Batterer intervention programmes: A meta-analytic review of effectiveness

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ABSTRACT

A meta-analysis of the state-of-the-art on the efficacy of batterer treatment programmes was conducted from the year 1975 to 2013. A total of 19 Spanish and English language research articles were retrieved yielding 49 effect sizes from a sample of 18,941 batterers. The results revealed that the recidivism rate as measured by couple reports (CR) was significantly higher than the rate based on official reports (OR), since the recidivism as measured by OR is underestimated. Overall, treatment showed a medium positive effect size (δ = 0.41). Nevertheless, the counternull effect size, \( ES_{\text{counternull}} = 0.82 \), suggested a null effect as probable as a treatment efficacy rate of 38%. The intervention type was not a significant moderator of recidivism, but the counternull effect sizes, \( ES_{\text{counternull}} = 0.82 \) and 0.94, revealed an efficacy rate of 38% and 42% based on ORs, for Duluth Model and behavioral-cognitive treatment, respectively. The long-term treatment interventions had a significantly positive medium effect size, \( \delta = 0.49 \). The implications of these findings for the design and assessment of future intervention programmes are discussed.

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Prior to the first meta-analysis on the efficacy of batterers’ treatment programmes, the reviews of intervention programmes yielded contradictory results. Thus, while Hamberger and Hastings (1993), and Rosenfeld (1992) concluded that treatments did not work, Davis and Taylor (1999) found that the effect of treatment was substantial, \( h = 0.41 \). Though several authors (Babcok, Green, & Robie, 2004) assert these effect sizes are modest in terms of Cohen’s (1988) classification categories, i.e., a small effect size (\( h < 0.50 \)), it should be noted that Cohen himself indicated that the magnitude of the effect size should not be taken as an absolute value, but should rather be interpreted according to the effects anticipated in a given context. Thus, if this effect size is contrasted with the effect size between cognitive distortions and violence as measured in \( d = 0.82 \) (Chereji, Pintea, & David, 2012), corresponding to a 68.5% improvement with treatment in contrast to 32.5% of the control group (a large effect size), the results do not appear to be promising. Notwithstanding the foregoing, in comparison to the treatment efficacy of delinquents as

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measured by the recidivism rate with a small effect size of \( d \) ranging from 0.23 to 0.42 (Redondo, Sánchez-Meca, & Garrido, 1999, 2001, 2002), the data obtained by Davis and Taylor represent an increase similar to the treatment efficacy expected in this context. Moreover, the effect size of Davis and Taylor (1999) entails a 20% increase in the recidivism rate, which is equated to 40% of batterers reoffending in comparison to the 60% of non-treated offenders. Previous meta-analyses have identified moderators with significant positive effects with a small treatment efficacy effect size (Babcock et al., 2004; Feder & Wilson, 2005; Levesque & Gelles, 1998). Furthermore, these authors have obtained inconsistent results or even negative treatment effects. Though the effect sizes were small, they were comparable to those obtained for the treatment of delinquents and were indicative of treatment efficacy. To put it another way, a woman is 5% less likely to be reassaulted by a man who was arrested, sanctioned, and sent to a batterers’ programme than by a man who was simply arrested and sanctioned (Babcock et al., 2004, p. 1044). Working with an estimated population of 100,000 batters, this would equal 5,000 fewer batters; in relation to the hypothetical recidivism base rate of approximately 25% (Bennett, Call, Flett, & Stoops, 2005; Gondolf, 2004) this would imply a recidivism rate of around 20,000 of treated batters.

The most consistent results highlight that the recidivism base rate of non-treated batters as measured by Official Reports (ORs) is lower (21%) than the measure based on Couple Reports (CRs), which is estimated to be 35% (Babcock et al., 2004; O’Leary et al., 1989; Rosenfeld, 1992). Surprisingly, previous meta-analyses have tended to focus on design variables, e.g., experimental vs. quasi-experimental variables, which have a methodological-scientific significance but do not provide specific guidelines aimed at enhancing treatment efficacy. With this purpose in mind, Arce and Fariña (2010), Lila, Oliver, Galliana, and Gracia (2013) and McGuire, Mason, and O’Kane (2000) have defined variables which are considered to be fundamental for the implementation of batterers’ treatment, specifically for those ordered in the community such as: contents, length (number and interval between sessions), duration, intervention level, risk assessment, treatment adherence and progress, and the rationale underlying intervention. First, programmes that are tailored to the specific needs of each batterer enhance treatment efficacy (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000), whereas standard programmes with similar content across the board for all batters not only lack efficacy but may even prove counterproductive due to the failure to adapt the intervention to the needs of each batterer (Bowen, Gilchrist, & Beech, 2005). Thus, programmes should seek to address the specific needs of each individual batterer though in practice this strategy is almost always neglected. Second, gender violence is entrenched in a culture of violence that has been described as a form of toxic cognition that is essentially internal, stable, and global (Maruna, 2004). Consequently, brief interventions are less effective than long-term programmes since the duration of each session as well as the number of and interval between sessions have a decisive impact on the acquisition and consolidation of socio-cognitive skills given that domestic violence is grounded in internal, stable, and global cognition associated to ongoing recidivism and violent behaviour (Collie, Vess, & Murdoch, 2007; Hutchings, Gannon, & Gilchrist, 2010), which is highly resistant to treatment and hinders adherence (Isorna, Fernández-Ríos, & Souto, 2010; Wormith & Olver, 2002). Third, conventional interventions, of which multimodal interventions (cognitive-behavioural) have proven to be most effective (Beelman & Lösel, 2006; Redondo et al., 1999, 2001, 2002), have focused exclusively on the batterer and have often neglected other aspects that are crucial for social integration and competence through social bonding and employment. Thus, alienation or unemployment foster the continuity of a cycle of violence (Fariña, Arce, & Novo, 2008; Gracia, Herrero, Lila, & Fuente, 2009). Moreover, multimodal interventions involving individual (cognition) and group (behavioural) sessions achieve better outcomes than group-only sessions (Arce & Fariña, 2010; Novo, Fariña, Seijo, & Arce, 2012). An exhaustive control of treatment adherence and progress is not feasible in group sessions, and they fail to strengthen responsibility taking among batterers. Thus, multimodal and multilevel interventions involving individual and group sessions are more effective than exclusively individual sessions. Forth, a treatment requires an ongoing means of measuring the effects of treatment –in this case, treatment progress. In general contexts, such as clinical evaluation, the aim of the assessment is to determine treatment outcomes, but forensic or prison contexts require a differential diagnosis of feigning (American Psychiatric Association, 2000) focused on ensuring treatment adherence and progress. In other words, the feigning of treatment adherence and progress is prevalent among convicted batterers and sexual offenders who seek to gain prison benefits, hence the high risk of recidivism. Fifth, the therapeutic rationale underlying most batterer treatment programmes undermines treatment efficacy in two ways. Treating batterers as patients implies batterers are not responsible for their own behaviour owing to exogenous causes, which hinders treatment adherence and progress, and justifies the persistence of a culture of violence (Maruna & Copes, 2005). Furthermore, the professional implementing the treatment programme may be conceived as an unwitting accomplice aiding the batterer. An alternative is a rationale whereby the role of the professional is to apply the law and serve the wider interests of society to ensure the batterers become fully aware that they are the only ones to be held directly accountable for their behaviour.

The assessment of batterers’ treatment programme efficacy has been the source of much controversy regarding reliability of measures. Though recidivism in domestic violence is the most extensively used criterion for measuring treatment efficacy, a wide range of measures have been employed to assess recidivism rates such as police or court reports, trial convictions, prison sentencing, victim reports, partner reports, or even batterer self-reports. Due to the considerable amount of overlapping between police, court, and prison databases, these data are often jointly referred to as Official Reports/Registers. Nevertheless, the reliability of these sources as an estimate of recidivism remains a controversial issue in the literature (Novo et al., 2012). For instance, meta-analysis (Babcock et al., 2004; O’Leary et al., 1989; Rosenfeld, 1992) have found a 21% recidivism rate based on ORs and 35% rate based on CRs \( (d = 0.42) \), i.e., CRs report 0.42 standard deviation more recidivism than ORs (a medium effect size). A further instance concerns the treatment effects on cognition that sanction and forerun (in comparison to cognitive distortions that have not been shown to precede violence) violence (Maruna & Mann, 2006) –in this case intimate partner violence, what Novo et al. (2012) referred to as the internal mechanisms underlying violence. Though the reliability of these measures based on psychometric instruments has been attested, recidivism continues to be the standard measure of batterers’ treatment efficacy, both in the field of science and in terms of socio-political assessment.

Ever since the advent of batterer re-education programmes, two models have been the most extensively used for the treatment of batterers, i.e., the Duluth Model and interventions that have been encompassed under the umbrella term of Cognitive-Behavioural Treatment programmes (CBT). The former, which is currently the most prominent of the two models, takes its name from the pioneering programme set up in Duluth (Minnesota) and combines a gender (feminist) approach with a psychoeducational approach grounded in the assumption that the primary cause of gender violence is patriarchal and sexist ideology that sanctions male dominance and relegates women to submissive obedience. Hence, the goal of treatment is to challenge male dominance and to foster egalitarian relationships. On the other hand, CBT programmes
envisage violence as a learned behaviour, which is best offset by
promoting and reinforcing non-violent alternatives aimed at
developing social skills and anger management (Babcock et al. 2004).
A further option arising from literature reviews and meta-analysis is
the creation of another treatment category referred to as “Other
Types of Intervention” (OTI) covering a wide variety of treatment
programmes such as Psychodynamic counselling, Anger Management,
and Mind Body Bridging.

Thus, the aim of this study was to perform a meta-analysis to
learn the state-of-the-art of the efficacy of batterer treatment
programmes from the 1975 to 2013 by assessing studies measuring
treatment efficacy in terms of the recidivism rate.

Method

Database search

The search was restricted to studies assessing batterers’
treatment programmes efficacy from 1975, one year after
Martinson’s (1974) doctrine suggesting that “nothing works” in
relation to the treatment of delinquents, to the present date (2013).
A review of the batterers’ treatment literature was undertaken
using the following search strategies: a) search in broad spectrum
databases (both small databases and specialized databases with
quality control such as Scopus and the Web of Knowledge were
included), such as PsycInfo, ERIC, Scirus, Google, and Google
Academia; b) search in gender violence observatories (e.g., www.
work-with-perpetrators.eu; www.VAWnet.org; www.mincava.
umn.edu; www.courtinnovation.org; www.cienciaspenales.net;
www.iresweb.org); c) researchers in the field were contacted (i.e.,
the corresponding authors of both retrieved and excluded articles
were contacted); and d) the reference sections of previous meta-
analyses were reviewed and cross-referenced.

The list of keywords was generated through a system of successive
approximations whereby relevant keywords cited in the articles and
previous meta-analysis were cross-referenced. The most productive
keywords (other keywords overlapped with the search results) were:
batterer, intervention program, evaluation, assessment, effectiveness,
intimate partner violence, partner-violent men, recidivism, reoffending, attrition, domestic violence, batterers’ reeducation
programmes, gender violence aggressors, recidivism, programmes
evaluation, prison treatment, and efficacy.

Criteria for inclusion in the study

Bearing in mind the objectives of the meta-analysis, in order to
be selected for the study the articles retrieved from the database
search should meet the following criteria: a) report sample size; b) report
recidivism rate for treatment completers; c) recidivism measured by
ORs (official reports, e.g., police, court, or prison reports) and couple
reports (the aggressor self-reports were excluded since batterers
were classified as quasi-experimental (see Table 2 for the
list of the 13 retrieved articles and the selection criteria). Given that
treatment non-compliance is associated to recidivism, i.e., recidivism
rates among treatment dropouts are higher or even doubled the rate
among non-treated batterers (Bennett & Williams, 2001; Dutton,
Bodnarchuk, Kropp, Hart, & Ogloff, 1997), studies contrasting the recidivism rates of non-equivalent control groups artificially amplify
treatment efficacy. As for these designs, the recidivism rate contrast
values were .21 for ORs, and .35 for CRs, which are in accordance
with the base rates that have been consistently reported in the
literature (Babcock et al., 2004; O’Leary et al., 1989; Rosenfeld, 1992).
Once the effect sizes had been calculated, the following were
computed: the weighted mean (SEr); standard deviation (SDr);
the true variance (S2r); standard error (SEr); and the confidence
interval (90% CI). If the interval contained zero, it indicated
heterogeneity (no significant effect) and further analysis was
conducted to successively examine other moderators.

To estimate the practical utility of treatments, the Binomial Effect
Size Display (BESD) was applied (Rosenthal & Rubin, 1982)
transforming δ into r by means of the formula $r = \delta / (\delta^2 + 4)$. The r was
converted to a BESD by means of the formula $(.5 \pm r/2) \times 100$.
The measure of overlapping distributions was performed by U1 statistic
(Cohen, 1988).

Most of the effect sizes were not significant (the confidence intervals contained 0), indicating the acceptance of H0. However, the
confidence intervals were not exactly precise for accepting the null
hypothesis (Cortina & Dunlap, 1997; Frick, 1996). For the effects
that were not significant (the confidence interval contained 0) with a
medium or large effect size, the hypothesis of a null effect (0) was
contrasted by means of $ES_{contenual} = \sqrt{4r^2}/(1 + 3r^2)$.
Table 1
Quasi-experimental designs

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Treatment type and intervention format</th>
<th>Duration and length of intervention</th>
<th>Measure of recidivism during follow-up</th>
<th>Recidivism rate %</th>
<th>Recidivism rate δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Saunders (1996)</td>
<td>61</td>
<td>G1: Duluth + CBT</td>
<td>12 sessions + 20 support (32 weeks)</td>
<td>24 months (OR -CR)</td>
<td>OR: 23.2%</td>
<td>OR: -0.07</td>
</tr>
<tr>
<td></td>
<td>68</td>
<td>G2: Psychodynamic process Group</td>
<td></td>
<td></td>
<td>G1: 12.3%</td>
<td>CR: 0.03</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>G2: 20.3%</td>
<td>CR: 0.05</td>
</tr>
<tr>
<td>2. Dobash, Dobash, Cavanagh and Lewis (1996)</td>
<td>40</td>
<td>Duluth Group</td>
<td>6-7 months</td>
<td>12 months (OR -CR)</td>
<td>OR: 7%</td>
<td>CR: 31%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>G1: 4%</td>
<td>CR: 0.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>G2: 33.3%</td>
<td>CR: 0.05</td>
</tr>
<tr>
<td>3. Murphy, Musser, and Maton, (1998)</td>
<td>235</td>
<td>Duluth Group</td>
<td>22 sessions</td>
<td>12-18 months (OR)</td>
<td>OR: 15.7%</td>
<td>0.2</td>
</tr>
<tr>
<td>4. Babcock and Steiner (1999)</td>
<td>106</td>
<td>Duluth Group</td>
<td>36 weeks</td>
<td>24 months (OR)</td>
<td>OR: 8%</td>
<td>0.6</td>
</tr>
<tr>
<td>5. Jones and Condolf (2002)</td>
<td>213</td>
<td>Duluth Group</td>
<td>P1: 3 months</td>
<td>15 and 30 months (OR)</td>
<td>OR: 10%</td>
<td>0.47</td>
</tr>
<tr>
<td></td>
<td>208</td>
<td></td>
<td>P2: 3 months</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>215</td>
<td></td>
<td>P3: 5.5 months</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>217</td>
<td></td>
<td>P4: 9 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Jenkins and Menton (2003)</td>
<td>114</td>
<td>CBT Group</td>
<td>9 weeks</td>
<td>30 months (OR)</td>
<td>OR: 10%</td>
<td>0.47</td>
</tr>
<tr>
<td>7. Bowen, Gilchrist, and Beech (2005)</td>
<td>86</td>
<td>Duluth Group</td>
<td>24 weeks + 5 sessions</td>
<td>11 months (OR)</td>
<td>OR: 21%</td>
<td>0</td>
</tr>
<tr>
<td>8. Bennet, Call, Flett, and Stoops (2005)</td>
<td>384</td>
<td>Duluth Group</td>
<td>24 weeks</td>
<td>18 months (OR)</td>
<td>OR: 15.4%</td>
<td>0.21</td>
</tr>
<tr>
<td>9. Labriola, Rempel, and Davis (2005)</td>
<td>157</td>
<td>Duluth Group</td>
<td>26 weeks</td>
<td>12 months (OR)</td>
<td>OR: 6%</td>
<td>0.75</td>
</tr>
<tr>
<td>10. Tollefson and Gross (2006)</td>
<td>102</td>
<td>Duluth Group</td>
<td>20 sessions</td>
<td>7-58 months (OR)</td>
<td>OR: 18%</td>
<td>0.11</td>
</tr>
<tr>
<td>11. Tollefson, Webb, Shumway, Block, and Nakamura (2009)</td>
<td>57</td>
<td>Mind-body Bridging Group</td>
<td>8-10 sessions</td>
<td>9-27 months (OR)</td>
<td>OR: 9%</td>
<td>0.53</td>
</tr>
<tr>
<td>12. Coulter and VandeWeerd (2009)</td>
<td>1424</td>
<td>G1 and G2 Duluth Group</td>
<td>G1: 8-12 weeks</td>
<td>1-10 years (OR)</td>
<td>OR: 10%</td>
<td>0.47</td>
</tr>
<tr>
<td></td>
<td>9386</td>
<td>G3 specialized Treatment</td>
<td>G2: 26 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1712</td>
<td></td>
<td>G3: 26 sem-1year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Pérez, Giménez-Salinas, and Juan (2012)</td>
<td>598</td>
<td>CBT Group</td>
<td>25 weeks</td>
<td>12 months (OR)</td>
<td>CR: 4.6%</td>
<td>0.88</td>
</tr>
</tbody>
</table>

Coding

For the analysis of moderators the following were coded: the recidivism variables (OR, n = 18,148, k = 33; CR, n = 1,456, k = 13); follow-up time (less than 12 months, k = 13; more than 12 months, k = 35); duration of treatment (< 16 sessions/weeks and > 16 sessions/weeks); intervention level (individual vs. multilevel –the multilevel intervention contingency was not registered); type of session (individual, group, or combined –no type of intervention [individual or combined] contingency was registered). Although Stith, Rosen, & McCollum, 2004 defined a couple intervention as an individual intervention [experimental group 1], actually this is not an individual intervention); contents (adapted to the needs of each batterer vs. homogeneous for all batterers –only one contingency was registered that may be attributed to adapted content, but it referred to clinical cases [group 3 of the study of Coulter & VandeWeerd, 2009], not to batterer treatment); treatment adherence and progress (control of treatment adherence and progress: yes vs. no –no contingency was registered in the measurement of this variable); rationale behind the intervention (therapeutic vs. re-educational –information was not available for coding this variable in a reliable way); risk control (yes vs. no –information was not available for coding this variable in a reliable way); and treatment type (Duluth, k = 29; CBT, k = 8; and OTI, k = 9).

Coding reliability. The coding was carried out separately by two researchers who agreed on all of the coding of the different categories. Thus, coding was reliable.

Results. The results reveal a significantly higher rate (+.156), z = 13.0, p < .001, with a very substantial difference (< 13 SD) in recidivism as measured by CRs in comparison to ORs. Thus, the ORs entail covert recidivism given that this rate may be higher as many couples refused to report their partner’s recidivism due to the threat of re-victimization (i.e., a woman may fear that the disclosure of recidivism in the presence of her partner may lead to subsequent retribution), a recidivism rate of .156 that was significantly greater, z = 51.23, p < .001, than the statistically admissible margin of error (.05).

Outlier analysis

Prior to performing the meta-analysis, an outlier analysis was performed to avoid contaminating the results. As treatment efficacy varies according to the variable under assessment, an outlier analysis was conducted for each measure, with the decision criterion being ±2SD of the mean effect size δ. The results found that three studies of Stith et al. (2004) were more than 2 standard deviations above the mean for treatment efficacy and were thus eliminated.

Global analysis

Figure 1 illustrates the procedure for calculating the 17 meta-analysis, as well as the resulting effect sizes (δ), the number of studies (k) included in each analysis, and the sample size (n). Of the
46 initial effect sizes, with a sample of 18,941 subjects, the $\delta$ weighted mean was 0.41, 90% CI [-0.12, 0.94], that is, the results revealed a non significant positive treatment effect. What is more, treatment may have considerable negative effects: as much as a 6% increase in the recidivism rate. Notwithstanding this, the effect size is not necessarily null, $ES_{null} = 0.82$, that is, there is as much evidence to support a null treatment effect as there is to show a 38% intervention efficacy rate. Nevertheless, the credibility interval of the effect size suggested the existence of further moderators. Thus, the studies were classified according to the duration of the follow-up period.
since previous reviews claim it is one of the main moderators of criminal recidivism (Gondolf, 2000, 2002; Redondo et al., 2001) and since prior analysis have found differences in recidivism as measured by ORs or CRs in relation to the follow-up period.

**Effects due to the variable of the measure of recidivism**

The meta-analysis of the ORs with an n of 18,148 batterers found a non significant positive weighted mean treatment effect, $\delta = 0.42$, 90% CI [-0.07, 0.91]. However, as the magnitude of the size was close to medium, the counternull effect was computed, $ES_{\text{counternull}} = 0.84$, indicating that the probability of finding a null recidivism treatment effect is equal to getting a 39% success rate. As for the meta-analysis of the CRs with a total population of 1,456 batterers, treatment effect was not significant, $\delta = 0.05$, 90% CI [-0.52, 0.63]. Moreover, the CI showed that treatment might have negative or even detrimental effects leading to increased recidivism rates reaching 27.8% ($\delta = -0.52$).

Given that the confidence intervals for both the ORs and CRs measures of recidivism had a negative lower limit, i.e., though treatment had a positive weighted mean effect it may also have had a negative effect, further search for moderators was undertaken to identify the variables underlying the difference in effects.

**Effects due to the measure of recidivism and follow-up time.** In line with previous studies that assert that recidivism occurs primarily within the first two years, and in the case of domestic violence in the first six months (Gondolf, 2000, 2002; Redondo et al., 2001), the two follow-up categories were coded: < 12 months and ≥ 12 months. The results revealed an effect size for recidivism as measured by ORs at 12-month follow-up ($k = 4$) of $\delta = 0.18$, 90% CI [-0.36, 0.65], that is, a positive but non significant mean effect size that may even be highly negative (succinctly, the recidivism rate may rise to 17.7%), whereas for a follow-up period longer than 12 months ($k = 29$) of $\delta = 0.04$, 90% CI [-0.45, 0.53] there is a not significant or near null effect that can be very negative (i.e., it can lead to a 22.0% increase in the recidivism rate). Likewise, the treatment effects in the measure of recidivism in CRs revealed a non significant mean effect close to 0, with negative effects of 28.3% at 12-month follow-up ($k = 8$), $\delta = 0.03$, 90% CI [-0.59, 0.65] and non significant positive and potentially negative effects reaching 18.2% in the follow-up period longer than 12 months, ($k = 5$), $\delta = 0.12$, 90% CI [-0.37, 0.61]. These results indicated the confidence intervals of $\delta$ had a negative lower limit both in the OR and CR measures and in both follow-up periods, thus an analysis of the moderators was conducted. At this point, the moderator type of analysis was the best candidate for analysis, since numerous studies have reported that treatment type has effects on recidivism, the highest effects being observed in cognitive-behavioural treatments (Redondo et al., 1999, 2001, 2002). Bearing in mind that the effects size were not significant and overlapped ($U_1 = .00$ and .04, for the overlapping distribution of the short and long-term follow-up in the ORs and CRs, respectively), the variance for the short and long-term follow-up in the ORs and CRs was small ($S^2 = 0.11$, and 0.14 for short-term follow-up in the ORs and CRs, respectively, and 0.09 and 0.09 for the long-term follow-up in the ORs and CRs, respectively), and the distribution of treatment types for each of the follow-up periods would entail several cells with insufficient studies, the ORs and the CRs were aggregated for the analysis of treatment types (cognitive-behavioural, Duluth, and others).

**Effects due to the measure of recidivism and the type of intervention.** The results of the meta-analysis exhibited a non significant positive mean effect in the ORs for the Duluth Model treatment type ($k = 24$), $\delta = 0.41$, 90% CI [-0.09, 0.92]; a non significant positive mean effect for the CBT programmes ($k = 5$), $\delta = 0.47$, 90% CI [-0.20, 1.14]; and a significant positive mean effect and a moderate size for the OTI ($k = 4$), $\delta = 0.52$, 90% CI [0.29, 0.75]. As the effect sizes were not significant for the Duluth Model or the CBT programmes, but were approximately a medium size, they were contrasted with a null effect. Counternull effect size was 0.82 for the Duluth Model, that is, data suggested that the probability of the null effect for the Duluth Model in reducing recidivism was equal to a 38% efficacy rate. As for the CBT programmes, a $ES_{\text{counternull}} = 0.94$ supported as much a null effect as a 42% success rate. In the measure of recidivism based on CRs the results found a non significant positive mean treatment effect of the Duluth Model ($k = 5$), $\delta = 0.12$, 90% CI [-0.06, 0.30]; a non significant positive mean effect of the CBT programmes ($k = 3$), $\delta = 0.18$, 90% CI [-0.08, 0.44]; and a non significant negative mean effect of the OTI, ($k = 5$), $\delta = -0.06$, 90% CI [-0.81, 0.69]. In other words, treatment may even have negative effects on recidivism rates reaching 37.5%.

**Effects due to the measure of recidivism and the duration of the intervention.** The measure of recidivism based on ORs in the brief interventions had a non significant positive weighted mean effect ($k = 14$), $\delta = 0.18$, 90% CI [-0.58, 0.94]; and long-term programmes had a statistically significant weighted mean positive effect ($k = 19$), $\delta = 0.49$, 90% CI [0.05, .93], i.e., a medium positive effect size.

The treatment effects as measured by CRs in brief interventions had a non significant weighted mean positive effect ($k = 6$), $\delta = 0.16$, 90% CI [-0.07, 0.39]; long-term treatment programmes had a non significant weighted mean positive effect ($k = 5$), $\delta = 0.14$, 90% CI [-0.09, 0.37].

**Discussion**

This meta-analysis has certain limitations that should be borne in mind when extrapolating or generalizing the results to other populations. First, the effects of a meta-analysis may be inadvertently contaminated by other variables that preclude the estimate of an effect size due to treatment. Second, details of several of the moderators initially selected for this study were not fully reported or were not accurately measured by the studies selected for this meta-analysis. Third, the measures for batterer treatment efficacy based on ORs and CRs were not entirely accurate since they entailed a margin error in the estimates of the recidivism rates (hidden victimization/undetected delinquency). Most of the interventions were evaluated by the authors themselves who were conscious that the continuity of their intervention programme depended on positive outcomes which may undermine the reliability of the evaluation (thus, the detected outliers were the 3 effect sizes of the same author with a positive effect $2SD > M$, whereas the interventions with the highest negative effect sizes corresponded to the external assessments of Jones and Gondolf, 2002). Taking these limitations into account in generalizing the results, the following conclusions may be drawn:

On the whole, the treatment of batterers had a positive but non statistically significant effect. As for some specific treatments, it may also have had considerably negative effects both in ORs and CRs. Nevertheless, this does not imply that the batterers’ treatment efficacy rate is null, given that the probability of an effect being null is equal to a 38% efficacy rate which is quite a respectable efficacy. Hence, the evidence remains inconclusive and sharp conclusions cannot be drawn (Eckhardt et al., 2013; Smedslund, Dalsbo, Steiro, Winsvold, & Clench-Aas, 2011).

Treatment efficacy was not sensitive to the moderator duration of the follow-up (short-term vs. long-term) in the ORs or CRs. In other words, the follow-up period was not a differential indicator of treatment efficacy, which contradicts the findings of Gondolf that the greatest recidivism rate occurs during the first months (Gondolf, 2000, 2002).

The ‘type of intervention’ moderator (Duluth Model, CBT or OTI Programmes) had no significant effects in CRs or ORs for the Duluth Model and the CBT Programmes though the effects were significant for the OTIs. The lack of a significant treatment effect in the Duluth Model and CBT Programmes corroborated the findings of Babcok et
al. (2004). However, the contrast of the observed effect size with a null effect size (0 efficacy rate) showed that the evidence for supporting a null recidivism efficacy rate in the ORs for the Duluth Model and CBT treatment programmes was the same as a 38% and 42% efficacy rate, respectively. As for the positive effects of the OTIs, these rest on psychological-psychotherapeutic treatment (Coulter & VandeWeerd, 2009) in which the main aim of treatment is psychopathology, not gender violence. Thus, this intervention is the most apt for addressing the needs of batterers. Consequently, further studies are required on the effects of treatment type to identify those variables that are mitigating its potential effects, such as the control of treatment adherence (Arce, Fariña, Carballal, & Novo, 2009), the psychological adjustment (Lila, Gracia, & Murgui, 2013) or the motivation for change (Eckhardt et al., 2013).

The ‘duration of the intervention’ moderator (brief vs. long) had no significant effect in the CRs whereas in ORs, long-term interventions had a significant mean effect size though no significant mean effect size was found in brief interventions. Thus, long-term interventions were more efficacious in the ORs, i.e., they officially reduce recidivism, but do not appear to do so in the daily life of couples (CRs).

Though the treatment of batterers may have negative effects on recidivism rates, treatment should be aimed at achieving positive effects, i.e., the implementation of treatment programmes that entail negative effects is entirely unacceptable. This underscores the need to identify the characteristics of treatment efficacy studies with considerable negative effect sizes, which in this meta-analysis were as follows: Group 3 of The San Diego Navy Experiment (Dunford, 2009) that was defined as a mixed (Duluth Model and CBT) group and interventions adapted to the batterers’ needs (OTI: psychological-psychotherapeutic programme for batterers with psychopathology) and long-term interventions, which would indicate other causes are responsible for the negative treatment effects. These findings suggest that further research is required to ascertain the causes underlying these negative effects.

In conclusion, overall, the treatment of batterers is not efficacious, though some programmes were (k = 16 for the positive effect of a small effect size or larger than e 0.20) or had negative effects (k = 7). Of the moderators, only the type of intervention (i.e., OTIs) and the duration of the intervention (long-term) were significant, i.e., interventions adapted to the batterers’ needs (OTI: psychological-psychotherapeutic programme for batterers with psychopathology) and long-term interventions, which would indicate that (toxic) cognition that sanctions domestic violence is highly resistant to treatment. Nonetheless, the results remain inconsistent and further studies are required to assess the efficacy of batterer treatment programmes, i.e., to examine moderators that may explain why some batterers respond to treatment yet others fail to do so under similar treatment programmes. This calls for authors, reviewers, and editors to provide explicit details regarding the treatment contents, techniques, and methods. This study has focused on certain variables that are crucial for the assessment of treatment, but have often been neglected in the literature, since initially they have been considered of minor importance though the results of this meta-analysis have shown they are robust, e.g., the techniques and methods applied that involve active, focused, collaborative learning (the principle of responsibility), the implementation of treatment programmes by specialized and trained staff, and the implementation of additional judicial measures (Lila, García, & Lorenzo, 2010; McGuire et al., 2000). 

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Conflicts of Interest
The authors of this article declare no conflicts of interest.