

More Likely to Dropout, but What if They Don't? Partner Violence Offenders With Alcohol Abuse Problems Completing Batterer Intervention Programs

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Abstract

There is general consensus that alcohol abuse is a risk factor to be considered in batterer intervention programs. Intimate partner violence perpetrators with alcohol abuse problems are more likely to dropout of batterer intervention programs. However, there is little research on intimate partner violence perpetrators with alcohol abuse problems completing batterer intervention programs. In this study, we analyze dropout rates among perpetrators with alcohol abuse problems and explore whether perpetrators with alcohol abuse problems completing a batterer intervention program differ from those who do not have alcohol abuse problems in a number of outcomes. The sample was 286 males convicted for intimate partner violence against women, attending a community-based batterer intervention program. Final (i.e., recidivism) and proximal (i.e., risk of recidivism, responsibility attributions, attitudes toward violence, sexism, psychological adjustment, and social integration) intervention outcomes were analyzed. Chi-square test, binary logistic regression, and one-way

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ANOVA were conducted. Results confirmed higher dropout rates among perpetrators with alcohol abuse problems. Results also showed a reduction in alcohol abuse among perpetrators with alcohol abuse problems completing the batterer intervention program. Finally, results showed that, regardless of alcohol abuse problems, perpetrators who completed the batterer intervention program showed improvements in all intervention outcomes analyzed. Perpetrators both with and without alcohol abuse problems can show positive changes after completing an intervention program and, in this regard, the present study highlights the need to design more effective adherence strategies for intimate partner violence perpetrators, especially for those with alcohol abuse problems.

Keywords

alcohol, batterer intervention programs, dropout, intervention outcomes, intimate partner violence perpetrators

The limited evidence for the effectiveness of batterer intervention programs (BIPs) is one of the most challenging problems for both scholars and professionals working in this research and intervention area. The available meta-analysis regarding BIP effectiveness concluded that the intervention's effect size is small (Arias, Arce, & Vilariño, 2013; Babcock, Green, & Robie, 2004; Eckhardt et al., 2013; Feder & Wilson, 2005). High rates of treatment attrition have been considered in the literature as one of the main reasons for the lack of general evidence of BIP effectiveness (Babcock et al., 2004; Cadsky, Hanson, Crawford, & Lalonde, 1996; Crane, Eckhardt, & Schlauch, 2015; Eckhardt et al., 2013). Various studies show that percentages of intimate partner violence (IPV) perpetrators failing to complete treatment range between 15% and 60% (L. W. Bennett, Stoops, Call, & Flett, 2007; Rondeau, Brodeur, Brochu, & Lemire, 2001). Treatment attrition is also an important issue for IPV recidivism, as many variables that have been found to predict treatment attrition tend to be the same as those that also predict IPV recidivism (Jewell & Wormith, 2010; Wormith & Olver, 2002). Research has focused on three main categories of variables that can be predictors of treatment attrition and recidivism (Daly & Pelowski, 2000; Jewell & Wormith, 2010): demographic variables (e.g., age, ethnicity, unemployment, socioeconomic status; Carlson, Harris, & Holden, 1999; Chaudhuri & Daly, 1992; Klein, 1996), violence related factors (e.g., prior arrests or convictions, personal experiences of abuse, severity of abuse; Bowen & Gilchrist, 2006; Cadsky et al., 1996;

Carney, Buttell, & Muldoon, 2006), and intrapersonal characteristics (e.g., alcohol and drug use, anger, psychopathology, motivation; L. Bennett & Goodman, 2003; Cadsky et al., 1996; Daly & Pelowski, 2000).

Alcohol abuse is not only one of the main intrapersonal risk factors linked to IPV (e.g., L. Bennett & Williams, 2003; Foran & O'Leary, 2008; Langenderfer, 2013; World Health Organization, 2010) but also is one important predictor of both IPV perpetrators' treatment attrition and recidivism (e.g., Bowen & Gilchrist, 2006; Cadsky et al., 1996; Daly & Pelowski, 2000; Hilton & Harris, 2005; Olver, Stockdale, & Wormith, 2011; for a review, see Jewell & Wormith, 2010). The strong association between alcohol abuse and IPV perpetration is well illustrated by the fact that about 50% of IPV perpetrators referred to BIPs have some alcohol abuse problems (AAPs; Arteaga, López-Goñi, & Fernández-Montalvo, 2015; O'Farrell, Van Hutton, & Murphy, 1999; Stuart, Moore, Kahler, & Ramsey, 2003; Stuart, O'Farrell, & Temple, 2009). The strong link between alcohol abuse and IPV led the World Health Organization (2010) to recommend the reduction of alcohol abuse through prevention interventions as a strategy to reduce IPV. However, as L. W. Bennett (2008) noted, alcohol abuse and IPV have often been viewed as "separate problems with different interventions" (p. 237).

Most BIPs do not specifically address AAPs (Babcock et al., 2004; Crane et al., 2015; Langenderfer, 2013; Lila, Oliver, Catalá-Miñana, & Conchell, 2014). In this context, an issue that has received little attention in the existing literature is what happens to perpetrators with AAPs who remain in BIPs that do not specifically address AAPs (for an exception, see Hamberger & Hastings, 1990). As L. W. Bennett (2008) noted, BIPs and alcohol abuse treatments share activities and work on similar variables (e.g., anger, stress). Also, both types of interventions are usually group-based and focus on attitude change and recidivism/relapse prevention. According to this author, one might expect that BIPs could reduce substance abuse problems for perpetrators that complete these programs. Another important issue is whether perpetrators with AAPs who complete BIPs benefit to the same extent as those perpetrators without AAPs (WAAP) in partner violence related variables. These are still unanswered research questions that clearly deserve further attention.

The Present Study

The first aim of this study is to ascertain whether IPV perpetrators with AAPs attending a BIP in Spain are "more likely to dropout," confirming previous literature mostly emerging from Anglophone countries (Cadsky et al., 1996; Daly & Pelowski, 2000; Olver et al., 2011). In relation to the "what if they don't?" research question, the second aim of the present study is to explore

whether perpetrators with AAPs attending a BIP that does not specifically address this issue, report a reduction in their AAPs. Finally, the third aim of this study is to analyze whether intervention outcomes among perpetrators with AAPs completing a BIP differ from those who do not have such problems. We consider both proximal and final outcomes following the distinction proposed by Velonis, Cheff, Finn, Davloor, and O'Campo (2016). According to these authors, "final" outcomes correspond to long-term consequences of program participation such as recidivism, whereas "proximal" outcomes would correspond to changes in skills, attitudes, and intentions resulting from participating in the program. Thus, in this study, we analyze recidivism as a BIP final outcome, which has been considered one of the main indicators of effectiveness (Scott, King, McGinn, & Hosseini, 2011). The following proximal outcomes are also analyzed:

- a. Risk of recidivism: Risk of recidivism reduction assessed by trained program staff is based on risk factors solidly associated with IPV, and is commonly used as a BIP outcome (e.g., Andrés-Pueyo & López, 2005; Scott et al., 2011).
- b. Responsibility attribution: Denial, lack of assumption of responsibility, and victim blaming are common among IPV perpetrators, and most BIPs address responsibility assumption as a main intervention target (e.g., Henning & Holdford, 2006; Lila, Gracia, & Herrero, 2012; Scott & Straus, 2007).
- c. Attitudes toward IPV: Attitudes of tolerance toward IPV are an important risk factor and a common intervention goal in BIPs (e.g., Eckhardt, Samper, Suhr, & Holtzworth-Munroe, 2012; Gracia, Rodríguez, & Lila, 2015).
- d. Sexism: Sexist prejudices have been linked to attitudes that legitimize IPV against women, and therefore, are a common intervention target in BIPs (e.g., Glick, Sakalli-Ugurlu, Ferreira, & de Souza, 2002; Pérez-Ramírez, Giménez-Salinas Framís, & de Juan Espinosa, 2013).
- e. Psychosocial adjustment: Some recent strength-based approaches are based on the idea that perpetrators' psychological adjustment helps to promote change (e.g., Bouman, Schene, & Ruiter, 2009; Langlands, Ward, & Gilchrist 2009).

Method

Participants and Procedure

The sample consisted of 286 males convicted for IPV against women, attending a community-based BIP conducted in Valencia, Spain. Perpetrators had

Table 1. Sociodemographic Data ($N = 286$).

	<i>M (SD)/%</i>
Age	38.80 (11.10)
Income (€/year)	3.97 (2.32)
Marital status	
Married or coupled	25
Single	33.20
Separated	18.90
Divorced	22.50
Widowed	0.40
Education level	
No schooling	9.30
Primary	47.30
Secondary	34.20
College	9.30
Place of birth	
Spain	59.90
Latin America	24.50
Non-Spanish Europe	9.60
Africa	5.30
Asia	0.70
Unemployed	38.40

been sentenced to less than 2 years in prison with no previous criminal record and received a suspended sentence conditional on attendance to an intervention program. Data were collected as a part of regular intake (pretreatment) and follow-up (posttreatment at 9 months) self-report measures for men entering the program using standardized questionnaires. The study was approved by the University of Valencia Ethics Committee and was conducted in accordance with the Declaration of Helsinki. Signed informed consent for participation in the study was obtained from the participants before they were interviewed. Sociodemographic data are shown in Table 1.

Intervention

The intervention was a community-based BIP, coordinated with penitentiary social services. It lasted about 9 months and was run by two therapists in 30 to 32 weekly group sessions each lasting 2 hr. The groups were closed (i.e., no new members were enrolled after the program starts) and they consisted of 10 to 12 participants. The *evaluation phase* included the administration of

self-reports, standardized tests, three in-depth interviews, and a recidivism risk assessment. The *intervention phase* was a cognitive-behavioral intervention. Throughout the BIP, different intervention techniques were applied, such as group dynamics, group inquiry/debate, monitored exercises, case studies, role-play, videos, homework, and training on psychological strategies and techniques (e.g., cognitive restructuring, emotion management skills). The program design was based on an ecological model framework (Heise, 2011); the sessions and activities aimed to increase skills and reduce risk factors at the individual level (e.g., emotional control techniques), interpersonal level (e.g., positive communication skills in intimate relationships), situational level (e.g., social support), and sociocultural level (e.g., gender roles and sexist attitudes; see Lila, Oliver, Catalá-Miñana, & Conchell, 2014, for a more complete description of the BIP).

Measures

Sociodemographic data. Information was collected about age, marital status (1 = *married or coupled*; 2 = *single*; 3 = *separated*; 4 = *divorced*; 5 = *widowed*), education level (1 = *no schooling*; 2 = *primary*; 3 = *secondary*; 4 = *college*), place of birth (1 = *Spain*; 2 = *Latin America*; 3 = *Non-Spanish Europe*; 4 = *Africa*; 5 = *Asia*), employment status (1 = *employed*; 2 = *unemployed*), and income (from 1 = *less than 1,800 €/year* to 12 = *more than 120,000 €/year*). The mean income in Spain for 2016 was 26,000 €/year).

Dropout. All participants were labeled as *program completer* (0) if they finished the BIP or *dropout* (1) if they stopped attending after the evaluation phase had started.

AAPs

Alcohol Use Disorders Identification Test (AUDIT). The test consists of 10 items on self-reported alcohol consumption in adults, ranging from 0 (*never*) to 4 (*daily or almost daily*) (Babor & Grant, 1989; Spanish Version by Contel, Gual, & Colom, 1999). It was designed to detect harmful alcohol consumption, as well as a possible dependence. The cutoff score is equal to or greater than 8, above which the participant's alcohol consumption was deemed to be harmful and carried the risk of becoming alcoholic (internal consistency pretreatment = .79; posttreatment = .80). The AUDIT has good sensitivity and specificity as a screening tool (Allen, Litten, Fertig, & Barbor, 1997), and has been widely used with samples of IPV offenders (e.g., Crane et al., 2015; Leone, Crane, Parrott, & Eckhardt, 2016), including Spanish ones (e.g., Jose,

O'Leary, Graña Gomez, & Foran, 2014; Romero-Martínez, Lila, Martínez, Pedrón-Rico, & Moya-Albiol, 2016).

Recidivism. Recidivism was considered to occur (during the year following completion of the BIP) when the Ministry of Interior's monitoring system registered further incidents of IPV, other type of offences in an intimate partner context (e.g., harassment, destruction of property), or any breach of the conditions mandated by a judge (e.g., breaching a restraining order), informed by any of the institutions involved in victims' protection services (police, courts of law, penitentiary social services, etc.). This variable was coded 0 = *lack of recidivism*; 1 = *presence of recidivism*.

Recidivism risk

Spousal Assault Risk Assessment (SARA). SARA was used by trained program staff to evaluate the recidivism risk (Kropp, Hart, Webster, & Eaves, 1995; Spanish Version by Andrés-Pueyo & López, 2005). This assessment is a 20-item protocol, in the form of a clinical checklist, which includes the main risk factors of IPV. Responses are gathered on a 3-point scale (0 = *not present*, 1 = *possibly present*, and 2 = *present*). Although the SARA is not an actuarial measure, it can be used as such in research (Grann & Wedin, 2002). The total score ranges between 0 and 40. Higher scores indicate higher recidivism risk. The SARA has proved its predictive validity (Messing & Thaller, 2012), and its Spanish version has been used with samples of IPV perpetrators (e.g., Lila, Oliver, Lorenzo, & Catalá, 2013; Llor-Esteban, García-Jiménez, Ruiz-Hernández, & Godoy-Fernández, 2016). In this study, 57% of the sample was classified as low recidivism risk, 31.80% as medium, and 11.20% as high.

Responsibility attribution

Intimate Partner Violence Responsibility Attribution Scale (IPVRAS). IPVRAS is a self-administered 12-item 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) that aims to assess where the offender places the cause of his conviction for IPV (Lila, Oliver, Catalá-Miñana, Galiana, & Gracia, 2014). It comprises three dimensions: responsibility attributed to the legal system (internal consistency pretreatment = .78; posttreatment = .79), responsibility attributed to the victim (internal consistency pretreatment = .69; posttreatment = .70), and responsibility attributed to the offender's personal context (internal consistency pretreatment = .73; posttreatment = .74). This scale has been related in theoretically expected ways with a number of variables indicating construct and criterion-related validity, such as system blaming, alcohol consumption, stress, or sexism (Lila, Oliver, Catalá-Miñana, Galiana et al., 2014).

Attitudes toward IPV. Tolerance of partner violence against women was measured through a question that asked "Under what circumstances do you think a female victim of violence from her partner should report it to the legal authorities?" The response categories were 1 = *as soon as the woman feels she is being threatened by her partner even if there is no physical aggression*, 2 = *if there is physical aggression though nonsevere*, 3 = *only if severe physical aggression is present*, and 4 = *aggression among partners should not be reported*. Higher scores mean higher tolerance of IPV against women. This question has been used previously in a Spanish national survey on public attitudes regarding violence against women (Gracia & Herrero, 2006) to assess attitudes toward partner violence among Latin American immigrants in Spain (Gracia, Herrero, & Lila, 2008), and among IPV offenders (Catalá-Miñana, Lila, Conchell, Romero-Martínez, & Moya-Albiol, 2013; Lila, Oliver, Lorenzo et al., 2013).

Sexist attitudes

Ambivalent Sexism Inventory. This 22-item inventory uses a 6-point Likert-type scale ranging from 0 (*strongly disagree*) to 5 (*strongly agree*) to measure both hostile and benevolent sexist attitudes (Spanish Version by Expósito, Moya, & Glick, 1998). Hostile sexism entails openly negative attitudes toward women (internal consistency pretreatment = .88; posttreatment = .94) whereas benevolent sexism encompasses more traditional, paternalistic attitudes toward women (internal consistency pretreatment = .82; posttreatment = .74). This inventory has been widely used with Spanish samples of IPV perpetrators (Catalá-Miñana, Lila, Conchell et al., 2013; Lila, Oliver, Catalá-Miñana, & Conchell, 2014; Pérez-Ramírez et al., 2013; Vargas, Lila, & Catalá-Miñana, 2015), as well as with community and professional samples to assess attitudes toward IPV (Gracia, García, & Lila, 2011, 2014; Lila, Gracia, & García, 2013; Valor-Segura, Expósito, & Moya, 2011).

Psychological adjustment

Center for Epidemiologic Studies Depression Scale-7 (CES-D). This scale comprises the most common symptoms of depression. It is a 4-point Likert-type scale ranging from 1 (*rarely or never; less than 1 day*) to 4 (*all the time or most of the time; 5-7 days*) (internal consistency: pretreatment = .83; posttreatment = .86) (Radloff, 1977; Short Version by Herrero & Gracia, 2007). Previous studies with IPV perpetrators have used this scale to assess BIP outcomes (Catalá-Miñana et al., 2013; Lila, Oliver, et al., 2013).

Intimate Social Support Questionnaire. This is a three-item unidimensional scale that assesses participants' perception of having social support from

close relatives and friends (N. Lin, Dean, & Ensel, 1986; Spanish Version by Herrero, Gracia, Fuente, & Lila, 2012). The response format is a 5-point Likert-type scale (1 = *most of the time*, 5 = *never*), where a higher score means more perceived support provided by close relationships and trust (internal consistency pretreatment = .62; posttreatment = .67). This questionnaire has been used previously as predictor of alcohol consumption and recidivism risk reduction among IPV offenders (Catalá-Miñana, Lila, & Oliver, 2013; Lila, Gracia, & Murgui, 2013).

Analysis

First, participants were classified as *AAP perpetrators* or *WAAP perpetrators* according to the AUDIT guidelines (cutoff score ≥ 8). Attrition analysis ($n = 114$) was conducted among AAP perpetrators who dropped out of treatment and AAP perpetrators who completed treatment. Group differences were analyzed using one-way ANOVA for continuous variables and χ^2 tests for categorical variables. Second, the relation between alcohol abuse and dropout ($N = 286$) was analyzed using a binary logistic regression with alcohol abuse as the independent variable and *dropout* as the dependent variable. Third, a χ^2 test was conducted to compare AAP and WAAP perpetrators' recidivism (final outcome). Finally, Repeated Measures ANOVAs were used to compare proximal treatment outcome scores among program completers, at pre- and posttreatment time points ($n = 206$), using alcohol abuse as the between-subjects variable.

Results

Alcohol abuse groups and attrition analysis. From the total sample of IPV perpetrators, 114 participants were classified as AAP (scored ≥ 8) and 172 were classified as WAAP. Participants who dropped out were 80 (27.97%). There were no statistically significant differences between program completer and noncompleter AAP perpetrators at baseline on sociodemographic and treatment outcomes variables (see Table 2).

Dropout and alcohol abuse. Results showed higher dropout rates in the AAP perpetrators group (36%) than in the WAAP group (22.67%) ($\chi^2 = 6.011$; $p < .05$; $\phi^2 = .15$). A binary logistic regression with alcohol abuse as the independent variable and dropout as the dependent variable was conducted. Alcohol abuse added a significant amount of prediction to the null model (the constant-only model) given that the chi-square differences were statistically significant ($\Delta\chi^2 = 5.93$; $\Delta df = 1$; $p = .015$). The model R^2

Table 2. Differences Between Completers and Noncompleters at Baseline in AAP Perpetrators Group ($n = 114$).

	Completer		Noncompleter		F/χ^2	p	η^2/φ
	$M/\%$	SD	$M/\%$	SD			
Age	38.05	10.74	35.73	8.24	1.42	.236	.01
Income	3.41	1.99	3.41	2.17	<0.01	.999	<.01
Marital status					7.49	.112	.26
Married or coupled	19.17		33.33				
Single	35.62		66.67				
Separated	29.92		28.21				
Divorced	23.29		10.26				
Widowed	<0.01		2.56				
Education level					1.07	.784	.10
No schooling	6.85		10.26				
Primary	53.42		56.41				
Secondary	30.14		28.21				
College	9.59		5.13				
Place of birth					2.48	.648	.15
Spain	52.05		46.15				
Latin America	36.99		35.90				
Non-Spanish Europe	5.48		12.82				
Africa	4.11		5.13				
Asia	1.37		<0.01				
Unemployed	47.95		31.58		2.74	.098	.16
AAPs	12.60	4.73	14.05	5.28	2.26	.136	.02
Recidivism risk	8.67	5.02	11.00	6.56	3.44	.067	.04
IPVRAS							
Legal	12.18	4.41	11.52	4.51	.49	.488	.01
Victim	12.60	4.22	11.61	3.67	1.29	.259	.01
Personal context	9.67	3.96	8.97	3.98	0.68	.410	.01
Tolerance toward IPV	1.78	0.81	1.66	0.80	0.53	.470	.01
Hostile sexism	2.82	1.19	2.87	1.11	0.04	.847	<.01
Benevolent sexism	3.17	0.99	3.48	0.56	2.21	.142	.03
Depression	14.45	4.56	14.95	5.84	0.26	.614	<.01
Intimate social support	9.49	3.07	10.08	2.79	0.98	.326	.01

Note. AAP = alcohol abuse problem; IPVRAS = Intimate Partner Violence Responsibility Attribution Scale; IPV = Intimate Partner Violence.

was .02. Specifically, there was a significant and positive association of alcohol abuse with dropout, alcohol abuse being associated with 92%

increased odds of dropout ($W = 5.93$; odds ratio [OR] 1.92; 95% confidence interval [CI] = [1.14, 3.23]).

Alcohol abuse reduction. There was a significant reduction in alcohol consumption among AAP perpetrators completing a BIP that does not specifically address this issue (see Table 3). There was an interaction effect Group (AAPs vs. WAAPs) $\times$ Time (pretreatment vs. posttreatment) in alcohol abuse. The AAP perpetrators group showed lower alcohol use after treatment— M (SD) pretreatment = 12.47 (4.70), M (SD) posttreatment = 8.49 (5.90); ($F = 56.088$; $p < .001$; $\eta^2 = .23$)—but no differences between pre- and posttreatment in the WAAP perpetrators group— M (SD) pretreatment = 2.55 (2.24), M (SD) posttreatment = 2.84 (3.54); $F = .56$; $p = .453$ (see Figure 1).

As the AUDIT mean score at posttreatment in the AAP perpetrators group was around the threshold of hazardous drinking (8 points as the cutoff score), differences between those who stopped abusing alcohol after treatment ($n = 34$) and those who continued abusing alcohol ($n = 38$) were analyzed. No differences were found in recidivism ($p = .87$) and proximal outcomes ($.055 < ps < .787$). However, differences were found in alcohol consumption. Perpetrators who stopped abusing alcohol after the treatment showed a significant reduction of alcohol consumption ($F = 66.99$; $p < .001$; $\eta^2 = .48$), but no significant reduction was found among perpetrators who continued abusing alcohol after treatment ($F = 1.58$; $p = .213$). Also, perpetrators who continued abusing alcohol after treatment showed higher alcohol consumption both at pretreatment ($F = 4.42$; $p = .039$; $\eta^2 = .06$) and posttreatment phases ($F = 75.42$; $p < .001$; $\eta^2 = .52$) than those perpetrators who stopped abusing alcohol after treatment (see Figure 2).

Recidivism. There were 19 recidivists among the participants. A chi-square test showed no significant differences in recidivism between AAP perpetrators (10.96%) and WAAP perpetrators (8.23%) who completed the intervention ($\chi^2 = 0.41$; $p = .524$).

Proximal outcomes. Descriptive statistics of proximal outcomes among program completers ($n = 206$) are shown in Table 3. There were significant differences between pre- and posttreatment in numerous outcomes. After intervention, program completers showed lower recidivism risk, lower IPV responsibility attribution to the legal system and the victim, lower tolerance of IPV, lower hostile and benevolent sexism, less symptoms of depression, higher intimate social support, and lower AAPs. Regarding the third aim of the research, interaction effects were nonsignificant (see Table 3), showing that there were no differences in the intervention outcomes between AAP and

Table 3. Descriptive Statistics and 2 × 2 Repeated Measures ANOVAs for Program Completers Sample (n = 206).

	Pretreatment		Posttreatment		Time (Pre- and Posttreatment)			Group (AAP vs. WAAAP) × Time (Pre- Posttreatment)		
	M	SD	M	SD	F	p	η ²	F	p	η ²
AAPs	6.03	5.78	4.82	5.24	31.26	<.001	.14	41.99	<.001	.18
Recidivism risk	7.63	5.05	5.63	4	59.52	<.001	.24	.52	.473	<.01
IPVRAS										
Legal	12.24	4.27	10.66	3.97	18.69	<.001	.09	.77	.380	<.01
Victim	12.96	4.43	11.42	4.59	17.53	<.001	.09	.56	.814	<.01
Personal context	7.74	3.76	7.66	3.68	0.191	.662	<.01	.17	.685	<.01
Tolerance toward IPV	1.61	0.761	1.35	0.597	20.09	<.001	.10	.25	.616	<.01
Hostile sexism	2.6	1.13	2.24	1.15	12.14	.001	.09	.96	.328	<.01
Benevolent sexism	3.06	1.05	2.57	1.01	32.67	<.001	.22	.19	.660	<.01
Depression	13.38	5.03	12.34	4.62	6.65	.011	.03	.16	.694	<.01
Intimate social support	10.31	3.15	10.76	2.93	4.51	.035	.02	3.21	.075	.02

Note. AAPs = perpetrators with alcohol abuse problems; WAAAPs = without alcohol abuse problems; IPVRAS = Intimate Partner Violence Responsibility Attribution Scale; IPV = Intimate Partner Violence.

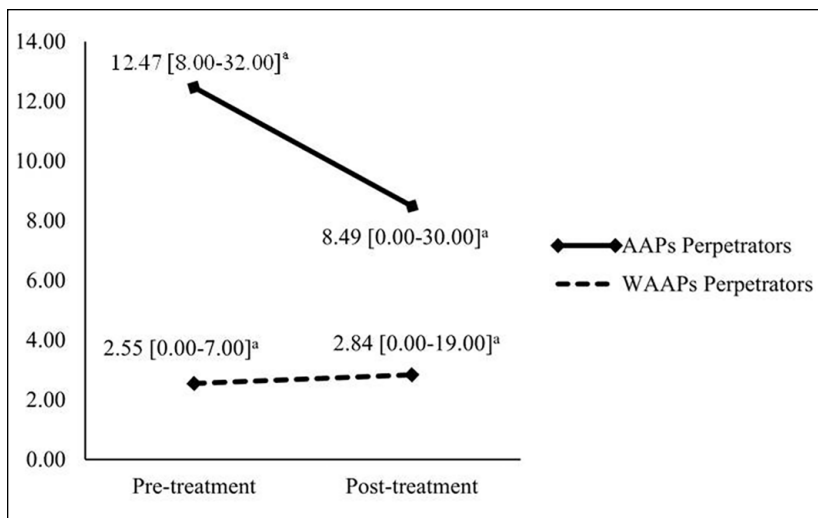


Figure 1. Interaction effect Time (pre- vs. posttreatment) $\times$ Group (AAP vs. WAAP) by AAPs.

Note. AAP = alcohol abuse problem; WAAPs = without alcohol abuse problem.

^aMean [minimum-maximum].

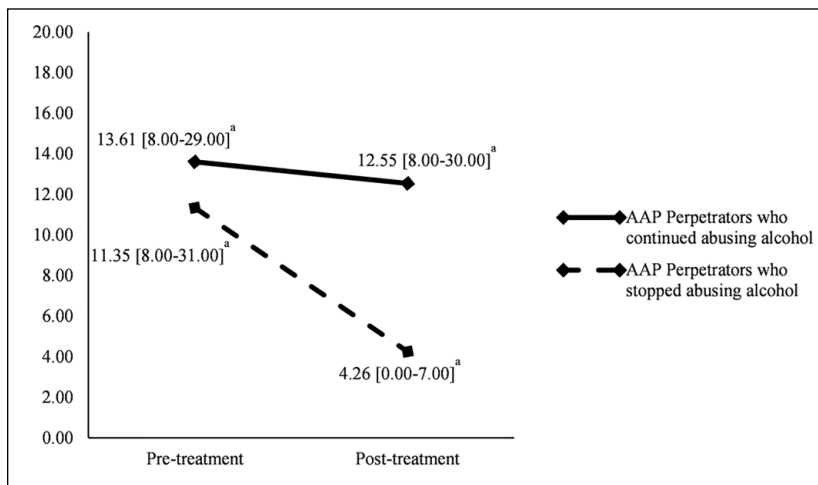


Figure 2. Alcohol consumption of AAP Perpetrators who stopped abusing alcohol and AAP Perpetrators who continued abusing alcohol.

Note. AAP = alcohol abuse problem.

^aMean [minimum-maximum].

WAAP perpetrators completing the BIP. These results indicated that, regardless of AAPs, perpetrators who completed the BIP showed improvements in all intervention outcomes analyzed.

Discussion

This study aimed (a) to examine whether IPV perpetrators with AAPs are more likely to dropout of a BIP with no specific alcohol abuse treatment, (b) to explore whether perpetrators with AAPs completing a BIP experience a reduction in their AAPs, and (c) to analyze whether intervention outcomes among perpetrators with AAPs completing a BIP differ from those who do not have AAPs. Regarding the first aim, our results show that in line with the previous literature, IPV perpetrators with AAPs are more likely to dropout (e.g., Cadsky et al., 1996; Daly & Pelowski, 2000; Olver et al., 2011). Just as the strong association between alcohol abuse and IPV appears to hold across different cultural contexts (Jose et al., 2014; O'Leary, Slep, Avery-Leaf, & Cascardi, 2008; Stuart et al., 2006), the results of this study confirm that for a non-Anglophone sample, the likelihood of dropout is higher among IPV perpetrators with AAPs. This finding highlights the need, regardless of the IPV perpetrator's culture, to pay greater attention to AAPs starting from the initial contact, to strengthen measures that encourage perpetrators with AAPs to remain on intervention programs. In this vein, several promising advances are appearing, including motivational strategies at the beginning of the intervention for perpetrators with AAPs (e.g., Crane et al., 2015). Greater knowledge of and attention to the factors that place perpetrators at risk of noncompliance might encourage the development of more effective BIPs.

Our second aim was to analyze whether perpetrators with AAPs completing a BIP reduced their alcohol consumption. As anticipated by L. W. Bennett (2008), the results of our study show a significant reduction in consumption among the perpetrators with AAPs, even though no specific intervention was made to treat the problem. This reduction may be due to various factors such as, for example, the therapists' supervision and guidance, learning healthy alternatives for conflict resolution, and/or support from the intervention group and the therapists in the BIP. Although our data do not allow us to identify the factors underlying the reduction in their alcohol consumption, the fact that this occurs among IPV perpetrators with AAPs who complete the intervention program adds to the debate about whether the effectiveness of BIPs is improved when specific alcohol abuse treatment is also included (e.g., Crane et al., 2015; Stuart et al., 2013). The idea behind this approach is that by targeting alcohol abuse in BIPs, a successful decline in alcohol consumption will play a role in reducing IPV (Goldkamp, 1997; Klostermann &

Fals-Stewart, 2006; Murphy & Ting 2010; Stuart, 2005). Wilson, Graham, and Taft (2014) conducted a systematic review of the effects on IPV of alcohol interventions and concluded that the evidence for the effectiveness of combined alcohol and IPV interventions was limited. The studies these authors reviewed showed significant effects on both IPV and alcohol consumption; however, these effects were not persistent over time, and there was no evidence about the mediating role of alcohol intervention. The fact that even without specific treatment, alcohol consumption fell among the participants in our study highlights the effect the treatment provided by the BIP has on the individual's behavior, an impact that should be taken into account in future studies analyzing the effectiveness of combined alcohol and IPV interventions. However, our results also show that among perpetrators with AAPs, two different groups can be identified: those who stopped abusing alcohol and those who continued abusing alcohol after treatment. Although we did not find significant differences between these two groups in proximal or final intervention outcomes, hazardous drinking after treatment among some perpetrators may highlight the need for more specialized treatment for higher risk alcohol cases.

Regarding the third research aim (to analyze whether intervention outcomes among perpetrators with AAPs completing a BIP differ from those who do not have AAPs), we find no significant differences between the two groups in any of the variables analyzed. Regarding the final outcome (recidivism), the percentage of recidivism found is similar to other studies analyzing recidivism 1 year after completing the intervention (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008; Kingsnorth, 2006; S. C. Lin et al., 2009). Although in our study, the percentage of recidivism is slightly higher for the group of IPV perpetrators with AAPs (10.96% vs. 8.23%), the difference is not significant. Although this result seems to contradict previous literature linking alcohol abuse and recidivism (e.g., Hamberger & Hastings, 1990), it is important to take into account that the sample in this study was not a particularly high risk one within the IPV perpetrators population, as they were convicted to less than 2 years in prison, and had no previous IPV criminal record. Future studies with higher risk perpetrators, longer follow-up periods, and larger samples should help to clarify this discrepancy. Regarding the proximal outcomes, results showed that, regardless of AAPs, perpetrators who completed the BIP showed improvements in all intervention outcomes analyzed. All perpetrators who completed the intervention showed a reduction of recidivism risk, responsibility attribution (to the legal system and to the victim), tolerance of IPV against women, hostile and benevolent sexism, depressive symptomatology, and an increase in intimate social support. These variables have been related to violent behavior in previous

research; thus, the changes observed may contribute to the reduction of future IPV (e.g., Coulter & VandeWeerd, 2009; Lila et al., 2013; Scott & Straus, 2007; Wallach & Sela, 2008). It should be noted that, with the abovementioned exception concerning the variable AAPs, interaction effects were not significant. Hence, the *completer* participants benefited from the program in terms of the variables evaluated, regardless of whether they belonged to the group of perpetrators with AAPs or the group of perpetrators WAAPs. The fact that no differences were found between the two groups in the outcomes analyzed, together with the reduction of AAPs among a substantial number of participants, highlights the potential general benefits of BIPs. This finding is particularly relevant in countries like Spain where the resources available for intervention programs with IPV perpetrators are still very scarce, and do not specifically address AAPs. As our results suggest, for BIPs to be successful, attention should also focus on strengthening adherence strategies among perpetrators with AAPs.

This study has some limitations. First, regarding implications in terms of diversity, it would be advisable to replicate the results of this study with larger and different samples, such as different ethnic groups, higher risk IPV perpetrators population, women perpetrators, IPV in same sex intimate relationships, and cross-cultural comparisons. Second, even if alcohol reduction is not a target in this program, alcohol consumption could be influenced indirectly through the program's explicit rule that participants must not have consumed alcohol or other substances prior to attending the sessions, or by therapists' informal advice. This effect was not controlled in the present study. Third, some of the measures used in this study were self-reports, and the results are therefore subject to the limitations this type of instrument can have in this population (Gracia et al., 2015). The same may apply to the instruments used to measure alcohol consumption. If physiological measures were included, or measures that participants could not manipulate, the results might vary. Fourth, recidivism was measured only according to officially reported reoffending. The percentage of recidivism that might be derived from information provided by victims would certainly be higher (Williams & Houghton, 2004). However, Spanish legislation prevents the services referring IPV perpetrators to intervention programs from providing information that would allow access to their victims. Last, there is no posttreatment data from participants who dropout of the treatment, which would increase the reliability of the results.

Summing up, this study shows that IPV perpetrators with AAPs are more likely to dropout. But, what if they don't? Perpetrators both with and without AAPs can show positive changes after completing an intervention program and, in this regard, the present study highlights the need to design

more effective adherence strategies for IPV perpetrators, especially for those with AAPs.

Authors' Note

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Declaration of Conflicting Interests

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