral therapy for intimate partner violence perpetrators. *Psychotherapy*, *49*(2), 180-189. http://dx.doi.org/10.1037/a0025751

Weber, E. N., Taylor, A. R., Cantos, A. L., Amado, B. G., & O'Leary, K. D. (2019). Exploring typology categorizations of male perpetrators: a methodology study. *European Journal of Psychology Applied to Legal Context*, *11*(2), 93-97. https://doi.org/10.5093/ejpalc2019a5

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults: assessment in a large health maintenance organization. *Journal of Interpersonal Violence*, *18*(2), 166-185. https://doi.org/10.1177/0886260502238733