ANÁLISIS DE FACTORES DE RIESGO Y NECESIDADES DE INTERVENCIÓN EN HOMBRES CON PROBLEMAS DE CONSUMO DE ALCOHOL Y OTRAS DROGAS CONDENADOS POR VIOLENCIA DE GÉNERO: PROPUESTA DE INTERVENCIÓN

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Este trabajo se lo quiero dedicar también a los hombres que han participado en el Programa Contexto, y en especial a aquellos que han puesto toda su energía para mejorar su forma de relacionarse con las mujeres. El sentido de este trabajo es precisamente contribuir con un simple granito de arena en la prevención de la violencia contra las mujeres a través del trabajo con el agresor, promoviendo el cambio relacional, para que no vuelvan a ejercer violencia contra ninguna mujer. Este trabajo se lo dedico también a todas las mujeres que se han visto en una relación de la que no era nada fácil salir, atravesada por el control, el poder, el no ser vistas, y cualquier otra forma de violencia. A todas, porque todas vivimos en esta sociedad marcada por unos roles de género que nos oprimen.

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Tu historia, Lara
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Study 2

Abbreviations

ADAPs = Alcohol and other Drug Abuse Problems

ADUPs = Alcohol and other Drug Use Problems

AEI = Anger Expression Index

AMT = Alcohol Myopia Theory

APA = American Psychiatric Association

ASI = Ambivalent Sexism inventory

AUDIT = Alcohol Use Disorders Identification Test

BIP = Batterer Intervention Program

CBT = Cognitive Behavioral Therapy

CDC = Centers for Disease Control and Prevention

CESD-7 = Center for Epidemiologic Studies Depression Scale-7

CI = Confidence Interval

CPAD = Consumo Problemático de Alcohol y otras Drogas

CTS-2 = Revised Conflict Tactics Scale

FRA = European Union Agency for Fundamental Rights

GDP = Gross Domestic Product

GLM = Good Lives Model

IMP = Individualized Motivational Plan

IPV = Intimate Partner Violence

IPVAW = Intimate Partner Violence Against Women

IPVRAS = Intimate Partner Violence Responsibility Attribution Scale

IRI = Interpersonal Reactivity Index

JCR = Journal Citation Reports

LR = Likelihood Ratio

MCMI-III = Millon Clinical Multiaxial Inventory-III

MET = Motivational Enhancement Therapy

MI = Motivational Interviewing

MMAT = Mixed Methods Appraisal Tool

OR = Odds Ratio

PCSQ = Perceived Community Support Questionnaire

PEI = Principles of Effective Interventions

PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PS-IPVAW = Perceived severity of intimate partner violence against women

PSRI = Perceived Social Rejection Index

RCT = Randomized Clinical/Controlled Trials

RNR = Riesgos, Necesidades y Responsividad/ Risks-Needs-Responsivity

RSES = Rosenberg Self-esteem Scale

RV = Razón de Verosimilitud

SARA = Spousal Assault Risk Assessment

SCL-90-R = Symptom-Checklist-90-Revised

SD = Standard Deviation

SDGs = Sustainable Development Goals

SDS = Severity Dependence scale

SDSCan = Severity Dependence scale (Cannabis)

SDSCo = Severity Dependence scale (Cocaine)

SE = Standard Error

STAXI-2 = State-Trait Anger Expression Inventory

UN = United Nations

VMRP = Violencia contra la Mujer en las Relaciones de Pareja

WHO = World Health Organization

WWP EN = European Network for the Work with Perpetrators of Domestic Violence

Abstract

Intimate partner violence (IPV) is the most common form of violence against women and has been internationally recognized as a global public health concern of pandemic proportions. Intervention programs for IPV perpetrators are aimed at preventing IPV and promoting change in men convicted of IPV. Two main challenges have been identified in such programs to increase their effectiveness: conducting risk assessments to tailor interventions to the specific risks and needs of high-risk IPV perpetrators and decreasing participants' elevated dropout rates. Court-mandated participants attending intervention programs for IPV perpetrators who also have alcohol and other drug use problems (ADUPs) have been identified as a high-risk and highly resistant group of IPV perpetrators, compared to those without ADUPs. This doctoral thesis included three studies whose main objectives were (1) to identify the main risk factors and treatment needs of participants with ADUPs court-mandated to attend intervention programs for IPV perpetrators (Studies 1 and 2) and (2) to examine whether incorporating goal setting as a motivational intervention strategy resulted in lower dropout rates for IPV perpetrators and specifically those with ADUPs (Study 3). Results indicated that participants with ADUPs presented specific risk factors for IPV that required attention across multiple levels: sociodemographic, individual, social-relational, attitudinal, and violence-related factors. The main risk factors identified in IPV perpetrators with ADUPs were higher anger and impulsivity levels, heightened clinical symptomatology, increased scores on the antisocial, borderline, and narcissistic personality disorders, lower empathy, self-esteem and intimate support, heightened exposure to stressful life events and trauma, and greater likelihood of dropout, recidivism, and psychological IPV perpetration. Moreover, goal setting was associated with lower dropout rates both for a full sample of participants and specifically for those with ADUPs, even after adjusting for relevant variables. These results have important treatment implications, as identified risk factors could be translated into key intervention targets. Tailoring perpetrator programs to the specific risks and needs of high-risk participants such as those with ADUPs has shown promising results. Therefore, our findings could inform intervention development and facilitation to design strategies addressing identified risk factors to improve participants' outcomes. Our findings also support the use of goal setting as a key motivational strategy in such programs to reduce resistance towards the intervention by making participants play an active role in their process of change. Incorporating evidence-based strategies to target participants' specific risks and needs may improve the intervention

program's effectiveness, thereby preventing IPV against women and promoting safe and healthy violence-free intimate relationships.

Resumen

1. Introducción

La violencia contra la mujer en las relaciones de pareja (VMRP; i.e., violencia de género) es la forma más común de violencia contra las mujeres y ha sido ampliamente reconocida a nivel internacional como un problema de salud pública de dimensiones pandémicas (World Health Organization [WHO], 2021). Esta forma de violencia incluye todo comportamiento ejercido por una pareja o expareja, que genere un daño físico, sexual, económico o psicológico sobre la mujer (WHO, 2014).

Un informe reciente de la WHO (2021) reveló que el 27% de las mujeres de entre 15 y 49 años que han tenido alguna vez una relación de pareja, han experimentado violencia física y/o sexual por parte de su pareja o expareja en algún momento de su vida. Además, las mujeres tienen un riesgo significativamente mayor de sufrir violencia en las relaciones de pareja que los hombres (Centers for Disease Control and Prevention [CDC, 2022]; WHO, 2013).

La literatura subraya que la VMRP no puede atribuirse a un único factor o teoría, sino que es un fenómeno multifactorial (CDC, 2014). Así, se han identificado diversos factores de riesgo que interactúan entre sí y aumentan la probabilidad de su ocurrencia. En este sentido, Heise (2011) adaptó el modelo ecológico de Bronfenbrenner (1979) para categorizar los factores de riesgo en diferentes niveles. El nivel individual incluye factores como una menor edad, bajo nivel educativo, y el consumo de sustancias (Cafferky et al., 2018). El nivel relacional abarca factores de riesgo como la falta de apoyo social íntimo (Capaldi et al., 2012). El nivel comunitario incluye aspectos como vivir en áreas con escasos recursos, desempleo y falta de oportunidades (Gracia et al., 2021) y el nivel macrosocial incorpora factores sociales como los roles de género tradicionales y el sistema patriarcal (CDC, 2021).

El consumo problemático de alcohol y otras drogas (CPAD) ha sido identificado en la literatura de forma consistente como uno de los principales factores de riesgo de la VMRP en los hombres agresores (Jewell y Wormith, 2010; Olver et al., 2011). La estrecha relación entre el CPAD y la VMRP ha sido explicada desde diferentes enfoques. Por un lado, el CPAD provoca efectos psicofarmacológicos que afectan al procesamiento cognitivo y emocional y que facilitan la violencia (Leonard y Quigley, 1999). Por otro lado, dentro de las dinámicas de poder de género, algunos hombres pueden utilizar el abuso de sustancias como justificación o medio para ejercer control sobre las mujeres (Gadd et al., 2019). Además, algunos hombres pueden consumir sustancias como mecanismo para afrontar situaciones difíciles, o para automedicarse

ante sintomatología de trauma, como la ansiedad o la depresión (Gilchrist et al., 2022). Asimismo, otros modelos sugieren que existen factores como la edad, la experiencia de trauma, o ciertas características de la personalidad, como los rasgos antisociales, que pueden facilitar tanto el CPAD como la VMRP (Leonard y Quigley, 1999).

Los programas de intervención con hombres condenados por delitos de violencia de género han generado un creciente interés en los últimos años, situándose como una estrategia fundamental en la prevención de la violencia de género. Su principal objetivo es reducir la reincidencia y promover relaciones igualitarias libres de violencia a través del trabajo con el agresor (Cheng et al., 2021). Teniendo en cuenta que los agresores de pareja a menudo ejercen violencia sobre más de una mujer, o mantienen su relación con la víctima a lo largo del tiempo, los programas de intervención con agresores son una estrategia clave en la protección a las víctimas (Lila et al., 2013). Además, estos programas constituyen una herramienta fundamental en el sistema judicial para hacer frente a la VMRP. Así, los hombres condenados por delitos de violencia de género a menos de dos años de prisión, y sin antecedentes penales, pueden ser derivados por mandato judicial a acudir a un programa de intervención grupal con agresores en medio abierto como medida alternativa al ingreso en prisión.

Las revisiones sistemáticas y metaanálisis que estudian la efectividad de los programas de intervención con agresores han mostrado resultados positivos, pero con un tamaño del efecto pequeño o moderado en la reducción de la reincidencia (Arce et al., 2020; Nesset et al., 2019; Tarzia et al., 2020). Estos trabajos señalan los principales desafíos existentes que deberían ser abordados para incrementar la efectividad de los programas. En primer lugar, la mayoría de los programas no se ajustan a las necesidades de intervención y los factores de riesgo específicos de los participantes de alto riesgo, sino que siguen un modelo de intervención estándar para todo el grupo (Karakurt et al., 2019). Además, dado que la mayoría de los participantes acuden por mandato judicial, a menudo los agresores presentan una elevada resistencia a la intervención, poca motivación al cambio, y negación de su responsabilidad (Lila et al., 2014). En consecuencia, los programas de intervención muestran elevadas tasas de abandono por parte de los participantes, lo que a su vez se vincula con un mayor riesgo de reincidencia (Lila et al., 2019).

En respuesta a estas limitaciones, en los últimos años se han diseñado nuevos enfoques de intervención que han obtenido resultados prometedores: el modelo de riesgos, necesidades y responsividad (RNR; Andrews y Bonta, 2010; Travers et al., 2021) y las estrategias

motivacionales (DiClemente et al., 2017). El modelo RNR subraya la necesidad de llevar a cabo análisis de riesgo robustos que permitan ajustar los programas a los factores de riesgo y necesidades de intervención identificadas en los participantes (Bonta y Andrews, 2017). Las revisiones sistemáticas llevadas a cabo recientemente muestran que aquellos programas que siguen estos principios muestran una mayor efectividad en comparación con los programas tradicionales de intervención con agresores (Travers et al., 2021; Karakurt et al., 2019). Por otro lado, las estrategias motivacionales, que surgieron en el campo del tratamiento de adicciones, siguen un enfoque centrado en la persona, colaborador y no confrontativo, cuyo objetivo principal es facilitar el cambio (Miller y Rollnick, 2009). La incorporación de las estrategias motivacionales en los programas de intervención con agresores ha mostrado resultados prometedores para reducir el riesgo de abandono y mejorar la adherencia a la intervención en los agresores de pareja (Pinto e Silva et al., 2023; Santirso, Gilchrist, et al., 2020). Teniendo en cuenta que los grandes desafíos en estos programas son trabajar con los participantes de alto riesgo y reducir las tasas de abandono de los participantes, incorporar estos enfoques podría mejorar la efectividad de los programas.

Los participantes con CPAD han sido reconocidos como uno de los grupos de agresores de mayor riesgo y altamente resistentes (Jewell y Wormith, 2010). En concreto, los participantes con CPAD presentan una menor adherencia a la intervención, ejercen violencia más severa, y tienen más probabilidades de abandonar la intervención y de reincidir que los participantes sin CPAD (Cafferky et al., 2018; Olver et al., 2011). Además, los participantes con CPAD pueden presentar otros factores de riesgo y necesidades de intervención, más allá de su consumo problemático, que requieren atención. Por ejemplo, a nivel individual, la investigación señala que este grupo de agresores tiende a presentar mayores dificultades en el procesamiento cognitivo y en la gestión de la ira, y experimentar más problemas de salud mental (Petersson y Strand, 2017; Romero-Martínez et al., 2019a). A nivel social-relacional, los participantes con CPAD tienen más probabilidades de haber experimentado situaciones traumáticas (Travers et al., 2022). En cuanto a las actitudes hacia la violencia de pareja, a menudo los participantes con CPAD atribuyen la responsabilidad sobre sus comportamientos violentos a su consumo de sustancias (Lila et al., 2014).

La relación entre el CPAD y la VMRP se encuentra bien ilustrada por el hecho de que aproximadamente el 50% de todos los participantes presentan CPAD. Sin embargo, la investigación sugiere que lograr la abstinencia o reducir el consumo en los agresores puede no ser suficiente para disminuir su alto riesgo de abandonar la intervención y reincidir (G. Gilchrist

et al., 2021). Por lo tanto, se necesita más investigación para examinar los factores de riesgo de los participantes con CPAD, más allá de su consumo problemático, en comparación con los participantes sin CPAD. Este análisis podría ser fundamental para diseñar estrategias de intervención específicas destinadas a reducir los factores de riesgo de los participantes con CPAD, lo que, según las últimas investigaciones, podría mejorar sus resultados de intervención (Travers et al., 2021; Turner et al., 2023).

Una de las estrategias de intervención que podría ser útil para ajustar los programas de intervención con agresores a las necesidades de los participantes, es el establecimiento de metas, una estrategia motivacional en la que los participantes, guiados por las coordinadoras, pueden plantearse objetivos de intervención relevantes para ellos y alineados con sus valores, tomando así un rol activo en su propio proceso de cambio (Lila et al., 2018; Roldán-Pardo et al., 2023). Además, el establecimiento de metas podría ser clave para trabajar en aquellos factores de riesgo identificados en los participantes con CPAD, convirtiéndose así en una herramienta fundamental para reducir sus tasas de abandono y mejorar su compromiso con la intervención. Teniendo en cuenta que el abandono se relaciona con un mayor riesgo de reincidencia, y que estos riesgos son mayores en los participantes con CPAD, es necesario investigar si el establecimiento de metas podría ser una estrategia motivacional efectiva para reducir el abandono en los participantes que acuden a programas de intervención con agresores, y, específicamente, en aquellos con CPAD, quienes además, podrían presentar otros factores de riesgo más allá de su consumo problemático que requieren atención.

2. Objetivos

Los principales objetivos de esta tesis doctoral fueron identificar los principales factores de riesgo y necesidades de intervención de los participantes con CPAD derivados por mandato judicial a acudir a un programa de intervención con agresores, y examinar si incorporar el establecimiento de metas como estrategia motivacional se relacionaba con menores tasas de abandono en los hombres que acuden a intervención con agresores, y específicamente, en aquellos con CPAD.

La presente tesis doctoral incluye tres estudios. Los Estudios 1 y 2 se llevaron a cabo para responder al primer objetivo. En concreto, el Estudio 1 tuvo como objetivo identificar los principales factores de riesgo y necesidades de intervención de los participantes con CPAD. Para ello, se utilizó una amplia muestra de hombres condenados por delitos de violencia de género que participaron en un programa de intervención con agresores y se comparó a los

participantes con y sin CPAD en cuatro grupos de variables: (1) factores de riesgo sociodemográficos; (2) factores de riesgo vinculados a los trastornos de personalidad y al ajuste psicológico; (3) factores de riesgo social-relacionales, y (4) factores de riesgo relacionados con la violencia. En esta línea, el Estudio 2 consistió en llevar a cabo una revisión sistemática para identificar los factores de riesgo específicos en los participantes con CPAD que acuden por mandato judicial a programas de intervención con agresores.

El Estudio 3 responde al segundo objetivo de la tesis, examinar el rol del establecimiento de metas en la reducción del abandono en una muestra de agresores de pareja, y específicamente en aquellos con CPAD. Este estudio tuvo cuatro objetivos específicos: (1) examinar las características de los agresores al inicio de la intervención asociadas a una mayor probabilidad de establecerse metas, (2) examinar si los agresores con CPAD tenían una mayor probabilidad de establecerse una meta, (3) analizar si el establecimiento de metas predecía tasas más bajas de abandono en una muestra completa de agresores y (4) en una submuestra de agresores con CPAD, después de ajustar por variables sociodemográficas, individuales, relacionales y actitudinales.

3. Metodología

La revisión sistemática (Estudio 2) fue llevada a cabo siguiendo las directrices PRISMA (Page et al., 2021). El protocolo se registró en la *International Prospective Register of Systematic Reviews* (PROSPERO 2022 CRD42022297377). Las bases de datos consultadas para realizar la búsqueda sistemática fueron: Web of Science, PsycINFO, y Scopus. La búsqueda se realizó en octubre del 2020 y se repitió en noviembre de 2021. La estrategia de búsqueda fue una adaptación de una búsqueda sistemática realizada anteriormente por el equipo de investigación (Santirso, Gilchrist, et al., 2020). Los criterios de inclusión fueron: (1) estudios publicados en revistas revisadas por pares; (2) estudios cuantitativos; (3) la muestra incluía al menos un 70% de hombres derivados por mandato judicial a asistir a un programa de intervención para agresores; (4) los resultados se presentaron por separado para los hombres; (5) se compararon los factores de riesgo para la VMRP (por ejemplo, niveles de ira) entre los agresores con y sin CPAD y/o se compararon los niveles de CPAD entre agresores con y sin factores de riesgo para la VMRP (e.g., participantes con niveles altos versus bajos niveles de ira) y/o se evaluó la asociación entre los factores de riesgo y los niveles de CPAD, y (6) los datos se recogieron al inicio del programa de intervención con agresores. Se evaluó la calidad

metodológica de los estudios incluidos utilizando la herramienta *Mixed Methods Appraisal Tool* (MMAT; Hong et al., 2018).

Los Estudios 1 y 3 fueron estudios empíricos que utilizaron una muestra de hombres condenados por delitos de violencia de género, sin antecedentes penales, y derivados por mandato judicial a asistir a un programa de intervención con agresores como medida alternativa al ingreso en prisión. Así, los criterios de inclusión de los participantes eran hombres (1) condenados por delitos de violencia de género, y con una pena suspendida a condición de participar en un programa de intervención con agresores, (2) con 18 o más años de edad, (3) que no presentaran un trastorno psicológico, neurológico, o cognitivo grave que impidiera el correcto funcionamiento del grupo y (4) que firmaron un consentimiento informado para participar en el estudio garantizando la confidencialidad de los datos.

La muestra de participantes utilizada en los estudios eran hombres que acudieron al Programa Contexto, un programa de intervención social en medio abierto para prevenir la violencia de género a través del trabajo con el agresor (Lila et al., 2018). Los datos fueron recogidos como parte de la evaluación inicial que tiene lugar habitualmente al inicio de la intervención. Esta evaluación pre-intervención incluye una batería de cuestionarios autoinformados que evalúan las características sociodemográficas de los participantes, y variables de personalidad y ajuste psicológico, variables social-relacionales, relacionadas con la violencia, y variables actitudinales. Los datos sobre el establecimiento de metas, la motivación al cambio y el estadio de cambio fueron recogidos en la tercera entrevista motivacional que tiene lugar antes de la intervención grupal. Los participantes podían establecerse una meta voluntariamente que fuera relevante para ellos y que pudieran trabajar durante la intervención. Los datos sobre abandono se recogieron al finalizar la intervención. Los estudios de la tesis doctoral fueron aprobados por la Comisión de Ética en Investigación Experimental de la Universitat de València (Ref. H1537520365110).

Las variables examinadas en los Estudios 1 y 3 se encuentran recogidas en el Capítulo 3 de la tesis doctoral, y se describen con mayor profundidad en cada uno de los estudios (Capítulo 4). En resumen, las variables sociodemográficas incluyeron la edad, condición de inmigrante, empleo, nivel educativo, estado civil, convivencia, hijos/as, e ingresos económicos. Las variables individuales incluyeron variables de trastornos de la personalidad, ajuste psicológico y consumo de sustancias. En concreto, se examinaron las puntuaciones en las escalas de trastornos de personalidad, ira, impulsividad, autoestima, sintomatología clínica,

depresión, empatía, decodificación emocional, consumo de alcohol, consumo de cannabis, y de cocaína, y dependencia a alcohol y a las drogas. En cuanto a las variables social-relacionales, se examinó el apoyo social comunitario, el apoyo íntimo, los eventos vitales estresantes, y el rechazo social percibido. Las variables relacionadas con la violencia fueron la exposición a violencia familiar en la infancia o adolescencia, la gravedad percibida de la VMRP, la violencia física y psicológica autoinformada, y la motivación al cambio. Las variables actitudinales examinadas incluyeron el sexismo benevolente, el riesgo de reincidencia, el estadio de cambio, la responsabilidad atribuida a la víctima, y las actitudes hacia los roles de género. Además, se estudió el abandono de la intervención, y si los participantes se habían establecido o no una meta. Para identificar a los participantes con CPAD, se examinaron las puntuaciones de los participantes en las variables de consumo de sustancias, de manera que aquellos que superaban el punto de corte establecido para cada escala, eran identificados como participantes con CPAD (para más información, consultar los Capítulos 3 y 4).

En cuanto al análisis de datos, en el Estudio 1 (n = 1,039) se realizaron análisis univariados para comparar a los hombres derivados por mandato judicial a participar en un programa de intervención con agresores con CPAD (n = 204), con aquellos sin CPAD (n = 835) en cuatro conjuntos de variables: (1) sociodemográficas, (2) trastornos de personalidad y ajuste psicológico, (3) social-relacionales, y (4) variables relacionadas con la violencia. Los resultados fueron interpretados de acuerdo con su tamaño del efecto.

En el Estudio 3 se realizaron regresiones logísticas binarias para examinar la asociación (1) entre las características de los participantes al inicio de la intervención y la probabilidad de establecerse una meta y (2) dichas características y la probabilidad de abandonar la intervención. Se aplicó una corrección de Bonferroni para mitigar la probabilidad de cometer un error de tipo I (i.e., falsos positivos). Para interpretar los resultados, se utilizó tanto el nivel de error planificado (p < .05) como el valor p ajustado. Además, para identificar los mejores predictores tanto de establecimiento de metas como de abandono, se realizó un análisis de regresión logística binaria multivariante con un enfoque de selección paso a paso mediante eliminación hacia atrás basado en el criterio de la razón de verosimilitud (RV). Este enfoque fue útil para examinar si el establecimiento de metas predecía una menor tasa de abandono después de ajustar por otras variables relevantes, incluyendo variables sociodemográficas, individuales (e.g., salud mental y consumo de sustancias), social-relacionales, y actitudinales, tanto en la muestra completa de agresores, como específicamente en aquellos participantes con CPAD.

4. Resultados

El Estudio 1 mostró los factores de riesgo específicos y las necesidades de intervención de los hombres con CPAD ($n = 204$) que acuden por mandato judicial a intervención con agresores, en comparación con aquellos sin CPAD ($n = 835$) en variables (1) sociodemográficas, (2) trastornos de personalidad y ajuste psicológico, (3) social-relacionales, y (4) variables relacionadas con la violencia. Los resultados mostraron, en cuanto a las variables sociodemográficas, que los participantes con CPAD presentaron significativamente mayores tasas de desempleo, menor proporción de personas migrantes (i.e., tamaño del efecto negligible), y una edad menor (i.e., tamaño del efecto pequeño), en comparación con los participantes sin CPAD. Este hallazgo es consistente con literatura previa mostrando la adultez joven como un período crítico en el consumo de sustancias (Expósito-Álvarez, 2023). Con respecto a las variables vinculadas con los trastornos de personalidad y el ajuste psicológico, los participantes con CPAD tendieron a mostrar puntuaciones significativamente mayores en las escalas del trastorno de personalidad narcisista y paranoides, estado de ira y menor autoestima (i.e., tamaño del efecto pequeño), mayor sintomatología clínica, rasgo de ira, trastorno de ansiedad y depresión (i.e., tamaño del efecto moderado), y puntuaciones más elevadas en impulsividad, trastorno de personalidad antisocial, límite y agresivo (i.e., tamaño del efecto grande). Estos resultados son consistentes con el modelo espurio, que sostiene que los problemas de salud mental impactan a las personas facilitando tanto el consumo de sustancias como la violencia contra la pareja (Leonard y Quigley, 1999). A su vez, los efectos psicofarmacológicos del consumo de sustancias pueden tener un efecto perjudicial en la salud mental de las personas (Hanson et al., 2011). En cuanto a las variables social-relacionales, los participantes con CPAD mostraron una mayor tendencia a percibir mayor rechazo social, menor apoyo social comunitario e íntimo (i.e., tamaño del efecto pequeño), y a haber experimentado un mayor número de situaciones vitales estresantes en comparación con los participantes sin CPAD (i.e., tamaño del efecto moderado). Estos resultados son consistentes con literatura previa mostrando que algunas personas consumen sustancias como mecanismo para hacer frente a emociones desagradables, como la soledad o el estrés (Russel et al., 2017). En cuanto a las variables relacionadas con la violencia, los participantes con CPAD informaron de haber ejercido niveles significativamente mayores de violencia psicológica, y mostraron un mayor riesgo de violencia futura contra otras personas y contra la pareja (i.e., tamaño del efecto pequeño). Estos resultados son consistentes con las investigaciones que identifican a los participantes con CPAD como participantes de alto riesgo y altamente resistentes (Lila et al.,

2020). Además, en consonancia con la literatura existente, los participantes con CPAD presentaron una probabilidad mayor de haber sido expuestos a violencia familiar en la infancia o en la adolescencia (i.e., tamaño del efecto pequeño; Travers et al., 2022). Por último, los participantes con CPAD, mostraron una mayor motivación al cambio y se encontraron en un estadio de cambio más avanzado que los participantes sin CPAD, lo que va en línea con otros estudios que muestran en estos participantes una mayor conciencia de necesidad de cambio (Alexander y Morris, 2008).

La revisión sistemática llevada a cabo para identificar los factores de riesgo específicos de los hombres con CPAD que acuden por mandato judicial a intervención con agresores (Estudio 2), mostró que los factores de riesgo identificados se podían clasificar en cuatro categorías principales: (1) variables sociodemográficas, (2) trastornos de personalidad y ajuste psicológico, (3) variables social-relacionales, y (4) actitudes hacia las mujeres. La categoría 2 se podía dividir en cuatro subcategorías: (2.1) trastornos de la personalidad, (2.2) sintomatología clínica, (2.3) funciones ejecutivas y (2.4) otros factores de riesgo.

En cuanto a las variables sociodemográficas, los estudios incluidos mostraron evidencia mixta para edad, condición de migrante, y estado civil, no encontrando diferencias significativas en la mayoría del resto de variables sociodemográficas. Sin embargo, se necesitan más estudios para examinar el impacto de las variables sociodemográficas en los participantes con CPAD, ya que, por ejemplo, la literatura sugiere que experimentar dificultades económicas debido al consumo de sustancias puede incrementar los conflictos en pareja y facilitar la VMRP (Gadd et al., 2019). La segunda categoría fue la más estudiada. Concretamente, en relación con los trastornos de personalidad, los resultados mostraron que los hombres con CPAD presentaron puntuaciones significativamente mayores en las escalas de trastorno de la personalidad límite, antisocial, agresiva, ansiosa, narcisista y paranoide, en comparación con los participantes sin CPAD. En cuanto a las variables de sintomatología clínica, los factores de riesgo específicos de los participantes con CPAD más destacables fueron la ira y la impulsividad. Además, estos participantes mostraron mayores niveles de sintomatología clínica y de trauma, menores niveles de empatía y autoestima y tolerancia al distrés, y mayor desregulación emocional. Además, los agresores con CPAD, en comparación con aquellos sin CPAD, mostraron una mayor rigidez mental, y una serie de indicadores psicobiológicos que podrían sugerir alteraciones cognitivas que podrían afectar a la autorregulación del comportamiento. Otros factores de riesgo específicos identificados en los participantes con CPAD fueron el juego patológico, y mayores limitaciones en la capacidad de afrontamiento y resolución de problemas. Estos hallazgos van

en línea con los resultados del Estudio 1, y son consistentes con la literatura que muestra una peor regulación psicoemocional, cognitiva y del comportamiento en los agresores con CPAD, lo que a su vez puede incrementar el riesgo de abandono y de reincidencia en estos participantes (Oberleitner et al., 2013; Romero-Martínez et al., 2023). Además, estos resultados sugieren la posibilidad de que algunos participantes con CPAD recurran al consumo de sustancias como un mecanismo de defensa para afrontar o automedicarse ante emociones difíciles (Gilchrist et al., 2022).

Con respecto a las variables social-relacionales, los factores de riesgo más sobresalientes en los participantes con CPAD fueron haber experimentado más eventos vitales estresantes y presentar historia de trauma en la infancia. Estos resultados son consistentes con la literatura que muestra que los agresores con historia de trauma pueden consumir alcohol y otras drogas como medio para sentir control y poder sobre sus vidas (Gilchrist et al., 2022). Por otro lado, se encontraron resultados mixtos en cuanto al apoyo social comunitario y al rechazo social percibido por estos participantes. Sin embargo, los resultados mostraron que los participantes con CPAD perciben un menor apoyo social íntimo, en comparación con aquellos sin CPAD.

En cuanto a las variables relacionadas con las actitudes hacia las mujeres, el factor de riesgo más relevante en los participantes con CPAD fue la atribución de responsabilidad de su conducta violenta a su contexto personal. Este resultado es consistente con la investigación que sugiere que algunos agresores pueden utilizar el CPAD como excusa para controlar a su pareja o para justificar su comportamiento violento (Radcliffe et al., 2017). El resto de las variables en esta categoría normalmente no mostraron diferencias significativas entre agresores con y sin CPAD, lo que es consistente con los resultados del Estudio 1. En conclusión, los participantes con CPAD presentan factores de riesgo específicos en comparación con los participantes sin CPAD. Los factores de riesgo identificados podrían ser objeto de atención en los programas de intervención, con el fin de mejorar los resultados de intervención de este grupo de participantes de alto riesgo, contribuyendo así a reducir sus altas tasas de abandono y de reincidencia.

El principal objetivo del Estudio 3 fue examinar el rol del establecimiento de metas en la reducción de las tasas de abandono en los hombres que acudían por mandato judicial a intervención con agresores y, específicamente, en aquellos con CPAD. En primer lugar, se examinaron las características de los agresores asociadas a una mayor probabilidad de establecerse una meta, ya que el establecimiento de metas es una estrategia motivacional

opcional. Los resultados de las regresiones simples indicaron que las características de los participantes significativamente asociadas con la probabilidad de establecerse metas incluyeron una edad más joven, la ausencia de hijos, niveles elevados de empatía (i.e., perspectiva empática), puntuaciones más altas en la escala de trastorno de personalidad hipomaníaco (i.e., niveles altos de excitación, energía y cambios de humor) y dependencia de drogas, un mayor apoyo comunitario formal, la percepción de un mayor rechazo social relacionado con la condena por violencia de género, una reducida adherencia a las creencias sobre roles de género y sexismo hostil, y encontrarse en un estadio de cambio más avanzado. Cuando se aplicó la corrección de Bonferroni para controlar el error Tipo I, solo una edad menor predecía significativamente una mayor probabilidad de establecerse una meta, lo que podría ser explicado por una mayor apertura al cambio y a recibir consejos por parte de los agresores más jóvenes (Carl et al., 2020). Cuando se llevó a cabo la regresión logística multivariante, las variables que permanecieron en el último paso de la predicción del establecimiento de metas fueron la juventud, una mayor capacidad de toma de perspectiva empática, puntuaciones más altas en hipomanía y un mayor apoyo comunitario formal. Estos resultados sugieren que los hombres más empáticos, y con mayor apoyo social, podrían reconocer el impacto de su comportamiento violento en su red social, lo que podría aumentar su disposición para el cambio (Romero-Martínez et al., 2019c). Además, las puntuaciones más altas en hipomanía podrían indicar un elevado nivel de energía y motivación que podría ser canalizado hacia la acción y el establecimiento de metas (McGinn et al., 2020). Este estudio mostró que el CPAD no se relacionada con una mayor o menor probabilidad de establecerse una meta. Dado que el porcentaje de hombres que se establecieron meta fue elevado, estos resultados podrían indicar que los participantes, independientemente de si presentaban CPAD o no, reconocían la importancia de plantearse metas de cambio.

Para investigar si el establecimiento de metas predecía una menor tasa de abandono después de ajustar por variables relevantes en la muestra total de agresores, primero se realizaron regresiones simples. Los resultados mostraron que los factores protectores del abandono incluían el establecimiento de metas, puntuaciones mayores en personalidad compulsiva, niveles altos de empatía, y apoyo comunitario formal e informal. Los factores de riesgo identificados para el abandono incluyeron niveles elevados de angustia personal empática y de ira estado, junto con puntuaciones más altas en diversas subescalas de trastornos de personalidad, como depresión mayor, paranoia, esquizoide, somatomorfo, y delirante. Además, tener CPAD predijo significativamente una mayor probabilidad de abandono,

incluyendo puntuaciones más altas en la AUDIT, un mayor consumo de cannabis y cocaína, y puntuaciones más altas en las subescalas de dependencia de alcohol y drogas. Esto concuerda con la creciente investigación que destaca el CPAD como un factor de riesgo clave para el abandono entre hombres derivados por mandato judicial a programas de intervención con agresores (Jewell y Wormith, 2010; Lila et al., 2020; Olver et al., 2011).

Además, nuestros resultados mostraron que experimentar un mayor número de eventos vitales estresantes, un mayor rechazo social percibido asociado a la condena por violencia de género, mostrar niveles más altos de sexismo hostil y tener un riesgo elevado de reincidencia, también se asociaron con mayores tasas de abandono en la muestra completa de agresores. Cuando se aplicó la corrección de Bonferroni, solo el establecimiento de metas surgió como un factor protector significativo contra el abandono. Además, el modelo multivariado reveló que las variables en el último paso del análisis que predijeron el abandono fueron el establecimiento de metas (i.e., establecerse metas predecía un menor riesgo de abandono) y tener CPAD (i.e., presentar CPAD precedía un mayor riesgo de abandono). Estos resultados destacan el papel positivo del establecimiento de metas como estrategia motivacional que podría incorporarse a los programas de intervención para agresores y resaltan la necesidad de abordar el CPAD como estrategia clave para reducir las elevadas tasas de abandono encontradas en estos programas.

Para responder al principal objetivo de este estudio, se investigó si el establecimiento de metas también predecía tasas más bajas de abandono para los participantes con CPAD. Las regresiones logísticas simples revelaron que establecerse metas, un mejor rendimiento en la decodificación emocional y un mayor apoyo comunitario informal percibido estaban significativamente asociados con tasas más bajas de abandono. Cuando se aplicó la corrección de Bonferroni, nuestros resultados mostraron que solo el establecimiento de metas predecía un menor abandono entre los agresores con CPAD. Además, el modelo multivariado reveló que los participantes con CPAD que establecieron metas tenían aproximadamente 5 veces más probabilidades de permanecer en el programa en comparación con aquellos que no establecieron ninguna meta. Además, con cada aumento de 1 unidad en la puntuación de apoyo comunitario informal, la probabilidad de abandono disminuyó en un 9%.

En resumen, el establecimiento de metas fue una estrategia efectiva para reducir las tasas de abandono tanto en la muestra completa de agresores como específicamente en aquellos con CPAD, quienes, según la literatura y en línea con nuestros resultados, tienen más probabilidades de abandonar. Una posible explicación de por qué el establecimiento de metas podría mejorar

la participación en la intervención podría ser que promueve un ambiente terapéutico no confrontativo donde los participantes pueden elegir voluntariamente objetivos personales que son significativos para ellos. Así, el establecimiento de metas podría fomentar que los participantes tomen un papel activo en su propio proceso de cambio, lo que es de vital importancia en el contexto de las intervenciones grupales para agresores en medio abierto, que a menudo siguen un modelo estandarizado que no se ajusta a las necesidades de los participantes.

5. Conclusiones

Esta tesis doctoral tuvo dos principales objetivos: (1) analizar los factores de riesgo y las necesidades de intervención de hombres con CPAD derivados por mandato judicial a acudir a un programa de intervención con agresores y (2) examinar si el uso de una estrategia de intervención motivacional específica, el establecimiento de metas, se relacionaba con menores tasas de abandono en los agresores de pareja, y específicamente en aquellos con CPAD.

Los resultados mostraron que los participantes con CPAD, un grupo de participantes que representan aproximadamente el 50% de los hombres que acuden a los programas, tuvieron una mayor presencia de factores de riesgo para ejercer violencia en múltiples niveles: nivel sociodemográfico, individual, social-relacional y actitudinal. Recogiendo los hallazgos de los Estudios 1 y 2, a nivel sociodemográfico, se encontraron resultados mixtos respecto a la edad, el estatus de inmigrante, el desempleo y el estado civil, por lo que se requiere más investigación para evaluar la presencia de factores de riesgo sociodemográficos específicos en los agresores con CPAD. A nivel individual, se encontraron diversos factores de riesgo específicos que diferencian a los participantes con CPAD de aquellos sin estos problemas. Los factores de riesgo más destacados fueron niveles altos de ira e impulsividad. Además, los participantes con CPAD presentaron mayores niveles de sintomatología clínica y de síntomas relacionados con la experiencia traumática, y obtuvieron mayores puntuaciones en las escalas que evalúan diversos trastornos de la personalidad, entre los que destacan el narcisista, antisocial, y de personalidad límite. Además, a nivel individual, los participantes con CPAD mostraron menores niveles de empatía y autoestima y mayores limitaciones en las funciones ejecutivas en comparación con los participantes sin CPAD. A nivel social-relacional, los hombres con CPAD informaron de un menor apoyo íntimo, y era más probable que hubieran experimentado un mayor número de situaciones vitales estresantes e historia de trauma en la infancia o adolescencia, en comparación con aquellos sin CPAD. A nivel actitudinal, los participantes con CPAD solían

atribuir la responsabilidad de su conducta violenta a su contexto personal (e.g., sus problemas de consumo, de gestión de la ira). Por último, los participantes con CPAD presentaron un mayor riesgo de reincidencia en su conducta violenta contra la pareja y contra otras personas, e informaron de haber ejercido un mayor nivel de violencia psicológica contra su pareja que aquellos sin CPAD.

Estos resultados tienen implicaciones prácticas importantes, ya que los factores de riesgo y las necesidades de intervención identificadas podrían traducirse en nuevos objetivos de intervención para este grupo de participantes de alto riesgo y altamente resistentes. La literatura reciente subraya específicamente la necesidad de llevar a cabo análisis de riesgo de los participantes de alto riesgo para ajustar la intervención a sus riesgos y necesidades (Bonta y Andrews, 2017). Así, estudios recientes muestran resultados prometedores en aquellos programas que, frente a los tradicionales, adaptan la intervención a los factores de riesgo de sus participantes, haciendo que los programas resuenen con las necesidades específicas de cada participante (Massa et al., 2020; Travers et al., 2021). Por ejemplo, los programas podrían trabajar desde un enfoque informado en trauma o incluir componentes sobre salud mental (Butters et al., 2021). Sin embargo, es necesario evaluar la eficacia de estrategias de intervención que trabajen sobre esos factores de riesgo identificados, para poder implementar estrategias basadas en la evidencia, y aumentar así la eficacia de los programas de intervención con agresores.

El Estudio 3 se centró en investigar una nueva propuesta de intervención, el establecimiento de metas, una estrategia motivacional en la que los participantes voluntariamente pueden plantearse una meta relevante para ellos que pueden trabajar de manera individual y grupal a lo largo de la intervención. Algunas características personales de los participantes se asociaron a una mayor probabilidad de que se establecieran una meta, como fue tener una menor edad, puntuar más alto en la escala de hipomanía, exhibir mayores niveles de perspectiva empática, y percibir un mayor nivel de apoyo comunitario. Para estudiar si el establecimiento de metas se relacionaba con una menor tasa de abandono después de controlar por variables relevantes, primero se estudiaron las características de los participantes que se asociaban a un mayor riesgo de abandono. Los principales predictores del abandono en la muestra total de participantes fueron el establecimiento de metas (i.e., factor protector contra el abandono), y tener CPAD. Cuando se seleccionaron específicamente a aquellos participantes con CPAD, los principales factores protectores contra el abandono fueron el establecimiento de metas y percibir un mayor apoyo social informal.

Estos hallazgos demuestran que los participantes que se establecieron metas, incluidos aquellos con CPAD, mostraron una menor tendencia a abandonar la intervención en comparación con aquellos que no se establecieron meta, incluso después de ajustar por variables relevantes, incluyendo variables sociodemográficas, individuales, social-relacionales y actitudinales. Estos resultados tienen importantes implicaciones prácticas, ya que el abandono del programa ha sido consistentemente identificado en la literatura como uno de los principales factores de riesgo para la reincidencia en la violencia de pareja (Jewell y Wormith, 2010). Por lo tanto, estos hallazgos animan a los y las profesionales que trabajan en programas de intervención con agresores a incluir el establecimiento de metas como una estrategia central para reducir la resistencia a la intervención, potenciar la motivación interna para el cambio, y disminuir la probabilidad de abandono por parte de los participantes, dos de los principales desafíos que las intervenciones deben abordar para aumentar su efectividad. Además, el establecimiento de metas puede servir como una estrategia motivacional para trabajar no solo la reducción de la conducta violenta, sino también la disminución de los factores de riesgo asociados identificados en estos estudios.

En definitiva, nuestros resultados podrían contribuir en el diseño e implementación de los programas de intervención con agresores, informando sobre las necesidades de intervención y los factores de riesgo específicos que necesitan ser abordados con los participantes con CPAD, y sobre las estrategias motivacionales efectivas para los participantes de alto riesgo, para así mejorar la efectividad de los programas, con el fin último de prevenir la violencia de pareja contra las mujeres y promover relaciones seguras e igualitarias libres de violencia.

Chapter 1: Introduction

1. Intimate partner violence

Intimate partner violence (IPV) is the most common form of violence against women and has been internationally recognized as a global public health and human rights concern of pandemic proportions (World Health Organization [WHO], 2021). IPV encompasses a spectrum of harmful behaviors perpetrated by current or former male intimate partners that cause physical, sexual, economic, and psychological harm to women (WHO, 2013, 2014).

Physical violence within IPV manifests as direct physical assaults and threats of violence (Leemis et al., 2022). Sexual abuse, within this context, includes but is not limited to, coercion or manipulation to engage in sexual acts against the victim's will, unwanted or non-consensual sexual behavior, and non-contact forms of sexual harassment, including verbal abuse or the unauthorized distribution of intimate images (Breiding et al., 2015). Economic abuse involves strategies such as preventing the victim from working and exerting financial control to maintain dominance over their life (Peterson et al., 2018). Finally, psychological harm encompasses a range of tactics, including emotional abuse such as gaslighting, where false information is used to make the victim question their own sanity, memory, or perception, as well as tactics aimed at humiliation (Breiding et al., 2015). This type of violence also includes social harm, which involves isolating the victim from their support network, including family and friends, and manipulating social connections to exert further influence (National Institute of Justice, 2007). In addition, psychological harm includes intimidation and stalking tactics aimed at instilling fear in the victim (Smith et al., 2017). It may also include tactics aimed at undermining the victim's sense of self-worth, and other behaviors, such as damaging the victim's relationship with their children or using child visitation to harass the female intimate partner (Office on Violence Against Women, 2023).

The likelihood of heterosexual women experiencing IPV from a male partner is considerably higher than the risk men face from a female partner (Centers for Disease Control and Prevention [CDC, 2022]; WHO, 2013). A WHO (2021) report on global prevalence estimates of IPV revealed that 27% of women who have been married or in a relationship between ages 15-49 have experienced physical and/or sexual violence from a current or former male intimate partner at some point in their lives. In Europe, physical and/or sexual IPV has been reported to affect 22% of women during their lifetime, while the prevalence of psychological IPV was 43% (European Union Agency for Fundamental Rights, 2014). Notably, Spain exhibits one of the lowest prevalence rates of IPV within the European context, with

around 13% of women having suffered physical and/or sexual IPV at least once in their lifetime (Martín-Fernández et al., 2019, 2020).

IPV against women by male intimate partners affects the lives of millions of women on a global scale (Sardinha et al., 2022). It causes severe short- and long-term physical, psychological, sexual and reproductive health problems for women. IPV also has an adverse effect on the health and wellness of their children. The consequences of such violence encompass substantial social and economic costs including reduced ability to work, salary loss, social isolation, and reduced ability to take care of oneself and one's children (WHO, 2021). In Spain, according to a recent report funded by the Spanish Ministry of Equality and conducted by Mañas-Alcón et al. (2024), economic costs related to IPV in Spain ascended to approximately 4 billion euros in 2022, which is equivalent to approximately 0.31% of the Gross Domestic Product (GDP).

At an international level, the Sustainable Development Goals (SDGs), endorsed by United Nations (UN) member states in 2015, underscore the imperative to achieve gender equality and women empowerment in Goal 5, which is focused on eliminating all forms of violence against women including IPV in their target 5.2.1. However, according to a recent report by the UN (2023) there has been a slow pace of progress in reducing IPV, and the world is not on track to fulfill this commitment. The encouraging robust finding is that IPV is preventable through targeted interventions and evidence-based strategies (Sardinha et al., 2022).

1.1. Risk factors for intimate partner violence

Burgeoning research has explored the diverse risk factors for IPV, recognizing its multifactorial nature (CDC, 2014). Building on Bronfenbrenner's (1979) ecological model, Heise (2011) proposed a valuable framework by categorizing IPV risk factors into individual, relational, community, and societal levels. This categorization sheds light on how factors across various contexts, from individual characteristics to wider social norms, interact and contribute to the occurrence of IPV.

In this regard, risk factors that increase the likelihood of IPV perpetration at the individual level include but are not limited to, young age, low education or income, mental health problems, and substance use (Cafferky et al., 2018; CDC, 2014; Heise, 2011; WHO, 2019). At the relational level, risk factors for IPV comprise aspects such as low social support, relationship conflicts, a history of experiencing poor parenting, and childhood exposure to

violence and trauma (Capaldi et al., 2012; CDC, 2021). At the community level, those who live in areas characterized by poverty, limited opportunities, high unemployment, violence, low neighborhood cohesion, easy access to substances, and a lack of community response and sanctions against IPV are at higher risk of perpetrating IPV (Arrojo & Santirso, 2023; CDC, 2021; Gracia et al., 2021). Finally, at the societal level, risk factors for IPV perpetration include, but are not limited to, patriarchal and sexist ideas, male dominance and traditional gender role beliefs (CDC, 2021; Willie & Kershaw, 2020).

1.1.1. *Alcohol and other drug use problems*

While IPV cannot be sufficiently explained by a single factor or theory, alcohol and other drug use problems (ADUPs) stand out as one of the main risk factors for IPV extensively documented in the literature (Jewell & Wormith, 2010; Langenderfer et al., 2013; Leonard & Quigley, 2017; Olver et al., 2011).

With regards to the use of different drugs among IPV perpetrators, while alcohol remains the clear leader in substance use among IPV perpetrators (Langenderfer, 2013), both cocaine and cannabis show concerning prevalence (Cafferky et al., 2018). A meta-analytic review conducted by Cafferky et al. (2018), showed that both alcohol and other drugs were significantly associated with IPV perpetration, with similar moderate effect sizes. In addition, a study conducted by Yu et al. (2019) found that men with ADUPs were 7 to 8 times more likely to be arrested for IPV compared to men without these issues. Notably, the effects of ADUPs on IPV may differ when participants are intoxicated (i.e., under the influence of alcohol or drugs), craving (i.e., intense desire for the substance) or in withdrawal (i.e., symptoms experienced when stopping use). For instance, the meta-ethnography conducted by Gilchrist et al. (2019) found that IPV is most likely to occur not only when men are intoxicated, but also during withdrawal, craving or struggling to pay for drugs, when irritability and frustration tend to escalate.

Several theories have been proposed to explain the entrenched link between IPV and ADUPs. However, it is imperative to underscore that these theories offer partial explanations for this association. Importantly, ADUPs are neither necessary nor sufficient in explaining IPV. Instead, ADUPs may play a contributing role in IPV and may have the potential to exacerbate its occurrence (Leonard & Quigley, 2017).

A traditional explanation for conceptualizing alcohol-related problems in IPV perpetrators has been the Alcohol Myopia Theory (AMT; Steele & Josephs, 1990), which posits that alcohol consumption impairs individuals' cognitive resources, by narrowing their attentional focus. As a result, individuals may be more likely to focus on salient cues that trigger their aggression, while ignoring less salient information that might inhibit their aggressive behavior. Similarly, and according to the I[3] model proposed by Finkel and Eckardt (2013), alcohol could function as a disinhibitor, altering executive functioning and impairing self-regulation. Thus, intoxicated individuals may experience diminished inhibitory control, which may narrow social information processing to the most salient cue within a relationship conflict (Eckhardt et al., 2013). Salient cues may act as instigating forces, such as aggressive communication, and threats, thus increasing the probability of an unregulated aggressive response (Finkel, 2007).

Three conventional conceptual models were also suggested to shed light on this complex relationship: the indirect effect model, the spurious model, and the proximal effects model (Leonard & Quigley, 1999). The indirect effect model posits that alcohol fosters family conflicts, thus increasing the likelihood of IPV. Conversely, the spurious model underscores factors that may contribute to both alcohol and IPV, such as age, childhood trauma, antisocial personality disorder and other personality characteristics. The proximal effects model, similar to AMT (Steele & Josephs, 1990), stands for the psychopharmacological impact of alcohol on cognitive functioning, together with the expectancy or excuse that may be associated with intoxication and that could facilitate IPV (Leonard & Quigley, 1999).

Feminist approaches to IPV have shifted the focus away from the physiological consequences of ADUPs to elucidate IPV (Gadd et al., 2019). Rather, the emphasis has been on how some men who perpetrate IPV maintain power over women by blaming their violent behavior on alcohol, insisting that their alcohol consumption caused them to behave in unusual ways or denying any memory of their violent acts (Gadd et al., 2019; McMurran & Gilchrist, 2008). In this line, Radcliffe et al. (2019) conducted a narrative analysis of in-depth interviews with men in substance use treatment with a history of IPV and their female partners. The study revealed that the psychopharmacological effects of substance use, including intoxication, craving and withdrawal, although frequently referenced, were rarely presented as the only explanation for men's aggressive behavior. Instead, their narratives focused on jealousy, general mistrust, and women's resistance to male authority and control. This study also showed that men were more likely to explain IPV as a sporadic incident resulting from specific conflicts,

often exacerbated by ADUPs, such as intoxication and withdrawal. Conversely, women described IPV as a recurring pattern of abuse, often associated with ADUPs and disputes over obtaining substances (Radcliffe et al., 2019).

Gilchrist et al. (2022), in their descriptive model on the pathways between IPV and ADUPs in men, described three groups of pathways in men in substance use treatment who perpetrated IPV against women: the rule-breaking pathway, the entrenched substance use pathway, and the relationship insecurity pathway.

Concerning the rule-breaking pathway, the exposure to childhood physical and emotional abuse within patriarchal family structures appeared to foster a need for control and power in this group of IPV perpetrators. This need for control and power could be exhibited through misogynistic attitudes and behaviors such as ADUPs and antisocial behavior. An important finding was that men in this group reported IPV incidents separate from any discussion of substance use, and reported general violence to both men and women, including incidents of severe physical violence. While some participants in this pathway attributed their violent behavior to ADUPs, many recognized that their ADUPs were not a determining factor but rather an affirmation of pre-existing beliefs about gender roles. In addition, there was a tendency among some perpetrators to target women with histories of trauma and victimization, possibly with the intention of exerting perceived power or control over them. This pathway echoes the well-known typology of the generally violent and antisocial perpetrator, characterized by high levels of all types of violence, and moderate to severe IPV and ADUPs (Holtzworth-Munroe & Stuart, 1994).

Men in the entrenched substance use pathway experienced early trauma (e.g., particularly sexual abuse and humiliating experiences) and early onset of ADUPs, which contributed to a highly interrelated relationship between ADUPs and IPV. Substance use often served as a coping mechanism to deal with past trauma or as a way to self-medicate unpleasant emotions associated with early trauma experiences. This is consistent with the self-medication hypothesis (Khantzian, 1997), which suggests that individuals with a history of trauma may use substances as a way to alleviate trauma symptoms and cope with difficult emotions (Lawrence et al., 2023). A substance use lifestyle was common among this group of perpetrators and their partners, with some men using it as an excuse for their violent behavior. In addition, although substance use appeared to exacerbate partner conflict, especially when intoxicated, craving or

in withdrawal, many participants felt that both ADUPs and IPV were related to their past traumatic experiences and related mental health problems.

Men in the relationship insecurity pathway typically reported perpetrating IPV exacerbated by substance use and as a result of their insecurity and sexual jealousy. Men in this group were less likely to have had early traumatic experiences, often reporting happy and stable childhoods. Rather, their use of substances tended to follow adverse life events, such as relationship breakdowns, or bereavement and was often recreational or event driven. Their lifestyles were often stable in terms of employment, social support, and secure housing, but ADUPs increased when some of these protective factors were compromised or absent. Incidents of IPV tended to be impulsive and physical and driven by feelings of insecurity and fear of abandonment. This is consistent with research linking insecure attachment styles with ADUPs (Fairbairn et al., 2018). This group of perpetrators may use substance use to help regulate their affect, relational distress, and relationship concerns, in an effort to compensate for a lack of attachment and self-regulatory strategies (Coffman & Swank, 2021; Schindler, 2019).

Overall, the complex interplay between ADUPs and IPV has been attributed to several factors. Firstly, the psychopharmacological effects of substance use can impair cognitive processes, potentially facilitating IPV (Leonard & Quigley, 1999). Secondly, within gendered power dynamics, some men may use ADUPs as a justification or means to exert control over women (Gadd et al., 2019). Additionally, substance use can serve as a method to maintain antisocial behavior in some generally violent individuals, self-medicate or cope with past traumatic experiences, or exacerbate feelings of sexual jealousy and fear of abandonment among insecure individuals (Gilchrist et al., 2022). These underlying factors may contribute to understanding the complex phenomenon of substance-related IPV.

2. Intervention programs for intimate partner violence perpetrators

To mitigate IPV, international efforts have been made to implement interventions aimed at reducing IPV such as victim-support services and other victim-centered interventions which are key to reducing harm and providing support to survivors (Ogbe et al., 2020). However, IPV perpetrators frequently abuse multiple victims or maintain their relationship with the victim (Lila et al., 2013), so intervention programs targeting men who perpetrate IPV are also crucial to promoting change in men and reducing IPV recidivism. As a result, laws have been instituted for males who have been arrested for IPV to receive community-based intervention programs for IPV perpetrators. These interventions originated in the late 1970s, stemming from the

recognition of IPV as a significant social and public health concern (Lila & Gilchrist, 2023). Since then, perpetrator programs have constituted a pivotal component of the criminal justice strategy in addressing IPV (Cunha & Caridade, 2023).

Historically, the two main intervention approaches for IPV perpetrator programs have been the Duluth Model (Pence & Paymar, 1993) and the Cognitive Behavioral Therapy (CBT) Model (Wexler, 2000). The Duluth Model posits that men use violence in their intimate partner relationships as a form of control over women and to preserve their position of power (Babcock et al., 2016). It focuses on psychoeducation and awareness of the use of violence from a feminist and ecological perspective (Eckhardt et al., 2006). The CBT model, on the other hand, views violence against women as a maladaptive response to relationship conflict and focuses on addressing dysfunctional cognitions, enhancing communication skills, managing emotions, and employing anger management techniques to mitigate IPV (Eckhardt et al., 2014). Over time, however, the distinction between the Duluth and CBT models has gradually become less clear, resulting in intervention programs in which the two models overlap and are equally integrated (Babcock et al., 2004, 2016).

In Spain, following the enactment of the Comprehensive Law 1/2004 on Measures for Integral Protection against Gender-Based Violence (Boletín Oficial del Estado, 2004), there has been a significant increase in the number of intervention programs for IPV perpetrators. CBT-based interventions are the most widely implemented approach in Spain. These intervention programs are available to men serving prison sentences for IPV, and to men who have been court-mandated to attend community-based interventions in a group format. This thesis focuses on the latter group, specifically on men sentenced to less than 2 years in prison, who have no previous criminal record, and have a suspended sentence on the condition that they attend an intervention program for IPV perpetrators (Lila et al., 2018).

2.1. Effectiveness of intervention programs for IPV perpetrators

The development and spread of intervention programs for IPV perpetrators have been a significant advance in promoting healthy, egalitarian behaviors alternative to violence and reducing recidivism in male perpetrators convicted of IPV crimes (Babcock et al., 2016). These programs have been considered the primary model for court-mandated perpetrators to increase accountability awareness of their violent attitudes and acts (Voith et al., 2018). As a consequence, an interest in evaluating these programs' effectiveness has been raised (Cheng et al., 2021; Lila & Gilchrist, 2023).

Systematic reviews and meta-analyses investigating the effectiveness of these programs have yielded mixed findings, indicating positive but small to moderate effect sizes in preventing further IPV incidents (Arce et al., 2020; Nesset et al., 2019; Tarzia et al., 2020). In their widely cited meta-analytic review, Babcock et al. (2004) examined 22 studies and concluded that intervention programs for IPV perpetrators demonstrated significant effects with a small effect size in reducing official recidivism across both experimental and quasi-experimental studies. Regarding victim-reported recidivism, significant reductions with a small effect size were found in quasi-experimental studies, whereas such reductions were not observed in experimental studies. Overall, this review demonstrated that these programs may lead to an approximate 5% decrease in IPV recidivism among treated IPV perpetrators compared to those who did not receive treatment.

The systematic review conducted by Nesset et al. (2019), which included four randomized controlled trials (RCT) and two non-randomized control trials, demonstrated that three of the four RCTs found a significant reduction in IPV after the intervention program. However, due to mixed findings in the other studies, the overall evidence for CBT effectiveness remained inconclusive (Nesset et al., 2019).

The meta-analytic review conducted by Arce et al. (2020) analyzed 25 studies and found positive but not generalizable results. Specifically, the review showed a significantly positive reduction of recidivism assessed by police reports of a medium effect size for intervention programs for IPV perpetrators. By contrast, this effect was not observed in victim-reported recidivism. Based on the findings of this meta-analysis, there was an estimated overall effectiveness of approximately 21% in reducing the recidivism rate when comparing intervened IPV perpetrators to non-intervened perpetrators (Arce et al., 2020).

In their meta-analysis, Cheng et al. (2021) examined 14 studies to update evidence on the effectiveness of intervention programs for IPV perpetrators. Results revealed that these programs were effective in reducing IPV recidivism and general offense recidivism as reported by the criminal justice system, although not as indicated by survivor reports. Participants in such programs were approximately three times less likely to exhibit IPV recidivism and about 2.5 times less likely to engage in general offense recidivism compared to non-treated control or comparison groups. However, the pooled effect size varied depending on the research design. Specifically, while studies using a quasi-experimental design found a significant pooled effect size, randomized controlled trials showed a nonsignificant one (Cheng et al., 2021).

Likewise, a recently updated systematic review by Wilson et al. (2021) which included 11 experimental and rigorous quasi-experimental studies that evaluated court-mandated intervention programs for IPV perpetrators and measured official or victim-reported IPV recidivism, concluded that there was insufficient evidence to draw conclusions about the effectiveness of these programs.

Although this body of research suggests inconclusive findings on the effectiveness of intervention programs for IPV perpetrators, it is important to note, as Tarzia et al. (2020) underscored, that more robust study methodologies are required to provide better evidence of effectiveness. This includes larger sample sizes, decreased attrition rates, and more rigorous control conditions. In addition, the growing body of research in this field highlights key challenges that must be addressed to increase the effectiveness of intervention programs for IPV perpetrators.

First, most intervention programs for IPV perpetrators follow a one-size-fits-all model, a standardized treatment designed to reduce IPV and promote healthy relationships among men attending interventions in a group-based format (Richards et al., 2022). However, intervention programs for IPV perpetrators often lack tailored strategies to address the specific risks and needs presented by high-risk and highly resistant participants (Butters et al., 2021; Karakurt et al., 2019). Second, perpetrators often exhibit significant resistance to the intervention and low motivation to change, which limits their ability to work effectively during the program (Jewell & Wormith, 2010). Because the majority of participants are court-mandated, perpetrators often lack intrinsic motivation for treatment, and may even deny responsibility for their violence or exhibit victim-blaming attitudes (Lila et al., 2014; Martín-Fernández et al., 2018; Tutty et al., 2020). As a result, intervention programs for IPV perpetrators often have high dropout rates (Karakurt et al., 2019; Olver et al., 2011), which ascended to an average of 35.44% according to a recent systematic review (Cunha et al., 2024). These elevated rates are of particular concern, given the well-established link between high dropout rates and the increased likelihood of IPV recidivism (Lila et al., 2019). In sum, many intervention programs overlook the diverse needs and characteristics of their participants, which may contribute to the high dropout rates and low treatment engagement typically seen in such programs (Cunha et al., 2024). Therefore, strong efforts should be made to reduce the typically high dropout rates and increase treatment engagement and motivation to change.

New approaches have been developed to address these challenges and increase intervention effectiveness. Specifically, to address the first challenge, the risk-needs-responsivity (RNR) approach (Andrews & Bonta, 2010) has emerged to tailor the interventions to participants' specific risks, so that their diverse individual needs are addressed. In addition, motivational strategies have been increasingly incorporated into intervention programs for IPV perpetrators as a promising approach to increase the motivation to change and reduce dropout and recidivism (DiClemente et al., 2017).

Overall, there is still room for improvement in increasing the effectiveness of intervention programs for IPV perpetrators. This can be achieved by targeting the risks and needs of high-risk participants identified in the literature and by promoting motivation to change and treatment engagement, two aspects that are particularly important for participants with ADUPs (Travers et al., 2021).

2.2. Participants with ADUPs

Individuals attending intervention programs for IPV perpetrators who also present ADUPs have been identified as a high-risk and highly resistant group of perpetrators (Jewell & Wormith, 2010). Specifically, participants with ADUPs are more likely to present lower treatment engagement, drop out from the intervention program, perpetrate more severe violence, and recidivate (Cafferky et al., 2018; Lila et al., 2020; Jewell & Wormith, 2010; Olver et al., 2011).

Literature on the addiction field also underscores the strong connection between ADUPs and IPV in addiction treatment. Approximately 40% of men undergoing treatment for alcohol abuse or dependence disclose that they have recently engaged in physical IPV perpetration (Taft et al., 2010), a percentage that is at least twice as high as that of men in the general population (O'Farrel et al., 2003; Gilchrist et al., 2015). In intervention programs for IPV perpetrators, participants with ADUPs represent approximately 50% of all participants. Given that this group of perpetrators is at higher risk of dropout and recidivism, it is significant to include ADUPs as a key target in such programs (Crane et al., 2015).

2.2.1. *Risk factors and intervention needs of participants with ADUPs*

Consistent with the European Standards for Perpetrator Programmes (European Network for the Work with Perpetrators of Domestic Violence [WWP EN], 2023), conducting risk assessments is key to identifying participants' needs at intake, and tailoring the intervention to address those risks (Bonta & Andrews, 2017; Richards et al., 2022).

Given the significance of effectively addressing ADUPs in intervention programs for IPV perpetrators as a major risk factor for IPV (Cafferky et al., 2018), it is important to note that participants with ADUPs may also exhibit additional risk factors and treatment needs associated with their ADUPs that require attention.

For instance, at the individual level, research indicates that participants with ADUPs often present poorer cognitive abilities, diminished anger management skills, and increased mental health issues (Eckhardt et al., 2008; Moore & Stuart, 2004; Petersson & Strand, 2017; Romero-Martínez et al., 2019a). At the social-relational level, participants with ADUPs are more likely to have experienced numerous stressful life events and childhood trauma, and they tend to have lower levels of intimate social support (Catalá-Miñana et al., 2013, 2017; Travers et al., 2022). Additionally, in terms of attitudes towards IPV, participants with ADUPs often attribute blame for their violent acts to their personal circumstances, including ADUPs (Lila et al., 2014). According to the meta-analytic review conducted by Crane et al. (2015), these associated factors, along with the psychopharmacological effects of alcohol, may contribute to the moderate effect size identified in the direct proximal effects of alcohol on increasing the likelihood of IPV (Wilson et al., 2017). Further, achieving abstinence or reducing ADUPs alone has revealed positive but non-sustained effects in reducing IPV, thus, addressing ADUPs while overlooking their associated factors may not be sufficient to decrease the likelihood of IPV recidivism (G. Gilchrist et al., 2021). However, more research is needed to identify the risk factors and treatment needs of participants with ADUPs beyond their substance use issues relative to those without these problems. This analysis could provide clarity for the development of evidence-based strategies tailored to the specific needs and risks of participants with ADUPs, thereby reducing their increased risk of dropout and recidivism, which could lead to improved program effectiveness (Crane et al., 2016).

Overall, participants with ADUPs may benefit from risk assessments and approaches such as the risks-needs-responsivity model (Andrews & Bonta, 2010) to address their specific risks and needs, and from motivational strategies to reduce their resistance towards the

intervention and their elevated dropout rates (Travers et al., 2021; Turner et al., 2023). Improving the outcomes of this high-risk group of participants may enhance the effectiveness of intervention programs for IPV perpetrators.

3. Risk-needs-responsivity approach

In response to the limitations of one-size-fits-all intervention programs for IPV perpetrators, recent research has advocated for the use of individualized treatment that addresses participant's risks and needs, including ADUPs and their associated risk factors (Babcock et al., 2016; Turner et al., 2023; Karakurt et al., 2019). In this line, the risk-needs-responsivity (RNR) model was proposed by Andrews and Bonta (2010) as a means to address the heterogeneity of group-based formats and the identified risk levels and specific needs of participants (Bonta & Andrews, 2017). The RNR model supports the idea that the best effectiveness outcomes are achieved when the type of treatment is matched to the participant's risks and needs, and thus, the RNR model is consistent with the Principles of Effective Interventions (PEI), which include the principles of treatment and fidelity in addition to the principles of RNR (Richards et al., 2022).

According to the RNR model (Andrews & Bonta, 2010), the risk principle states that the intensity of the intervention should be adjusted to the participant's risk level of recidivism, underscoring the need to conduct robust risk assessments in such interventions that help identify participants' risk factors. The needs principle stands for attending to the participant's specific criminogenic needs, which are those dynamic factors closely linked to the maintenance of their violent behavior, including individual factors, such as substance use, and contextual needs, such as social-relational and attitudinal risk factors. This principle encourages programs to design individualized treatment plans based on identified criminogenic needs and risks to address them by using evidence-based strategies. The responsivity principle advocates for cognitive-behavioral programs that are also adjusted to the individuals' risk factors and criminogenic needs. Thus, interventions should consider participants' motivation to change, learning styles, treatment engagement and other individual differences that may impact treatment success (Bonta & Andrews, 2017). According to the PEI framework (Radatz & Wright, 2016), the treatment principle stands for using cognitive social learning strategies to elicit change, including role-playing, skills-building, problem-solving and modeling techniques. The treatment principle also highlights the importance of acute rather than moderate-intensity treatment modalities (Richards et al., 2022). Lastly, the fidelity principle advocates for

qualified, highly trained and monitored programs' facilitators and staff, and states that the quality of such programs should be properly evaluated and assessed (Radatz & Wright, 2016).

Recent meta-analyses and systematic reviews have shown that adherence to these principles increases the effectiveness of intervention programs for IPV perpetrators over standard programs (Butters et al., 2021; Travers et al., 2021; Karakurt et al., 2019). Specifically, as suggested by Olver et al. (2011), interventions that follow the RNR model typically have the lowest dropout and IPV recidivism rates (Babcock et al., 2004). Other recent research also supports the RNR model in IPV interventions as a means of addressing participants' criminogenic needs to improve perpetrator outcomes (Hilton & Radatz, 2021; Richards et al., 2022). Similarly, several studies focused on men in substance use treatment who reported perpetrating IPV suggest that addressing participant's risk factors is key to increasing motivation to change and treatment engagement (Dheensa et al., 2022; Dillon et al., 2020).

Translating this approach to the urgent need to target ADUPs in intervention programs for IPV perpetrators, the research emphasizes that risk assessment is essential to identify the treatment needs and the risk, and protective factors associated with ADUPs in this high-risk group of participants (Leonard & Quidley, 2017). This will allow for the development of individualized plans that are sensitive and responsive to the risks and needs of these participants (Massa et al., 2020). Despite the potential benefits of following the RNR principles demonstrated in recent literature, the integration of these principles into IPV interventions is only just emerging (Richards et al., 2022). This body of research highlights that intervention efforts should be made to integrate these principles into intervention strategies for IPV perpetrators.

Although screening for ADUPs among men participating in intervention programs for IPV perpetrators is crucial, it is surprisingly not a standard risk assessment practice in most intervention programs. Formal and clinical diagnoses of alcohol or drug dependence, as defined by the American Psychiatric Association (APA, 2013), typically fall outside these programs' scope. However, an increasing number of IPV interventions now integrate validated self-report screening scales, such as the *Alcohol Use Disorder Identification Test* (AUDIT; Babor & Grant, 1989) and the drug and alcohol dependence scale from the *Millon Clinical Multiaxial Inventory-III* (MCMI-III; Millon, 2007), into their assessment practices. These tools aid in identifying potential ADUPs, identified by the frequent and problematic use of substances leading to

potential harm for the individual or others. This shift is critical for comprehensive risk assessment, considering the well-established link between ADUPs and IPV perpetration.

4. Motivational strategies

As stated before, one of the most prominent and promising approaches to overcome the challenges faced by IPV programs to increase their effectiveness is the incorporation of motivational-based approaches (Pinto e Silva et al., 2023; Santirso, Gilchrist, et al., 2020; Soleymani et al., 2018). For example, an updated systematic review conducted by Wilson et al. (2021) revealed inconclusive results regarding the effectiveness of intervention programs for IPV but underscored that a new generation of IPV programs is incorporating motivational strategies with promising results (Wilson et al., 2021).

Motivational strategies, which originated in the addiction field and were proven effective for highly resistant patients, could be defined as a person-centered, collaborative approach which seeks to promote ambivalence about change and elicit motivation for change (Miller & Rollnick, 2002, 2009; Rogers, 1951). Motivational strategies acknowledge that individuals participating in the interventions exhibit different levels of readiness to change. According to the Transtheoretical Model of change (Prochaska & DiClemente, 1982), individuals progress towards change through a number of stages of change, including precontemplation (i.e., feeling resistant, unmotivated and avoiding information), contemplation (i.e., being ambivalent about change), preparation (i.e., exhibiting a clear action to change), action, and maintenance. By fostering a strong therapeutic alliance, facilitators strive to enhance participants' awareness of the implications of changing and not changing while using a nonjudgmental style throughout the change process (Lundahl et al., 2010). To guide participants toward behavior change, facilitators rely on four therapeutic principles (Moyers & Rollnick, 2002): (1) expressing empathy, which involves active listening and guiding participants to explore their inner thoughts and motivations, (2) evoking discrepancy, which means that facilitators encourage participants to reflect on inconsistencies between their values, goals, and current behaviors, while promoting motivation to change, (3) rolling with resistance, which refers to accepting participants' defenses and reluctance to change as a natural stage in the process of change rather than a pathological sign that needs to be confronted and (4) enhancing participants' self-efficacy, which involves that facilitators empower participants by highlighting their strengths and abilities and by increasing their confidence in their ability to change (Lundahl et al., 2010; Miller & Rollnick, 2002, 2013). Motivational strategies also incorporate

four communication skills, also known as OARS, that facilitators may use to elicit change talk, which include asking open-ended questions, offering affirmations, engaging in reflective listening, and summarizing the conversation (Miller & Rollnick, 2013).

When incorporated into intervention programs for IPV perpetrators, motivational strategies include motivational interviewing (MI; Crane & Eckhardt, 2013; Musser et al., 2008; Kistenmacher & Weiss, 2008), goal setting (Roldán-Pardo et al., 2023), retention techniques (Mbilinyi et al., 2011; Taft et al., 2001), strategies based on strengths-based approaches (Lehmann & Simmons, 2009) and the stage of change model (Prochaska & DiClemente, 1982).

Recent systematic reviews have demonstrated improved treatment outcomes when incorporating motivational strategies into intervention programs for IPV perpetrators (Pinto e Silva et al., 2023; Soleymani et al., 2018; Wilson et al., 2021). Specifically, a growing body of research reveals that incorporating motivational strategies into intervention programs for IPV perpetrators could improve treatment engagement, reduce dropout and recidivism rates, and increase motivation to change, which are key factors in enhancing programs' effectiveness (Alexander et al., 2010; Kistenmacher & Weiss, 2008; Murphy et al., 2020; Musser et al., 2008; Santirso et al., 2020; Scott et al., 2011; Stuart et al., 2007). In this line, a meta-analysis conducted by Santirso, Gilchrist, et al. (2020) showed that participants assigned to intervention programs for IPV perpetrators without motivational strategies had 1.73 times greater dropout rates than participants assigned to perpetrator programs that incorporated motivational strategies. Similarly, a recent meta-analysis and systematic review conducted by Cunha et al. (2024) showed that participants who received motivational interviewing as an adjunct to the intervention program for IPV perpetrators showed lower dropout rates. Consistent with prior research, studies included in this meta-analysis also showed that the incorporation of MI into perpetrator programs helped promote motivation to change, treatment adherence and intervention dose (Santirso, Lila, et al., 2020; Pinto e Silva et al., 2023; Soleymani et al., 2022).

Participants may feel less resistant to the intervention if their motivation to change is increased and their level of treatment engagement rises, which may be encouraged by the empathetic, nonconfrontational and collaborative nature of motivational strategies (Babcock et al., 2016; Murphy & Ting, 2010; Santirso, Gilchrist, et al., 2020). For example, a study conducted by Soleymani et al. (2022) showed that participants who received MI to increase their engagement reported significantly higher levels of readiness for IPV intervention, supporting the idea that MI can be effective in preparing individuals to engage in intervention

programs for IPV perpetrators. The study conducted by Crane and Eckhardt (2013) also revealed that participants who received one brief MI session before the intervention took place attended a significantly higher number of sessions than participants in the control group.

In an RCT conducted by Lila et al. (2018), IPV perpetrators assigned to an individualized motivational plan (IMP) added to a standard intervention for IPV perpetrators attended more sessions, were in a later stage of change, reported less physical IPV after treatment and exhibited lower recidivism risk than participants in the standard control condition. Motivational strategies could also improve other relevant variables that play a critical role in the participants' likelihood of IPV recidivism, including cognitive abilities such as emotion decoding abilities and empathy. In this regard, an RCT by Romero-Martínez et al. (2019c) showed that only IPV perpetrators receiving motivational strategies before a standard group-based intervention improved their empathy (i.e., higher empathetic perspective-taking) and their emotional decoding abilities. Furthermore, it appears that motivational strategies are particularly effective for IPV perpetrators who are more resistant to the intervention (Rollnick et al., 1992) and at higher risk of IPV recidivism, such as court-mandated participants who have ADUPs (Dheensa et al., 2022; Mbilinyi et al., 2011; Schumacher et al., 2011; Stephens-Lewis et al., 2021; Stuart et al., 2013).

4.1. Integrated interventions for perpetrators with ADUPs

Addressing ADUPs and their associated risk factors in men participating in intervention programs for IPV perpetrators could be a potentially effective strategy for reducing IPV, in alignment with the recommendations from the WHO (2010), and existing research (G. Gilchrist et al., 2021; Leonard & Quigley, 2017; Siria et al., 2022). Bennet (2008) reviewed various methods for integrating interventions to address ADUPs in IPV perpetrators and suggested that integrated interventions have potential compared to consecutive or parallel approaches. Potential benefits of integrated interventions included reduced personnel requirements, improved time efficiency, and increased participant adherence and completion rates (Gilchrist & Hegarty, 2017).

Recent systematic reviews and meta-analyses in this area highlight that integrated interventions addressing both IPV and ADUPs hold significant promise in increasing the effectiveness of perpetrators programs (Karakurt et al., 2019; Tarzia et al., 2020; Turner et al., 2023; Wilson et al., 2021). In this line, RCTs examining the efficacy of motivation-based integrated interventions addressing IPV and ADUPs demonstrate potential to increase program

effectiveness (Mbilinyi et al., 2023; Stuart et al., 2013). For example, Murphy et al. (2018) evaluated the efficacy of a 4-session motivational enhancement therapy (MET) for partner-violent men with ADUPs attending intervention programs for IPV perpetrators as opposed to 4 individual treatment sessions of alcohol education and showed some benefits for participants in the MET condition, such as greater recognition of alcohol problems but did not evidence a unique effect of MET on decreasing ADUPs and IPV. Additionally, a more extensive integrated intervention (e.g., initial motivational interviewing plus a cognitive behavioral substance abuse-domestic violence intervention) showed promise in decreasing addiction to drugs and IPV compared to drug counselling in substance-dependent men arrested for IPV in the United States (Easton et al., 2018). This body of research underscores the need to develop integrated evidence-based strategies that address both IPV and ADUPs to improve treatment outcomes, such as reducing dropout rates, increasing treatment engagement, and reducing risk factors associated with ADUPs, with the ultimate goal of reducing the risk of IPV recidivism.

4.2. Goal setting

Goal setting has emerged as a core intervention strategy in programs for IPV perpetrators, which could help address key intervention targets in standard motivation-based programs, and ADUPs and their associated risk factors in integrated interventions (Lila et al., 2018). Goal setting serves as a motivational strategy rooted in a humanistic, strengths-based approach that emphasizes the collaborative construction of goals that align with participants' personal values (Langlands et al., 2009; Ward, 2002). The collaborative nature of goal setting represents facilitators guiding and accompanying participants to map out their process of change and enable action toward change (Bolton et al., 2016; Lee et al., 2007; Lila et al., 2018). Within this framework, goals could be tailored to participants' needs for autonomy, competence, and relatedness, as articulated by Deci and Ryan (2000). These goals contribute to the cultivation of a life characterized by personal growth and the search for meaning, thereby moving away from violent behaviors and attitudes (Langlands et al., 2009; Zarling et al., 2015).

The conventional definition of goals includes personally valuable objectives that inspire better self-performance (Ryan, 1970). Coming from a business model, the SMART model (Drucker, 1954) advocates for goals which are specific, measurable, achievable, relevant, and timely. They have been used, for instance, in integrated interventions for men with substance use problems who perpetrated IPV (E. Gilchrist et al., 2021). Goal setting is designed to enhance

participants' self-regulation and self-efficacy while increasing treatment engagement in such programs (E. Gilchrist et al., 2021).

The study conducted by Roldán-Pardo et al. (2023) qualitatively analyzed and categorized the personal goals of a sample of men who were court-mandated to participate in an intervention program for IPV perpetrators. Using thematic analysis, four core categories emerged: 'interpersonal relationships', 'personal resources for daily life', 'coping strategies', and 'motivation to change'. Interpersonal relationship goals were the most prevalent core category and included themes related to social relationships, interpersonal conflict solving and communication skills. An example of a real case participant's goal was "to show affection to people who are important to me" (Roldán-Pardo et al., 2023, p. 6). Personal resources for daily life included goals categorized as personal well-being, emotional decoding, cognitive abilities, and daily problem-solving. Examples included goal themes such as increasing self-esteem and self-confidence and being more flexible with others. The core category of coping strategies included aspects related to managing emotions, self-control and substance use. Examples of goals related to substance use included aspects such as stopping using alcohol or cocaine in order to feel healthier. Lastly, self-determined goals that fit into the core category of motivation to change included goals related to taking responsibility and commitment to the IPV intervention.

Goal setting echoes the well-known Good Lives Model (GLM; Ward, 2002). This model underscores the importance for individuals to pursue a life that is meaningful and fulfilling, that supports pro-social values and that is contrary to violence and IPV perpetration. This could entail addressing the risk factors for IPV recidivism while recognizing and setting constructive goals. Both the GLM framework and goal setting resonate with the idea that individuals are more prone to end violence when they strive for a meaningful, fulfilling and purposively life (Langlands et al., 2009). Intervention programs following this approach, in contrast to traditional IPV interventions, not only manage participants' risk directly but also promote positive life changes and support long-term behavior change (Stewart & Slavin-Stewart, 2013; Ward & Gannon, 2006).

Tailoring treatment plans to the individualized goals of participants could be crucial to addressing participants' needs in alignment with their values. An example of this individualized treatment plan in intervention programs for IPV perpetrators is the IMP (Lila et al., 2018) which

was designed as a set of motivational strategies including goal setting as a core strategy to address participants' needs while reducing their risk of recidivism.

Incorporating goal setting as a pivotal motivational strategy in intervention programs for IPV perpetrators holds promise in improving treatment outcomes. Research indicates that goal setting could help participants in fostering attitudinal and behavioral change, reducing IPV recidivism rates, and increasing their personal responsibility assumption and motivation to change (Curwood et al., 2011; Lee et al., 2003, 2014; Murphy & Meis, 2008). In this regard, Waller (2016) conducted a systematic review of the effectiveness of such programs and revealed that the only study which utilized goal setting as an intervention strategy showed the lowest dropout rates relative to other intervention modalities such as the CBT model or the Duluth model (Lee et al., 2007). These findings highlight the potential effectiveness of goal setting in maintaining treatment adherence (Waller, 2016).

However, further research is needed to examine whether goal setting improves treatment outcomes, particularly in high-risk groups of IPV perpetrators, such as those with ADUPs. Understanding how goal setting has an impact on treatment outcomes can guide professionals in tailoring interventions to individual needs and strengthening goal achievement strategies. Moreover, identifying whether high-risk perpetrators, such as those with ADUPs, also benefit from goal setting can inform intervention design and facilitate the implementation of targeted strategies to reduce IPV recidivism rates and improve intervention effectiveness (Stephens-Lewis et al., 2021). For example, encouraging participants to set goals related to ADUPs could be an effective integrated strategy to reduce IPV and address their underlying risk factors (Dheensa et al., 2022).

Based on existing research, incorporating goal setting as a core component of motivation-based intervention programs may hold particular promise in addressing participants' risk factors and needs and promoting retention, which is key in reducing IPV recidivism rates and increasing programs' effectiveness (Diclemente et al., 2017). Hence, it is of significant relevance to further explore the role of goal setting in reducing dropout rates and increasing treatment engagement among IPV perpetrators, especially among participants with ADUPs, who may present additional risk factors that should be explored and addressed (Dheensa et al., 2022; McDonagh et al., 2023).

Chapter 2: Objectives

1. Objectives

The general objective of this thesis was to identify the main risk factors and treatment needs of participants with ADUPs court-mandated to attend intervention programs for IPV perpetrators and to examine whether incorporating goal setting as an intervention strategy resulted in lower dropout rates for IPV perpetrators, and specifically those with ADUPs. This doctoral thesis presents three research papers, published in scientific journals indexed in the Journal Citation Reports (JCR), which respond to these specific objectives:

Objective 1. To identify the main risk factors and treatment needs of men with ADUPs court-mandated to attend an intervention program for IPV perpetrators. This goal was the subject of the first and second studies:

- **Study 1.** This study aimed to address objective 1 in a sample of court-mandated men participating in an intervention program for IPV perpetrators, by comparing participants with and without substance abuse problems in four sets of potential risk factors: (1) sociodemographic; (2) personality disorders and psychological adjustment; (3) social/relational factors; and (4) violence-related factors.

    - Expósito-Álvarez, C., Lila, M., Gracia, E., & Martín-Fernández, M. (2021). Risk factors and treatment needs of batterer intervention program participants with substance abuse problems. *The European Journal of Psychology Applied to Legal Context, 13*(2), 87-97. https://doi.org/10.5093/ejpalc2021a9

- **Study 2.** This study aimed to address objective 1 through a systematic review of quantitative research papers to analyze the specific risk factors of men with ADUPs court-mandated to attend intervention programs for IPV perpetrators.

    - Expósito-Álvarez, C., Santirso, F. A., Gilchrist, G., Gracia, E., & Lila, M. (2023). Participants in court-mandated intervention programs for intimate partner violence perpetrators with substance use problems: A systematic review of specific risk factors. *Psychosocial Intervention, 32*(2), 89-108. https://doi.org/10.5093/pi2023a7

Objective 2. To evaluate the role of goal setting in reducing dropout in men attending an intervention program for IPV perpetrators, and specifically among those with ADUPs.

- o **Study 3.** This study aimed to (1) evaluate baseline characteristics of IPV perpetrators associated with a higher likelihood of setting goals, (2) examine whether IPV perpetrators with ADUPs were more likely to set a goal, (3) analyze whether goal setting predicted lower dropout rates in a full sample of IPV perpetrators and (4) among IPV perpetrators with ADUPs, after adjusting for sociodemographic, individual, social-relational, and attitudinal variables.

  - o Expósito-Álvarez, C., Gilchrist, G., Gracia, E., & Lila, M. (2024). Evaluating the role of goal setting in reducing dropout for men with and without substance use problems attending a court-mandated intimate partner violence perpetrator program. *Victims & Offenders, 19*(6), 1175-1207. https://doi.org/10.1080/15564886.2024.2322960

Chapter 3: Method

This chapter provides a comprehensive overview of the methodology employed in the three studies within this doctoral thesis. Studies 1 and 3 were empirical studies which used a sample of men, convicted of IPV crimes, without previous criminal records and court-mandated to attend a community-based intervention program for IPV perpetrators in Valencia, Spain. Study 2 was a systematic review of the specific risk factors of men with ADUPs court-mandated to attend intervention programs for IPV perpetrators.

1. The systematic review

The systematic review (Study 2) was conducted following the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines (Page et al., 2021). The study protocol was registered with the *International Prospective Register of Systematic Reviews* (PROSPERO 2022 CRD42022297377) on 13 January 2022. A systematic search was conducted using the Web of Science, PsycINFO, and Scopus electronic databases. The search strategy was adapted from a previous review conducted by the research team (Santirso, Gilchrist, et al., 2020), and was conducted in October 2020 and repeated in November 2021. Inclusion criteria were 1) studies published in peer-reviewed journals; 2) quantitative studies; 3) at least 70% of the sample were men who were court-mandated to participate in an intervention program for IPV perpetrators; 4) outcomes were reported specifically for men; 5) studies analyzed the differences in risk factors for IPV (e.g., levels of anger) between IPV perpetrators with and without ADUPs and/or studies analyzed the levels of ADUPs in participants with and without a risk factor (e.g., levels of ADUPs in participants with high versus low anger levels) and/or the association between risk factors and levels of ADUPs was assessed; and 6) data were collected at intake of the intervention program for IPV perpetrators. Extracted data included 1) study characteristics, including country, sample size, % of men court-mandated, ADUPs and risk-factors related measures, methodology, and a summary of the main results reporting the risk factors identified in participants with ADUPs, and 2) a summary of identified risk factors, and the number of included studies that evaluated at least one risk factor for IPV in participants with ADUPs. The *Mixed Methods Appraisal Tool* (MMAT; Hong et al., 2018; Pace et al., 2012) was used to assess the methodological quality (i.e., risk of bias) of the included studies.

2. Empirical studies

2.1. Participants and procedure

Eligible participants for Studies 1 and 3 were men (a) who perpetrated IPV and had a suspended sentence on the condition that they participate in the intervention program, (b) who were over 18 years of age, (c) who did not have a severe psychological, neurological, or cognitive disorder that would interfere with the functioning in the intervention group, and (d) who had signed an informed consent form to participate in the study that guaranteed confidentiality.

The intervention program, known as Programa Contexto, is a cognitive-behavioral intervention, using a feminist approach, and based on the ecological model, and evidence-based strategies such as motivational strategies, which aims to prevent IPV and promote safe and healthy relationships by working with the perpetrator (Lila et al., 2018). The program includes 2-h 35 weekly sessions (70h.) and consists of five modules: (1) the first module is aimed at building therapeutical alliance, establishing norms for the correct functioning of the group, explaining basic concepts of IPV, and promoting responsibility attribution; (2) the second module is aimed at promoting emotional management through evidence-based strategies (i.e., anger management techniques); (3) the third module is aimed at fostering empathy, positive communication skills, and acknowledgement of the consequences of IPV on victims; (4) the fourth module is aimed at promoting gender equality by discussing on gender roles, sexist attitudes, and educating on healthy sexual relationships based on mutual consent and communication, and (5) the fifth module is aimed at consolidating intervention objectives and prevent IPV recidivism. The program is developed in a group format and close-ended groups often range from 10 to 12 participants.

The program also includes a new therapeutical set of motivational strategies: the individualized motivational plan (IMP; Lila et al., 2018; Romero-Martínez et al., 2019c; Santirso, Lila, et al., 2020). The IMP is based on evidence-based strategies, such as motivational interviewing (Miller & Rollnick, 2002), the Good Lives Model (Langlands et al., 2009), and the stage of change approach (Prochaska & DiClemente, 1982), and includes goal setting as one of its core strategies. The main elements of the IMP are (1) five individual motivational interviews, three conducted at intake to encourage goal identification, one conducted at the middle of the intervention to supervise goal progress and one at the end to monitor goal achievement and (2) three group sessions, one at the beginning, one at the middle and the last

one at the end of the intervention, which are focused on goal sharing, allowing participants to get feedback and support from facilitators and other group members. Additionally, facilitators encourage goal reinforcement throughout the intervention, matching participants' goals to the contents covered in each session (Lila et al., 2018; Roldán-Pardo et al., 2023; Santirso, Gilchrist, et al., 2020).

Data for this doctoral thesis was collected as part of the regular initial assessment that takes place at program intake. This study employed a self-reported assessment battery comprised of various questionnaires. This pre-intervention assessment took place during two 2h-sessions. Collected data included socio-demographic characteristics, personality disorders and psychological adjustment variables, substance use variables, social-relational variables, violence-related variables, and attitudinal variables. Data on motivation to change and the stage of change, the risk of IPV recidivism and goal setting were assessed and collected by program facilitators during the third individual motivational interview session, which was held for each participant before the group-based sessions began. Regarding goal setting, goals were co-constructed by both facilitators and participants. Participants could voluntarily set a goal that was meaningful to them and that they could work on during the intervention process. The goal construction was registered in a sheet completed by facilitators and participants during the third individual motivational session. Data on dropout were collected at the end of the intervention. Participants were informed that refusal to participate in the study would not affect their legal situation. Studies within this doctoral thesis were approved by the Experimental Research Ethics Committee of the University of Valencia (Ref. H1537520365110).

2.2. Measures

A comprehensive description of the measures employed in each study is detailed within each study included in this doctoral thesis. Overall, measures included in this doctoral thesis were socio-demographic, individual, social-relational, violence-related and attitudinal variables to assess participants' characteristics and potential risk factors for IPV using a multi-level framework in alignment with the ecological model. Dropout data and data on goal setting were also collected. Substance use variables were used to screen for ADUPs.

Dropout

- *Dropout* was coded as 0 = *completers* when participants completed the intervention program, 1 = *dropout* when they stopped attending group-based sessions at any time after the first attendance, and 2 = *no intervention* (i.e., "no-shows") when participants did not attend any session of the intervention program (Study 3).

Goal setting

- *Goal setting* was coded as 0 = *goal not set* when participants chose not to set any goal, and 1 = *goal set* when participants chose to set a goal during the third individual motivational interview (Study 3).

Socio-demographic variables

- Socio-demographic characteristics included *age*, *immigrant status*, *employment*, *educational level*, *civil status*, *cohabitation with partner* and *children*, *having children*, and *income* (Study 1 and 3).

Individual variables included personality disorder variables, psychological adjustment variables (i.e., mental health variables), and substance use variables.

- o *Personality disorders* were measured using the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 2007; Spanish version by Cardenal & Sánchez, 2007). Scores above 75 suggested a mental health concern, and scores above 85, a significant clinical concern or a personality disorder.

  - MCMI-III scales included clinical personality pattern scales (*antisocial, avoidant, compulsive, dependent, depressive, histrionic, masochistic, narcissistic, passive-aggressive, sadistic, and schizoid*), severe personality scales (*borderline, paranoid, and schizotypal*), clinical syndrome scales (*anxiety, dysthymia, posttraumatic stress*

disorder and somatoform) and severe clinical syndromes (*delusional disorder, major depression and thought disorder*; Study 1 and 3).

o *Psychological adjustment variables* which measured mental health issues included:

  ▪ *Anger*, which was measured using the *State-Trait Anger Expression Inventory* (Spielberger, 1999; Spanish version by Miguel-Tobal et al., 2001), is a self-reported inventory that measures *anger trait*, and *anger state*, and provides an overall *anger expression index* (Study 1 and 3).

  ▪ *Impulsivity* was assessed using a self-reported Likert-type scale, the *Plutchick Impulsivity Scale* (Plutchik & Van Praag, 1989; Spanish version by Páez et al., 1996; Study 1 and 3).

  ▪ *Self-esteem* was measured using the *Rosenberg Self-esteem scale* (Rosenberg, 1965; Spanish version by Martín-Albo et al., 2007), a self-reported Likert-type scale (Study 1 and 3).

  ▪ *Clinical symptomatology* was assessed using the *Symptom-Checklist-90-Revised* self-reported inventory (Derogatis, 1977; Spanish version by De las Cuevas et al., 1991; Study 1).

  ▪ *Depression*, which was measured using the *Center for Epidemiologic Studies Depression Scale-7* (Radloff, 1977; Spanish version by Herrero & Gracia, 2007), is a self-reported Likert-type scale (Study 3).

  ▪ *Empathy*, which was assessed using the *Interpersonal Reactivity Index* (IRI; Davis, 1983; Spanish version by Mestre et al., 2004), is a self-reported Likert-type scale which includes four subscales: *perspective-taking, fantasy, empathetic concern,* and *personal distress* (Study 3).

  ▪ *Emotional decoding* was measured using the *Reading the Mind in the Eyes* (Eyes test; Baron-Cohen et al., 2001), which evaluates the ability to identify emotions from photographs of men's and women's eye regions (Study 3).

o *Substance use variables*

  ▪ *Alcohol use* was assessed using the Spanish version by Contel et al. (1999) of the well-validated *Alcohol Use Disorders Identification Test* (AUDIT; Babor & Grant, 1989; Study 3).

- *Cannabis* and *cocaine use* were assessed using the Spanish version of the self-reported *Severity Dependence scale* (SDSCan; SDSCo; Miele et al., 2000; Vélez-Moreno et al., 2013; Study 3).

- *Alcohol* and *drug dependence* were measured using the alcohol and drug dependence scales of the MCMI-III (Millon, 2007; Spanish version by Cardenal & Sánchez, 2007). Only scores above 75 suggested a significant alcohol and drug use problem (Study 1 and 3).

- *Alcohol and drug abuse problems (ADAPs).* Study 1 used scores of the MCMI-III (Millon, 2007) clinical syndrome scales measuring alcohol dependence and drug dependence to screen for ADAPs. Participants with scores equal to or above the cut-off point (≥ 75) in these subscales were classified as participants with ADAPs ($n = 204$), while those below this cut-off point were identified as participants without ADAPs ($n = 835$).

- *Alcohol and other drug use problems (ADUPs).* Participants in Study 3 were identified as participants with ADUPs ($n = 127$) if they scored above the cut-off point on any of the substance use variables, including AUDIT (≥ 8; Babor & Grant, 1989), SDSCan or SDSCo (≥ 3; Kaye & Darke, 2002), or the alcohol or drug dependence scale (≥ 75; MCMI-III; Millon, 2007). Those who scored below the cut-off point in each of the substance use variables were identified as participants without ADAPs ($n = 158$). While the term ADAPs was used in Study 1 to suggest an alcohol or drug dependence problem as indicated by the MCMI-III subscales, the term ADUPs will be consistently used throughout this doctoral thesis as a broader term to refer to frequent and problematic use of substances (i.e., alcohol and other drug use) that results in potential harm to the individual or others.

Social-relational variables

- *Community support* was assessed using the *Perceived Community Support Questionnaire* (PCSQ; Gracia & Herrero, 2006), a self-reported scale which measures *community integration, community participation*, and support from *informal* and *formal community organizations* (Study 1 and 3).

- *Intimate support* was measured using the Spanish adaptation by Herrero et al. (2011) of the *Intimate Social Support Questionnaire* (Lin et al., 1986; Study 1 and 3).

- *Stressful life events* were evaluated using the *Stressful Life Events Questionnaire* (Gracia & Herrero, 2004; Study 1 and 3).

- *Perceived social rejection* was assessed using the *Perceived Social Rejection Index* (Catalá-Miñana et al., 2013; Study 1 and 3).

Violence-related variables

- *Family violence exposure* was assessed using the sixth item of the *Spousal Assault Risk Assessment* (SARA; Kropp et al., 1999; Spanish version by Andrés-Pueyo et al., 2008) to evaluate participants' exposure to family violence as a victim or witness during their childhood or adolescence (Study 1).

- *Perceived severity of intimate partner violence against women* (IPVAW) was assessed using the *Perceived severity of IPVAW Scale* (PS-IPVAW; Gracia et al., 2008; Study 1).

- *Self-reported physical* and *psychological IPV* was assessed using the well-validated *Revised Conflict Tactics Scale* (CTS-2; Straus et al., 1996; Spanish version by Loinaz et al., 2012; Study 1).

- *Motivation to change* was evaluated by facilitators using a one-item Likert-type scale (Vargas et al., 2020; Study 1).

Attitudinal variables

- *Ambivalent sexism*, including hostile and benevolent sexist ideas, was assessed using the *Ambivalent Sexism Inventory* (ASI; Glick & Fiske, 1997; Spanish version by Expósito et al., 1998; Study 1, identified as a violence-related variable, and Study 3).

- *The risk of IPV recidivism* was assessed by facilitators using the *SARA* protocol (Kropp et al., 1999; Spanish version by Andrés-Pueyo et al., 2008; Study 1, identified as a violence-related variable, and Study 3).

- *The stage of change* was evaluated by facilitators according to the transtheoretical model of change (Prochaska & DiClemente, 1982; Study 1, identified as a violence-related variable, and Study 3).

- *Responsibility attribution to the victim* was assessed using the subscale of the *Intimate Partner Violence Responsibility Attribution Scale* (IPVRAS; Lila et al., 2014) which evaluates responsibility attributed to the victim (Study 3).

- *Gender roles* were assessed using the self-reported *Gender Ideology Scale* (Moya et al., 2006; Study 3).

2.3. Data analysis

A full description of the data analysis is presented in each study within this doctoral thesis. Overall, Study 1 ($n = 1,039$) conducted a series of univariate analyses to compare court-mandated participants with ADAPs ($n = 204$), and those without ($n = 835$) in four sets of variables: 1) sociodemographic, 2) personality disorders and psychological adjustment, 3) social-relational, and 4) violence-related variables. Differences between groups were assessed using χ^2-tests for dichotomous variables, standardized residuals (Z_{resid}) for polytomous categories, and Welch's *t*-tests for continuous variables. Adjusted *p*-values were used to control for type I errors (i.e., false positives). Effect sizes were used to interpret the results. To evaluate the effect size for categorical variables, Cramér's V was computed, while Cohen's *d* and Cohen's U_3 were used for continuous variables based on Hedge's correction.

Study 3 used binary logistic regressions to identify participants' baseline characteristics associated with goal setting and dropout, in a full sample of IPV perpetrators ($n = 285$) and specifically in IPV perpetrators with ADUPs ($n = 127$). Associations were estimated with odds ratio (OR) and 95% confidence interval (CI). To identify the best subset of predictors for goal setting and dropout, a multivariate binary logistic regression analysis was conducted using a backward elimination stepwise selection approach based on the likelihood ratio (LR) criterion. Only variables $p < .1$ in the univariate analysis and clinically relevant were deemed appropriate for inclusion in the multivariate model. This approach also helped to examine whether goal setting predicted lower dropout after adjusting for relevant variables, including sociodemographic, individual (e.g., mental health, substance use), social-relational and attitudinal variables, both for the full sample of participants, and specifically for those with ADUPs. Nagelkerke R^2 assessed the model's ability to explain the variation in the outcome variable. The Hosmer-Lemeshow test evaluated the model's goodness of fit. Classification accuracy was also examined. A Bonferroni correction was applied to mitigate the likelihood of Type I error. Both the adjusted *p*-value and a planned error rate of 0.05 were used to interpret the results.

Chapter 4: Studies

Study 1

Risk factors and treatment needs of batterer intervention program participants with substance abuse problems[1]

Risk factors and treatment needs of batterer intervention program participants with substance abuse problems

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Abstract

The aim of the present study was to identify the main risk factors and treatment needs of batterer intervention program (BIP) participants with alcohol and drug abuse problems (ADAPs), beyond issues strictly related to their substance abuse, taking into account four sets of variables: sociodemographic (i.e., age, educational level, income, employment, and immigrant status); personality disorders and psychological adjustment (i.e., clinical symptomatology, personality disorders, anger, impulsivity, and self-esteem); social-relational variables (i.e., community support, intimate support, stressful life events, and perceived social rejection); and violence-related variables (i.e., family violence exposure, perceived severity of intimate partner violence against women [IPVAW], ambivalent sexism, risk of future violence, physical and psychological intimate partner violence, motivation to change, and stage of change). The study was based on a sample of 1,039 male IPVAW offenders court-mandated to a community-based BIP. Results from comparisons between BIP participants with and without ADAPs were interpreted in terms of effect sizes to highlight the most salient differences. Differences with moderate effect sizes were found for clinical symptomatology, anger trait, anxiety disorder, depressive disorder, stressful life events, motivation to change and stage of change. Differences with large effect sizes were found for impulsivity, antisocial disorder, borderline disorder, and aggressive disorder. Several intervention strategies are proposed to guide and adjust interventions to risk factors and treatment needs of BIP participants with ADAPs.

Keywords: intimate partner violence; batterer intervention programs; alcohol abuse; substance abuse; risk factors; treatment needs; partner violence offenders

Los factores de riesgo y las necesidades de tratamiento de los participantes en los programas de intervención con maltratadores con problemas de abuso de substancias

Resumen

El objetivo de este estudio fue identificar los principales factores de riesgo y necesidades de tratamiento de los participantes en un programa de intervención con maltratadores (BIP) con problemas de abuso de alcohol y/o drogas (ADAP), más allá de sus problemas de abuso de substancias, teniendo en cuenta cuatro conjuntos de variables: sociodemográficas (i.e., edad, nivel educativo, ingresos, empleo y estatus de inmigrante), trastornos de personalidad y ajuste psicológico (i.e., sintomatología clínica, trastornos de personalidad, ira, impulsividad y autoestima), variables socio-relacionales (i.e., apoyo comunitario, apoyo íntimo, eventos vitales estresantes y rechazo social percibido) y variables relacionadas con la violencia (i.e., exposición a violencia familiar, gravedad percibida de la violencia contra la mujer en las relaciones de pareja, sexismo ambivalente, riesgo de violencia futura, violencia de pareja física y psicológica, motivación al cambio y estadio de cambio). El estudio se basó en una muestra de 1,039 hombres condenados por violencia de género y remitidos a un programa de intervención para maltratadores como medida penal alternativa. Los resultados de las comparaciones entre los participantes con y sin ADAP se interpretaron en función de los tamaños del efecto para destacar las diferencias más salientes. Se encontraron diferencias con tamaños del efecto moderados para sintomatología clínica, rasgo de ira, trastorno de ansiedad, sucesos vitales estresantes, motivación para el cambio y estadio de cambio. Se encontraron diferencias con tamaños del efecto grandes para impulsividad, trastorno antisocial, de personalidad límite y de agresividad. Se proponen diversas estrategias de intervención para guiar y ajustar las intervenciones a los factores de riesgo y necesidades de tratamiento de los participantes de los programas de intervención para maltratadores con ADAP.

Palabras clave: violencia de pareja, programas de intervención en maltratadores, abuso de alcohol, abuso de substancias, factores de riesgo, necesidades de tratamiento, maltratadores.

Introduction

Intimate partner violence against women (IPVAW) has been acknowledged as a public health, social policy, and human rights concern of epidemic proportions that affects approximately 30% of women at some point in their lives on a worldwide scale (World Health Organization [WHO, 2013]). In Europe, according to the survey conducted by the European Union Agency for Fundamental Rights (FRA), physical and sexual IPVAW had a lifetime prevalence of 22% across the 28 member countries, ranging from 13% in Spain to 32% in Denmark (FRA, 2014; Gracia et al., 2019; Martín-Fernández et al., 2019, 2020).

In response to the high prevalence of IPVAW, intervention programs for IPVAW offenders–often referred to as batterer intervention programs (BIPs)–have been widely implemented. Typically, BIPs aim to reduce recidivism by promoting alternative behaviors to violence, raising responsibility awareness, and changing attitudes. Meta-analysis and systematic reviews on BIP effectiveness often show positive but modest effects on reducing IPVAW recidivism, particularly when they incorporate motivational strategies (Arce et al., 2020; Babcock et al., 2016, 2004; Cheng et al., 2019; Eckhardt et al., 2013; Feder & Wilson, 2005; Santirso, Gilchrist, et al. 2020). However, the literature finds that major challenges continue to hamper BIP effectiveness, most notably high dropout rates, low motivation to change, high levels of denial, minimization of responsibility and victim blaming, and dealing with high-risk and highly resistant participants (Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017; Eckhardt et al., 2008; Henning & Holdford, 2006; Holtzworth-Munroe et al., 2000; Jewell & Wormith, 2010; Lila et al., 2019; Lila et al., 2014; Olver et al., 2011).

BIP participants with alcohol and/or drug abuse problems (ADAPs) are among the most high-risk and highly resistant groups of IPVAW offenders (Bennett, 2008; Crane et al., 2015; Lila et al., 2020; Romero-Martínez et al., 2019a). ADAPs are one of the strongest correlates of IPVAW (Foran & O'Leary, 2008; Langenderfer, 2013; Leonard & Quigley, 2017; Moore & Stuart, 2004; WHO, 2010), and around 50% of BIP participants have some type of substance abuse problem (Crane et al., 2015; Kraanen et al., 2010; Stuart et al., 2003; Stuart et al., 2009). Research has also shown that ADAPs in BIP participants are strong predictors of low treatment adherence, dropout, recidivism, and severe violence (Easton et al., 2018; Jewell & Wormith, 2010; Moore & Stuart, 2004; Olver et al., 2011). In addition, IPVAW offenders with ADAPs tend to present a history of trauma (Alexander, 2014; Thomas et al., 2013), trait jealousy (Brem et al., 2018; Burch & Gallup, 2020), anger management problems (Eckhardt et al., 2008),

emotion dysregulation (Grigorian et al., 2020), diminished empathetic and cognitive abilities (Romero-Martínez et al., 2019b; Romero-Martínez et al., 2016; Vitoria-Estruch et al., 2017), and poorer mental health (Moore & Stuart, 2004; Stuart et al., 2003; Thomas et al., 2013).

Given the above characteristics, BIP participants with ADAPs can be defined as offenders who have specific risk factors and treatment needs beyond their substance abuse problems. Identifying and addressing the main risk factors and treatment needs among these BIP participants may contribute to the improvement of BIP effectiveness by targeting the intervention not only to reduce ADAPs but also to address these other related problems. However, available research does not provide a comprehensive view of the main risk factors and treatment needs that differentiate BIP participants with ADAPs from those without ADAPs. Research examining differences between BIPs participants with and without ADAPs typically focus on a single set of variables (e.g., personality, cognitive abilities, treatment related variables) and rely on modest sample sizes that limit the generalization of the results (Giancola et al., 2003; Romero-Martínez et al., 2016; Stuart et al., 2003).

The present study addresses the limitations of past research using a large sample of IPVAW offenders attending a BIP to compare participants with and without ADAPs on variables tapping a wide range of risk factors and treatment needs. The aim is to identify the main risk factors and treatment needs of BIP participants with ADAPs that may help to inform and maximize the effectiveness of new intervention approaches with this group of offenders. To examine differences in risk factors and treatment needs between the two groups (offenders with and without ADAPs), we consider four sets of variables: (1) sociodemographic (i.e., age, educational level, income, employment, and immigrant status); (2) personality disorders and psychological adjustment (i.e., clinical symptomatology, personality disorders, anger, impulsivity, and self-esteem); (3) social/relational variables (i.e., community support, intimate support, stressful life events and perceived social rejection); and (4) violence-related variables (i.e., family violence exposure, perceived severity of IPVAW, ambivalent sexism, risk of future violence, intimate partner violence, motivation to change, and stage of change).

Method

Participants and procedure

The study is based on a sample of 1,039 male IPVAW offenders sentenced to less than two years in prison, without previous criminal records, and court-mandated to a community-based cognitive-behavioral BIP in Valencia (Spain). Eligible participants were male offenders over 18 years of age without severe substance abuse problems, severe cognitive impairments (i.e., brain damage, degenerative disorders), and/or psychopathologies (i.e., schizophrenia, psychosis) that could interfere with the functioning of the intervention group. Data were gathered as part of regular in-take (pre-treatment) data collection for participants entering the BIP. The number of participants assessed varied across measures. Participants were properly informed about the research protocol and signed a written consent form in which confidentiality was guaranteed. This study was approved by the Experimental Research Ethics Committee of the University of Valencia (Ref. H1537520365110).

Measures

Alcohol and Drug Abuse Problems. These problems were measured with the alcohol dependence and drug dependence clinical syndrome scales included in the *Millon Clinical Multiaxial Inventory-III* (see the inventory description below). Scores above 75 suggest a significant alcohol and/or drug problem, while scores 85 or higher indicate a persistent, significant clinical concern or personality disorder related to alcohol and/or drug problems.

Sociodemographic variables. Information was collected for age (in years), educational level (0 = *no schooling*, 1 = *primary*, 2 = *secondary*, 3 = *college*), immigrant status (0 = *no*, 1 = *yes*), employment status (0 = *unemployed*, 1 = *employed*) and income (from 0 = *less than 1,800 €/year* to 10 = *more than 60,000 €/year*).

Personality disorders and psychological adjustment variables

Symptom-Checklist-90-Revised (SCL-90-R; Derogatis, 1977; Spanish version by De las Cuevas et al., 1991). The SCL-90-R is a 90-item self-report inventory to assess psychological symptoms and psychological distress, rated on a 5-point Likert-type scale (0 = *none*, 4 = *very much*). In this study, a global index was used (the positive symptom total subscale), indicating the total number of symptoms reported. The original version validation reported Cronbach's alpha reliability coefficients between .81 and .90. The SCL-90-R has been

widely used with samples of Spanish BIP participants (Carbajosa, Catalá-Miñana, Lila, Gracia, et al., 2017; Catalá-Miñana et al., 2013; Fernández-Montalvo et al., 2020).

Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 2007; Spanish version by Cardenal & Sánchez, 2007). The MCMI-III was used to measure personality disorders and clinical syndromes. It is a self-report inventory composed of 175 true or false questions. The following subscales were used in this study: five clinical personality pattern scales (depressive, dependent, narcissistic, antisocial, and aggressive), two severe personality scales (borderline and paranoid), and three clinical syndrome scales (anxiety, alcohol dependence, and drug dependence). Scores above 75 suggest a significant personality trait or mental health concern, while scores 85 or higher indicate a persistent, significant clinical concern or personality disorder. The Spanish version reported Cronbach's alpha reliability coefficients between .65 and .92. This version has demonstrated validity to identify specific risk personality traits for IPVAW perpetration and has been widely used in Spanish BIPs (Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017; Catalá-Miñana et al., 2014; Romero-Martínez et al., 2021).

State-Trait Anger Expression Inventory (STAXI-2; Spielberger, 1999; Spanish version by Miguel-Tobal et al., 2001). The STAXI-2 is a 44-item inventory which evaluates state anger, as a situational response, and trait anger, as a predispositional quality. Responses are on a 4-point Likert-type scale (1 = *not at all*, 4 = *very much*). The Spanish version reported Cronbach's alpha reliability coefficients between .67 and .89. This inventory has traditionally been used with BIP participants (Fernández-Montalvo et al., 2020; Romero-Martínez et al., 2015; Siria et al., 2021).

Plutchik's Impulsivity Scale (Plutchik & van Praag, 1989; Spanish version by Páez et al., 1996). This is a 15-item self-report scale that assesses impulsivity, an immediate response that occurs when behavioral consequences are not taken into consideration, on a 4-point Likert-type scale (1 = *never*, 4 = *almost always*). For this study, Cronbach's α was .74. The Spanish version of this scale has been widely used with samples of BIP participants (Lila et al., 2019; Romero-Martínez et al., 2013; Sahagún-Flores & Salgado-Pascual, 2013).

Rosenberg Self-esteem Scale (RSES; Rosenberg, 1965; Spanish version by Martín-Albo et al., 2007). RSES is a 10-item scale to measure participants' feelings of global self-worth. Responses are on a 4-point Likert-type scale (1 = *totally disagree*, 4 = *totally agree*). For this study, Cronbach's α was .77. This scale has been used with Spanish samples of IPVAW

offenders (Catalá-Miñana et al., 2013; Guerrero-Molina et al., 2020; Lila, Gracia & Murgui, 2013).

Social/relational variables

Perceived Community Support Questionnaire (PCSQ; Gracia & Herrero, 2006). This is an 18-item scale that assesses three dimensions of community social support: community integration (α = .69), community participation (α = .76), and support from community organizations (α = .72). Responses are on a 5-point Likert-type scale (1 = *totally disagree*, 5 = *totally agree*). This scale has been used with samples of IPVAW offenders (Catalá-Miñana et al., 2013; Vargas et al., 2017).

Intimate Social Support Questionnaire (Lin et al., 1986; Spanish adaptation by Herrero et al., 2011). This is a 3-item unidimensional scale which measures participants' perception of intimate support from close relatives and friends (i.e., intimate partner, family, and friends). Responses are on a 5-point Likert-type scale (1 = *most of the time*, 5 = *never*), Cronbach's α was .62. This scale has been used previously with samples of Spanish BIP participants (Catalá-Miñana et al., 2017; Lila, Gracia, & Murgui, 2013; Lila et al., 2019).

Stressful Life Events Questionnaire (Gracia & Herrero, 2004). This questionnaire was used to measure the accumulation of stressful situations. From a list of 33 stressful life events, participants identify those they have experienced during the last six months. High scores indicate an accumulation of stressful life events. Cronbach's α was .74. It has been previously used in the field of Spanish BIPs (Catalá-Miñana et al., 2013; Lila, Gracia, & Murgui, 2013; Lila et al., 2019).

Perceived Social Rejection Index (PSRI; Catalá-Miñana et al., 2013). This is a unidimensional 13-item scale which measures participants' perceived social rejection as a consequence of their conviction of IPVAW. Responses are on a 5-point Likert-type scale (1 = *strongly disagree*, 5 = *strongly agree*). A higher score implies greater perceived social rejection. Cronbach's α was .82. The PSRI has been used with Spanish BIP participants (Catalá-Miñana et al., 2013; Catalá-Miñana et al., 2017).

Violence-related variables

Family violence exposure. In this study, the participants' exposure as a victim or witness to family violence during adolescence and/or childhood was assessed by trained program staff using the sixth item of the Spousal Assault Risk Assessment (see the SARA protocol description below). Exposure was rated as 0 = *no exposure*, 1 = *infrequent exposure*, 2 = *frequent exposure*.

Perceived severity of IPVAW Scale (PS-IPVAW; Gracia et al., 2008). This scale presents eight IPVAW scenarios that participants had to rate in terms of severity on a 10-point Likert-type scale (0 = *not severe at all*, 10 = *extremely severe*). Cronbach's α was .81. This scale has been used in the law enforcement context, and with Spanish samples of IPVAW offenders (Catalá-Miñana et al., 2013; Gracia et al., 2009, 2014; Lila, Gracia, & García, 2013; Lila et al., 2016; Vargas et al., 2015; Vargas et al., 2017).

Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1997; Spanish version by Expósito et al., 1998). This 22-item inventory was used to assess hostile and benevolent sexist attitudes. The hostile sexism scale includes explicit negative attitudes toward women, while the benevolent sexist attitudes scale represents paternalistic attitudes, in both cases based on the assumption of women's inferiority. Responses are on a 5-point Likert-type scale (1 = *strongly disagree*, 5 = *strongly agree*). Cronbach's α was .89 for hostile sexism and .84 for benevolent sexism. This inventory has customarily been used with BIP participants (Juarros-Basterretxea et al., 2018; Juarros-Basterretxea et al., 2019; Vargas et al., 2015; Vitoria-Estruch et al., 2018).

Spousal Assault Risk Assessment Guide (SARA; Kropp et al., 1999; Spanish version by Andrés-Pueyo et al., 2008). This is a 20-item protocol used to assess risk of recidivism toward former or present partners and non-partners. It was completed by trained psychologists who rated risk factors as 0 = *low*, 1 = *moderate*, and 2 = *high risk*. Cronbach's α was .70. The Spanish version of this risk assessment guide has been widely used with samples of IPVAW offenders (Gallardo & Salgado, 2017; Lila et al., 2018; Romero-Martínez et al., 2021; Vargas et al., 2020).

Revised Conflict Tactics Scale (CTS-2; Straus et al., 1996; Spanish version by Loinaz et al., 2012). CTS-2 is a 78-item self-report scale that assesses how individuals choose to resolve relationship conflicts, thus evaluating the presence of violence. Participants report on their behaviors over the previous 12 months (0 = *this has never happened*, 6 = *more than 20 times in the past year*, 7 = *not in the past year, but it happened before*). Cronbach's α was .83 for physical

violence and .79 for psychological violence. The CTS-2 has been used previously with Spanish BIP participants (Juarros-Basterretxea et al., 2018; Lila et al., 2018; Vargas et al., 2017).

Motivation to change (Vargas et al., 2020). Facilitators rated participants' motivation to change at the program intake using one item on a 5-point Likert-type scale, from 1 = *not at all* to 5 = *very much*.

Stage of change (Carbajosa, Catalá-Miñana, Lila, Gracia, et al., 2017). Facilitators rated participants' stage of change (1 = *precontemplation*, 2 = *contemplation*, 3 = *preparation*, 4 = *action*, 5 = *maintenance*). This measure has been used previously with Spanish samples of IPVAW perpetrators (Lila et al., 2018; Vargas et al., 2020).

Analytic plan

The MCMI-III scales measuring alcohol and/or other drug abuse problems (cutoff score ≥ 75) were used to classify BIP participants into two groups, one with ADAPs ($n = 204$), and one without ($n = 835$). A series of univariate analyses were conducted to compare BIP participants with and without ADAPs in four sets of variables: 1) sociodemographic, 2) personality disorders and psychological adjustment, 3) social/relational variables, and 4) violence-related variables. For dichotomous variables, χ^2-tests were carried out, and for polytomous variables, standardized residuals (Z_{resid}) were computed to assess differences in the various categories (Agresti, 2019). For continuous variables, Welch's *t*-tests were conducted, because this procedure is more robust when the homoscedasticity assumption is not met and the sample size is different in the two groups (Delacre et al., 2017; Fagerland & Sandvik, 2009; Howell, 2002; Ruxton, 2006; Wang, 1971).

When running multiple univariate tests, the chance of making type I errors (i.e., false positives) increases, as more tests are conducted. For this reason, *p*-values were adjusted for each set of variables using the false discovery rate, a procedure aimed to control the expected proportion of significant results by penalizing the *p*-values associated with the null hypothesis (Benjamini, 2010; Benjamini & Hochberg, 1995).

In addition to the adjusted *p*-values, different effect size measures were computed. Effect size measures reflect the distance between the groups compared and allow researchers to assess the magnitude of the differences found in the data. Hence, the larger the effect size for a given statistical test, the lower the likelihood of finding results biased due to sampling error (Fan, 2001; Kirk, 1996; Maher et al., 2013; Rosenthal, 1984; Sullivan & Feinn, 2012). Cramér's V was computed to evaluate the effect size for dichotomous and polytomous variables, whereas

Cohen's *d* and Cohen's U_3 were obtained for continuous variables based on Hedge's correction, which does not assume equal sample sizes for the groups (Hedges & Olkin, 1985). Cramér's V ranges between 0 and 1 and indicates the strength of the association between two categorical variables, with values above .10, .30, and .50 indicating small, moderate, and large effect sizes, respectively (Cohen, 1988; Rea & Parker, 1992). Cohen's *d* reflects the standardized mean difference between two groups (i.e., participants with and without ADAPs), and *d* values above 0.20, 0.50, and 0.80 are usually interpreted as small, moderate, and large effect sizes (Cohen, 1988). Cohen's U_3 is an analogous measure of Cohen's *d* that expresses the proportion of participants of one group scoring higher than the average of the other group (Hanel & Mehler, 2019).

Therefore, in this study we will focus on the effect size measures to interpret the results, in addition to the adjusted *p*-values, in order to ensure that the differences found between participants with and without ADAPs are substantive. Another advantage of focusing on effect size measures is that the statistical power also tends to be higher as the effect size estimates increase (Chow, 1988; Field, 2013). In our study, the sample size was large enough to ensure adequate statistical power for all tests. Particularly, for small effect sizes (i.e., $d = 0.20$) power ranged between 0.88 and 0.97 in our sample, meaning that the probability of making type II statistical errors (i.e., false negatives) was low. Power values above 0.80 are usually considered as acceptable for psychological research (Cohen, 1988).

All analyses were conducted using the statistical package R (R Core Team, 2020), with psych and car libraries (Fox & Weisberg, 2019; Revelle, 2020).

Results

Sociodemographic variables

We first examined the differences between participants with and without ADAPs according to sociodemographic variables (Table 1). Although significant differences were found in employment and immigrant status, with higher unemployment ($Z_{resid} = 2.97$) and lower proportion of immigrants ($Z_{resid} = -2.73$) among participants with ADAPs, the effect sizes were negligible ($V_{Cramér} < .10$). Significant differences with a small effect size were found for age, indicating that participants with ADAPs were on average younger than those without ADAPs. No significant differences were found in educational level and income.

Table 1. Differences between participants with and without ADAPs in sociodemographic variables.

	ADAP		no ADAP		$\chi^2(df)/t(df)$	p	V/d	U_3
	N	M (SD)	N	M (SD)				
Age	202	37.22 (10.17)	742	40.94 (12.08)	4.41 (370.4)	<.001	0.32	0.626
Educational level					7.35 (3)	.077	0.06	
No Schooling	14		57					
Primary	102		333					
Secondary	76		267					
College	10		76					
Income	201	3.07 (2.33)	720	3.18 (2.22)	0.62 (308.94)	.537	0.05	0.52
Employment					8.33 (1)	.01	0.09	
Unemployed	102		283					
Employed	100		445					
Immigrant status					6.99 (1)	.014	0.09	
Immigrant	47		250					
No Immigrant	155		501					

Note. ADAPs = Batterer intervention program participants with alcohol and/or other drug abuse problems; no ADAPs = Batterer intervention program participants without alcohol and/or other drug abuse problems.

Personality disorders and psychological adjustment variables

Regarding differences in personality disorders and psychological adjustment variables, significant differences with small effect sizes were found in narcissist and paranoid disorders, and in anger state. In all these variables, participants with ADAPs presented higher levels (Table 2). Specifically, 68.4% and 61.4% of participants with ADAPs had higher scores than the mean score of participants without ADAPs in narcissist and paranoid disorder subscales of the MCMI-III. For anger state this percentage was 60.3%. Significant differences with a small effect size were also found in self-esteem, with lower levels among participants with ADAPs (64.4% of them scored below the average of participants without ADAPs).

Significant differences with moderate effect sizes were found in clinical symptomatology (SCL-90), anger trait, and in anxiety and depressive disorder subscales of the MCMI-III. In all cases, participants with ADAPs showed higher levels than those without ADAPs. Specifically, 78.2% were above the average score of participants without ADAPs in both clinical symptomatology and anger trait. Regarding anxiety and depressive disorders, 76.1% and 73.2%, respectively, showed higher scores than the average of participants without ADAPs.

Significant differences with large effect sizes were found in antisocial, borderline, and aggressive disorder subscales of the MCMI-III, indicating that 95.4%, 92.2%, and 91.1% of participants with ADAPs scored above the average of those without ADAPs in these variables, respectively. In addition, significant differences with a large effect size were found in impulsivity, with higher levels among participants with ADAPs (84.1% of them scored higher than the average of participants without ADAPs).

Table 2. Differences between participants with and without ADAPs in personality disorders and psychological adjustment variables

	ADAP		no ADAP		$\chi^2(df)/t(df)$	p	d	U_3
	N	M (SD)	N	M (SD)				
Clinical Symptomatology	137	40.36 (20.77)	497	25.57 (18.49)	-7.55 (199.30)	<.001	0.78	0.782
Personality Disorders								
Depressive	143	44.71 (25.08)	436	29.32 (24.88)	-6.38 (240.28)	<.001	0.62	0.732
Dependent	204	53.09 (28.08)	673	51.23 (31.06)	-0.81 (366.29)	.419	0.06	0.524
Narcissist	204	70.04 (19.61)	673	58.80 (24.46)	-6.75 (411.93)	<.001	0.48	0.684
Antisocial	204	72.67 (17.76)	673	36.20 (22.80)	-23.95 (424.64)	<.001	1.69	0.954
Aggressive	204	62.83 (21.88)	673	32.16 (22.97)	-17.34 (349.41)	<.001	1.35	0.911
Borderline	204	59.60 (21.56)	673	29.33 (21.31)	-17.61 (332.21)	<.001	1.42	0.922
Paranoid	143	52.63 (24.41)	436	44.85 (28.01)	-3.19 (274.38)	.002	0.29	0.614
Anxiety	204	63.85 (29.17)	673	42.79 (30.01)	-8.98 (343.46)	<.001	0.71	0.761
Anger								
State	196	17.85 (5.28)	687	16.70 (4.08)	-2.82 (264.91)	.006	0.26	0.603
Trait	196	19.10 (6.02)	686	15.16 (4.74)	-8.46 (267.94)	<.001	0.78	0.782
Impulsivity	201	1.90 (0.45)	726	1.52 (0.36)	-11.08 (267.87)	<.001	1.00	0.841
Self-Esteem	201	3.06 (0.48)	719	3.23 (0.46)	4.38 (308.24)	<.001	0.37	0.644

Note. ADAPs = Batterer intervention program participants with alcohol and/or other drug abuse problems; no ADAPs = Batterer intervention program participants without alcohol and/or other drug abuse problems.

Social/relational variables

Regarding social/relational variables (Table 3), significant differences with small effect sizes were found in perceived social rejection, community, and intimate support. In particular, 64.1% of participants with ADAPs showed higher levels of perceived social rejection than the average of those without ADAPs. Participants with ADAPs also perceived significantly less community social support (i.e., community participation, community integration, and support from community organizations) and intimate support. Specifically, 60.3%, 58.7%, and 58.3%, and 57.9% of participants with ADAPs scored below the average of participants without ADAPs in these variables, respectively.

Significant differences with a moderate effect size were found in stressful life events, showing that participants with ADAPs presented a higher number of stressful life events (73.2% of them above the average number of stressful life events of participants without ADAPs).

Table 3. Differences between participants with and without ADAPs in social/relational variables

	ADAP		no ADAP		$\chi^2(df)/t(df)$	p	d	U_3
	N	$M\,(SD)$	N	$M\,(SD)$				
Community Support								
Integration	201	3.36 (0.93)	726	3.54 (0.80)	2.41 (287.76)	.019	0.22	0.59
Participation	201	2.66 (1.05)	726	2.93 (1.05)	3.20 (319.35)	.004	0.26	0.60
Informal	201	3.53 (1.06)	723	3.73 (0.91)	2.46 (287.60)	.019	0.21	0.58
Intimate support	200	3.42 (0.99)	718	3.63 (1.05)	2.53 (334.04)	.019	0.20	0.58
Stressful life events	204	4.34 (3.06)	835	2.53 (2.91)	-7.61 (298.82)	<.001	0.62	0.73
Perceived social rejection	200	2.40 (0.84)	711	2.12 (0.76)	-4.22 (297.30)	<.001	0.36	0.64

Note. ADAPs = Batterer intervention program participants with alcohol and/or other drug abuse problems; no ADAPs = Batterer intervention program participants without alcohol and/or other drug abuse problems.

Violence-related variables

Finally, for the violence-related variables (Table 4), significant differences with small effect sizes were found in psychological violence, family violence exposure, and risk of future violence against partners and non-partners. Participants with ADAPs were more psychologically aggressive toward their partners, with 67.0% of them showing higher levels of psychological aggression than the average of participants without ADAPs. Participants with ADAPs were also more exposed to family violence in childhood (Z_{resid} = 5.02), and had higher risk of future violence against partners and non-partners (Z_{resid} = 3.91 and Z_{resid} = 3.56, respectively) than participants without ADAPs.

Significant differences with moderate effect sizes were found in motivation to change and state of change. Participants with ADAPs presented higher motivation to change and stage of change, with 71.9% and 73.6% of them scoring above the average of participants without ADAPs, respectively.

No significant differences were found in perceived severity of IPVAW, hostile and benevolent sexism, and physical violence toward their partners.

Table 4. Differences between participants with and without ADAPs in violence-related variables

	ADAP		no ADAP		$\chi^2(df)/t(df)$	p	V/d	U_3
	N	M (SD)	N	M (SD)				
Family violence exposure					25.37 (2)	<.001	0.18	
No exposure	116		477					
Infrequent exposure	19		87					
Frequent exposure	39		53					
Perceived severity of IPVAW	199	8.80 (1.40)	694	8.77 (1.88)	-0.24 (424.44)	.897	0.02	0.508
Ambivalent sexism								
Hostile sexism	173	2.48 (1.21)	561	2.40 (1.22)	-0.82 (287.73)	.515	0.07	0.528
Benevolent sexism	173	2.82 (1.05)	561	2.81 (1.14)	-0.06 (306.75)	.950	0.01	0.504
Risk of future violence								
Towards partner					15.54 (2)	.001	0.14	
Low	76		308					
Moderate	44		198					
High	52		102					
Towards non-partner					32.11 (2)	<.001	0.2	
Low	92		457					
Moderate	58		120					
High	22		31					
Intimate partner violence								
Physical Violence	139	0.29 (0.68)	461	0.22 (1.15)	-0.96 (386.60)	.481	0.07	0.528
Psychological Violence	139	2.03 (3.25)	461	0.94 (3.25)	-3.70 (179.97)	.001	0.44	0.67
Motivation to change	138	2.57 (1.25)	447	1.91 (1.10)	-5.53 (206.28)	<.001	0.58	0.719
Stage of change	134	1.39 (0.62)	438	1.13 (0.35)	-4.48 (160.14)	<.001	0.63	0.736

Note. ADAPs = Batterer intervention program participants with alcohol and/or other drug abuse problems; no ADAPs = Batterer intervention program participants without alcohol and/or other drug abuse problems.

Discussion

The aim of the present study was to identify the main risk factors and treatment needs of BIP participants with ADAPs, beyond their substance abuse problems, taking into account four sets of variables: sociodemographic, personality disorders and psychological adjustment, social-relational variables, and violence-related variables. Results from comparisons between BIP participants with and without ADAPs were interpreted in terms of effect sizes to highlight the most salient differences (i.e., moderate and large effect sizes) between these two groups of IPVAW offenders.

Regarding the first set of variables, significant differences were found with negligible effect sizes for immigrant and employment status (lower proportion of immigrants and higher rate of unemployment among participants with ADAPs), and with a small effect size for age (participants with ADAPs were younger). However, no significant differences with moderate or large effects were found for sociodemographic variables.

For the second set of variables (personality disorders and psychological adjustment variables), significant differences were found for all variables measured except for the dependent personality pattern. Traditional theoretical perspectives on the association between alcohol and IPVAW, such as the spurious model proposed by Leonard and Quigley (1999), suggest that personality and psychological symptomatology influence both drinking behavior and IPVAW. Likewise, alcohol and other drugs may influence psychological functioning because of the psychopharmacological effects they can have on emotional and cognitive processing (Hanson et al., 2011). In this study, however, not all differences in personality disorders and psychological adjustment variables were equally relevant. First, we found that participants with ADAPs showed higher scores in narcissistic disorder, paranoid disorder, and anger state, and lower scores in self-esteem than participants without ADAPs, although these significant differences all had small effect sizes. Second, significant differences with moderate effect sizes were found for clinical symptomatology, anger trait, anxiety disorder, and depressive disorder, with participants with ADAPs scoring higher than participants without ADAPs. Described in terms of Cohen's U_3, the percentages of participants with ADAPs that scored above the average of participants without ADAPs were 78.2% for clinical symptomatology and anger trait, 76.1% for anxiety disorder, and 73.2% for depressive disorder. Our results for clinical symptomatology and depressive disorder are consistent with previous research reporting higher levels of clinical symptomatology among offenders with substance abuse problems attending BIPs (Brown et al., 1999; Catalá-Miñana et al., 2013; Romero-

Martínez et al., 2013; Thomas et al., 2013), and higher levels of depressive symptomatology among hazardous drinkers attending BIPs (Stuart et al., 2003). As for anger trait and anxiety disorder, our results are in line with research suggesting that higher alcohol and another substance use among individuals with these characteristics is a coping strategy to alleviate negative feelings (Eftekhari et al., 2004; Hofmann et al., 2009). Third, the most salient risk factors and treatment needs that emerged from our study in this second set of variables were impulsivity, antisocial disorder, borderline disorder, and aggressive disorder. Comparisons between participants with and without ADAPs in these variables yielded significant differences with large effect sizes. Described in terms of Cohen's U_3, the percentages of participants with ADAPs that scored above the average of participants without ADAPs were 84.1% for impulsivity, 95.4% for antisocial disorder, 92.2% for borderline disorder, and 91.1% for aggressive disorder. These results are in line with previous research showing higher levels of impulsivity in IPVAW offenders with ADAPs (Easton et al., 2008). Our results can also be linked to research showing that IPVAW offenders with antisocial, borderline, and aggressive personalities are more likely to have alcohol and drug problems (Fals-Stewart et al., 2005; Holtzworth-Munroe & Stuart, 1994; Klostermann & Fals-Stewart, 2006; Winters, 2005).

Significant differences were found in all social-relational variables, the third set examined in this study. Although with small effect sizes, results showed that IPVAW offenders with ADAPs reported higher levels of perceived social rejection, lower levels of community support (participation, integration, and support from community organizations), and intimate support than participants without ADAPs. Stressful life events, with a moderate effect size, emerged as the most salient risk factor in this set of variables (73.2% of participants with ADAPs reported a higher number of stressful life events than the average of participants without ADAPs). Our results are in line with a substantial body of research linking stress and ADAPs (Armeli et al., 2007; Russell et al., 2017; Wills & Hirky, 1996).

Violence-related variables was the fourth set of variables examined in this study. Although significant differences between participants with and without ADAPs were found in psychological violence, family violence exposure, and risk of future violence against partners and non-partners, with higher scores among participants with ADAPs, these differences had small effect sizes. Interestingly, the most salient factors found in this set of variables were motivation to change and stage of change, which presented significant differences between groups with moderate effect sizes. In terms of Cohen's U_3, 71.9% of participants with ADAPs showed higher motivation to change and 73.6% scored higher in stage of change than the

average of participants without ADAPs. These results are consistent with Alexander and Morris (2008), who suggested that offenders with alcohol-related problems could be more motivated to change because their substance abuse can cause them feelings of distress and guilt, which act as internal motivations to change.

Our findings have substantial treatment implications for BIP participants with ADAPs since the most salient risk factors and treatment needs we identified for these participants could be considered important intervention targets that go beyond their substance abuse problems. Clearly, substance abuse problems remain a key intervention target for BIP participants with ADAPs, and a major challenge is how to combine alcohol and drug abuse reduction strategies alongside IPVAW to produce better BIP outcomes. Bennett (2008) described different approaches to combine ADAPs and IPVAW interventions (i.e., consecutive, parallel, or integrated interventions). Research seems to favor integrated interventions as they provide a number of advantages over consecutive and parallel approaches, such as needing fewer professionals, saving time, or increasing the probability of participants attending and completing the intervention (Gilchrist & Hegarty, 2017; Leonard & Quigley, 2017; McMurran, 2017). However, these different approaches to combine ADAPs and IPVAW treatments do not usually take into account other risk factors and treatment needs among participants with ADAPs such as those found in the present study.

Several theoretical approaches have been proposed to guide and adjust interventions to increase sensitivity to BIP participants' risk factors and treatment needs. Leonard and Quigley (2017) stressed the need to identify instigatory and inhibitory factors (i.e., risk and protective factors, respectively) underlying alcohol-related IPVAW, and suggested that interventions should address these factors because reducing or eliminating ADAPs alone may not be sufficient to prevent IPVAW occurring. Similarly, a review conducted by Massa et al. (2020) on the instigating-impelling-inhibiting model or "I^3 model" (Finkel, 2007), highlighted the importance of developing specific treatment plans in BIPs targeting identified risk factors and treatment needs. Another theoretical approach to adjust interventions to participants risk and needs is the risk-need-responsivity (RNR) framework (Andrews & Bonta, 2010). In a meta-analysis and systematic review, Travers et al. (2021) found that when BIPs adhered to RNR principles results were more promising than the more traditional 'one-size-fits-all' intervention approach.

Another important challenge for BIPs is how to take into account individual risk factors and treatment needs in a group format intervention. Research suggests that the group format used in the vast majority of BIP interventions (Babcock et al., 2016; Price & Rosenbaum, 2009) has some advantages over individual intervention formats. In this regard, Murphy et al. (2020) found that a group intervention program produced consistently equivalent or greater benefits than an individual intervention. For these authors, "the mutual support and positive social influence available in group intervention may be particularly helpful for IPV perpetrators" (p. 2847). The risk factors and treatment needs of participants beyond their ADAPs, such as the ones identified in our study, could be addressed by adapting and integrating some specific intervention strategies into group format BIPs. For example, BIP participants who present the risk factor of impulsivity could be given specific cognitive rehabilitation activities to do outside the sessions to help reduce it (Romero-Martínez et al., 2021). Intervention strategies could also be integrated in group format BIPs to address specific risk factors and treatment needs of participants with ADAPs, while at the same time benefiting all group participants. For example, strategies based on dialectical behavior therapy (Cavanaugh et al., 2011; Linehan, 1993) could be included in some group sessions to address problems of dependency and emotional instability associated with several personality disorders. Also, BIPs could integrate activities derived from mindfulness-based stress reduction group therapy to counteract stress and enhance psychological adjustment (Nesset et al., 2020).

Finally, some general intervention strategies could also be particularly beneficial for BIP participants with ADAPs. For example, retention techniques to increase participants' compliance with treatment and reduce dropout are particularly relevant for participants with ADAPs, given their high dropout rate from BIPs (Lila et al., 2020; Moore & Stuart, 2004; Olver et al., 2011). Previous research has found that participants with ADAPs who completed the intervention not only showed the same improvements in all intervention outcomes as participants without ADAPs, but also reduced their alcohol consumption (Lila et al., 2020). In turn, motivational strategies can also be particularly relevant for BIP participants with ADAPs. As we found in this study, participants with ADAPs presented higher motivation to change, and more advanced stage of change, suggesting that these participants are more aware of their need to change (Alexander & Morris, 2008). In this regard, a promising strategy to address individual risk factors and treatment needs of participants with ADAPs within a group format BIP is to use motivational strategies (e.g., motivational interviewing at intake) to establish individualized intervention goals, including those related to ADAPs, that can be addressed and monitored both

individually and in group sessions (e.g., Lila et al., 2018; Romero-Martínez et al., 2019b; Santirso, Lila, et al. 2020).

The present study has certain limitations. Several tests were conducted to assess the differences among participants with and without ADAPs. Although we focused on the interpretation of effect sizes rather than purely statistical significance (i.e., *p*-values), it is important to note that the effect size estimators used in this study depend on the statistics of their tests and their distributions (Maher et al., 2013). Although the cut-offs Cohen (1988) proposed for the size effect statistics are commonly applied, they are also arbitrary. We therefore urge a cautious interpretation of the variables close to these cut-offs using Cohen's U_3 as a measure of practical significance. Another limitation is the cross-sectional nature of this study, which precludes assessment of how the differences between participants with and without ADAPs might change during and after the intervention. Further, in terms of external validity, more research is needed to generalize these results to other samples, such as women perpetrators, the LGBTIQ+ population, and different ethnic groups.

In conclusion, the literature has underscored the need to assess risk factors and treatment needs of participants with ADAPs to properly adjust BIPs to their specific characteristics. We tackled this issue by identifying the most salient risk factors and treatment needs of participants with ADAPs and by informing BIPs about potential intervention targets. Intervention strategies were also suggested to address the risk factors and treatment needs identified among participants with ADAPs. More efforts in this direction are required to improve BIP effectiveness by making interventions more sensitive and responsive to participants' risk factors and treatment needs.

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Study 2

Participants in court-mandated intervention programs for intimate partner violence perpetrators with substance use problems: A systematic review of specific risk factors[1]

Participants in court-mandated intervention programs for intimate partner violence perpetrators with substance use problems: A systematic review of specific risk factors

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Abstract

Men with alcohol and/or other drug use problems (ADUPs) court-mandated to attend intervention programs for intimate partner violence (IPV) perpetrators have been identified as a high-risk, highly resistant group of IPV perpetrators, as they present lower treatment adherence and higher dropout and recidivism rates. Previous research suggests that IPV perpetrators with ADUPs may require tailored interventions to address their specific risk factors. The present systematic review was conducted using PRISMA guidelines to identify the specific risk factors in men with and without ADUPs on entry to court-mandated perpetrator programs. The following databases were searched from inception to November 2021: Web of Science, PsycINFO, and Scopus. There was a screening of 3,995 records, and 29 quantitative studies were included in the review. Risk factors present in males court-mandated to perpetrator programs were grouped into four categories: sociodemographic risk factors, personality disorders and psychological adjustment, social-relational risk factors, and risk factors related to attitudes towards women. Results indicated that the main risk factors in IPV perpetrators with ADUPs, compared to those without, were higher clinical symptomatology (e.g., anger and impulsivity), personality disorders, poorer executive functions, having experienced more stressful life events, higher exposure to childhood trauma, lower intimate social support and higher responsibility attributed to the offenders' personal context. These results contribute to a deeper understanding of the complex phenomenon of IPV and ADUPs, and could help to inform key targets for perpetrator programs that may improve the well-being of their (ex)-partners and increase the effectiveness of intervention programs for IPV perpetrators.

Keywords: intimate partner violence; intervention programs; substance use; risk factors; systematic review.

Participantes que acuden por mandato judicial a programas de intervención para agresores de pareja con problemas de consumo de sustancias: Una revisión sistemática de los factores de riesgo específicos

Resumen

Los hombres que presentan consumo problemático de alcohol y otras drogas (CPAD) y que acuden por mandato judicial a programas de intervención para agresores de pareja constituyen un grupo de agresores resistentes a la intervención y de alto riesgo, ya que presentan una menor adherencia al tratamiento y una mayor frecuencia de abandono y reincidencia. La investigación previa indica que los participantes con CPAD pueden necesitar intervenciones adaptadas en las que se traten los factores de riesgo específicos. La presente revisión sistemática se ha llevado a cabo siguiendo las directrices PRISMA con el fin de conocer los factores de riesgo específicos en participantes con y sin CPAD al inicio de la intervención. La búsqueda bibliográfica se realizó en las siguientes bases de datos hasta noviembre del 2021: Web of Science, PsycINFO y Scopus. Se examinaron 3,995 estudios, incluyéndose 29 estudios cuantitativos en la revisión. Los factores de riesgo de los hombres que acudieron por mandato judicial a intervenciones con agresores de pareja se agrupan en cuatro categorías: sociodemográficos, trastornos de la personalidad y ajuste psicológico, sociorrelacionales y relativos a las actitudes hacia la mujer. Los resultados indican que los principales factores de riesgo en agresores de pareja con CPAD, comparados con aquellos que no tienen este problema, se caracterizan por una mayor sintomatología clínica (e.g., ira e impulsividad), trastornos de la personalidad, deficiencias en las funciones ejecutivas, mayor exposición a hechos vitales estresantes, trauma en la infancia, menor apoyo social íntimo y mayor tendencia a atribuir la responsabilidad de la conducta violenta a su contexto personal. Estos resultados contribuyen a una comprensión más profunda de la compleja relación entre la violencia de pareja y el CPAD y de los objetivos clave de los programas para agresores, con el fin de aumentar el bienestar de la (ex)pareja y la eficacia de dichos programas.

Palabras clave: violencia de pareja; programas de intervención; consumo de sustancias; factores de riesgo; revisión sistemática

Introduction

Intimate partner violence (IPV) against women has been internationally recognized as a serious and widespread phenomenon of epidemic proportions that includes physical, sexual, economic, social, and psychological harm toward women perpetrated by a current or former male intimate partner (World Health Organization [WHO], 2013, 2014). According to a recent WHO report (2021) on global IPV prevalence estimates, 27% of ever-married or partnered women aged 15-49 years have suffered physical and/or sexual violence from a current or former male intimate partner at least once in their lifetime. The persistently high prevalence of IPV has led governments and organizations to implement intervention programs for IPV perpetrators to promote healthy behaviours alternative to violence for male perpetrators convicted of IPV offences to reduce recidivism, and protect victims (Scott et al., 2011; Voith et al., 2018; WHO, 2021). Intervention programs for IPV perpetrators can be mandated by courts in lieu of incarceration, or perpetrators can self-refer to some intervention programs (Cheng et al., 2021; Dalton, 2007). Reviews on the effectiveness of such intervention programs for court-mandated IPV perpetrators have found mixed results, with positive but low to moderate effect sizes on reducing recidivism (Arce et al., 2020; Babcock et al., 2004; Cheng et al., 2021; Feder & Wilson, 2005; Santirso et al., 2020; Smedslund et al., 2011; Stephens-Lewis et al., 2021). Scientific literature in this field has pointed to the main challenges that hinder the effectiveness of intervention programs for IPV perpetrators, specifically, high dropout rates, low treatment adherence, low levels of personal responsibility attribution, and low levels of motivation to change; which are particularly present in court-mandated (Bowen & Gilchrist, 2004), high-risk and highly resistant perpetrators (Carbajosa et al., 2017; Eckhardt et al., 2008; Jewell & Wormith, 2010). Risk factors that increase the occurrence of IPV recidivism in these perpetrators include previous mental health issues (Petersson & Strand, 2017), sociodemographic characteristics (i.e., immigrant status), childhood experience and/or exposure to family violence, experience of stressful life events (Lila et al., 2019), trauma (Kwong et al., 2003), and substance use (Langenderfer, 2013). Another challenge that has been widely recognized in scientific research is the lack of individualized intervention programs specifically tailored to participants' risk factors such as substance use and/or other underlying problems (Butters et al., 2021; Karakurt et al., 2019).

Alcohol and/or other drug use problems (ADUPs) have been strongly and consistently associated with IPV perpetration (Cafferky et al., 2018). Approximately 50% of perpetrators attending intervention programs for IPV have ADUPs (Crane et al., 2015; Kraanen et al., 2010; Stuart et al., 2003; Stuart et al., 2009). Although ADUPs are "neither a necessary nor a sufficient cause, excessive alcohol use does contribute to the occurrence of partner violence and that contribution is approximately equal to other contributing causes such as gender roles, anger, and marital functioning" (Leonard & Quigley, 2017, p. 7). In addition, ADUPs are strongly associated with low treatment adherence, dropout, recidivism, and severe violence in perpetrators court-mandated to attend IPV intervention programs (Bowen & Gilchrist, 2006; Easton et al., 2018; Jewell & Wormith, 2010; Lila et al., 2020; Moore & Stuart, 2004; Olver et al., 2011). Thus, perpetrators with ADUPs have been identified as a high-risk, highly resistant group of IPV perpetrators who may require tailored interventions to address their IPV perpetration (Gilchrist & Hegarty, 2017). Compared to those without ADUPs, risk factors associated with ADUPs in this population include poorer cognitive abilities (Romero-Martínez et al., 2016; Romero-Martínez, Lila, & Moya-Albiol, 2019; Vitoria-Estruch et al., 2017), exposure to childhood trauma (Alexander, 2014; McBurnett et al., 2001), stressful life events (Lila et al., 2013), less perceived social support (Catalá-Miñana et al., 2017; Taft et al., 2010), psychopathological symptoms (Stuart et al., 2003; Thomas et al., 2013), impulsivity, antisocial, borderline, and aggressive personality disorders (a term coined by Millon (2007) describing a clinical personality pattern characterized by a tendency to act impulsively, violently and antisocially; (Expósito-Álvarez et al., 2021). In consideration of the above characteristics, dealing with perpetrators with ADUPs and other associated risk factors frequently represents a challenge for professionals in these intervention programs (Karakurt et al., 2019; McMurran, 2017).

Several authors state that risk assessments are required to help professionals to identify specific risk and protective factors in IPV perpetrators with ADUPs (Leonard & Quigley, 2017), and develop treatment plans sensitive and responsive to these risk factors and treatment needs (Finkel, 2007; Massa et al., 2020; Travers et al., 2021). Achieving abstinence or reducing ADUPs alone has been shown to have positive but not sustained effects on reducing IPV recidivism in this high-risk and highly resistant group of perpetrators (Wilson et al., 2014). Thus, identifying and addressing risk factors associated with ADUPs could have the potential to improve IPV perpetrator program effectiveness (Karakurt et al., 2019; Leonard & Quigley, 2017; Murphy & Ting, 2010). This could be especially beneficial for court-mandated

participants who, compared to self-referred participants, present higher IPV recidivism rates (Mills et al., 2013; Shepard et al., 2002), higher social desirability and denial (Daly et al., 2001), are more antisocial (Dixon & Browne, 2003; Turner et al., 2022), exhibit higher levels of external locus of control, and are less motivated to change (Bowen & Gilchrist, 2004), also shown by their increased likelihood to be in the precontemplation stage (Tutty et al., 2020). Therefore, those referred by the judicial system to attend interventions for IPV perpetrators may require more tailored support to address risk factors that contribute to increasing their resistance to treatment (Cheng et al., 2021; Cunha et al., 2022; Tutty et al., 2020). However, more research is needed to provide an integrated view of the main risk factors present in court-mandated IPV perpetrators with ADUPs.

The present systematic review filled this gap by rigorously analyzing the specific risk factors in men with and without ADUPs court-mandated to attend intervention programs for IPV perpetrators. Although there are other types of partnerships that involve IPV (e.g., LGBTIQ+; Badenes-Ribera et al., 2016; Coston, 2021; Gilchrist et al., 2023; Liu et al., 2021; Peitzmeier et al., 2020), the present systematic review focuses on male perpetrators, as IPV is most commonly and severely perpetrated by men against women (Centers for Disease Control and Prevention [CDC, 2022]; WHO, 2013). As far as we are aware, this is the first systematic review to identify the specific risk factors beyond issues strictly related to substance use that differentiate IPV perpetrators with and without ADUPs in court-mandated group-based intervention programs for IPV perpetrators. A better understanding of the main risk factors present in participants with ADUPs on entry to such programs will help inform intervention needs for this high-risk, highly resistant population, which may improve their treatment outcomes (Crane et al., 2016; Massa et al., 2020).

Method

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The study protocol was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO 2022 CRD42022297377) on 13 January 2022.

Search strategy

A systematic search of the following electronic databases was conducted: Web of Science, PsycINFO, and Scopus. The search strategy on terms related to IPV was developed by the research team and adapted from a previous review conducted by the team (Santirso et al., 2020). No limitation was applied for the year or language of publications. Citations were managed using Endnote Version X9. The search was conducted in October 2020 and repeated in November 2021. The search strategy was performed through an iterative process using multiple combinations of the keywords in four clusters and included the following terms: (intimate* violen* OR partner* violen* OR domestic* violen* OR marital* violen* OR couple* violen* OR spous* violen* OR husband* violen* OR situation* violen* OR partner* abus* OR domestic* abus* OR spous* abus* OR marital* abus* OR husband* abus* OR intimate* terror* OR partner* aggress* OR husband* aggress* OR spous* aggress* OR marital* aggress* OR couple* aggress*) AND (alcohol* OR substance OR drug OR drinking) AND (intervention* OR program* OR treatment* OR therapy* OR group) AND (batterer* OR offender* OR perpetrator* OR aggres* OR men). We complemented the electronic search with backward and forward searches to further identify relevant publications.

Eligibility

Inclusion criteria were: (1) studies published in peer-reviewed journals to guarantee minimum methodological standards in the included studies; 2) quantitative studies; 3) sample included at least 70% men who were court-mandated to attend an intervention program for IPV perpetrators; 4) results were presented separately for men; 5) risk factors for IPV (e.g., levels of anger) were compared between IPV perpetrators with and without ADUPs and/or levels of ADUPs were compared between IPV perpetrators with and without risk factors for IPV (e.g., participants with high versus low anger) and/or the association between risk factors and levels of ADUPs was evaluated; 6) data were collected on entry to court-mandated IPV perpetrator intervention. Two reviewers (CEA and FA) independently screened the records by abstract and title to identify studies that met eligibility criteria. Full texts of the selected studies were

independently assessed by three authors (CEA, FA, and GG) and discrepancies were resolved by discussion and consensus with additional authors (ML and EG). When we needed further clarification to establish eligibility or supply additional data required for our review, the authors of the studies were contacted by email.

Data extraction

Two of the researchers independently extracted the data (CEA and FA). Study characteristics that were extracted included the country where each intervention took place, their sample size, % of men court-mandated to attend an intervention program for IPV perpetrators, methodology, ADUPs-related measures, risk factors-related measures, and a summary of the main results showing the risk factors in IPV perpetrators with ADUPs. The extracted data included a summary of documented risk factors for IPV in perpetrators with and without ADUPs analyzed in included studies, the number of included studies that assessed at least one risk factor in each category, and the number of included studies that investigated each risk factor. Discrepancies were resolved by consensus with a third author (GG or ML).

Assessment of methodological quality

Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018; Pace et al., 2012). Specifically, the designs evaluated were non-randomized quantitative studies. For each study design, the MMAT presents a five-question checklist to assess the methodological quality of the studies. The response options were 'yes', 'no', or 'can't tell' if the study does not report appropriate information to answer. Three authors (CEA, FA, and GG) independently assessed the risk of bias in included studies with disagreement resolved by discussion and consensus with additional authors (ML and EG).

Results

Database searches resulted in 6,053 records. Once duplicates were removed, 3,995 records remained. After initial exclusion based on titles and abstracts, 53 records were selected for full-text assessment. Twenty-four studies were excluded as: they were not quantitative studies ($n = 2$); the target population was less than 70% men court-mandated to an intervention program for IPV perpetrators ($n = 10$); the results were not presented separately for men ($n = 3$); comparisons of risk factors for IPV between IPV perpetrators with and without ADUPs, comparisons of levels of ADUPs between IPV perpetrators with and without risk factors, or associations between risk factors and ADUPs were not available ($n = 7$) and the data collected on entry to IPV perpetrator program were not presented ($n = 2$). A total of 29 manuscripts met the inclusion criteria and were included in the review (Figure 1).

Figure 1. PRISMA flow diagram
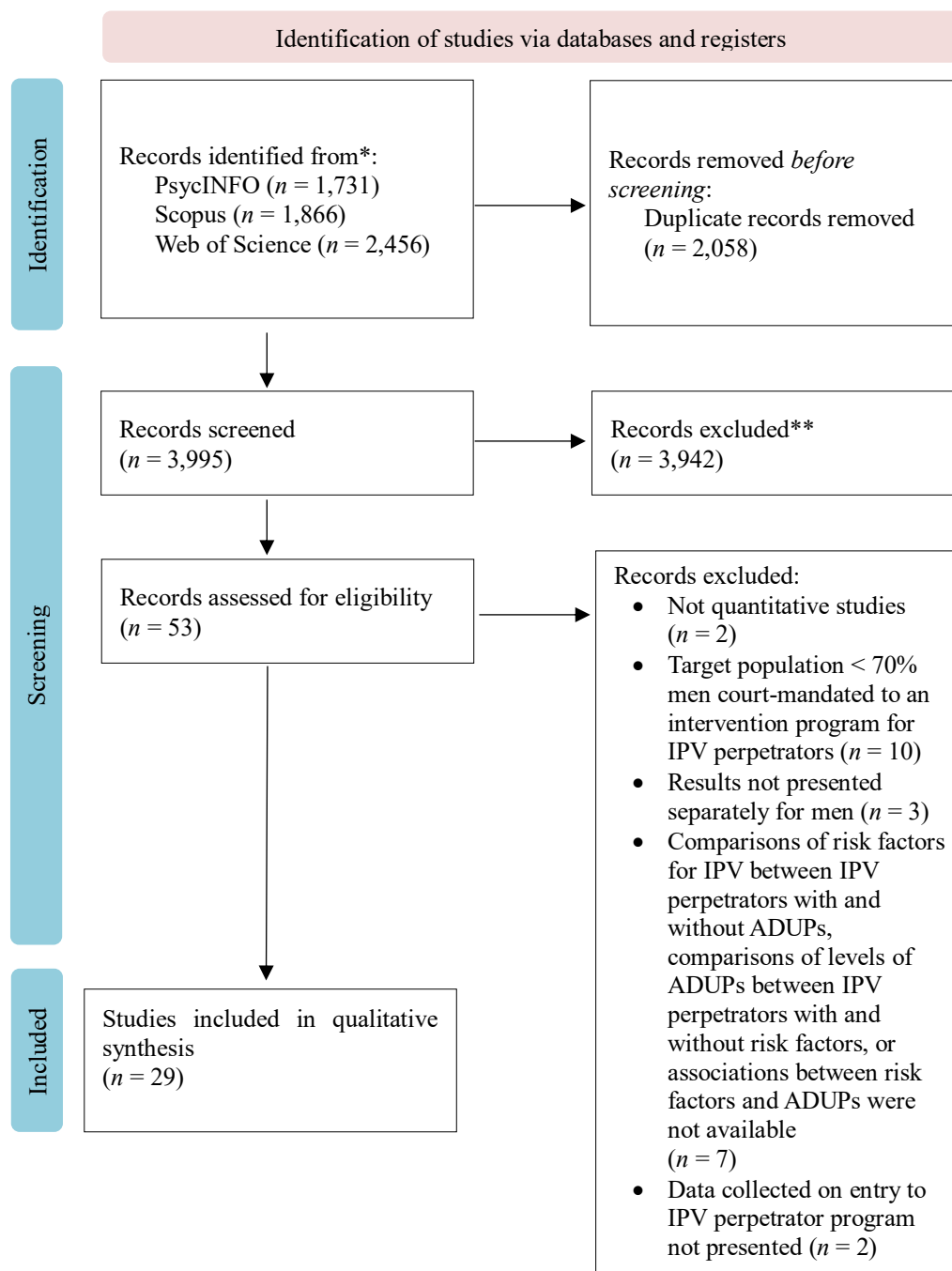
Risk of bias results

Risk of bias in included studies was assessed, using MMAT criteria for quantitative non-randomized studies ($n = 29$; see Figure 2). In terms of the representativeness of the target population, only seven studies gave clear indicators, including inclusion and exclusion criteria of the target population and reasons why certain eligible individuals chose not to participate (Studies 2, 9, 10, 12, 14, 22, and 26). Measurements were appropriately described in all studies (see Figure 2). With regard to complete outcome data, most of the studies ($n = 22$) gave all numbers and accounted for missing data, except for seven studies, six of which only met one of these conditions (Studies 1, 4, 7, 11, 24, and 29), and one which did not mention missing data (Study 5). Unexpected or inappropriate methods were used to control for confounding factors in six studies (Studies 1, 2, 8, 10, 19, and 27). In terms of the presence of contamination in the assignment of the intervention, the intervention was not administered as intended in two studies (Study 2, 3), and one study used a sample recruited from domestic violence programs in several communities (Study 8). All studies were included in the narrative synthesis regardless of quality.

Figure 2. Risk of bias of included studies

Study Number	Authors	Are the participants representative of the target population?	Are measurements appropriate regarding both the outcome and intervention (or exposure)?	Are there complete outcome data?	Are the confounders accounted for in the design and analysis?	During the study period, is the intervention administered (or exposure occurred) as intended?
[Study 1]	Alexander (2014)	can't tell	yes	can't tell	yes	yes
[Study 2]	Boira & Jodrá (2013)	yes	yes	yes	can't tell	no
[Study 3]	Brasfield et al. (2012)	can't tell	yes	yes	yes	no
[Study 4]	Brem, Florimbio, et al. (2018)	can't tell	yes	can't tell	yes	yes
[Study 5]	Brem, Shorey, et al. (2018)	can't tell	yes	no	yes	yes
[Study 6]	Catalá-Miñana et al. (2013)	can't tell	yes	can't tell	yes	yes
[Study 7]	Catalá-Miñana et al. (2017)	can't tell	yes	yes	yes	yes
[Study 8]	Chiffriller & Hennessy (2009)	can't tell	yes	yes	can't tell	can't tell
[Study 9]	Eckhardt et al. (2008)	yes	yes	yes	yes	yes
[Study 10]	Expósito-Álvarez et al. (2021)	yes	yes	yes	can't tell	yes
[Study 11]	Grigorian et al. (2020)	can't tell	yes	can't tell	yes	yes
[Study 12]	Lila et al. (2014)	yes	yes	yes	yes	yes
[Study 13]	Marsh & Martinovich (2006)	can't tell	yes	yes	yes	yes
[Study 14]	Murphy et al. (2007)	yes	yes	yes	yes	yes
[Study 15]	Redondo et al. (2019)	can't tell	yes	yes	yes	yes
[Study 16]	Romero-Martínez et al. (2013)	can't tell	yes	yes	yes	yes
[Study 17]	Romero-Martínez et al. (2015)	can't tell	yes	yes	yes	yes
[Study 18]	Romero-Martínez et al. (2016)	can't tell	yes	yes	yes	yes
[Study 19]	Romero-Martínez, Lila, Gracia, et al. (2019)	can't tell	yes	yes	can't tell	yes
[Study 20]	Saunders et al. (1992)	can't tell	yes	yes	yes	yes
[Study 21]	Semiatin et al. (2017)	can't tell	yes	yes	yes	yes
[Study 22]	Siria et al. (2021)	yes	yes	yes	yes	yes
[Study 23]	Snow et al. (2006)	can't tell	yes	yes	yes	yes
[Study 24]	Stuart et al. (2003)	can't tell	yes	can't tell	yes	yes
[Study 25]	Thomas et al. (2013)	can't tell	yes	yes	yes	yes
[Study 26]	Travers et al. (2022)	yes	yes	yes	yes	yes
[Study 27]	Vitoria-Estruch et al. (2017)	can't tell	yes	yes	can't tell	yes
[Study 28]	Vitoria-Estruch et al. (2018)	can't tell	yes	yes	yes	yes
[Study 29]	Wolford-Clevenger et al. (2017)	can't tell	yes	can't tell	yes	yes

Key		
	green	yes
	yellow	can't tell
	red	no

Study characteristics

Twenty-nine studies reported data for 8,893 male perpetrators attending intervention programs for IPV perpetrators. As shown in Table 1, most studies were conducted in the USA (*n* = 14; Studies 1, 3, 4, 5, 8, 9, 11, 14, 20, 21, 23, 24, 25, and 29) and Spain (*n* = 13; Studies 2, 6, 7, 10, 12, 15 to 19, 22, 27, and 28). One study was conducted in New Zealand (Study 13) and one in Ireland (Study 26). Samples sizes ranged from 16 IPV perpetrators (Study 17) to 1,039 (Study 10). In 24 of the 29 studies, the total sample of adult males was court-mandated to attend an intervention program for IPV perpetrators (Studies 1 to 7, 9 to 13, 15 to 19, and 23 to 29). In the remaining studies (Studies 8, 14, 20, 21, and 22) and in accordance with the inclusion criteria for the study selection, the lowest percentage of court-mandated participants was 70% (Study 20). In addition, while the majority of included studies explicitly clarified that participants were men who perpetrated IPV against women (IPVAW) or mentioned IPVAW as the theoretical framework of the study (*n* = 25; Studies 1 to 10, 12, 14 to 20, and 22 to 28), four studies did not clarify the male IPV perpetrators' sexual orientation (Studies 11, 13, 21, and 29).

Table 1. Risk factors in intimate partner violence (IPV) perpetrators with alcohol and/or other drug use problems (ADUPs) in the selected studies

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[1]	Alexander (2014)	United States of America (USA) 473 100%	Comparison of groups of participants	Alcohol abuse [*Alcohol Use Disorders Identification Test* (AUDIT; Allen et al., 1997)] Drug abuse (Self-reported)	Exposure to childhood trauma (Ad-hoc)	*Alcohol abuse* Men with trauma history > No trauma history *Drug abuse* Men with trauma history *vs.* No trauma history (*ns*)
[2]	Boira and Jodrá (2013)	Spain 61 100%	Cluster analysis	Alcohol and drugs abuse [*Millon Clinical Multiaxial Inventory-II* (MCMI-II; Millon, 1998); Semistructured Interview (Echeburúa & Corral, 1998)]	*Clusters:* Cluster 1 (Lower clinical symptomatology) and Cluster 2 (Higher clinical symptomatology) *Clustering variable:* Clinical symptomatology [*Symptoms Checklist-90 Revised* (SCL-90-R; Derogatis, 1975; Spanish version by González de Rivera, 2002)]	*Alcohol abuse* MCMI-II and semi-structured interview: Higher clinical symptomatology > Lower clinical symptomatology *Drugs abuse* MCMI-II: Higher clinical symptomatology > Lower clinical symptomatology Semi-structured interview: Higher clinical symptomatology *vs.* Lower clinical symptomatology (*ns*)
[3]	Brasfield et al. (2012)	USA 341 100%	Bivariate correlations and comparison of groups of participants	Hazardous drinking (AUDIT; Saunders et al., 1993)	Pathological gambling [*The South Oaks Gambling Screen* (SOGS; Lesieur & Blume, 1987)] Impulsivity [*Eysenck Impulsiveness Questionnaire* (EIQ; Eysenck et al., 1985)]	*Hazardous drinkers vs. Non-hazardous drinkers* Pathological gambling (+) *Hazardous drinking* Impulsivity (+)

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[4]	Brem, Florimbio, et al. (2018)	USA 331 100%	Correlational analysis and structural equational modeling	Alcohol problems [*The Psychiatric Diagnostic Screening Questionnaire* (PDSQ; Zimmerman, 2002; Zimmerman & Mattia, 2001)]	Antisocial personality disorder (ASPD) [*The Personality Diagnostic Questionnaire-4's Antisocial Personality Disorder* (PDQ-4-ASPD scale; Hyler, 2004)] Distress tolerance [The *Distress Tolerance Scale* (DTS; Simons & Gaher, 2005)]	*Alcohol problems* ASDP traits (+); Distress tolerance (-)
[5]	Brem, Shorey, et al. (2018)	USA 74 100%	Correlational analysis and moderation analysis	Alcohol problems (AUDIT; Saunders et al., 1993)	Trait jealousy [*The Interpersonal Jealousy Scale* (IJS; Mathes & Severa, 1981)]	*Alcohol problems* Trait jealousy (*ns*); Alcohol problems (+) relates to physical and sexual IPV among men with high levels of trait jealousy

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[6]	Catalá-Miñana et al. (2013)	Spain 291 100%	Bivariate correlations and comparison of groups of participants	Alcohol consumption (AUDIT; Babor & Grant, 1989; Spanish version by Contel-Guillamón et al., 1999)	Clinical symptomatology (SCL-90-R; Derogatis et al., 1977) Impulsivity [*Impulsivity Scale* (IS; Plutchik & Van Praag, 1989)] Self-esteem [*Self-esteem Scale* (Rosenberg, 1989)] *Responsibility attribution scale* (Lila et al., 2012). Subscales: Responsibility attributed to the legal context; Responsibility attributed to the victim; Responsibility attributed to the offender's personal context. *Attitudes towards intimate partner violence against women (IPVAW) scale* (Gracia et al., 2008, 2011) *Intimate Social Support Questionnaire* (Lin et al., 1986) *Perceived Social Rejection Index* (PSRI; Ad-hoc) *Stressful Life Events Questionnaire* (Gracia & Herrero, 2004) Satisfaction with economic status: 2-item of *European Social Survey* (2007) *Perceived Community Support Questionnaire* (PCSQ; Gracia & Herrero, 2006). Dimensions: Community integration; Community Participation; Support from formal and informal community organizations	*Risk consumers vs. Non-risk consumers* Clinical symptomatology (+); Impulsivity (+); Perceived social rejection (+); Stressful life events (+); Satisfaction with economic status (+); Self-esteem (-); Intimate Social Support (-); Community integration (*ns*); Community Participation (*ns*); Support from formal community organizations (*ns*); Support from informal community organizations (*ns*); Responsibility attributed to the offender's personal context (+); Responsibility attributed to the legal context (*ns*); Responsibility attributed to the victim (*ns*); Attitude towards IPVAW (*ns*)
[7]	Catalá-Miñana et al. (2017)	Spain 231 100%	Logistic regression and ROC analysis	Alcohol abuse (AUDIT; Babor & Grant, 1989; Spanish version by Contel-Guillamón et al., 1999)	Age (Self-reported) Marital status (Self-reported) Ethnicity (Self-reported; Spanish or Latin American) Accumulation of stressful life events (*Stressful Life Events Questionnaire;* Gracia & Herrero, 2004) Perception of social support (*Intimate Social Support Questionnaire;* Lin et al., 1986; Spanish version in Herrero et al., 2012) Social rejection (PSRI; Ad-hoc)	*Alcohol abuse* Age (*ns*); Marital status (*ns*); Ethnicity (Latin American) (+); Stressful life events (+): Intimate support (-); Social rejection (*ns*)

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[8]	Chiffriller & Hennessy (2009)	USA 201 97%	Cluster analysis	Alcoholism [*Michigan Alcoholism Screening Test* (MAST; Selzer et al., 1975)]	*Typologies:* Pathological batterers; Sexually violent batterers; Generally violent batterers; Psychologically violent batterers; Family-only batterers *Clustering variables:* Personality characteristics [*Basic Personality Inventory* (BPI; Jackson, 1989)] Jealousy [*Multidimensional Jealousy Scale* (MJS; Pfeiffer & Wong, 1989)] IPV [*Revised Conflict Tactics Scales* (CTS2; Straus et al., 1996)] Attachment styles [*Relationship Scales Questionnaire* (RSQ; Griffin & Bartholomew, 1994)]	*Alcoholism* Typologies: Pathological batterers vs. Sexually violent batterers vs. Generally violent batterers *vs.* Psychologically violent batterers vs. Family-only batterers (*ns*)
[9]	Eckhardt et al. (2008)	USA 190 100%	Cluster analysis	Alcohol use (AUDIT; Saunders et al., 1993) Drug use [*Drug Abuse Screening Test* (DAST; Skinner, 1982)]	*Clusters:* High anger-expressive, Low anger, and Moderate anger-inexpressive *Clustering variable:* Anger [*State–Trait Anger Expression Inventory* (STAXI; Spielberger, 1988)]	*Alcohol use* High anger-expressive > Low anger; Low anger vs. Moderate anger-inexpressive (*ns*); Moderate anger-inexpressive *vs.* High anger-expressive (*ns*) *Drugs use* High anger-expressive > Low anger; Low anger *vs.* Moderate anger-inexpressive (*ns*); High anger-expressive > Moderate anger-inexpressive

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[10]	Expósito-Álvarez et al. (2021)	Spain 1039 100%	Comparison of groups of participants	Alcohol and/or drug abuse problems (ADAPs) [Alcohol dependence and drug dependence clinical syndrome scales included in *Millon Clinical Multiaxial Inventory-III* (MCMI-III; Millon, 2007; Spanish version by Cardenal & Sánchez, 2007)]	Sociodemographic variables (Self-reported): Age, Educational level, Immigrant status, Employment status, Income Clinical symptomatology (SCL-90-R; Derogatis, 1977; Spanish version by De las Cuevas et al., 1991) Personality disorders (MCMI-III; Millon, 2007; Spanish version by Cardenal & Sánchez, 2007). Subscales: Depressive; Dependent; Antisocial; Aggressive; Borderline; Paranoid; Anxiety personality disorder Anger [*State-Trait Anger Expression Inventory-2* (STAXI-2; Spielberger, 1999; Spanish version by Miguel-Tobal et al., 2001)]. Subscales: Anger state; Anger trait *Plutchik's Impulsivity Scale* (Plutchik & Van Praag, 1989; Spanish version by Páez et al., 1996) *Rosenberg Self-esteem Scale* (Rosenberg, 1965; Spanish version by Martín-Albo et al., 2007) Community support (PCSQ; Gracia & Herrero, 2006) *Intimate Social Support Questionnaire* (Lin et al., 1986; Spanish adaptation by Herrero et al., 2011) *Stressful Life Events Questionnaire* (Gracia & Herrero, 2004) Perceived social rejection (PSRI; Catalá-Miñana et al., 2013) Family violence exposure [The sixth item of the *Spousal Assault Risk Assessment* (SARA; Kropp et al., 1999; Spanish version by Andrés-Pueyo et al., 2008)] *Perceived severity of IPVAW scale* (PS-IPVAW; Gracia et al., 2008) *Ambivalent Sexism Inventory* (Glick & Fiske, 1997; Spanish version by Expósito et al., 1998). Subscales: Hostile and Benevolent sexism	*Participants with ADAPs vs. without ADAPs* Age (-); Educational level (*ns*); Income (*ns*); Unemployment (+); Immigrant (-); Clinical symptomatology (+); Depressive personality disorder (+); Dependent (*ns*); Narcissist (+); Antisocial (+); Aggressive (+); Borderline (+); Paranoid (+); Anxiety personality disorder (+); Anger state (+); Anger trait (+); Impulsivity (+); Self-esteem (-); Community integration (-); Participation (-); Informal Community support (-); Intimate support (-); Stressful life events (+); Perceived social rejection (+); Exposure to family violence (+); Perceived severity of IPVAW (*ns*); Hostile sexism (*ns*); Benevolent sexism (*ns*)

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[11]	Grigorian et al. (2020)	USA 391 100%	Bivariate correlations and structural equation modeling	Alcohol use problems (AUDIT; Babor et al., 2001; Saunders et al., 1993)	Emotion dysregulation [*The Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004)]	*Alcohol use problems* Emotion dysregulation (+)
[12]	Lila et al. (2014)	Spain 423 100%	Correlational analysis	Abusive alcohol consumption (AUDIT; Babor & Grant, 1989)	Responsibility Attribution [*Intimate Partner Violence Responsibility Attribution Scale* (IPVRAS; Lila et al., 2014)]	*Abusive alcohol consumption* Responsibility attribution to the offenders' personal context (+)
[13]	Marsh & Martinovich (2006)	New Zealand 38 100%	Comparison of groups of participants	Alcoholism [*The Short Michigan Alcoholism Screening Test* (SMAST; Selzer et al., 1975)]	Traumatic Brain Injury (TBI; Medical history interview)	*Alcoholism* TBI *vs.* Non-TBI (*ns*)
[14]	Murphy et al. (2007)	USA 159 79% and 6% a court case pending	Cluster analysis	Alcohol abuse (AUDIT; Babor et al., 1992) Drug abuse (DAST; Skinner, 1982)	*Clusters*: Pathological anger; Low anger control; Normal anger *Clustering variable:* Anger problems (STAXI; Spielberger, 1988)	*Alcohol abuse* Pathological anger > Low anger control and Normal anger *Drug abuse* Pathological anger > Low anger control and Normal anger
[15]	Redondo et al. (2019)	Spain 483 100%	Cluster analysis	Alcohol use (AUDIT; Saunders et al., 1993)	Anger profiles (*clusters*): Undercontrolled and overcontrolled *Clustering variables:* Anger (STAXI; Spielberger, 1988; Spanish adaptation by Miguel-Tobal et al., 2001) General Aggression [*Aggression Questionnaire* (AQ; Buss & Perry, 1992; Spanish adaptation by Redondo et al., 2017)]	*Alcohol abuse* Undercontrolled anger > Overcontrolled anger

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[16]	Romero-Martínez et al. (2013)	Spain 145 100%	Cluster analysis	Alcohol consumption [AUDIT (Contel-Guillamón et al., 1999); *CAGE Test* (Spanish adaptation by Rodríguez-Martos et al., 1986); Alcohol dependence scale of the MCMI-III (Millon, 2007)]	Sociodemographic variables (Self-reported): Educational level, Nationality, Employment status, Economic income per year, Marital status (Single; Married; Divorced) Empathy [*Interpersonal Reactivity Index* (IRI; Davis, 1983; Spanish adaptation by Mestre et al., 2004)]. Subscales: IRI perspective taking; Empathetic concern; Personal distress, and Fantasy Anger (STAXI-2; Spielberger, 1999; Spanish adaptation by Miguel-Tobal et al., 2001) Impulsivity (*Plutchik Impulsivity Scale;* Páez et al., 1996) Emotional decoding (*Eyes Test;* Baron-Cohen et al., 2001). Dimensions: Eyes test performance; Eyes test positive, Neutral, and Negative emotions Cognitive flexibility [*Wisconsin card sorting test* (WCST; Heaton et al., 2011)]. Dimensions: WCST total trials; Total mistakes; Perseverative mistakes; Non-perseverative mistakes; Perseverative mistakes %; Failure to maintain set; Trials to complete the first category; Number of categories; Conceptual level; Learn to learn *Ambivalent Sexism Inventory* (Expósito et al., 1998) *Parental Acceptance-Rejection Questionnaire* (Rohner et al., 1978)	*High alcohol consumption vs. Low alcohol consumption* Educational level, Nationality, Employment status and Economic income per year (*ns*); Marital status: Divorced (+); IRI perspective taking (-); IRI empathic concern (*ns*); IRI personal distress (+); IRI fantasy (*ns*); Trait Anger (+); Anger Expression (+); Impulsivity (+); Eyes test performance (-); Eyes test positive emotions (*ns*); Negative emotions (*ns*); Neutral emotions (-); WCST total trials (+); Total mistakes (+); Perseverative mistakes (+); Non-perseverative mistakes (+); Perseverative mistakes % (+); Failure to maintain set (*ns*); Trials to complete the first category (*ns*); Number of categories (-); Conceptual level (*ns*); Learn to learn (*ns*); Hostile sexism (+); Benevolent sexism (*ns*); Perceived parental rejection (+)
[17]	Romero-Martínez et al. (2015)	Spain 16 100% of IPV offenders	Mediation analysis	Alcohol abuse [AUDIT (Contel-Guillamón et al., 1999); Alcohol dependence scale of the MCMI-III (Millon, 2007)]	Anger Expression Index (STAXI; Spielberger, 1999)	*Alcohol abuse* Anger Expression Index (+)

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[18]	Romero-Martínez et al. (2016)	Spain 116 100%	Cluster analysis	Alcohol abuse [AUDIT (Spanish version by Contel-Guillamón et al., 1999); Alcohol disorders scale of MCMI-III (Millon, 2007)]	Sociodemographic variables (Self-reported): Educational level, Nationality, Employment status, Economic income per year, Marital status Empathy (IRI; Mestre et al., 2004) Theory of mind/Emotional decoding (*Eyes Test;* Baron-Cohen et al., 2001) Cognitive Flexibility (WCST; Heaton et al., 2011)	*High alcohol vs. low alcohol* Educational level, Nationality, Employment status and Economic income per year (*ns*); Marital status: Single (+); Eyes Test performance (-); IRI perspective taking (-); Personal distress (+); Empathetic concern (*ns*); Fantasy (*ns*); WCST number of categories completed (-); WCST percentage of perseverative errors (+); The number of trials (+); The number of perseverative errors (+)
[19]	Romero-Martínez, Lila, Gracia, et al. (2019)	Spain 423 100%	Comparison of groups of participants	Alcohol consumption (AUDIT; Gual et al., 1999)	*Plutchik Impulsivity Scale* (Plutchik & Van Praag, 1989) Emotional decoding (*Eyes Test;* Baron-Cohen et al., 2001) Cognitive flexibility (Perseverative errors; WCST; Heaton et al., 2011).	*High alcohol vs. Low alcohol consumption* Impulsivity (+) *Dropped out and high alcohol vs. Dropped out and low alcohol* Emotional decoding (-); WCST perseverative errors (+)
[20]	Saunders et al. (1992)	USA 182 70%	Cluster analysis	Alcohol use (Structured intake interview)	Typologies (*clusters*): Generally violent; Emotionally volatile, and Family-only aggressors *Clustering variables:* Generalized violence (Intake interview) Severity of violence [*Conflict Tactics Scale* (CTS; Straus, 1979)] Anger toward a partner [A modified version of the *Novaco Anger Index* (Novaco, 1975)] Depression (*Beck Depression Inventory*; Beck et al., 1961) Liberal views of sex roles [A version of the *Attitudes Toward Women Scale* (Spence & Helmreich, 1979)]	*Alcohol use* Generally violent > Emotionally volatile and Family-only aggressors

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[21]	Semiatin et al. (2017)	USA 293 75%	Bivariate correlation and multiple regression analysis	Alcohol use (AUDIT; Saunders et al., 1993) Drug use frequency (Structured interview)	Posttraumatic stress disorder (PTSD) symptoms (*The PCL-C;* Blanchard et al., 1996). Dimensions: PTSD total symptoms; Reexperiencing, Avoidance/numbing; Hyperarousal	*Alcohol use* PTSD total symptoms (+); Reexperiencing (+); Avoidance/numbing (+); Hyperarousal (*ns*) *Drug use frequency* PTSD total symptoms (+); Reexperiencing (+); Avoidance/numbing (+); Hyperarousal (+); Uniquely (+) associated with reexperiencing symptoms
[22]	Siria et al. (2021)	Spain 981 71.4%	Comparison of groups of participants	Alcohol and drug dependence (MCMI-III; Millon, 1997; Spanish version of Cardenal & Sánchez, 2007)	Childhood family violence (CFV) [*The General Structured Interview of Batterer Men* (Echeburúa & Fernández-Montalvo, 1998)]	*Alcohol dependence* Perpetrators with CFV > Without CFV *Drug dependence* Perpetrators with CFV > Without CFV
[23]	Snow et al. (2006)	USA 147 100%	Correlation and path analysis	Problem drinking (AUDIT, Babor & Grant, 1989)	Coping [*Coping Strategy Indicator* (CSI; Amirkhan, 1990)]. Dimensions: Avoidance; Problem-solving, and Support-seeking coping.	*Problem drinking* Avoidance coping (+); Problem solving (-); Support-seeking coping (*ns*)
[24]	Stuart et al. (2003)	USA 150 100%	Comparison of groups of participants	Hazardous drinking [Meeting clinical guidelines for hazardous drinking (National Institute for Alcohol Abuse and Alcoholism, 1995); drinking to the point of intoxication (AUDIT; Saunders et al., 1993)]	Depression (CESD; Radloff, 1977)]	*Hazardous drinkers vs. Non-hazardous drinkers* Depression (+)

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[25]	Thomas et al. (2013)	USA 798 100%	Comparison of groups of participants	Alcohol and other drugs (AOD) use [Criteria: (a) self-identified with a substance abuse problem; (b) reported attendance at Alcoholics Anonymous meetings; (c) a score of 2 or more on the CAGE (Mayfield et al., 1974); (d) reported the use of psychoactive substances for more than 180 days in the last year; or (f) reported consuming six or more drinks per occasion or drinking at least ten times a month]	Demographic characteristics (Self-reported): Age, Income, Years of education, Full-time employed, Race/ethnicity (African-American; Hispanic/Latino; White/European; Other); Marital status Trauma [*The Trauma Symptom Checklist* (TSC-33; Briere & Runtz, 1989)] Anger (STAXI; Spielberger, 1988) Borderline personality structure [*The Borderline Personality Organization Scale* (BPO; Oldham et al., 1985)] Violence in the family of origin (Self-reported)	*AOD batterers vs. non-AOD batterers* Age (+); Years of education (-); White or Latino (+); Income (*ns*); Full-time employed (*ns*); Marital status (*ns*); Violence in the family of origin (+); Trauma (+); Anger (+); Borderline personality structure (+)
[26]	Travers et al. (2022)	Ireland 405 100%	Logistic regression analyses	Substance abuse (Issues with alcohol or drugs documented by Probation Officers)	Potentially traumatic experiences [T*he Assessment, Case Management and Evaluation* (ACE; Gibbs, 1998)]	The presence of substance abuse problems (+) increased the odds of IPV when analyzing the (+) relationship between trauma exposure and IPV offending
[27]	Vitoria-Estruch et al. (2017)	Spain 136 100%	Cluster analysis	Alcohol consumption (AUDIT; Contel-Guillamón et al., 1999)	Mental rigidity (WCST; Heaton et al., 2009)	*Alcohol consumption* High mental rigidity > Low mental rigidity

Table 1. (Continued).

Study Number	Study	Country, sample size (*N*) IPV perpetrators, and court-mandated (%)	Methodology used	ADUPs-related measures	Risk factors-related measures	Results
[28]	Vitoria-Estruch et al. (2018)	Spain 63 100%	Comparison of groups of participants	Alcohol consumption [Self-reported alcohol intake (g/day) and number of symptoms of Alcohol Use Disorder (AUD) listed in the DSM-5 (American Psychiatric Association, 2013)]	Sociodemographic variables (Self-reported): Age, Nationality, Marital status, Level of education, Employment status, and Income level History of traumatic brain injury (Self-reported) Temporary loss of consciousness (Self-reported) Attention [*Attention Switching Task;* AST; Cambridge Cognition Ltd., 2012) Frontal behavior [*Frontal Systems Behavior Scale* (FrSBe; Caracuel et al., 2012)] Empathy (IRI; Mestre et al., 2004)	*High alcohol (HA) vs. Low alcohol consumption (LA)* Age, Nationality, Marital status, Level of education, Employment status and Income level (*ns*); History of traumatic brain injury (*ns*); Temporary loss of consciousness (*ns*); Executive dysfunction (+); Disinhibition (+); Cost of shifting attention (+); IRI perspective taking (-); Fantasy (*ns*); Empathic concern (*ns*); Personal distress (*ns*)
[29]	Wolford-Clevenger et al. (2017)	USA 312 100%	Correlational analysis and hierarchical regression	Alcohol use problems (AUDIT; Saunders et al., 1993) Drug use problems [*The Drug Use Disorders Identification Test* (DUDIT; Stuart et al., 2004)]	Suicide ideation [Suicide ideation items of the PDSQ (Zimmerman & Mattia, 2001)] Suicide attempt history (Ad-hoc) Thwarted belongingness and perceived burdensomeness [*The Interpersonal Needs Questionnaire* (INQ; Van Orden et al., 2012)] Capability for suicide [*Acquired Capability for Suicide Scale* (ACSS; Van Orden et al., 2008)] Borderline Personality Disorder (BPD) symptoms [BPD subscale of *the Personality Diagnostic Questionnaire-4* (PDQ4; Hyler et al., 1988)] Depressive symptoms [The depression subscale of the *Psychiatric Diagnostic Screening Questionnaire* (PDSQ; Zimmerman & Mattia, 2001)]	Alcohol use problems Suicide ideation (+); Suicide attempt history (*ns*); Perceived burdensomeness (+); Thwarted belongingness (+); Capability for suicide (+); Borderline personality disorder symptoms (+); Depressive symptoms (+) *Drug use problems* Suicide ideation (+); Suicide attempt history (+); Perceived burdensomeness (+); Thwarted belongingness (+); Capability for suicide (+); Borderline personality disorder symptoms (+); Depressive symptoms (+)

Note. (+) = significantly higher/statistically significant positive association; (-) = significantly lower/ statistically significant negative association; (*ns*) = non-significant association/differences; vs. = versus; > = significantly greater than; < = significantly less than.

Risk factors in perpetrators court-mandated to intervention programs for IPV perpetrators with and without ADUPs

Table 2 displays a summary of investigated risk factors grouped into four main categories: (1) sociodemographic variables, (2) personality disorders and psychological adjustment, (3) socio-relational variables, and (4) attitudes towards women. Risk factors related to personality disorders and psychological adjustment were grouped into four subcategories: (2.1) personality disorders, (2.2) clinical symptomatology, (2.3) executive functions, and (2.4) other risk factors. The number of studies investigating each risk factor is presented separately for participants with alcohol and other drug use problems in Table 2. Where studies measured alcohol and other drug use conjointly (Studies 10, 25, and 26), results were included in both columns for IPV perpetrators with alcohol use problems and for IPV perpetrators with other drug use problems.

Table 2. Summary of risk factors in intimate partner violence (IPV) perpetrators with alcohol and/or other drug use problems (ADUPs) analyzed in identified studies

Risk factors	Number of studies	
	IPV perpetrators with alcohol use problems	**IPV perpetrators with other drug use problems**
Category 1. *Sociodemographic risk factors (n = 6)*		
Age	*n* = 4	*n* = 2
Educational level	*n* = 5	*n* = 2
Employment status	*n* = 5	*n* = 2
Immigrant status	*n* = 6	*n* = 2
Marital status	*n* = 5	*n* = 1
Income level	*n* = 5	*n* = 2
Category 2. *Personality disorders and psychological adjustment risk factors (n = 24)*		
2.1. Personality disorders (*n* = 4)		
Aggressive personality disorder	*n* = 1	*n* = 1
Antisocial personality disorder	*n* = 2	*n* = 1
Anxiety personality disorder	*n* = 1	*n* = 1
Borderline personality disorder	*n* = 3	*n* = 3
Dependent personality disorder	*n* = 1	*n* = 1
Narcissist personality disorder	*n* = 1	*n* = 1
Paranoid personality disorder	*n* = 1	*n* = 1
2.2. Clinical symptomatology (*n* = 19)		
Anger	*n* = 7	*n* = 4
Capability for suicide	*n* = 1	*n* = 1
Clinical symptomatology	*n* = 3	*n* = 2
Depression	*n* = 3	*n* = 2
Distress tolerance	*n* = 1	-
Emotion dysregulation	*n* = 1	-
Empathy	*n* = 3	-
Impulsivity	*n* = 5	*n* = 1
Perceived burdensomeness	*n* = 1	*n* = 1
Self-esteem	*n* = 2	*n* = 1
Suicidal ideation	*n* = 1	*n* = 1
Suicide attempt history	*n* = 1	*n* = 1
Thwarted belongingness	*n* = 1	*n* = 1
Trauma symptoms	*n* = 2	*n* = 2
2.3. Executive functions (*n* = 5)		
Attention (cost of shifting attention)	*n* = 1	-
Emotional decoding performance	*n* = 3	-
Frontal behavior	*n* = 1	-
Mental rigidity	*n* = 4	-
2.4. Other risk factors (*n* = 7)		
Coping	*n* = 1	-
History of traumatic brain injury	*n* = 2	-
Pathological gambling	*n* = 1	-
Temporary loss of consciousness	*n* = 1	-
Trait jealousy	*n* = 1	-
Typologies	*n* = 2	-
Category 3. *Social-relational risk factors (n = 8)*		
Childhood trauma history	*n* = 4	*n* = 4
Intimate social support	*n* = 3	*n* = 1
Perceived community support total	*n* = 2	*n* = 1
Perceived parental rejection	*n* = 1	-
Perceived social rejection	*n* = 3	*n* = 1
Satisfaction with economic status	*n* = 1	-
Stressful life events	*n* = 4	*n* = 2
Category 4. Risk factors related to attitudes towards women (n = 4)		
Ambivalent sexism	*n* = 2	*n* = 1
Perceived severity of intimate partner violence towards women	*n* = 2	*n* = 1
Responsibility attribution	*n* = 2	-

Sociodemographic risk factors

Sociodemographic risk factors were examined in six of the 29 included studies (see Table 2; Studies 7, 10, 16, 18, 25, and 28). Overall, most studies reported non-significant differences in sociodemographic risk factors between IPV perpetrators with and without ADUPs, except for age, immigrant status, and marital status, which showed mixed results (see Table 3 for a summary of critical findings).

Immigrant status was the most studied risk factor in this category. Three of the six studies showed non-significant differences in terms of immigrant status when comparing IPV perpetrators with and without ADUPs ([Studies 16, 18, and 28]; see Table 1). However, when assessing only Latin American IPV perpetrators in Spain, Study 7 found that being Latin American was a risk factor present in IPV perpetrators with hazardous alcohol consumption compared to non-hazardous alcohol consumption. Other studies reported that IPV perpetrators with ADUPs had a significantly lower prevalence of immigrant participants in Spain (Study 10) and a higher prevalence of Latino and white participants in the USA than IPV perpetrators without ADUPs (Study 25). Age, which was the least studied risk factor in this category ($n =$ 4), and marital status ($n = 5$) also showed mixed results within studies. Some studies reported no differences between groups in terms of age (Studies 7 and 28) or marital status (Studies 7, 25, and 28). Others showed that significantly greater proportions of perpetrators with ADUPs were older (Study 25), younger (Study 10), divorced (Study 16), and single than those without ADUPs (Study 18).

Most of the studies showed that participants with and without ADUPs were not significantly different in terms of employment status, income, and educational level (Studies 10, 16, 18, 25, and 28). Only one study showed that IPV perpetrators with ADUPs had significantly fewer years of education compared to those without (Study 25) and another reported a higher rate of unemployment among IPV perpetrators with ADUPs compared to those without (Study 10; see Table 1).

Personality Disorders and Psychological Adjustment Risk Factors

The most investigated risk factors were those related to the category of personality disorders and psychological adjustment, which were assessed in 24 out of 29 included studies. When considering subcategories, four studies investigated at least one risk factor related to personality disorders, 19 studies assessed at least one clinical symptomatology risk factor, five studies analysed at least one risk factor related to executive functions, and seven studies investigated other risk factors related to personality disorders and psychological adjustment in IPV perpetrators. Overall, the most salient risk factors related to personality disorders and psychological adjustment in IPV perpetrators with ADUPs, compared to those without ADUPs, were higher anger and impulsivity levels (see Table 3).

Personality Disorders. With regard to personality disorders, the most studied risk factor was borderline personality disorder ($n = 3$). Included studies found that IPV perpetrators with ADUPs showed significantly higher levels of borderline personality traits (Studies 10, 25, and 29) and higher levels of antisocial (Studies 4 and 10), aggressive, anxiety (i.e., a term coined by Millon, 2007 as a clinical personality pattern which refers to a sadistic tendency to react impulsively and violently, seeking risk and harm and resisting pain and punishment), narcissist, and paranoid personality disorders in IPV perpetrators with ADUPs (Study 10). No differences were reported regarding dependent personality disorder in IPV perpetrators with and without ADUPs (Study 10).

Clinical Symptomatology. The most investigated risk factors in the subcategory of clinical symptomatology were anger ($n = 7$) and impulsivity ($n = 5$; see Table 2). All studies investigating these risk factors consistently reported higher impulsivity, and anger including anger trait, anger state, and anger expression in IPV perpetrators with ADUPs compared to those without (Studies 3, 6, 9, 10, 14 to 17, 19, and 25). IPV perpetrators with ADUPs court-mandated to attend intervention programs for IPV showed significantly higher levels of clinical symptomatology, including depression, than participants without ADUPs (Studies 2, 6, 10, 24, and 29). Risk factors related to suicide ideation were studied in Study 29. Results were consistent among IPV perpetrators with alcohol use problems and those with drug use problems in terms of higher levels of suicide ideation, perceived burdensomeness, thwarted belongingness, and capability for suicide than IPV perpetrators without alcohol and drug use problems. However, only participants with drug use problems reported differences in terms of

suicide attempt history, with a higher prevalence in these participants than those without drug use problems (Study 29; see Table 1).

The three studies that investigated empathy (Studies 16, 18, and 28) found that IPV perpetrators with high alcohol consumption had a significantly lower score in perspective taking than the group with low alcohol consumption and no differences between groups in empathic concern and fantasy. Personal distress was higher in the group of high alcohol consumers compared to the group of low alcohol consumers in two studies (Studies 16 and 18) and non-significant differences were found between groups in another study (Study 28).

Compared to IPV perpetrators without ADUPs, court-mandated perpetrators with ADUPs showed significantly lower levels of distress tolerance (Study 4), self-esteem (Studies 6 and 10), higher levels of emotion dysregulation (Study 11), and trauma/ posttraumatic stress disorder (PTSD) symptoms (Studies 21 and 25). Particularly, PTSD hyperarousal symptoms were a risk factor when considering IPV participants who used drugs but not alcohol (Study 21; see Table 1).

Executive functions. Mental rigidity ($n = 4$) and emotional decoding performance ($n = 3$) were the most studied risk factors in this subcategory. Mental rigidity was a risk factor present in IPV perpetrators with high alcohol consumption compared to those with low alcohol consumption, which when it is high refers to deficient flexibility in self-regulated behavior (Study 27). Further, those with high, compared to low, alcohol consumption needed significantly more attempts in the Wisconsin Card Sorting Test (WCST; Heaton et al., 2011; Studies 16 and 18), which measures cognitive flexibility, and made more mistakes (Study 16), more perseverative mistakes (Studies 16, 18 and 19), more non-perseverative mistakes (Study 16) and lower number of categories completed (Studies 16 and 18). Non-significant differences were found between groups in failure to maintain set, trials to complete the first category, conceptual level, and learn-to-learn subscales (Study 16). Overall, these findings showed that IPV perpetrators had higher mental rigidity than those without.

Emotional decoding performance, understood as the process of recognizing and interpreting emotional facial expressions, was worse for high than low alcohol consumers across studies (Studies 16, 18, and 19). As shown in Table 1, Study 16 studied whether emotional decoding of neutral, positive, and negative emotions was different in the group of high and low alcohol consumption. Emotional decoding performance was worse for neutral

emotions in high alcohol consumers and showed non-significant differences between high and low consumers for positive and negative emotions (Study 16).

When comparing higher versus low alcohol consumers, IPV perpetrators with high alcohol consumption showed a significantly higher cost of shifting attention, which refers to a lack of flexibility to shift the attentional focus, and, in terms of frontal behaviour, higher executive dysfunction, and disinhibition, which describe an alteration of the normal functioning of cognitive processes necessary for the regulation of behavior (Study 28).

Other risk factors. Study 23 showed that IPV perpetrators with problem drinking reported higher levels of avoidance coping, lower levels of problem-solving, and no differences in support-seeking coping compared to those without problem drinking. With regard to pathological gambling, IPV perpetrators with hazardous drinking, compared to those without, showed higher levels of pathological gambling (Study 3).

Two studies investigated differences between typologies of IPV perpetrators with regard to alcohol use (Studies 8 and 20). In Study 20, IPV perpetrators with alcohol use were more 'generally violent'. This type of perpetrator was the most likely to be violent towards non-partners, having experienced abuse as a child, reported low or moderate levels of depression and anger, more frequent severe violence, and their violence was usually associated with alcohol abuse (Study 20). However, Study 8 showed non-significant findings. Non-significant differences were also recorded between IPV perpetrators with and without alcohol use problems with regard to temporary loss of consciousness (Study 28), history of traumatic brain injury (Studies 13 and 28), and trait jealousy (Study 5). However, alcohol problems were significantly and positively related to physical and sexual IPV perpetration by men with high levels of trait jealousy (Study 5).

Social-relational risk factors

As shown in Table 2, social-relational risk factors were investigated in eight of the 29 studies. The most studied and salient social-relational risk factors present in IPV perpetrators with ADUPs as compared to those without ADUPs were having experienced more stressful life events ($n = 4$) and childhood trauma history ($n = 4$; see Table 3). These findings were consistent across studies (Studies 1, 6, 7, 10, 22, 25, and 26). Only one study reported that exposure to childhood trauma was not a risk factor present in IPV perpetrators who used drugs but was present for those who used alcohol (Study 1; see Table 1).

In terms of social support, perpetrators with ADUPs showed lower levels of intimate support across studies (Studies 6, 7, and 10). However, mixed results were found for perceived community integration, community participation, and informal community support, with significantly higher levels among IPV perpetrators with ADUPs versus those without ADUPs in Study 10 and no differences between groups in Study 6. Mixed results were also found for perceived social rejection, with one study showing higher levels for participants with alcohol abuse than those without (Study 6) and other study reporting no differences between groups (Study 7).

Further, higher levels of perceived parental rejection (Study 16) and satisfaction with economic status (Study 6) were found for IPV perpetrators with high alcohol consumption versus low alcohol consumption.

Risk factors related to attitudes towards women

As shown in Table 2, risk factors related to attitudes towards women were the least studied category, with four studies investigating at least one risk factor relating to attitudes towards women. Overall, the main risk factor in this understudied category was responsibility attributed to the offenders' personal context, which showed that participants with ADUPs tended to place the responsibility for their violent behaviour on their personal circumstances (see Table 3).

IPV perpetrators with ADUPs did not differ from those without ADUPs in attitudes towards IPV against women (Studies 6 and 10), responsibility attributed to the legal context and the victim (Study 6), and hostile (Study 10) and ambivalent sexism (Studies 10 and 16).

However, hostile sexism was found to be a risk factor present in participants with high alcohol consumption compared to those with low alcohol consumption in Study 16. Moreover, responsibility attributed to the offenders' personal context was a risk factor identified in IPV perpetrators with ADUPs as compared to those without ADUPs in both studies investigating this risk factor (Studies 6 and 12).

Table 3. Critical findings from this study

1. Risk factors present in intimate partner violence (IPV) perpetrators with alcohol and/or other drug use problems (ADUPs) court-mandated to attend intervention programs for IPV perpetrators as compared to participants without ADUPs could be classified into four categories: sociodemographic risk factors, personality disorders and psychological adjustment, social-relational risk factors, and risk factors related to attitudes towards women.

2. Out of 29 included studies, 24 studies assessed at least one risk factor related to personality disorders and psychological adjustment, eight investigated at least one social-relational risk factor, six studied at least one socio-demographic risk factor and four investigated at least one risk factor related to attitudes towards women.

3. The presence of risk factors related to personality disorders and psychological adjustment was by far the most studied category in IPV perpetrators with ADUPs as compared to those without ADUPs. Four subcategories emerged from this category: personality disorders, clinical symptomatology, executive functions, and other risk factors.

4. Most findings concerning the category of socio-demographic risk factors showed that IPV perpetrators with ADUPs, as compared to those without these problems, did not generally present sociodemographic differences. Mixed results were found for age, immigrant status and marital status.

5. Most risk factors related to personality disorders and psychological adjustment were present in IPV perpetrators with ADUPs as compared to participants without ADUPs. Higher anger and impulsivity levels were the most relevant risk factors for this high-risk group of perpetrators.

6. Having experienced more stressful life events and having a childhood trauma history were the main social-relational risk factors present in participants with ADUPs as compared to those without these problems.

7. Most studies investigating risk factors related to attitudes towards women revealed that these factors did not differentiate IPV perpetrators with ADUPs from those without these problems. However, as compared to participants without ADUPs, those with ADUPs tended to place the responsibility for their violent behavior on their personal circumstances.

Discussion

This review provides a synthesis of existing literature, which suggested that overall, compared to those without ADUPs, IPV perpetrators with ADUPs who were court-mandated to attend perpetrator intervention programs were more likely to exhibit higher levels of personality disorders, including borderline, antisocial, aggressive, anxiety, narcissist, and paranoid personality disorders, and higher clinical symptomatology, including higher anger, impulsivity, depression, suicide risks, emotion dysregulation, trauma symptoms, and lower empathetic perspective-taking, distress tolerance and self-esteem. Compared to participants without ADUPs, those with ADUPs appeared to present poorer executive functions, including lower emotional decoding performance, higher mental rigidity, cost of shifting attention and greater executive dysfunction and disinhibition. Greater pathological gambling and poorer coping strategies were also found in this group of perpetrators.

The review also found IPV perpetrators with ADUPs, compared to those without ADUPs, were more likely to have experienced exposure to childhood trauma, stressful life events, satisfaction with economic status, perceived parental rejection, and lower intimate social support. In addition, compared to participants without ADUPs, those with ADUPs tended to display higher responsibility attributed to the offenders' personal context. Inconsistent findings were observed for empathetic personal distress, typologies, perceived community support, perceived social rejection, hostile sexism, and several socio-demographic variables.

Socio-demographic risk factors

Evidence from included studies found mixed results for age, immigrant status, and marital status. Mixed findings on immigration could be explained by the immigration paradox, which suggests that recent immigrants may report lower substance use and IPV due to factors such as stronger family ties or cultural norms that discourage such behaviors (Salas-Wright & Vaughn, 2014; Wright & Benson, 2010). However, as immigrants settle in the receiving country and face acculturative stress, their risk for IPV and substance use may increase (Bacio et al., 2013; Gracia et al., 2009; Vaughn et al., 2015). In addition, our findings seemed to show that educational level, employment status, or income level were not consistently considered risk factors that characterized IPV perpetrators with ADUPs compared to those without ADUPs. Research suggests that alcohol and drug use may generate higher financial pressures in perpetrators' domestic contexts, which in turn may intensify partner conflict (Gadd et al., 2019). In these economic disadvantage situations, IPV perpetrators may feel shame as they are failing

to fulfil the normative masculine role of being the provider, which could feed their desire for control and power (Gadd et al., 2019; Radcliffe et al., 2019). However, more research is required to investigate how sociodemographic context and other sociocultural factors (e.g., the country's economic situation, cultural patterns of alcohol use, and the role of masculinity on substance use) impact IPV perpetrators with ADUPs.

Personality disorders and psychological adjustment risk factors

The most salient risk factors found in this broad category were anger and impulsivity. Similar to other studies (Oberleitner et al., 2013; Winters, 2005), we found higher levels of anger in IPV perpetrators with ADUPs compared to those without in the studies included in this review. This group of IPV perpetrators were also at higher risk of recidivism and needed more intensive interventions (Oberleitner et al., 2013). One possible explanation underlying these findings could be that IPV perpetrators high in anger may seek alcohol and/or drugs to mitigate their intense and overwhelming emotional reactions (Oberleitner et al., 2013). Another possible explanation could be that substance use may disrupt neurocognitive resources involved in self-regulation, thus increasing the likelihood of IPV (Giancola et al., 2003). Relatedly, alcohol intoxication may act as a disinhibitor in accordance with the I^3 model (Finkel & Eckhardt, 2013) and as stated by the Alcohol Myopia Theory (Steele & Josephs, 1990). Intoxication may disrupt normal cognitive processing resulting in a myopic effect where only the most salient stimuli (such as the instigating, and impelling forces in line with the I^3 model) are kept over cues that may inhibit IPV (such as inhibiting forces). These results highlight the importance of developing effective intervention strategies for this high-risk group of IPV perpetrators. For example, a systematic review conducted by Gilchrist et al. (2015) of the effectiveness of cognitive behavioural therapy with anger management components for IPV perpetrators who used alcohol showed promising results in the short term and suggested that more research is needed to match this group of IPV perpetrators with specific intervention programs that address their individual needs. Enhancing distress tolerance for perpetrators who use substances has been shown to promote positive behaviour change and skills development (Gilchrist, Johnson, et al., 2021; Gilchrist, Potts, et al., 2021).

Previous studies also observed higher levels of impulsivity among IPV perpetrators with ADUPs (Easton et al., 2008; Stuart & Holtzwroth-Munroe, 2005). A meta-ethnography conducted by Gilchrist et al. (2019) on the interplay between substance use and IPV perpetration showed that survivors and perpetrators both explained IPV perpetration when under the influence of alcohol and other drugs referring to a change in self, as they used narratives in which intoxication transforms an idealized real self into an aggressive and impulsive non-real one. Further efforts are thus needed to develop effective strategies targeted at helping IPV perpetrators increase responsibility and awareness of their anger and impulsivity levels. For instance, a study conducted by Finkel et al. (2009) showed that two weeks of self-regulatory-based activities, such as training perpetrators to recognize internal signs of anger and impulsivity, reduced IPV perpetration in participants with low self-regulatory resources.

Other salient, identified risk factors in IPV perpetrators with ADUPs were, in terms of personality disorders, a trend towards higher scores on antisocial and borderline personality disorders, in terms of clinical symptomatology, higher clinical symptomatology, depression, and trauma symptomatology and, in terms of executive functions, higher mental rigidity. According to Gilchrist et al. (2022), one of the pathways into substance use-related IPV revealed that perpetrators reported using substances as a coping mechanism to help them deal with their emotional pain and mental health issues caused by unresolved previous trauma. Similarly, the self-medication hypothesis states that individuals with PTSD are more likely to develop ADUPs in light of a tendency to drink or use drugs to alleviate PTSD symptoms and cope with difficult internal experiences (Hawn et al., 2020; Khantzian, 1997; Lawrence et al., 2023). These findings underscore the need to address the function of substance use in intervention programs for IPV perpetrators with ADUPs. Effective interventions with this high-risk group of perpetrators should focus on re-scripting childhood experiences, reframing unhelpful schemas, and expressing emotional needs to enhance self-regulation and trauma healing (Gilchrist et al., 2022). However, as IPV perpetrators with ADUPs present high dropout and recidivism rates, retention strategies are also needed to help them complete the intervention and improve their outcomes (Lila et al., 2020; Olver et al., 2011). Based on the 'what works' body of knowledge, incorporating motivational strategies has proven effective in increasing treatment engagement and reducing dropout rates in high-risk IPV perpetrators (Santirso et al., 2020). However, further research is needed to ascertain whether the positive effects of motivationally focused alcohol interventions as adjuncts to court-mandated intervention

programs for IPV perpetrators are sustained in the long term (i.e., > 6 months post-intervention; Stuart et al., 2013).

Social-relational risk factors

Consistent with other studies (Rivas-Rivero & Bonilla-Algovia, 2022; Schumacher et al., 2008), stressful life events, a history of childhood trauma, and lower intimate support seemed to be associated with IPV perpetration among IPV perpetrators with ADUPs. These risk factors should be specifically targeted in interventions for IPV perpetrators as they have been shown to increase the likelihood of IPV recidivism (Kwong et al., 2003; Lila et al., 2019; López-Ossorio et al., 2021). Previous research suggests that unresolved trauma in IPV perpetrators could have an impact on ADUPs (e.g., substance use can be used as a way of coping with stress and trauma) and on intimate relationships by intensifying IPV perpetration (Gilchrist et al., 2019; Mathews et al., 2015). Specifically, IPV perpetrators who disclosed childhood trauma experiences could be perpetrating IPV and using drugs as a defence to regain control and power over their lives (Gilchrist et al., 2022; Øverup et al., 2015). These findings evidence the fact that exploring the history of trauma of IPV perpetrators with ADUPs and their narratives could inform interventions and improve outcomes. In this line, a meta-analysis and systematic review by Karakurt et al. (2019) showed that including trauma-based or substance-use treatment components yielded better outcomes than interventions without this component, as they reported more effective results in decreasing male IPV perpetration. Interventions targeting anti-social cognitions and schemas that sustain their use of violence while promoting intimate and network support could also be helpful (Gilchrist et al., 2022).

Risk factors related to attitudes towards women

In accordance with previous research, IPV perpetrators tend to use ADUPs and other personal circumstances (i.e., economic problems, loss of control) as an excuse for their violent behaviour during conflict (Gilchrist et al., 2019; Radcliffe et al., 2017). Further research is needed to deeply comprehend how traditional gender norms, victim-blaming attitudes, and the normalization of violence toward women play a role in men's ADUPs to justify their IPV perpetration (Martín-Fernández, Gracia, & Lila, 2018, 2022; Satyanarayana et al., 2015).

Interventions should work on reframing gender ideals and changing attitudes regarding normative gender roles that sustain IPV perpetration (Gilchrist et al., 2019; Martín-Fernández, Gracia, Marco, et al., 2018). For example, a cluster randomised controlled trial in the Democratic Republic of Congo showed that men in a male-only discussion group focused on challenging gender attitudes and reducing IPV reported greater reductions in intention to commit IPV, justification of IPV, and partner-reported frequency of drinking than the control group, where men participated in non-gender norms-related alternative group sessions (Vaillant et al., 2020). More evidence-based strategies are needed to target gendered power dynamics in intervention programs for IPV perpetrators.

Implications for research, practice and policy

Implications for research, practice and policy are presented in Table 4. The results of this systematic review highlight the importance of screening and identifying a wide range of risk factors in IPV perpetrators with ADUPs structured at different levels. It is essential to develop or improve intervention programs for IPV perpetrators based on the specific needs and identified risk factors of this highly resistant group of perpetrators (Finkel, 2007; Karakurt et al., 2019; Massa et al., 2020). Consistent with the risk-needs-responsivity (RNR) model (Andrews & Bonta, 2010), which strives for adapting intervention programs for IPV perpetrators to individual participant's specific needs and matching intervention strategies based on risk factors, there is a "need for more individualized approaches to perpetrator treatment that emphasize assessment, motivation enhancement, and interventions targeting mental health and substance use" (Butters et al., 2021, p.399). For example, motivational strategies such as setting self-determined goals to establish and monitor individualized intervention objectives, including those related to ADUPs and identified risk factors (e.g., "reducing my anger levels during partner conflict") have shown promising results in intervention programs for IPV perpetrators (Lila et al., 2018; Pinto e Silva et al., 2022; Santirso et al., 2020). To further address identified risk factors, for instance, a trauma-informed approach would be recommended for IPV perpetrators with co-occurring ADUPs, a history of childhood trauma and psychological symptomatology (Gilchrist et al., 2019; Karakurt et al., 2019; McKenna & Holtfreter, 2020). Similarly, assessing and identifying each participant's risk factors could help facilitators develop concrete exercises adapted to IPV perpetrators' needs (Leonard & Quigley, 2017; Massa et al., 2020). For example, those perpetrators with higher levels of aggressive or antisocial personality disorder could benefit from completing exercises that provide information and reflection on healthy relationships, and that helps them to realise

that their aggressive behaviours damage their potential to meet their own needs (Babcock et al., 2016). Overall, monitoring identified risk factors and implementing evidence-based practices that address them could improve participants' outcomes and help to reduce IPV perpetration. Finally, public funding should be attributed to intervention programs for IPV perpetrators that address documented risk factors for high-risk perpetrators with ADUPs. Global social policies aiming to prevent IPV perpetration (e.g., prevention initiatives focused on reducing tolerant attitudes towards violence against women), ADUPs, and their associated risk factors while promoting mental health are also crucial.

Table 4. Implications for research, practice, and policy

Implications for research
• Results provide evidence that higher levels of anger, impulsivity, stressful life events, and having a childhood history of trauma were the most documented risk factors that characterized intimate partner violence (IPV) perpetrators with alcohol and/or other drug use problems (ADUPs) in contrast to those without ADUPs • Need for more studies documenting socio-demographic risk factors and those related to attitudes towards women • Need for more studies evaluating which intervention strategies are more effective to address identified risk factors in IPV perpetrators with ADUPs • Need for more research on non-heterosexual men who perpetrated IPV • Need for more studies with improved methods of data collection and reporting • Need for more studies that investigate the possible differences in the effects of alcohol versus other drugs on IPV perpetration and their associated risk factors
Implications for practice
• Results provide in-depth knowledge of a wide range of risk factors in IPV perpetrators with ADUPs from a multi-level perspective • Identified risk factors could be considered as treatment needs for highly resistant groups of IPV perpetrators (i.e., court-mandated IPV perpetrators with ADUPs) • Specific intervention objectives can be drawn considering identified risk factors • Evidence-based practices should be implemented that tackle identified risk factors in IPV perpetrators with ADUPs
Implications for policy
• Need for consistent definitions and assessment of ADUPs in interventions for IPV perpetrators • Public funding should be attributed to intervention programs for IPV perpetrators targeting identified risk factors associated with ADUPs • Global social policies should be implemented to prevent IPV perpetration, ADUPs, and their associated risk factors

Strengths and limitations

This systematic review was conducted using PRISMA guidelines (Page et al., 2021), and, to our knowledge, it is the first systematic review to identify risk factors beyond substance use in IPV perpetrators with ADUPs court-mandated to attend intervention programs for IPV perpetrators. Furthermore, a wide range of risk factors was identified and structured at multiple levels, which contributes to a deeper understanding of the complex phenomenon of IPV and ADUPs and informs key intervention targets that could encourage treatment engagement and improve participants' outcomes and safety for women and children.

The present systematic review has certain limitations. Included studies used heterogeneous methodologies to study risk factors in IPV perpetrators with ADUPs compared to those without ADUPs (e.g., multiple regression, path analysis). This review is also limited by its lack of systematic searching of the grey literature. It is acknowledged that this could have led to a potential source of bias in the findings (Petticrew & Roberts, 2006). In addition, several studies defined and measured ADUPs (e.g., alcohol abuse, alcohol consumption, drug abuse) and some risk factors differently (e.g., borderline personality disorder; see Table 1). Furthermore, some of the results should be interpreted cautiously when only a few studies assessed a risk factor (e.g., only one study assessed suicide ideation). More studies are needed to add knowledge to these least-studied risk factors. Furthermore, the existing literature does not allow us to conclude which of the variables that interact with ADUPs potentiate IPV, so attention should be paid to the complexity of this relationship. Future reviews would also benefit from including a meta-analysis component to quantify the size of the findings. Further research is also needed to study risk factors present in women and other gender and sexual minorities (i.e., LGBTIQ+) to reduce heteronormative bias. These limitations should be considered when interpreting the results.

Conclusion

Men with ADUPs who are court-mandated to attend intervention programs for IPV perpetrators present with more complex social and mental health needs than men without ADUPs resulting in higher dropout and recidivism rates. This review has identified key risk factors in male IPV perpetrators with ADUPs that can be translated into important intervention targets beyond their substance use. Tailoring such interventions to participants' risk factors and treatment needs has shown promising results over standard interventions (Travers et al., 2021). Thus, integrating substance use components while implementing evidence-based strategies to reduce identified, associated risk factors could improve intervention outcomes and increase their effectiveness for perpetrators with ADUPs (Karakurt et al., 2019; Leonard & Quigley, 2017). A greater understanding of the risk factors that underlie IPV and ADUPs will inform researchers, professionals and policymakers of the main factors that should be targeted to reduce IPV and promote healthy relationships.

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Study 3

Evaluating the role of goal setting in reducing dropout for men with and without substance use problems attending a court-mandated intimate partner violence perpetrator program[1]

Evaluating the role of goal setting in reducing dropout for men with and without substance use problems attending a court-mandated intimate partner violence perpetrator program

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Abstract

High dropout rates, particularly among intimate partner violence (IPV) perpetrators with alcohol and other drug use problems (ADUPs), challenge IPV perpetrator programs' effectiveness. This study sought to examine factors associated with goal setting, a motivational strategy to promote engagement, in a sample of IPV perpetrators ($n = 285$), including participants with ADUPs ($n = 127$) and investigated whether goal setting predicted lower dropout by adjusting for relevant variables. Results revealed goal setting could be an effective strategy to reduce dropout in IPV perpetrators and those with ADUPs and support the need to tailor interventions to participants' needs to enhance effectiveness.

Keywords: alcohol; drug; goal setting; intimate partner violence; motivational strategies; perpetrator intervention programs; substance use.

Introduction

Intimate partner violence (IPV) refers to any behavior exerted by an intimate current or former partner, that causes physical, sexual, social, economic, or psychological harm including threats, coercion and controlling behaviors (World Health Organization [WHO], 2013, 2021a). Estimates published by the WHO show that physical and/or sexual IPV affects 1 in 3 women globally (WHO, 2021b). In Spain, around 13% of women have experienced IPV in their lifetime, one of the lowest prevalence rates among European countries (Martín-Fernández et al., 2019; 2020). Women are at substantially higher risk of experiencing IPV from a male partner than men are from a female partner (Centers for Disease Control and Prevention [CDC, 2022]; WHO, 2013).

Intervention Programs for IPV Perpetrators

IPV perpetrators often abuse multiple victims or continue their relationship with the victim (Lila et al., 2013), therefore, intervention programs targeting male IPV perpetrators have gained attention to prevent further IPV incidents and promote healthy, egalitarian relationships (Cheng et al., 2021; Rivas et al., 2016). Systematic reviews and meta-analyses on the effectiveness of intervention programs for IPV perpetrators suggest a positive but small effect on reducing IPV recidivism (Arce et al., 2020; Cheng et al., 2021; Nesset et al., 2019; Travers et al., 2021; Wilson et al., 2021). A number of scholars emphasize the factors that may affect the efficacy of these programs in mitigating IPV recidivism, including participants' difficulty in taking responsibility for their violent behavior (Lila et al., 2014), their low treatment adherence (Carbajosa et al., 2017), and their resistance to engage in the process of change, especially among court-mandated individuals, who tend to be in a precontemplation stage (Bowen & Gilchrist, 2004; Tutty et al., 2020). High dropout rates in intervention programs for IPV perpetrators also contribute to this modest effectiveness (Karakurt et al., 2019; Olver et al., 2011), which ranges from 20–35% according to the most recent systematic review (Travers et al., 2021).

A low and often external motivation to attend these programs (e.g., as a result of a court order, or pressure from a partner) may contribute to a greater resistance toward engaging in the intervention (Cadsky et al., 1996; Stuart et al., 2007). This is of particular concern since higher dropout rates have been consistently found in high-risk and highly resistant IPV perpetrators (Bennett et al., 2007; Lila et al., 2019; Stoops et al., 2010). In addition, the majority of existing intervention programs for IPV perpetrators inadequately address the specific needs and

characteristics of participants that have been consistently associated with a higher risk of recidivism and that, if addressed, could foster treatment engagement and motivation to change among high-risk and highly resistant IPV perpetrators (Lila et al., 2018). Previous literature shows that these risk factors for IPV recidivism include sociodemographic factors (e.g., being younger, immigrant status; Fitzgerald & Graham, 2016; Lila et al., 2019), mental health issues (e.g., personality disorders, including antisocial behaviors, low empathy levels and poor emotional decoding; Cunha, Pinheiro, et al., 2022; Romero-Martínez et al., 2019b), socio-relational difficulties (e.g., low social support; Capaldi et al., 2012), attitudinal risk factors (e.g., high sexism, traditional gender role beliefs; Eckhardt & Crane, 2014; Llor-Esteban et al., 2016) and drug misuse (Romero-Martínez et al., 2019b, 2023).

Alcohol and other drug use problems

Participants with alcohol and other drug use problems (ADUPs; Lila et al., 2020; Romero-Martínez et al., 2019a) have been identified as a key high-risk and highly resistant group among IPV perpetrators and represent approximately 50% of all participants attending intervention programs for IPV perpetrators (Crane et al., 2015). ADUPs are strongly correlated with both higher dropout and IPV recidivism rates (Cafferky et al., 2018; Easton et al., 2018; Moore & Stuart, 2004; Olver et al., 2011). The well-supported connection between ADUPs and IPV perpetration makes it clear that these co-occurring problems and the specific needs of participants with ADUPs should be targeted in intervention programs for IPV perpetrators (Expósito-Álvarez et al., 2021, 2023; Stephens-Lewis et al., 2021; Tarzia et al., 2020). A meta-analysis and systematic review showed that incorporating substance-use treatment components into IPV programs produced better outcomes by more effectively decreasing IPV perpetration than standard intervention programs for IPV perpetrators (Karakurt et al., 2019).

Motivational approaches

Motivational strategies, originally implemented in addiction treatment (W. R. Miller & Rollnick, 2002), include strategies such as motivational interviewing (MI), goal setting, and retention techniques to reduce hostility toward treatment, enhance engagement and resolve ambivalence about change (DiClemente et al., 2017; W. R. Miller & Rollnick, 2002; Smedslund et al., 2011). They also use a non-confrontational, collaborative conversational style based on empathy, reflective listening, and structured change planning to enhance participants' mobilization of the desire and willingness to change (W. R. Miller & Rollnick, 2002, 2013). A growing body of literature shows that including motivational strategies in intervention

programs for IPV perpetrators decreases dropout rates and improves other outcomes, including reduced IPV recidivism, increased readiness to change, greater assumption of personal responsibility for their abusive behavior, greater treatment engagement, less resistance to the intervention and a higher commitment to the intervention (Alexander et al., 2010; Babcock et al., 2016; Kistenmacher & Weiss, 2008; Lila et al., 2018; Mbilinyi et al., 2011; Murphy et al., 2018; Musser et al., 2008; Scott et al., 2011; Soleymani et al., 2022; Stuart et al., 2007, 2013). Moreover, a recent meta-analysis found that dropout rates were 1.73 times higher for perpetrators allocated to IPV intervention programs without motivational strategies compared to interventions that included motivational, person-centered strategies (Santirso, Gilchrist, et al., 2020).

Unless intervention programs for IPV perpetrators use targeted motivational strategies to support highly resistant perpetrators to engage and change their abusive behavior, traditional interventions based on confrontational approaches can lead to lower perceived understanding and trust and impede working alliances (Lehmann & Simmons, 2009). In addition, while standard cognitive-behavioral therapy approaches assume a well-motivated participant, IPV perpetrators are usually in a pre-contemplation or contemplation stage at intake (Prochaska & DiClemente, 1982), attending the program mostly to avoid punishment or negative consequences (Musser et al., 2008; Velonis et al., 2016). As a result, intervention programs for IPV perpetrators are increasingly incorporating motivational strategies to promote better engagement and retention and help participants find personal reasons to change which in turn may decrease their resistance toward the intervention (Alexander et al., 2010; Babcock et al., 2016; Crane & Eckhardt, 2013; Eckhardt et al., 2013; Musser et al., 2008). Moreover, motivational strategies seem to work specifically well for higher-risk highly resistant participants (Rollnick et al., 1992) such as court-mandated IPV perpetrators with ADUPs (Alexander et al., 2010; Dheensa et al., 2022; Stephens-Lewis et al., 2021), who have also been shown to present other associated risk factors that require attention, at the sociodemographic (e.g., immigrant status; Thomas et al., 2013), individual (e.g., higher depression, clinical symptomatology, anger and impulsivity levels, lower self-esteem and poorer executive functions, such as lower emotional decoding; Catalá-Miñana et al., 2013; Eckhardt et al., 2008; Murphy et al., 2007; Petersson & Strand, 2017; Romero-Martínez et al., 2013), social-relational (e.g., lower community and intimate support, higher perceived social rejection, having experienced more stressful life events; Catalá-Miñana et al., 2013, 2017), and attitudinal level (e.g., lower responsibility attribution; Lila et al., 2014) beyond their higher risk of dropout and

IPV recidivism (Expósito-Álvarez et al., 2021, 2023). In this line, research on substance use has revealed that the ability of the substance use treatment service to address these participants' risk factors is essential in enhancing low motivation to change and increasing treatment engagement among men with ADUPs (Dheensa et al., 2022; Dillon et al., 2020). However, the specific mechanism that underlies the effects of specific motivational strategies on dropout rates in IPV perpetrators and those at higher risk such as participants with ADUPs remains unclear (Crane et al., 2015). In addition, while systematic reviews on the effectiveness of motivational strategies in intervention programs for IPV perpetrators suggest promising results (Karakurt et al., 2019; Santirso, Gilchrist, et al., 2020), there is still room for improvement in understanding why they work, how to deliver the intervention to increase benefits and which specific motivational strategies work best and for whom (Stephens-Lewis et al., 2021).

Goal setting

Goal setting is a motivational strategy based on a humanistic, strengths-based approach that focuses on co-constructing any goal or desired achievement aligned to each participant's personal values that leads them to meaningful lives that are contrary to perpetrating IPV (Langlands et al., 2009; M. Y. Lee et al., 2007; Ward, 2002). Because of the collaborative, non-confrontational nature of motivational strategies, goal setting is an optional tool that IPV perpetrators, accompanied and guided by facilitators, may use to set an active role in their personal process of change (Lila et al., 2018). Although goal setting has not been widely studied and further research is needed (Roldán-Pardo et al., 2023), several studies suggest that this strategy could improve outcomes in intervention programs for IPV perpetrators, such as accomplishing attitudinal and behavioral changes, decreasing IPV recidivism, and increasing responsibility awareness and motivation to change (Curwood et al., 2011; Dheensa et al., 2022; M. Y. Lee et al., 2003, 2007, 2014). For example, a study which evaluated the role of goal setting in predicting recidivism in a sample of IPV perpetrators attending a solution-focused, goal-directed treatment program showed that goal specificity and goal agreement between facilitators and participants when co-constructing the goal was associated with a lower likelihood of recidivism (M. Y. Lee et al., 2007). Specifically, this program was oriented toward developing goals (interpersonal, specific, and agreed upon by facilitators and participants) to enhance commitment and increase confidence to work on goals, while providing feedback to amplify and consolidate changes (M. Y. Lee et al., 2007). It remains important to explore "what works best for whom" in motivation-based intervention programs, including goal setting, for IPV perpetrators, including those with ADUPs (Expósito-Álvarez et al., 2021, 2023; Roldán-

Pardo et al., 2023; Stephens-Lewis et al., 2021). Identifying whether a specific strategy such as goal setting is effective in reducing dropout, and for which groups of IPV perpetrators, could help inform interventions to incorporate or strengthen this strategy and facilitators to encourage participants to use it during their change process as a means to improve interventions' outcomes and effectiveness.

Current study

To address this gap, the present study is aimed at answering four research questions in a sample of men attending an IPV perpetrator intervention program: (1) What participant baseline characteristics were associated with a higher likelihood of setting goals? (2) Was having an ADUP associated with a higher likelihood of setting goals? (3) Was goal setting associated with reduced dropout rates in the full sample of participants and (4) among those with ADUPs after adjusting for sociodemographic, individual (e.g., mental health, substance use), social-relational and attitudinal variables?

Methods

Participants and procedure

Participants were 285 men court-mandated to attend an intervention program for IPV perpetrators in Valencia (Spain). This is a community-based intervention program for men convicted of IPV crimes and sentenced to less than 2 years in prison with a suspended sentence on the condition that they attend the perpetrator program (Lila et al., 2018). It includes 1.5-hour 5 individual sessions and 2-hour 35 weekly group sessions based on the ecological model framework (Heise, 1998) and aims to reduce risk factors and promote protective factors for IPV using evidence-based, cognitive-behavioral, and motivational strategies. Eligible participants were (a) men over 18 years, (b) who had no severe psychological, neurological disorder or cognitive impairment that could interfere with the functioning of the intervention group, (c) who had signed an informed consent form in which confidentiality was guaranteed and (d) had attended at least the initial assessment and the three individual motivational interviews before the start of the group-based sessions. With regards to sample size calculation, the widely cited "one in ten" rule was followed to ensure adequate power (Peduzzi et al., 1996), which posits that for multiple regression, there should be at least 10 events or cases for each predictor variable. The sample size in this study was adequately powered and reflected a balance between the practical constraints of participant recruitment and the methodological rigor required for meaningful statistical analyses.

Data on socio-demographic characteristics, mental health, substance use, social-relational variables, and attitudes toward IPV, were collected as part of the initial assessment for participants attending the intervention program for IPV perpetrators. These data were collected through a self-report assessment battery administered by the program staff in two, two-hour assessment sessions at intake. Data on goal setting and the risk of IPV recidivism were collected during the third individual motivational interview that took place before the group-based sessions started. Goals were co-constructed by both participants and facilitators, who worked together to establish personal objectives that were meaningful to the participants. Goals included personal objectives that could be worked on throughout the intervention and were often related to "interpersonal relationships" (e.g., "improving my relationship and communication with my son), "personal resources for daily life" (e.g., "to be able to control myself and to be calmer in order to feel better with myself and the people around me"), "coping strategies" (e.g., "to be able to solve problems without running away") and "motivation to

change" (e.g., "I do not want to have contact with my ex-girlfriend" (Roldán-Pardo et al., 2023). The goal construction was voluntary, and it was recorded on a sheet that facilitators and participants completed during the third individual motivational session. The researchers were able to determine from the participants' records whether they chose to set a goal or not. Data on the stage of change were assessed by facilitators during the first individual motivational interview at program intake. Data on dropout were collected at the end of the intervention. Participants were not provided with any incentives to participate in the study. Participants were informed that refusing to participate in the study would not impact their legal situation. All data were collected following approved procedures by the University of Valencia Ethics Committee (H1537520365110).

Individualized motivational plan

This intervention program for IPV perpetrators implements motivational strategies via an Individualized Motivational Plan (IMP; Lila et al., 2018), which is based on evidence-based approaches such as MI (W. R. Miller & Rollnick, 2002, 2013), the Good Lives Model (Langlands et al., 2009; Ward, 2002), solution-focused brief therapy (De Shazer & Berg, 1997), the therapeutic alliance (Bordin, 1979), and the stage of change approach (Prochaska & DiClemente, 1982). The IMP incorporates goal setting as one of its main strategies (Lila et al., 2018; Romero-Martínez et al., 2019b; Santirso, Lila, et al., 2020) and implements this approach through two core elements within the intervention: (1) five individual motivational interviews, three of which are at intake to promote goal identification, one at mid-way through the intervention which aims at reviewing progress on goals, and one at the end of the intervention which seeks both to supervise and follow up on participants' goal achievement and (2) three group sessions (i.e., at the beginning, middle, and end of the intervention) aimed at goal sharing for participants to receive feedback and support from facilitators and other group members. Moreover, goal reinforcement is promoted by facilitators throughout the duration of the intervention, linking participants' goals to the content of weekly group sessions (Lila et al., 2018; Roldán-Pardo et al., 2023; Santirso, Lila, et al., 2020). When participants chose not to set a goal, they still attended both individual and group sessions, where all motivational strategies included in the IMP except for goal setting were applied.

Measures

Goal Setting. Goal setting was coded as 0 if participants chose not to set any goal (0 = *goal not set*) and 1 if they chose to set a goal (1 = goal set) during the third individual motivational interview.

Dropout. Participants were coded as 0 = *completers* when they completed the intervention program, as 1 = *dropout* when they stopped attending group-based sessions at any time after the first attendance and as 2 = *no intervention* (i.e., "no-shows") when they did not attend any session of the intervention program.

Socio-demographic characteristics

Socio-demographic data were collected on age, immigrant status (0 = *no*; 1 = *yes*), civil status (1 = *married*; 2 = *single*; 3 = *separated/divorced/widowed*), cohabiting with a partner (0 = *no*; 1 = *yes*), cohabiting with children (0 = *no: "not living with children"*; 1 = *yes: "living with children"*; these categories refer to living arrangements), having children (0 = *no: "not having children"*; 1 = *yes; "having children, regardless of cohabitation"*), educational level (1 = *no schooling/primary studies*; 2 = *secondary/university studies*); employment (0 = *unemployment*; 1 = *employment*), and income (from 1 = *less than 1,800 €/year* to 12 = *more than 120,000 €/year*).

Mental health

Depression was measured using the *Center for Epidemiologic Studies Depression Scale-7* (CESD-7; Radloff, 1977; short version by Herrero & Gracia, 2007), a well-validated 7-item scale with a response ranging from 1 = *rarely or never* to 4 = *all the time or most of the time*. CESD-7 is a widely accepted self-report scale that assesses the frequency and severity of depressive symptoms. A greater total score indicates higher levels of depression. Cronbach's α for this study was .90 ($M = 13.88$, $SD = 5.95$). This scale has been previously used with samples of IPV perpetrators in Spain (Lila et al., 2019).

Impulsivity was measured using *Plutchick Impulsivity Scale* (Plutchik & Van Praag, 1989; Spanish version by Páez et al., 1996), a 15-item 4-point Likert-type scale from 1 = *never* to 4 = *almost always*. This self-report scale evaluates impulsivity as an immediate reaction that happens without considering potential behavioral consequences. Higher scores represent higher impulsivity levels. Cronbach's α for this study was .74 ($M = 28.3$, $SD = 6.16$). The Spanish version has been used with IPV participants (Lila et al., 2019).

Empathy was assessed using the Spanish version (Mestre et al., 2004) of the *Interpersonal Reactivity Index* (IRI; Davis, 1983). This index is composed of four subscales: *perspective-taking* (Cronbach's α = .68; M = 23.78, SD = 4.77) and *fantasy* (Cronbach's α = .66; M = 16.34, SD = 5.3) which evaluate cognitive empathy, and *empathic concern* (Cronbach's α = .71; M = 25.6, SD = 4.38) and *personal distress* (Cronbach's α = .72; M = 15.33, SD = 4.67), which measure emotional empathy. Participants responded to 28 items on a 5-point Likert scale. The total score ranges from 7 to 35 points in each subscale, with a greater score indicating stronger empathic abilities. The IRI has demonstrated convergent and discriminant validity in Spanish samples and the reliability found in this study is consistent with previous literature (Pérez-Albéniz et al., 2003). It has also been used with samples of IPV perpetrators (Romero-Martínez et al., 2013).

Emotional decoding was measured using the *Eyes test* (Baron-Cohen et al., 2001), which assesses the ability to interpret emotions by requiring participants to select the most fitting emotion from a set of four adjectives that describe the emotions depicted in 36 photographs of men and women's eye regions. Scores range from 0 to 36, with higher total scores indicating stronger emotional decoding abilities (M = 17.77, SD = 4.22). This test has shown good internal consistency and test-retest reliability (Vellante et al., 2013), and its Spanish version has been used with IPV perpetrators (Romero-Martínez et al., 2013).

Anger was measured using the *State-Trait Anger Expression Inventory* (STAXI-2; Spielberger, 1999; Spanish version by Miguel-Tobal et al., 2001). The STAXI-2 is a 49-item inventory which assesses state anger, as a situational response, and trait anger, as a predisposition quality. An overall anger expression index (AEI) was obtained by combining the scores of the two expression sub-scales, subtracting the scores of the two control sub-scales, and adding 36 to prevent any negative values. Responses were given on a 4-point Likert-type scale (1 = *not at all*; 4 = *very much*). The Spanish version demonstrated good test-retest reliability and Cronbach's α reliability coefficients of .89 for state anger (M = 14.12, SD = 4.22), .82 for trait anger (M = 16.26, SD = 5.33) and .69 (M = 22.4, SD = 10.36) for the AEI (Miguel-Tobal et al., 2001). This version has been used with IPV perpetrator populations (Siria et al., 2021).

Self-esteem was assessed using the *Rosenberg Self-esteem Scale* (RSES; Rosenberg, 1965; Spanish version by Martín-Albo et al., 2007). RSES is a 10-item scale with responses on a 4-point Likert-type scale ranging from 1 = *totally disagree* to 4 = *totally agree*, which

determines global feelings of self-worth and self-acceptance. For this study, Cronbach's α was .81 (*M* = 31.97, *SD* = 5.03). The Spanish version has been used with Spanish IPV perpetrators (Catalá-Miñana et al., 2013).

Personality disorders and clinical syndromes were measured using the *Millon Clinical Multiaxial Inventory-III* (MCMI-III), a self-report inventory with 175 true-false questions (Millon, 2007; Spanish version by Cardenal & Sánchez, 2007). The following scales were used: 11 clinical personality pattern scales (*schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, sadistic, compulsive, passive-aggressive, masochistic*), three severe personality scales (*schizotypal, borderline, and paranoid*), five clinical syndrome scales (*anxiety, somatoform, hypomanic, dysthymia, and posttraumatic stress disorder*) and the three severe clinical syndromes (*thought disorder, major depression, and delusional disorder*). Only scores of 75 or higher suggest a significant personality trait or mental health issue. This version demonstrated high internal consistency, reliability coefficients ranging from .66 and .90 and moderate levels of test-rest reliability (Millon et al., 2006) and it has been used with samples of Spanish IPV perpetrators (Carbajosa et al., 2017).

Substance use

Alcohol use was measured using the *Alcohol Use Disorders Identification Test* (AUDIT; Babor & Grant, 1989; Spanish version by Contel et al., 1999), a 10-item Likert-type scale, with responses ranging from 0 = *never* to 4 = *daily or almost daily*. This well-validated screening measure evaluates the quantity and frequency of drinking and alcohol-related consequences. A total score was used as the indicator of alcohol use, with higher scores indicating a higher risk of hazardous drinking. Scores of 8 or higher suggest harmful alcohol consumption. Cronbach α in this study was .81 (*M* = 5.56, *SD* = 6.09). This scale has been widely used with IPV populations in Spain (Catalá-Miñana et al., 2013; Lila et al., 2014).

Cannabis and cocaine use were assessed using the *Severity of Dependence scale* (SDSCan; SDSCo; Miele et al., 2000; Spanish version by Vélez-Moreno et al., 2013) which consisted of 5 items on a 4-point Likert-type self-report scale. Participants responded on a scale from 0 = *never* to 3 = *always*. Scores of 3 or above indicate dependence. Cronbach's α for *cannabis scale* was .90 (*M* = 1.10, *SD* = 2.72) and for *cocaine scale* .85 (*M* = 0.65, *SD* = 2.08). These scales have been used with IPV populations in Spain (Sarrate-Costa et al., 2022).

Alcohol and drug dependence were measured using the *alcohol dependence scale* and *drug dependence scale* of the MCMI-III (see the inventory description above; Millon, 2007; Spanish version by Cardenal & Sánchez, 2007), respectively. Higher scores indicate that the individual is likely to have a history of recent or recurrent alcohol and/or other drug abuse and has poor coping mechanisms for dealing with the consequences of alcohol and/or drug use. Only scores equal to or above 75 suggest a significant alcohol and drug problem, respectively.

ADUPs. Participants were grouped into those with ADUPs ($n = 127$) if they scored above the cut-off point in the AUDIT (≥ 8; Babor & Grant, 1989) and/or SDSCan and/or SDSCo (≥ 3; Kaye & Darke, 2002) and/or alcohol and/or drug dependence scale (≥ 75; MCMI-III; Millon, 2007). Men who scored below the cut-off point in each of the former scales were considered participants without ADUPs ($n = 158$).

Social-relational variables

Community support was assessed using the *Perceived Community Support Questionnaire* (PCSQ; Gracia & Herrero, 2006), an 18-item scale with responses given on a 5-point scale from 1 = *totally disagree* to 5 = *totally agree*. It comprises three dimensions: *community participation* ($\alpha = .76$; $M = 15.27$, $SD = 4.85$), and *support from informal* ($\alpha = .84$; $M = 19.05$, $SD = 4.52$) and *formal* ($\alpha = .77$; $M = 14.84$, $SD = 3.9$) *community organizations*. This scale has been used with Spanish samples of IPV perpetrators (Juarros-Basterretxea et al., 2018).

Intimate support was assessed using the *Intimate Social Support Questionnaire* (Lin et al., 1986; Spanish adaptation by Herrero et al., 2011), a 3-item unidimensional scale with responses ranging from 1 = *most of the time* to 5 = *never*, which measures participants' perception of intimate support from an intimate partner, family, and friends. For this study, Cronbach's α was .64 ($M = 10.58$, $SD = 3.21$), consistent with previous studies (Herrero et al., 2011). This scale has been used with samples of IPV perpetrators in Spain (Lila et al., 2019).

Stressful life events were assessed using the *Stressful Life Events Questionnaire* (Gracia & Herrero, 2004), in which participants have to identify stressful events they have experienced in the last six months from a list of 33 life events. A higher score indicates a greater accumulation of stressful life events ($M = 2.93$, $SD = 3.23$). This scale has adequate reliability coefficients and has been used with Spanish IPV perpetrators (Lila et al., 2014).

Perceived social rejection was evaluated using the *Perceived Social Rejection Index* (PSRI; Catalá-Miñana et al., 2013). This is a unidimensional 13-item 5-point Likert-type item scale which measures participants' perceived social rejection as a consequence of their conviction of IPV. Responses ranged from 1 = *strongly disagree* to 5 = *strongly agree*. A higher score represents greater perceived social rejection. Cronbach's α was .83 (*M* = 28.81, *SD* = 9.94). This scale has been previously used with Spanish IPV participants (Catalá-Miñana et al., 2013).

Attitudes towards IPV

Responsibility attribution to the victim was assessed using the subscale *responsibility attributed to the victim* of the *Intimate Partner Violence Responsibility Attribution Scale* (IPVRAS; Lila et al., 2014). This subscale is a 4-item 5-point Likert-type scale to ascertain whether IPV perpetrators place the responsibility for their violent act on the victim. Cronbach's α in this study was .66 (*M* = 12.97, *SD* = 4.46), consistent with previous research using a sample of IPV perpetrators in Spain (Lila et al., 2014).

Sexism was measured using the Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1997; Spanish version by Expósito et al., 1998), a 22-item inventory with responses ranging from 0 = *strongly disagree* to 5 = *strongly agree*. It includes two dimensions: *benevolent sexism* (α = .83; *M* = 28.22, *SD* = 11.92), which comprises paternalistic attitudes and *hostile sexism* (α = .90; *M* = 25.32, *SD* = 13.27) which represents explicit negative attitudes towards women. This scale has been used with Spanish IPV perpetrators (Juarros-Basterretxea et al., 2018).

Gender roles were measured using a 12-item scale, *Gender Ideology Scale* (Moya et al., 2006). Responses were given on a 4-point Likert-type scale (1 = *totally disagree*; 4 = *totally agree*). A higher total score indicates stronger sexism. For this study, Cronbach's α was .88 (*M* = 22.82, *SD* = 7.49), consistent with previous research, which also showed convergent and discriminant validity with Spanish samples (Moya et al., 2006).

The risk of IPV recidivism assessed by facilitators was measured using the *Spousal Assault Risk Assessment Guide* (SARA; Kropp et al., 1999; Spanish version by Andrés-Pueyo et al., 2008) at pre-intervention, a 20-item protocol used to assess the risk of recidivism toward former or present partners and non-partners. Risk factors were rated as 0 = *low*, 1 = *moderate*, and 2 = *high* risk. The indicator used was the total score. A higher score represents a higher risk of recidivism (*M* = 9.91, *SD* = 4.98). This protocol has been widely used with IPV perpetrators, including Spanish samples (Lila et al., 2019; Romero-Martínez et al., 2013).

The stage of change was assessed by facilitators during pre-intervention (Carbajosa et al., 2017). It was rated according to the transtheoretical model of change by Prochaska and DiClemente (1982) as follows: 1 = *precontemplation*; 2 = *contemplation*; 3 = *preparation*; 4 = *action*; 5 = *maintenance*. Data on the stage of change was collected during the first individual, motivational interview before the group-based sessions started. A higher score indicates a later stage of change (*M* = 1.19, *SD* = 0.44). This procedure has been used with Spanish samples of IPV perpetrators (Carbajosa et al., 2017; Lila et al., 2018).

Data analysis

Descriptive data were obtained using frequencies and percentages for categorical variables and means (*M*) and standard deviations (*SD*) for continuous variables. Research question 1 was examined using binary logistic regressions to identify participants' baseline characteristics associated with a higher likelihood of setting goals. Associations between goal setting and socio-demographic variables, mental health, substance use, social-relational variables, variables associated with attitudes towards IPV, risk of IPV recidivism and the stage of change were estimated with odds ratio (OR) and 95% confidence intervals (CI). A multivariate binary logistic regression analysis was performed using a backward elimination stepwise selection approach based on the likelihood ratio (LR) criterion to determine the best subset of predictors of goal setting. To support the selection of relevant variables, only variables *p* < .1 in the univariate analysis and clinically relevant were considered eligible for inclusion in the multivariate model. This analytical procedure aligns with well-established practices, as evidenced by analogous methodologies employed in prior research within this domain (G. Gilchrist et al., 2017; Sonis & Langer, 2008) and across diverse research areas (Brough et al., 2015; Vaporciyan et al., 2004). Furthermore, this methodological procedure for variable selection in logistic regression analysis (Hosmer et al., 2013) has also been elucidated by Bursac et al. (2008) and Chowdhury and Turin (2020). "Goal not set" was the reference category for goal setting. For categorical, independent variables, a reference category was chosen to perform the univariate and multivariate analyses. The extent to which the model explains the variation in the outcome variable was assessed using Nagelkerke R^2. The model's goodness of fit was tested using the Hosmer and Lemeshow test. A non-significant result in the Pearson chi-square test suggested that the model fitted the data well. The model's classification accuracy was also evaluated. Research question 2 was evaluated using a binary logistic regression to ascertain if having an ADUP was significantly associated with a higher likelihood of setting goals. The same procedure used to examine research question 1 was applied to identify univariate and

multivariate factors associated with dropout both for the full sample and specifically for those with ADUPs. This approach helped to research questions 3 and 4 and determine whether goal setting was associated with lower dropout by accounting for relevant variables. These binary logistic regressions were performed for participants who dropped out and completed the intervention program. The "completers" group was designated as the reference category for dropout. The use of simple logistic regressions allowed the assessment of the individual contribution of each variable and the identification of relevant and potential contributing factors to be included in the multivariate logistic regression (Hosmer et al., 2013), ensuring a more comprehensive understanding of the interplay of factors influencing goal setting and dropout in each model. While the likelihood of incurring Type I error was mitigated by the use of a rigorous multivariate approach, with a backward elimination stepwise selection, a Bonferroni correction was employed to further reduce the likelihood of Type I error during the interpretation of simple regression results. The Bonferroni correction was applied to adjust the alpha (*p*-value), aligning with the established methodology described in previous literature (S. Lee & Lee, 2018). This correction involved dividing the planned error rate (0.05) by the total number of tests conducted (Bonferroni, 1936). As a result, only *p*-values falling below the new critical threshold would be considered indicative of a significant association with the dependent variable (i.e., goal setting and dropout; R. G. Miller, 2012). The results of the simple regressions were interpreted in terms of both the more conservative adjusted critical *p*-value and the planned error rate (0.05). No evidence of multicollinearity of the independent variables included in the multivariate analyses was shown. Data analyses were carried out using IBM SPSS Statistics for Windows, Version 28.0 (Armonk, NY, USA).

Results

Descriptive data of the total sample are presented in Table 1. Participants were classified according to the presence of substance use problems as those with ADUPs ($n = 127$) and those without ($n = 158$).

What participant baseline characteristics were associated with a higher likelihood of setting goals?

A substantial number of participants from the full sample (77.54%) chose to set a goal at the initiation of the intervention program for IPV perpetrators. Univariate analysis showed that the baseline characteristics significantly associated with a higher likelihood of goal setting (see Table 1) were being younger, having no children, having higher empathetic perspective-taking, higher scores on the hypomanic disorder (i.e., higher levels of energy, excitement and mood change), higher scores on the drug dependence scale, greater formal community support, perceiving higher social rejection associated to their conviction of IPV, having lower hostile sexism, holding lower gender roles beliefs and being in a later stage of change. After applying the Bonferroni correction, where the planned error rate ($\alpha = 0.05$) was divided by the number of tests ($k = 63$), resulting in an adjusted p-value of .00079; only age, specifically being younger, emerged as a significant predictor associated with a higher likelihood of setting goals ($\alpha < .00079$).

Variables that remained in the last step of the multiple logistic regression model predicting goal setting included: being younger, having higher empathetic perspective-taking, higher scores on hypomania, and higher formal community support. Although not significant, gender role beliefs and the stage of change remained in the last step of the model. The ORs showed that the odds of setting goals significantly decreased by 3% for each year increase in age. For a 1-unit increase in the score of empathetic perspective-taking, hypomanic disorder, and formal community support, the odds of goal setting increased by 8%, 2%, and 11% respectively. The model fitted the data well (see Table 2), correctly classifying 79.1% of the cases.

Table 1. Participant baseline characteristics associated with goal setting in the full sample of participants

	Total cases (n complete cases = 285)	Total sample (n = 285)	Goal not set (n = 64)	Goal set (n = 221)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	M (SD)/N (%)	p	OR (95% CI)
ADUPs	285					
No		158(55.4)	39(60.9)	119(53.8)	.316	1.34(0.76, 2.36)
Yes		127(44.6)	25(39.1)	102(46.2)		
(1) Socio-demographics						
Mean Age (SD)	285	41.68(12.35)	46.92(13.13)	40.17(11.71)	<.001	0.96(0.93, 0.98) *
Immigrant status	285					
Not an immigrant		229(80.4)	54(84.4)	175(79.2)	Ref	1
Immigrant		56(19.6)	10(15.6)	46(20.8)	.359	1.42(0.67, 3)
Civil status	285					
Married		66(23.2)	18(28.1)	48(21.7)	Ref	1
Single		114(40)	20(31.3)	94(42.5)	.126	1.76(0.85, 3.64)
Separated/divorced/widowed		105(36.8)	26(40.6)	79(35.7)	.715	1.14(0.57, 2.29)
Lives with	276					
Alone		70(24.6)	14(22.6)	56(26.2)	Ref	1
Partner or partner with others		57(20)	15(24.2)	42(19.6)	.400	0.7(0.31, 1.61)
Others only		149(52.3)	33(53.2)	116(54.2)	.715	0.88(0.44, 1.77)
Has children	277					
No children		84(29.5)	12(19.4)	72(33.5)	Ref	1
1 or more children		193(67.7)	50(80.6)	143(66.5)	.036	0.48(0.24, 0.95) *
Live with children	276					
No		214(75.1)	44(71)	170(79.4)	Ref	1
Yes		62(21.8)	18(29)	44(20.6)	.161	0.63(0.33, 1.2)
Live with partner	276					
No		219(76.8)	47(75.8)	172(80.4)	.435	0.77(0.39, 1.5)
Yes		57(20)	15(24.2)	42(19.6)		
Educational level	285					
No schooling/Primary studies		158(55.4)	39(60.9)	119(53.8)	Ref	1
Secondary/University studies		127(44.6)	25(39.1)	102(46.2)	.316	1.34(0.76, 2.36)
Employment	285					
Unemployed/Students/Retired/On benefits		107(37.5)	30(46.9)	77(34.8)	Ref	1
Employed		178(62.5)	34(53.1)	144(65.2)	.082	1.65(0.94, 2.9)
Income	282	4.7(2.25)	4.4(2.32)	4.78(2.23)	.234	1.08(0.95, 1.23)

Table 1. (Continued).

	Total cases (n complete cases = 285)	Total sample (*n* = 285)	Goal not set (*n* = 64)	Goal set (*n* = 221)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)
(2) Mental health						
Depression	285	13.88(5.95)	13.02(5.95)	14.14(5.94)	.186	1.03(0.98, 1.09)
Impulsivity	281	28.3(6.16)	27.38(5.63)	28.57(6.29)	.174	1.03(0.99, 1.09)
Self-esteem	282	31.97(5.03)	32.14(5.22)	31.92(4.99)	.760	0.99(0.94, 1.05)
Empathy	282					
Fantasy		18.39(4.61)	17.92(4.84)	18.52(4.54)	.359	1.03(0.97, 1.1)
Perspective-taking		23.78(4.77)	22.58(4.96)	24.14(4.67)	.023	1.07(1.01, 1.14) *
Empathetic concern		25.6(4.38)	24.88(4.82)	25.82(4.23)	.131	1.05(0.99, 1.12)
Personal distress		15.33(4.67)	15.45(4.25)	15.3(4.8)	.815	0.99(0.94, 1.05)
Emotional decoding	279	18.78(4.23)	18.26(4.76)	18.93(4.07)	.273	1.04(0.97, 1.11)
Anger	272					
State Anger		17.12(4.22)	17.15(3.31)	17.11(4.46)	.960	1(0.94, 1.07)
Trait Anger		16.26(5.33)	15.81(4.9)	16.4(5.46)	.445	1.02(0.97, 1.08)
Anger Expression index		22.4(10.36)	21.81(10.05)	22.58(10.47)	.607	1.01(0.98, 1.04)
Personality disorders and clinical syndromes	267					
Schizoid		41.94(21.67)	43(21.6)	41.63(21.72)	.665	1(0.98, 1.01)
Avoidant		37.12(24.16)	37.73(22.9)	36.94(24.56)	.822	1(0.99, 1.01)
Depressive		36.1(25.72)	35.92(22.95)	36.16(26.51)	.949	1(0.99, 1.01)
Dependent		40.99(20.48)	40.03(20.91)	41.27(20.4)	.681	1(0.99, 1.02)
Histrionic		49.54(18.26)	47.63(15.4)	50.1(19.01)	.357	1(0.99, 1.02)
Narcissistic		67.82(13.81)	69.68(13.8)	67.28(13.81)	.235	0.99(0.97, 1.01)
Antisocial		47.66(23.41)	44.2(22.99)	48.66(23.5)	.195	1.01(1, 1.02)
Sadistic		38.94(23.37)	36.82(22.03)	39.56(23.77)	.424	1.01(0.99, 1.02)
Compulsive		65.12(19.86)	67.33(17.58)	64.48(20.47)	.328	0.99(0.98, 1.01)
Passive-aggressive		40.93(23.96)	40.98(22.41)	40.91(24.44)	.984	1(0.99, 1,01)
Masochistic		33.43(23.94)	34.9(24.6)	33.01(23.79)	.590	1(0.99, 1.01)
Schizotypal		35.25(26.77)	34.62(27.19)	35.43(26.71)	.836	1(0.99, 1.01)
Borderline		36.18(24.77)	34.05(24.67)	36.8(24.82)	.449	1(0.99, 1.02)
Paranoid		48.27(27.62)	52.1(25.3)	47.15(28.22)	.223	0.99(0.98, 1)
Anxiety		52.69(34.89)	48.73(33)	53.84(35.41)	.318	1(1, 1.01)
Somatoform		34.51(27.52)	34.22(27.61)	34.6(27.56)	.926	1(0.99, 1.01)
Hypomanic		54.27(22.7)	48.4(23.43)	55.97(22.23)	.024	1.01(1, 1.03) *
Dysthymia		30.34(28.42)	30.18(28.18)	30.39(28.56)	.961	1(0.99, 1.01)
Posttraumatic stress disorder		37.07(28.68)	33.03(26.89)	38.24(29.14)	.216	1.01(1, 1.02)
Thought disorder		37.17(29.99)	32.97(28.09)	38.39(30.48)	.218	1.01(1, 1.02)

Table 1. (Continued).

	Total cases (n complete cases = 285)	Total sample (*n* = 285)	Goal not set (*n* = 64)	Goal set (*n* = 221)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)
Major depression		33.64(31.27)	34.15(32.11)	33.49(31.01)	.886	1(0.99, 1.01)
Delusional disorder		41.77(30.51)	55.83(30.04)	50.59(30.62)	.243	0.99(0.98, 1)
(3) Substance use						
AUDIT score	284	5.56(6.09)	4.4(4.82)	5.89(6.38)	.089	1.05(0.99, 1.11)
Cannabis use score	255	1.1(2.72)	0.66(1.88)	1.24(2.92)	.152	1.11(0.96, 1.27)
Cocaine use score	254	0.65(2.08)	0.57(1.77)	0.67(2.17)	.736	1.03(0.89, 1.19)
Alcohol dependence score	267	49.95(24.91)	44.92(26.78)	51.41(24.21)	.077	1.01(1, 1.02)
Drug dependence score	267	50.12(28.88)	43.3(29.1)	52.1(28.6)	.039	1.01(1, 1.02) *
(4) Social-relational						
Community support	282					
Participation		15.27(4.85)	15.44(5.04)	15.22(4.81)	.757	0.99(0.94, 1.05)
Informal		19.05(4.52)	18.52(4.5)	19.2(4.52)	.286	1.03(0.97, 1.1)
Formal		14.84(3.9)	13.75(4.06)	15.17(3.8)	.012	1.1(1.02, 1.17) *
Intimate support	282	10.58(3.21)	10.86(3.12)	10.5(3.24)	.431	0.97(0.88, 1.05)
Stressful life events	282	2.93(3.24)	2.39(2.4)	3.08(3.43)	.134	1.08(0.98, 1.2)
Social rejection	280	28.81(9.94)	26.61(9.07)	29.47(10.1)	.045	1.03(1.01, 1.06) *
(5) Attitudes towards IPV						
Responsibility attributed to the victim	282	12.97(4.26)	13.43(4.09)	12.83(4.3)	.316	0.97(0.9, 1.03)
Ambivalent Sexism	285					
Benevolent sexism		28.22(11.92)	30.09(11.62)	27.68(11.97)	.155	0.98(0.96, 1.01)
Hostile sexism		25.32(13.27)	28.34(13.79)	24.44(13.02)	.039	0.98(0.96, 0.99) *
Gender roles scale	280	22.82(7.49)	25.46(8.52)	22.06(7)	.002	0.94(0.91, 0.98) *
Risk of IPV recidivism assessed by facilitators at pre-intervention	264	9.91(4.98)	10.33(5.07)	9.79(4.97)	.468	0.98(0.92, 1.04)
Stage of change at pre-intervention	284	1.19(0.44)	1.05(0.21)	1.24(0.48)	.006	5.18(1.6, 16.8) *

Note. Discrepancies in totals because of missing data; M = Mean; SD = Standard Deviation; OR = Odds Ratio; CI = Confidence Interval; ADUPs = Alcohol and other drug use problems; AUDIT = Alcohol Use Disorders Identification Test; IPV = Intimate partner violence; *p* < .05

Table 2. Multivariate factors associated with goal setting in intimate partner violence (IPV) perpetrators ($n = 254$)

Multivariate Analysis[a]	B	SE	Wald	p	OR (95% CI)
Age	-0.04	0.01	6.39	.011	0.97(0.94, 0.99) *
Empathetic perspective taking	0.08	0.04	3.92	.048	1.08(1.01, 1.17) *
Hypomanic clinical syndrome	0.02	0.01	4.66	.031	1.02(1.01, 1.03) *
Formal community support	0.10	0.04	5.30	.021	1.11(1.02, 1.2) *
Gender roles scales	-0.04	0.02	3.43	.064	0.96(0.92, 1)
Stage of change at pre-intervention	1.47	0.75	3.85	.050	4.36(1, 18.97)
R^2 Nagelkerke	0.239				
Classification of model	79.1%				
Pearson chi-square statistic (Hosmer and Lemeshow)	$p = 0.148$				

a. Variables included in the model in step 1: Age, Children, Employment, Empathetic perspective-taking, Hypomanic, Alcohol use, Alcohol dependence, Drug dependence, Formal community support, Social rejection, Hostile sexism, Gender role ideas, Stage of change at pre-intervention.

b. SE = Standard Error; OR = Odds Ratio; CI = Confidence Interval; *$p < .05$

Was having an ADUP associated with a higher likelihood of setting goals?

As shown in Table 1, having an ADUP was not significantly associated with setting goals.

Was goal setting associated with reduced dropout rates?

Full sample

A total of 58 (20.57%) participants dropped out of the intervention at some point after attending the first group-based session. As presented in Table 3, univariate factors significantly associated with dropout for the full sample included goal setting (i.e., setting a goal was significantly associated with lower odds of dropping out) and ADUPs (i.e., having ADUPs was significantly associated with higher odds of dropping out). Moreover, having lower empathetic perspective-taking and empathetic concern and higher empathetic personal distress and state anger were significantly associated with higher odds of dropping out of the intervention program. With regards to variables related to personality disorders and clinical syndromes, univariate analysis revealed that higher scores on major depression and schizoid, paranoid, somatoform and delusional personality disorders, and lower scores on the compulsive disorder were significantly associated with higher odds of dropping out. In terms of substance use problems, higher scores on the AUDIT, cannabis and cocaine use, and alcohol and drug dependence were significantly associated with higher odds of dropping out. The univariate analysis also revealed that participants with lower perceived informal and formal community support, higher stressful life events experienced, greater perceived social rejection related to the IPV conviction, and higher hostile sexism and risk of IPV recidivism assessed by facilitators at pre-intervention were significantly more likely to drop out. Following the application of the Bonferroni correction, where the planned error rate ($\alpha = .05$) was divided by the number of tests ($k = 64$), resulting in $\alpha = .00078$; only goal setting emerged as a significant predictor of a lower likelihood of dropping out from the intervention program ($\alpha < .00078$).

Variables $p < .1$ in the univariate analysis and clinically relevant were included in the first step of the multivariate analysis (see Table 4). To avoid double counting effects when entering ADUPs in the model, the remaining substance use variables were excluded.

Table 3. Univariate factors associated with dropout for the full sample and for participants with alcohol and other drug use problems (ADUPs)

	Full sample (IPV perpetrators with and without ADUPs; $n = 282$)					IPV perpetrators with ADUPs ($n = 127$)				
	Total cases ($n_{complete\ cases} = 282$)	Completers ($n = 224$)	Dropout ($n = 58$)	Univariate analysis		Total cases ($n_{complete\ cases} = 127$)	Completers ($n = 92$)	Dropout ($n = 35$)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	p	OR (95% CI)	N	M (SD)/N (%)	M (SD)/N (%)	p	OR (95% CI)
Goal setting	282					127				
Goal not set		36(16.1)	25(43.1)	Ref	1		11(12)	14(40)	Ref	1
Goal set		188(83.9)	33(56.9)	<.001	0.25(0.14, 0.48) *		81(88)	21(60)	<.001	0.2(0.08, 0.51) *
ADUPs	282									
No		132(58.9)	23(39.7)	Ref	1					
Yes		92(41.1)	35(60.3)	.009	2.18(1.21, 3.94) *					
(1) Socio-demographics										
Mean Age (SD)	282	41.35(12.04)	42.22(13.4)	.629	1.01(0.98, 1.03)	127	39.76(11)	39.66(12.75)	.964	1(0.97, 1.03)
Immigrant	282					127				
Not an immigrant		182(81.3)	44(75.9)	Ref	1		74(80.4)	27(77.1)	Ref	1
Immigrant		42(18.8)	14(24.1)	.361	1.38(0.69, 2.75)		18(19.6)	8(22.9)	.682	1.22(0.48, 3.13)
Civil status	282					127				
Married		54(24.1)	12(20.7)	Ref	1		14(15.2)	5(14.3)	Ref	1
Single		91(40.6)	22(37.9)	.832	1.09(0.5, 2.37)		47(51.1)	16(45.7)	.936	0.95(0.3, 3.07)
Separated/divorced/ widowed		79(35.3)	24(41.4)	.429	1.37(0.63, 2.97)		31(33.7)	14(40)	.702	1.27(0.38, 4.2)
Lives with	273					120				
Alone		57(26.1)	13(23.6)	Ref	1		24(27.3)	6(18.8)	Ref	1
Partner or partner with others		50(22.9)	7(12.7)	.336	0.61(0.23, 1.66)		13(14.8)	4(12.5)	.777	1.23(0.29, 5.16)
Any others		111(50.9)	35(63.6)	.373	1.38(0.68, 2.82)		51(58)	22(68.8)	.297	1.73(0.62, 4.81)
Has children	274					123				
No children		70(32.1)	13(23.2)	Ref	1		34(37.8)	10(30.3)	Ref	1
1 or more children		148(67.9)	43(76.8)	.199	1.56(0.79, 3.1)		56(62.2)	23(69.7)	.445	1.4(0.59, 3.29)
Live with children	273					120				
No		165(75.7)	47(85.5)	Ref	1		71(80.7)	27(84.4)	Ref	1
Yes		53(24.3)	8(14.5)	.125	0.53(0.24, 1.19)		17(19.3)	5(15.6)	.644	0.77(0.26, 2.3)

Table 3. (Continued).

	Full sample (IPV perpetrators with and without ADUPs; *n* = 282)					IPV perpetrators with ADUPs (*n* = 127)				
	Total cases (*n* complete cases = 282)	Completers (*n* = 224)	Dropout (*n* = 58)	Univariate analysis		Total cases (*n* complete cases = 127)	Completers (*n* = 92)	Dropout (*n* = 35)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)
Live with partner	273					120				
No		168(77.1)	48(87.3)	Ref	1		75(85.2)	28(87.5)	Ref	1
Yes		50(22.9)	7(12.7)	.101	0.49(0.21, 1.15)		13(14.8)	4(12.5)	.824	0.82(0.25, 2.74)
Educational level	282					127				
No schooling/Primary studies		122(54.5)	34(58.6)	Ref	1		53(57.6)	21(60)	Ref	1
Secondary/University studies		102(45.5)	24(41.4)	.571	0.84(0.47, 1.52)		39(42.4)	14(40)	.807	0.91(0.41, 2)
Employment	282									
Unemployed/Students/ Retired/On benefits		79(35.3)	27(46.6)	Ref	1		34(37)	16(45.7)	Ref	1
Employed		145(64.7)	31(53.4)	.116	0.63(0.35, 1.12)		58(63)	19(54.3)	.368	0.7(0.32, 1.53)
Income	279	4.76(2.22)	4.47(2.44)	.392	0.94(0.83, 1.08)	125	4.82(2.22)	4.38(2.55)	.342	0.92(0.77, 1.1)
(2) Mental health										
Depression	282	13.67(5.89)	14.95(6.21)	.145	1.04(0.99, 1.09)	127	15.22(6.43)	15.54(6.49)	.798	1.01(0.95, 1.07)
Impulsivity	278	27.95(5.92)	29.63(6.79)	.066	1.04(1, 1.09)	125	31.21(6.2)	32.03(6.34)	.511	1.02(0.96, 1.09)
Self-esteem	279	32.12(4.9)	31.56(5.59)	.454	0.98(0.92, 1.04)	125	30.92(5.22)	31(5.13)	.941	1(0.93, 1.08)
Empathy	279					125				
Fantasy		18.42(4.68)	18.25(4.46)	.800	0.99(0.93, 1.06)		19.3(4.91)	18.71(4.43)	.537	0.97 (0.9, 1.06)
Perspective-taking		24.07(4.88)	22.65(4.24)	.047	0.94(0.88, 0.99) *		22.85(4.82)	21.53(3.89)	.158	0.94(0.86, 1.03)
Empathetic concern		25.87(4.39)	24.58(4.02)	.047	0.93(0.87, 0.99) *		25.65(4.7)	24.24(3.59)	.117	0.93(0.85, 1.02)
Personal distress		14.99(4.68)	16.54(4.5)	.027	1.07(1.01, 1.14) *		16.54(4.87)	16.91(4.23)	.691	1.02(0.94, 1.11)
Emotional decoding	276	19(4.19)	17.78(4.37)	.059	0.93(0.87, 1)	124	19.26(4.35)	17.21(4.4)	.025	0.9(0.82, 0.99) *
Anger	269					118				
State Anger		16.8(3.35)	18.51(6.6)	.014	1.08(1.02, 1.15) *		17.55(4.13)	19.06(6.98)	.164	1.06(0.98, 1.14)
Trait Anger		15.94(5.04)	17.55(6.35)	.054	1.05(1, 1.11)		17.76(5.57)	19.35(6.75)	.199	1.05(0.98, 1.12)
Anger Expression index		21.89(9.69)	24.79(12.61)	.070	1.03(1, 1.06)		25.3(10.19)	27.97(13.44)	.253	1.02(0.99, 1.06)

Table 3. (Continued).

	Full sample (IPV perpetrators with and without ADUPs; *n* = 282)					IPV perpetrators with ADUPs (*n* = 127)				
	Total cases (*n* complete cases = 282)	Completers (*n* = 224)	Dropout (*n* = 58)	Univariate analysis		Total cases (*n* complete cases = 127)	Completers (*n* = 92)	Dropout (*n* = 35)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)
Personality disorders and clinical syndromes	264					120				
Schizoid		40.04(21.6)	49.14(20.63)	.008	1.02(1.01, 1.04) *		44.33(21.05)	50.52(20.17)	.158	1.02(0.99, 1.04)
Avoidant		37.14(24.48)	37(23.33)	.970	1(0.99, 1.01)		43.66(22.82)	38.61(23.07)	.290	0.99(0.97, 1.01)
Depressive		34.76(26.29)	41.82(22.71)	.082	1.01(1, 1.02)		43.55(25.19)	44.06(22.75)	.920	1(0.98, 1.02)
Dependent		40.93(21)	41.06(18.71)	.968	1(0.99, 1.02)		47.09(20.98)	41.81(19.4)	.220	0.99(0.97, 1.01)
Histrionic		50.15(18.77)	47.3(16.02)	.320	0.99(0.98, 1.01)		47.78(19.85)	43.94(15.85)	.330	0.99(0.97, 1.01)
Narcissistic		67.75(14.41)	67.68(11.27)	.973	1(0.98, 1.02)		66.78(17.18)	67.03(10.62)	.937	1(0.98, 1.03)
Antisocial		46.54(23.49)	52.12(23.17)	.132	1.01(1, 1.03)		62.22(16.36)	61.32(19.14)	.799	1(0.97, 1.02)
Sadistic		38.2(23.69)	42.06(22.32)	.294	1.01(0.99, 1.02)		52.45(18.96)	51.61(19.11)	.831	1(0.98, 1.02)
Compulsive		66.49(18.91)	60.18(23.04)	.045	0.98(0.97, 1) *		56.4(18.68)	52.39(22.76)	.330	0.99(0.97, 1.01)
Passive-aggressive		39.89(24.5)	45.68(21.43)	.126	1.01(1, 1.02)		49.89(20.96)	50.1(17.63)	.960	1(0.98, 1.02)
Masochistic		32.59(23.87)	36.18(24.36)	.341	1.01(0.99, 1.02)		42.04(21.22)	44.32(21.82)	.607	1.01(0.99, 1.03)
Schizotypal		35.1(26.9)	35.48(26.23)	.928	1(0.99, 1.01)		45.64(24.33)	41.32(24.14)	.393	0.99(0.98, 1.01)
Borderline		35.22(24.82)	41(24.14)	.138	1.01(1, 2.02)		49.51(20.06)	47.84(20.75)	.691	1(0.98, 1.02)
Paranoid		46.37(28.03)	55.7(25.18)	.034	1.01(1, 1.03) *		54.39(24.45)	58.23(23.66)	.448	1.01(0.99, 1.03)
Anxiety		51.85(35.51)	56.26(32.81)	.422	1(1, 1.01)		67.07(30.67)	56.87(32.8)	.122	0.99(0.98, 1)
Somatoform		32.62(27.68)	42.8(25.14)	.020	1.01(1.01, 1.03) *		42.21(27.47)	45.23(22.63)	.581	1(0.99, 1.02)
Hypomanic		53.12(23.27)	58.82(19.58)	.111	1.01(1, 1.03)		63.94(17.71)	61.77(20.41)	.571	0.99(0.97, 1.02)
Dysthymia		28.79(27.92)	37.18(30.05)	.062	1.01(1, 1.02)		38.29(28.31)	39.81(27.73)	.795	1(0.99, 1.02)
Posttraumatic stress disorder		36.44(29)	40.56(27.3)	.360	1.01(0.99, 1.02)		49.13(26.23)	41.35(26.74)	.161	0.99(0.97, 1)
Thought disorder		36.53(30.03)	39.6(30.51)	.516	1(0.99, 1.01)		50.43(27.98)	44.42(30.44)	.314	0.99(0.98, 1.01)
Major depression		31.8(31.03)	42.02(30.9)	.039	1.01(1, 1.02) *		43.6(31.95)	43.97(27.88)	.954	1(0.99, 1.01)
Delusional disorder		49.46(31.36)	60.46(25.53)	.025	1.01(1.01, 1.03) *		57.9(25.82)	60.39(24.94)	.639	1(0.99, 1.02)
(3) Substance use										
AUDIT score	281	5.19(5.75)	7.11(7.23)	.038	1.05(1.01, 1.09) *	127	9.12(6.89)	9.77(8.04)	.648	1.01(0.96, 1.07)
Cannabis use score	252	0.93(2.48)	1.85(3.46)	.037	1.11(1.01, 1.22) *	114	2.16(3.5)	3.03(4.09)	.260	1.06(0.96, 1.18)

Table 3. (Continued).

	Full sample (IPV perpetrators with and without ADUPs; *n* = 282)					IPV perpetrators with ADUPs (*n* = 127)				
	Total cases (*n* complete cases = 282)	Completers (*n* = 224)	Dropout (*n* = 58)	Univariate analysis		Total cases (*n* complete cases = 127)	Completers (*n* = 92)	Dropout (*n* = 35)	Univariate analysis	
	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)	N	M (SD)/N (%)	M (SD)/N (%)	*p*	OR (95% CI)
Cocaine use score	251	0.5(1.89)	1.25(2.68)	.030	1.15(1.01, 1.3) *	113	1.19(2.8)	2.13(3.23)	.141	1.1(0.97, 1.26)
Alcohol dependence score	264	48.41(24.67)	56.64(25.46)	.038	1.01(1.01, 1.03) *	120	63.71(19.83)	67.94(19.79)	.294	1.01(0.99, 1.04)
Drug dependence score	264	47.99(27.81)	58.7(32.53)	.020	1.01(1.01, 1.03) *	120	70.35(18.63)	73.1(29.82)	.548	1.01(0.99, 1.03)
(4) Social-relational										
Community support	279					125				
Participation		15.47(4.73)	14.47(5.33)	.168	0.96(0.9, 1.02)		14.79(4.68)	14.15(5.37)	.509	0.97(0.9, 1.06)
Informal		19.35(4.33)	17.93(5.14)	.037	0.94(0.88, 0.99) *		19.87(4.2)	17.88(5.5)	.038	0.92(0.84, 0.99) *
Formal		15.19(3.8)	13.58(4.02)	.006	0.9(0.84, 0.97) *		14.88(4.34)	14(4.33)	.314	0.96(0.87, 1.05)
Intimate support	279	10.62(3.22)	10.46(3.24)	.729	0.98(0.9, 1.08)	125	9.86(3.25)	10.47(3.12)	.342	1.06(0.94, 1.21)
Stressful life events	279	2.72(3.06)	3.81(3.79)	.031	1.09(1.01, 1.19) *	125	3.35(2.87)	4.41(4.17)	.114	1.1(0.98, 1.23)
Social rejection	278	28.13(9.9)	31.71(9.65)	.017	1.04(1.01, 1.07) *	124	31.07(10.19)	34.06(9.95)	.149	1.03(0.99, 1.07)
(5) Attitudes toward IPV										
Responsibility attributed to the victim	279	12.91(4.28)	13.18(4.21)	.669	1.02(0.95, 1.09)	125	12.85(4.72)	12.97(4.17)	.892	1.01(0.92, 1.1)
Ambivalent Sexism	282					127				
Benevolent sexism		27.91(12.08)	29.72(11.31)	.301	1.01(0.99, 1.04)		28.92(11.6)	29.17(11.12)	.913	1(0.97, 1.04)
Hostile sexism		24.08(13.25)	29.5(12.49)	.006	1.03(1.01, 1.06) *		26.67(12.83)	30.71(12.81)	.117	1.03(0.99, 1.06)
Gender roles scale	277	22.44(7.71)	24.18(6.57)	.124	1.03(0.99, 1.07)	123	22.98(7.43)	24.64(7.15)	.269	1.03(0.98, 1.09)
Risk of IPV recidivism assessed by facilitators at pre-intervention	262	9.5(4.97)	11.73(4.78)	.006	1.09(1.03, 1.16) *	120	11.76(5.25)	12.67(4.73)	.399	1.04(0.96, 1.12)
Stage of change at pre-intervention	281	1.18(0.42)	1.26(0.52)	.225	1.45(0.8, 1.66)	127	1.29(0.5)	1.34(0.59)	.636	1.19(0.58, 2.5)

Note. Discrepancies in totals because of missing data; M = Mean; SD = Standard Deviation; OR = Odds Ratio; CI = Confidence Interval; AUDIT = Alcohol Use Disorders Identification Test; IPV = intimate partner violence; *p* < .05

The multiple regression model tested with the best fit which evaluated whether goal setting predicted lower dropout revealed that goal setting and having ADUPs were the two predictors of dropout that remained significant in the last step of the model (see Table 4). Specifically, participants who set a goal had 73% lower odds of dropping out than participants who did not set any goal. Participants with ADUPs had 123% higher odds of dropping out than participants without these problems. The model provided a good fit to the data and correctly classified 83.6% of the cases (see Table 4).

Table 4. Multivariate factors associated with dropout in intimate partner violence (IPV) perpetrators

	B	SE	Wald	p	OR (95% CI)
Model 1[a]: Full sample (*n* = 232)					
Goal setting	-1.30	0.39	11.28	<.001	0.27(0.13, 0.58) *
ADUPs	0.80	0.37	4.62	.032	2.23 (1.07, 4.64) *
Model 2[b]: Participants with ADUPs (*n* = 122)					
Goal setting	-1.61	0.50	10.54	.001	0.20(0.08, 0.53) *
Informal community support	-0.10	0.05	4.38	.036	0.91(0.83, 0.99) *
	Model 1[a]	*Model 2[b]*			
R^2 Nagelkerke	.108	.173			
Classification of model	83.6%	77%			
Pearson chi-square statistic (Hosmer and Lemeshow)	*p* = .425	.320			

a. Variables in Step 1: Goal setting, ADUPs, Impulsivity, Empathetic perspective-taking, Empathetic concern, Empathetic personal distress, Emotional decoding, Ager expression index, Schizoid, Depressive, Compulsive, Paranoid, Dysthymia, Somatoform, Major Depression, Delusional disorder, Informal community support, Formal community support, Stressful life events, Social rejection, Hostile sexism, Risk of recidivism.

b. Variables included in the model in step 1: Goal setting, Emotional decoding, Informal community support.

c. ADUPs = Alcohol and other Drug Use Problems; SE = Standard Error; OR = Odds Ratio; CI = Confidence Interval; *p* < .05

Participants with ADUPs

Among participants with ADUPs, a total of 35 (27.56%) dropped out of the intervention. Univariate factors that were significantly associated with higher dropout in participants with ADUPs included goal setting (i.e., goal setting was associated with lower dropout), lower emotional decoding performance and lower perceived informal community support (see Table 3). After applying the Bonferroni correction, where the planned error rate ($\alpha = 0.05$) was divided by the number of tests (k = 63), resulting in an adjusted *p*-value of .00079; only setting goals was a significant predictor associated with a lower likelihood of dropping out ($\alpha < .00079$).

The multivariate analysis that was conducted to evaluate whether goal setting was associated with lower dropout in participants with ADUPs while adjusting for variables *p* <.1 in the univariate analysis revealed that goal setting and informal community support were significantly associated with dropout. Participants with ADUPs who set a goal had 80% lower odds of dropping out than participants with ADUPs who did not set any goal. Moreover, for a 1-unit increase in the score on informal community support, the odds of dropping out decreased by 9%. The model fitted the data well. The classification of the model was found to be 77% accurate (see Table 4).

Discussion

This study examined the role of goal setting as a motivational strategy in intervention programs for IPV perpetrators to reduce dropout rates in a sample of IPV perpetrators and specifically those with ADUPs, who have been identified as a high-risk and highly resistant group of perpetrators (Expósito-Álvarez et al., 2021, 2023; Lila & Gilchrist, 2023). Results suggest that goal setting is an effective motivational strategy to reduce dropout rates in both the full sample of participants and those with ADUPs. This is of significant relevance concerning the well-documented link between dropout and IPV recidivism (Jewell & Wormith, 2010; Lila et al., 2019; Olver et al., 2011). To the best of our knowledge, this is the first study aimed at examining goal setting and its impact on an intervention outcome. An exception was the study conducted by M. Y. Lee et al. (2007), which showed that goal setting was associated with lower recidivism in a sample of men attending intervention programs for IPV perpetrators.

This study first explored participant baseline characteristics that were significantly associated with a higher likelihood of setting goals at intake. Univariate analyses revealed that being younger, having no children, having higher empathetic perspective-taking, higher scores on the hypomanic disorder and drug dependence subscale, greater perceived formal community support, higher perceived social rejection associated with the IPV conviction, lower hostile sexism, and gender roles beliefs, and being in a later stage of change were associated with goal setting. One possible explanation for why perceiving greater social rejection in relation to the participants' IPV conviction was associated with a higher likelihood of setting goals may be due to their increased self-awareness of their problematic behaviors and greater acknowledgment of the harm they have caused (Curwood et al., 2011; M. Y. Lee et al., 2014). This may be further indicated by their increased likelihood of being in a later stage of change, which could lead them to feelings of self-blame and shame. Only age (i.e., being younger) predicted a higher likelihood of setting goals after applying the Bonferroni correction. A plausible explanation for why younger perpetrators were more likely to set goals could be that they may be more receptive to guidance than older ones (Carl et al., 2020).

The multivariate analysis showed that the variables that remained in the last step to predict goal setting were being younger, having a higher score on the hypomanic disorder scale (this is, higher energy, excitement, and mood change), higher empathetic perspective-taking, and perceiving greater community support. This could be explained by the fact that empathetic individuals with higher levels of perceived community support may be better able to understand

the psychological and physical impact of their actions on their relationships and social network, which in turn may encourage them to work toward positive change (Romero-Martínez et al., 2019b). However, further research is warranted to replicate these findings as the specific factors and underlying processes that contribute to perpetrators' likelihood of engaging in goal-setting strategies have remained unexplored to date (Curwood et al., 2011; M. Y. Lee et al., 2007).

This study also showed that having an ADUP was not significantly associated with setting goals. This could be explained by the fact that the percentage of perpetrators setting goals was high (77.54%) so it is possible that many participants recognized the importance of setting goals and working toward behavior change, which could have influenced participants to set goals regardless of their substance use history. In this vein, substance use problems may not necessarily impede participants' ability to recognize the need for behavior change and set goals for achieving it (Alexander & Morris, 2008; Expósito-Álvarez et al., 2021).

To evaluate whether goal setting predicted lower dropout when adjusting for sociodemographic, individual, social-relational, and attitudinal variables in the full sample, we first analyzed which of these variables were significantly associated with dropout. Univariate factors significantly associated with lower dropout rates in the full sample of IPV perpetrators included goal setting, higher empathetic perspective-taking, empathetic concern, a higher score in compulsive personality disorder, and higher perceived informal and formal community support. In contrast, ADUPs, higher levels of empathetic personal distress, state anger, a higher score on major depression, schizoid, paranoid, delusional and somatoform personality disorders subscales, higher scores on the AUDIT, higher cannabis and cocaine use, alcohol and drug dependence, higher stressful life events experienced, higher perceived social rejection related to their IPV conviction, higher hostile sexism, and higher risk of IPV recidivism were significantly associated with higher dropout rates in the full sample of participants. These results help expand knowledge on several previously unexplored contributing factors for dropout from IPV perpetrator programs (e.g., sexism, social support, stressful life events) and align consistently with existing research showing that IPV perpetrators who dropped out were more likely to have mental health concerns (Daly & Pelowski, 2000; Richards et al., 2021), cognitive impairments (Romero-Martínez et al., 2019a), higher levels of hostility (Catlett et al., 2010) and anger (Bowen & Gilchrist, 2006), and a higher risk of IPV recidivism than completers (Lauch et al., 2017; Olver et al., 2011). When the Bonferroni correction was applied to interpret the results of the univariate factors associated with dropout, only goal setting predicted a lower dropout. Furthermore, the multivariate model revealed that the predictors of dropout that

remained significant in the last step of the analysis were goal setting and having an ADUP. This is consistent with previous literature showing that participants with substance use problems are more likely to drop out (Bowen & Gilchrist, 2006; Gover et al., 2011; Jewell & Wormith, 2010; Lila et al., 2020; Olver et al., 2011; Richards et al., 2021; Romero-Martínez et al., 2019a). Additionally, and in line with our results, several authors indicated that goal setting could be related to higher treatment engagement, as it promotes a safe, non-confrontational therapeutical alliance that may motivate participants to engage in the intervention (Bolton et al., 2016; Curwood et al., 2011; M. Y. Lee et al., 2003, 2007, 2014). Similarly, Muldoon and Gary (2011) stated that one "in the room" motivator (this is, a motivator for compliance with the intervention for IPV perpetrators) is the participant's readiness to change. In this line, a systematic analysis of the effectiveness of intervention programs for IPV perpetrators conducted by Waller (2016) indicated that the study which utilized goal setting (M. Y. Lee et al., 2007) showed the lowest dropout rates in comparison to other treatment modalities such as the Duluth model or standard cognitive behavioral therapy.

When focusing only on participants with ADUPs, this study showed that univariate factors significantly associated with lower dropout rates were setting goals, emotional decoding abilities, and informal community support. These results are consistent with previous literature showing that IPV perpetrators who had high alcohol use and dropped out of the IPV perpetrator intervention program were less accurate in decoding emotional facial cues (Romero-Martínez et al., 2019b). Following the Bonferroni correction, only goal setting predicted being less likely to drop out. The last step of the multivariate analysis revealed that setting goals and perceiving greater informal community support were significantly associated with lower dropout rates when adjusting for sociodemographic, individual, social-relational, and attitudinal variables in IPV perpetrators with ADUPs. These results support our expectation as goal setting was significantly associated with reduced dropout rates for both participants with ADUPs and the full sample. Our findings also extend the current literature on the risk and protective factors for dropout by providing evidence that informal community support was a protective factor for dropout in participants with ADUPs, which was previously unexplored as mentioned by Cunha, Silva, et al. (2022). Additional research is needed to confirm these results.

Strengths and limitations

As far as we are aware, this is the first study to analyze the impact of goal setting in reducing dropout rates while adjusting for other relevant variables at a multi-level scale both in the full sample and specifically in those participants with ADUPs, who have been identified as a high-risk, highly resistant group of perpetrators who present other associated risk factors (Expósito-Álvarez et al., 2021, 2023). Our results also addressed a gap in the literature by examining the differences between participants who set and did not set goals and extended knowledge of the risk and protective factors for dropout from an IPV perpetrator program. Some limitations should be considered when interpreting the results. One potential limitation of the study is that it relied on multivariate analysis to test whether goal setting was associated with dropout after adjusting for other variables. It remains important to note that the use of regression analysis does not necessarily imply causality between variables and that other underlying factors may need to be considered in future research to fully capture the complex and multifaceted nature of dropout from court-mandated intervention programs for IPV perpetrators (Jeon, 2015). Future investigations with larger sample sizes would not only strengthen statistical power but also offer a more comprehensive understanding of how a particular motivational strategy impacts the participants' intervention process. Qualitative research to explore the participants' motivations, perceptions and experiences that lead them to complete, drop out or set goals and promote change in intervention programs for IPV perpetrators may shed light on this complex phenomenon (Dheensa et al., 2022; McGinn et al., 2020). Additionally, the presence of missing data, which varied from 0 to 11%, due to participants' not completing some self-reported measures, requires cautious interpretation and consideration when generalizing findings. Moreover, given the specific context of our study on participants attending the intervention in Spain, it is important to acknowledge that the generalizability of our results to other intervention programs or countries may be limited. Further research in diverse contexts is required to reinforce the reliability of our results.

Implications for research and practice

Reducing dropout rates is one of the main challenges that hinder the effectiveness of intervention programs for IPV perpetrators (Cunha, Silva, et al., 2022; Olver et al., 2011; Richards et al., 2021). Findings from this study may have important treatment implications as they underscore the role of goal setting as an effective strategy in intervention programs to reduce dropout rates in IPV perpetrators and specifically in those with ADUPs, who tend to

present higher dropout and recidivism rates (Cafferky et al., 2018). This could potentially be helpful to advance knowledge on "what works best for whom", as the study is focused on a specific motivational strategy and seems to be also suitable for high-risk and highly resistant participants such as those with ADUPs. Our findings support the implementation and enhancement of goal setting in intervention programs for IPV perpetrators, which may help to design evidence-based specific treatment plans adjusted to participants' risks and needs (Lila et al., 2018; Romero-Martínez et al., 2019b; Santirso, Lila, et al., 2020). This is in line with the risk-needs-responsivity (RNR) model (Andrews & Bonta, 2010), which outlines the need for individualized approaches focused on assessment, motivation enhancement, and targeting of participants' risks and needs, and which has shown promising results in intervention programs for IPV perpetrators (Butters et al., 2021; Massa et al., 2020; Travers et al., 2021). Our results could also help inform facilitators to encourage participants to set goals to help them reduce their hostility towards the intervention and increase retention (DiClemente et al., 2017), which is of particular relevance to reducing IPV recidivism rates.

Conclusion

This study investigated the role of goal setting as a motivational strategy in intervention programs for IPV perpetrators. We identified several participant characteristics that made them more likely to set goals. Additionally, we found risk and protective factors for dropout both in the full sample of participants and in those with ADUPs. Tailoring the intervention program to address these factors could be of great importance considering that risk factors for dropout typically are the same as those for IPV recidivism (Jewell & Wormith, 2010). Further, the multivariate models in the present study revealed that goal setting predicted lower dropout rates when accounting for other relevant variables in IPV perpetrators, including those with ADUPs. Based on these results, goal setting can effectively reduce dropout rates in these participants. Previous research also showed that goal theory could be beneficial in facilitating change in IPV perpetrators with ADUPs, emphasizing the importance of intrinsic motivations and the role of setting goals in promoting motivation and retention (Dheensa et al., 2022; Gilchrist et al., 2021). These findings invite further design of new intervention plans which include goal setting to facilitate the enhancement of participants' personal goals attainment and increase treatment engagement. According to the Good Lives Model, goal setting could also help mitigate participants' risk of recidivism and foster their capacity for living meaningfully and purposely (Langlands et al., 2009; Ward & Gannon, 2006).

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Chapter 5: General discussion and conclusions

1. General discussion

This chapter builds upon the detailed findings presented in the previous chapter by synthesizing the key results of each study. It also provides a comprehensive overview of the main findings of this doctoral thesis, exploring their practical implications, acknowledging their limitations, and proposing future research directions based on the insights gained from each study. This culminates in the conclusions that summarize the overall contribution and significance of the thesis.

Study 1 aimed to identify the main risk factors and treatment needs of IPV perpetrators with ADAPs, by comparing a sample of men with and without ADAPs court-mandated to attend an intervention program for IPV perpetrators in four groups of potential risk factors: sociodemographic, personality disorders and psychological adjustment, social-relational and violence-related variables. Similarly, Study 2 aimed to systematically review studies analyzing the specific risk factors of men with ADUPs on entry to court-mandated intervention programs for IPV perpetrators. Study 3 examined the role of goal setting, as a voluntary motivational strategy in intervention programs for IPV perpetrators, in reducing the dropout rates in a sample of IPV perpetrators court-mandated to participate in such programs, and specifically in a subsample of IPV perpetrators with ADUPs.

1.1. Discussion on the risk factors and treatment needs of participants with ADUPs

The first and second studies of this doctoral thesis addressed objective 1, by identifying the specific risk factors for IPV and the treatment needs exhibited by men with ADUPs who were court-mandated to attend an intervention program for IPV perpetrators.

The first study of this doctoral thesis, titled "Risk factors and treatment needs of batterer intervention program participants with substance abuse problems", used a sample of 1,039 IPV perpetrators court-mandated to attend an intervention program for IPV perpetrators to compare participants with and without ADAPs in four sets of variables. Sociodemographic variables included age, educational level, income, employment, and immigrant status. Personality disorders and psychological adjustment were measured by examining various factors, including clinical symptomatology, personality disorders, anger, impulsivity, and self-esteem. Social-relational variables comprised community support, intimate support, stressful life events, and perceived social rejection. Lastly, violence-related variables examined were family violence exposure, perceived severity of IPV against women, ambivalent sexism, risk of recidivism, physical and psychological IPV, motivation to change, and stage of change.

Results were interpreted in terms of effect sizes. Comparisons of sociodemographic variables showed significant differences between participants with and without ADAPs for unemployment and proportion of immigrants (i.e., with negligible effect sizes) and age (i.e., with a small effect size). Specifically, IPV perpetrators with ADAPs were more likely to experience higher unemployment rates, have a lower proportion of immigrant individuals, and be younger compared to participants without ADAPs. This is consistent with the literature showing that young adulthood is a critical period for ADAPs (Expósito-Álvarez, 2023).

Concerning personality disorders and psychological adjustment, participants with ADAPs tended to present significantly higher levels of narcissist and paranoid disorders, anger state and lower self-esteem (i.e., with small effect sizes), higher clinical symptomatology, anger trait, anxiety and depressive disorder (i.e., with moderate effect sizes), and higher scores on impulsivity, antisocial, borderline and aggressive disorders (i.e., with large effect sizes). These results resonate with the spurious model (Leonard & Quigley, 1999), as these risk factors associated with poor mental health may have an impact on both ADAPs and IPV. In addition, the psychopharmacological effects of ADAPs may impair emotional and cognitive processing (Hanson et al., 2011).

As for social-relational variables, participants with ADAPs, compared to those without, tended to perceive significantly higher social rejection, lower community and intimate support (i.e., with small effect sizes) and a higher number of stressful life events experienced (i.e., with moderate effect sizes). These results are consistent with previous studies suggesting that individuals may use alcohol or other drugs to cope with negative feelings, such as loneliness, anxiety or stress (Hofmann et al., 2009; Russel et al., 2017).

Regarding violence-related variables, participants with ADAPs reported significantly higher levels of psychological IPV perpetrated, and a higher risk of future violence against partners and non-partners, compared to participants without ADAPs (i.e., with small effect sizes). This is consistent with literature linking ADAPs with a more severe IPV and a higher likelihood of IPV recidivism (Jewell & Wormith, 2010; Lila et al., 2020), thereby supporting the identification of participants with ADAPs as a high-risk and highly resistant group of IPV perpetrators who require special attention in intervention programs. Further, IPV perpetrators with ADAPs showed a significantly higher likelihood of family violence exposure during childhood, compared to those without ADAPs (i.e., with a small effect size). This echoes recent research showing the role of trauma and early exposure to violence in perpetuating subsequent

violent behavior and substance use (Fritzon et al., 2021; Rivas-Rivero & Bonilla-Algovia, 2022; Travers et al., 2022). Interestingly, participants with ADAPs showed higher motivation to change and were in a later stage of change than participants without ADAPs (i.e., with moderate effect sizes). One potential explanation for this finding is that the consequences of ADAPs may evoke feelings of guilt or shame, leading to a greater awareness of the need for change and increased motivation (Alexander & Morris, 2008). However, further research is needed to explore the mechanisms underlying this relationship. Overall, men with ADAPs court-mandated to participate in an intervention program for IPV perpetrators face greater mental health and social challenges compared to those without ADAPs, which may increase their likelihood of higher dropout and recidivism rates.

The second study of the doctoral thesis was a systematic review titled "Participants in court-mandated intervention programs for intimate partner violence perpetrators with substance use problems: a systematic review of specific risk factors". It aimed to identify the specific risk factors of court-mandated IPV perpetrators with ADUPs beyond issues strictly related to their substance use. After screening 3,995 records against eligibility criteria, 29 quantitative studies were included. The assessment of the risk of bias in the included studies showed that the overall methodological quality was adequate (see Study 2). Risk factors exhibited among IPV perpetrators with ADUPs were grouped into four categories: (1) sociodemographic variables, (2) personality disorders and psychological adjustment, (3) social-relational variables, and (4) attitudes towards women. In addition, four distinct subcategories emerged from risk factors related to personality disorders and psychological adjustment: (2.1) personality disorders, (2.2) clinical symptomatology, (2.3) executive functions, and (2.4) other risk factors.

With regards to sociodemographic risk factors, only six studies out of 29 examined the association between this group of variables and ADUPs among IPV perpetrators. Included studies often found non-significant differences between participants with and without ADUPs in sociodemographic variables. However, mixed results were found for age, immigrant status and marital status. Therefore, more research is needed to examine the role of sociodemographic variables on ADUPs among IPV perpetrators. For instance, research suggests that experiencing financial pressure or social disadvantage situations as a result of substance use may increase partner conflict and facilitate the occurrence of IPV (Gadd et al., 2019).

Personality disorders and psychological adjustment risk factors were by far the most investigated group of variables among included studies (i.e., 24 studies out of 29). With regards

to personality disorders, results revealed that IPV perpetrators with ADUPs showed significantly higher scores on borderline, antisocial, aggressive, anxiety, narcissist and paranoid personality disorders compared to participants without ADUPs. Regarding clinical symptomatology, the most salient risk factors were anger and impulsivity. Included studies consistently showed that participants with ADUPs were higher in anger and impulsivity levels compared to participants without these issues. This is consistent with previous studies showing higher levels of anger and impulsivity among IPV perpetrators with ADUPs, which may in turn increase the likelihood of IPV recidivism (Easton et al., 2008; Oberleitner et al., 2013; Stuart & Holtzwroth-Munroe, 2005). Further, included studies revealed higher levels of clinical symptomatology and trauma-related symptoms among IPV perpetrators with ADUPs compared to those without, including depression and suicide ideation. This systematic review also found lower levels of empathy (i.e., empathetic perspective-taking), self-esteem and distress tolerance, and higher emotion dysregulation among IPV perpetrators with ADUPs. These findings are consistent with theories explaining how ADUPs, mental health issues and IPV may interact. This interplay of factors includes the psychopharmacological effects of ADUPs on emotional and cognitive processes and the role of mental health issues in facilitating both ADUPs and IPV (Leonard & Quigley, 1999). Further, it is consistent with the entrenched substance use pathway developed by Gilchrist et al. (2022), which underscores that ADUPs may be used by IPV perpetrators as a coping mechanism to face emotional pain or self-medicate in response to dysregulated or unpleasant emotions. With regards to executive functions, IPV perpetrators with ADUPs showed higher mental rigidity, lower emotional decoding performance and worse performance on switching the attentional focus (i.e., higher executive dysfunction) than those without, suggesting possible alterations in cognitive processes underlying self-regulated behavior. These results are consistent with a recent meta-analysis conducted by Romero-Martínez et al. (2023), which showed that IPV perpetrators without ADUPs outperformed those with ADUPs on continuous attention performance. It also showed that IPV perpetrators, including those with and without ADUPs, displayed worse neuropsychological functioning compared to non-violent men. Other risk factors found in participants with ADUPs were greater pathological gambling and poorer coping strategies, such as higher levels of avoidance coping and lower problem-solving skills.

With regards to social-relational variables, having experienced more stressful life events and a history of childhood trauma were the most salient risk factors among IPV perpetrators with ADUPs found in this category. Research suggests that IPV perpetrators with unresolved

trauma may use alcohol or other drugs to regain a sense of control and power (Gilchrist et al., 2022; Øverup et al., 2015). In addition, findings from the systematic review showed that IPV perpetrators with ADUPs exhibited lower levels of intimate support than those without. Mixed results were found for perceived community support and social rejection, suggesting that further research is needed to examine the role of social support as a protective factor for ADUPs among IPV perpetrators (Cunha et al., 2022).

Concerning risk factors related to attitudes towards women, the most salient risk factor was responsibility attribution to the perpetrators' personal context, consistent with research showing that IPV perpetrators may use their ADUPs and other personal circumstances (e.g., financial pressure, anger management issues) as an excuse for their controlling and violent behavior towards women (Radcliffe et al., 2017). The rest of the factors analyzed in this category often showed non-significant differences between IPV perpetrators with and without ADUPs, which was consistent with Study 1 (Expósito-Álvarez et al., 2021). Further research is needed to examine how traditional gender role beliefs may impact IPV perpetration among men with ADUPs (Martín-Fernández et al., 2018).

Overall, included studies showed that participants with ADUPs exhibited significantly higher scores on variables assessing personality disorders and clinical symptomatology alongside diminished executive functioning, compared to participants without ADUPs. Among these traits, anger and impulsivity emerged as particularly prominent risk factors, with participants with ADUPs demonstrating notably higher levels compared to those without ADUPs. Furthermore, participants with ADUPs were more likely to have experienced stressful life events and childhood trauma history, in contrast to those without these issues. While limited attention has been given to socio-demographic risk factors and attitudes toward IPV in participants with ADUPs, the available studies yield mixed results regarding socio-demographic variables. Interestingly, no significant differences were often observed between the groups in terms of their attitudes toward women. Notably, individuals with ADUPs often attributed their violent behavior to issues related to their substance use. These results underscore the complex interplay between IPV and substance abuse and the need for future studies that elucidate the multifaceted nature of these associations.

1.2. Discussion on goal setting

The third study of this doctoral thesis was titled "Evaluating the role of goal setting in reducing dropout for men with and without substance use problems attending a court-mandated intimate partner violence perpetrator program". Goal setting served as a voluntary motivational strategy for participants to set personal objectives that resonated with their individual needs and desires. These goals were targeted both individually and in their group throughout their intervention process. The general objective of this study was to evaluate whether goal setting predicted lower dropout rates in IPV perpetrators and, specifically in those with ADUPs, court-mandated to attend an intervention program for IPV perpetrators. Therefore, this study addressed the objective 2 of this doctoral thesis. The specific objectives of this study were (1) examining whether participant baseline characteristics were associated with a higher likelihood of setting goals; (2) investigating whether ADUPs were associated with a higher likelihood of setting goals; (3) examining whether goal setting predicted reduced dropout rates in a full sample of participants and (4) among IPV perpetrators with ADUPs, after adjusting for socio-demographic, individual (e.g., mental health and substance use), social-relational, and attitudinal variables.

Univariate analyses were conducted to address the first research question, which revealed significant associations between baseline characteristics and participants' propensity for goal setting. Results indicated that participant characteristics significantly associated with the likelihood of setting goals included younger age, absence of children, elevated levels of empathetic perspective-taking, higher scores on the hypomanic disorder (i.e., increased levels of excitement, energy and mood swings) and drug dependence scales, stronger formal community support, perception of heightened social rejection linked to IPV conviction, reduced adherence to gender role beliefs and hostile sexism, and being in a more advanced stage of change. Based on these results, participants with greater motivation to change and increased self-awareness of their problematic behaviors, including drug use, and feelings of blame or shame associated with their IPV conviction may demonstrate greater introspection and acknowledgement of their need to work toward positive change (Curwood et al., 2011). When the Bonferroni correction was applied, only a younger age emerged as a significant factor predicting a higher likelihood of setting goals. The observed association between younger IPV participants and a higher propensity for goal setting might be partially explained by their greater openness to advice (Carl et al., 2020). When the multiple logistic regression was conducted, variables that remained in the last step predicting goal setting were being younger, showing

greater empathetic perspective-taking, higher scores on hypomania, and greater formal community support. Empathetic IPV perpetrators with greater perceived community support may acknowledge the impact of their violent behavior on their social network, which may enhance their willingness to change (Romero-Martínez et al., 2019c). Additionally, higher scores on hypomania may indicate a high level of energy and motivation that could be channeled into taking action and setting more goals for behavior change (McGinn et al., 2020). It is important to note that higher scores on MCMI-III scales (Millon, 2007) should not be directly interpreted as the presence of a personality disorder. Instead, such scores indicate increased tendencies toward specific traits, such as heightened energy or impulsivity in the case of the hypomanic scale. Indeed, the presence of a potential personality disorder requires scores above the 85th percentile and further clinical assessments (Millon, 2007). Moreover, the presence of Axis I psychopathology has been demonstrated as a barrier to eliciting change among IPV perpetrators individuals (Crane et al., 2014).

A univariate analysis conducted to explore research question 2 revealed that having ADUPs was not significantly associated with a higher or lower propensity for participants to set goals. One potential explanation for this finding is the high overall percentage of perpetrators who set goals. This suggests that many participants, regardless of their substance use history, recognized the significance of setting goals and initiating behavior change. Consequently, ADUPs may not inherently hinder the ability to acknowledge the need for change and establish goals for achieving it, aligning with both prior research on this population (Alexander & Morris, 2008), and the findings of Study 1 (Expósito-Álvarez et al., 2021).

To investigate whether goal setting predicted lower dropout rates in the full sample (i.e., IPV perpetrators with and without ADUPs) after adjusting for socio-demographic, individual, social-relational, and attitudinal variables (i.e., research question 3), univariate, logistic regressions were first conducted to examine the association of each factor with dropout. Several factors were identified that significantly decreased the likelihood of dropping out among the full sample of IPV perpetrators. Protective factors for dropping out of the intervention program included setting goals, elevated levels of empathy (i.e., empathetic perspective-taking and concern), higher scores on compulsive personality and stronger perceived formal and informal community support. Conversely, several risk factors for dropout were found within the full sample of IPV perpetrators. These included elevated levels of empathetic personal distress and state anger, along with higher scores on various personality disorders subscales, such as major depression, paranoid, schizoid, delusional and somatoform traits. Additionally, having ADUPs

significantly predicted a higher likelihood of dropout, including higher scores on the AUDIT, higher cannabis and cocaine use, and higher scores on alcohol and drug dependence subscales. This is consistent with burgeoning research highlighting ADUPs as a key risk factor for dropout among men court-mandated to attend intervention programs for IPV perpetrators (Jewell & Wormith, 2010; Lila et al., 2020; Olver et al., 2011). Interestingly, socio-demographic factors were not significantly associated with dropout (e.g., civil status, educational level, immigrant status). In this vein, a study conducted by Vargas et al. (2020), showed non-significant differences in dropout between Spanish and Latin American IPV perpetrators participating in Programa Contexto (Spain). However, a recent meta-analysis showed that younger age, being non-white ethnicity, and being unemployed significantly correlated with dropout (Cunha et al., 2024). Moreover, our results showed that experiencing more stressful life events, a higher perceived social rejection associated with their IPV conviction, endorsing higher levels of hostile sexism and having an elevated risk of IPV recidivism, were also associated with increased dropout rates in the full sample of IPV perpetrators. These findings aligned with prior research on the risk and protective factors for dropout and provided insight into several previously unexplored factors that may be influencing dropout from intervention programs for IPV perpetrators (Cunha et al., 2024).

When the Bonferroni correction was applied, only goal setting emerged as a significant protective factor against dropout. Additionally, the multivariate model revealed that variables in the last step of the analysis which predicted dropout were goal setting and having ADUPs. Specifically, participants who had ADUPs were 2.23 times more likely to drop out, while participants who set goals were 3.7 times more likely to complete the intervention program. These results underscore the positive role of goal setting as a motivational strategy that could be incorporated into intervention programs for IPV perpetrators and highlight the need to address ADUPs as a key strategy to reduce the elevated dropout rates found in these programs (Lila et al., 2020; Waller, 2016).

Research question 4 aimed to investigate whether goal setting also predicted lower dropout rates for participants with ADUPs. Simple logistic regressions revealed that setting goals, better emotional decoding performance and greater perceived informal community support were significantly associated with lower dropout rates. In this vein, a study conducted by Romero-Martínez et al. (2019b) showed that IPV perpetrators who had high alcohol consumption and dropped out from the intervention program had worse emotional decoding performance. When the conservative, Bonferroni correction was applied, our results showed

that only goal setting predicted lower dropout among IPV perpetrators with ADUPs. Moreover, the multivariate model revealed that participants with ADUPs who set goals were approximately 5 times more likely to complete the program compared to those who did not set any goals. Additionally, with each 1-unit rise in the informal community support score, the odds of dropping decreased by approximately 9%. Based on this result, informal community support could be considered a protective factor for dropout, which expands knowledge of this understudied variable within IPV perpetrators (Cunha et al., 2022).

Overall, goal setting emerged as an effective strategy to reduce dropout rates across the full sample of IPV perpetrators. Notably, our results further demonstrate its effectiveness in mitigating dropout risk among IPV perpetrators with ADUPs, a high-risk group of perpetrators more likely to dropout (Lila et al., 2020). One possible explanation for why goal setting could enhance treatment engagement could be that it promotes a non-confrontational therapeutic environment where participants can voluntarily choose personal objectives that hold significance for them (Expósito-Álvarez, Roldán-Pardo, et al., 2024). In this line, goal setting may encourage participants to play an active role in their own process of change, which may be relevant for court-mandated individuals who attend group-based programs that often follow a "one-size-fits-all" model approach that does not adjust their intervention to the specific needs of their participants (Bolton et al., 2016; Lee et al., 2014).

2. Practical implications

This doctoral thesis helped expand knowledge on the risk factors for IPV exhibited by court-mandated participants with ADUPs compared to those without. Additionally, it demonstrated the significant role of goal setting, a targeted motivational strategy, in mitigating the elevated dropout rates observed in intervention programs for IPV perpetrators, especially among those with ADUPs.

2.1. Risk factors and treatment needs

According to the results obtained in Study 1 and Study 2, participants with ADUPs, compared to those without, have a higher number of risk factors at multiple levels that require attention (e.g., higher levels of anger and impulsivity, higher clinical symptomatology, history of childhood trauma, etc.). Our findings have important treatment implications as identified risk factors could be translated into key intervention targets. Reducing ADUPs may not be sufficient to improve treatment outcomes, so addressing the underlying factors and treatment needs present in this high-risk and highly resistant group of IPV perpetrators may be critical to

improving treatment engagement among these participants and reducing their likelihood of IPV recidivism (Leonard & Quigley, 2017).

Adjusting intervention programs for IPV perpetrators to the specific risks and needs of their participants is consistent with the RNR model and the PEI (Andrews & Bonta, 2010; Radatz & Wright, 2016). As noted in Chapter 1, these principles emphasize the importance of conducting risk assessments and tailoring the intervention programs to the risks and needs of participants. The meta-analysis conducted by Travers et al. (2021) found promising results for interventions that adhered to these principles compared to traditional standard interventions that followed a "one-size-fits-all" model approach.

It seems clear that participants with ADUPs could benefit from this approach, as they have specific social and mental health needs beyond their substance use problems that require attention. Implementing evidence-based strategies to address these identified risks and needs could enhance participants' treatment engagement, improve their treatment outcomes, and help them build healthier and safer relationships.

2.2. Intervention proposals

Study 3 showed that goal setting may be a promising motivational strategy for reducing the elevated dropout rates of IPV perpetrators participating in a court-mandated intervention program for IPV perpetrators. Notably, goal setting also predicted lower dropout rates for participants with ADUPs after adjusting for other relevant variables. These findings hold significant importance as dropout rates, which are particularly high for IPV perpetrators with ADUPs, have been consistently linked in the literature as a key risk factor for IPV recidivism (Cafferky et al., 2018). Therefore, one of the main challenges highlighted in the literature for increasing the effectiveness of such programs is to reduce high dropout rates (Cunha et al., 2022; Richards et al., 2022).

Our findings have important treatment implications as they contribute to our understanding of "what works best for whom", as Study 3 demonstrated that goal setting could be effective for all IPV perpetrators as a specific motivational strategy to reduce their dropout rates and was also shown to be appropriate for participants with ADUPs. In addition, the study showed that ADUPs were a significant risk factor for dropout. Certainly, addressing ADUPs continues to be a primary focus for participants attending intervention programs for IPV perpetrators. In this vein, as mentioned in Chapter 1, integrated approaches that combine strategies to reduce ADUPs and IPV among IPV perpetrators with ADUPs have shown

promising results in improving the effectiveness of intervention programs, according to recent systematic reviews (Karakurt et al., 2019; Tarzia et al., 2020; Turner et al., 2023; Wilson et al., 2021) and RCTs (Easton et al., 2018; Mbilinyi et al., 2023; Murphy et al., 2018; Stuart et al., 2013). For example, implementing motivational strategies (i.e., motivational interviewing), to address the risk factors and treatment needs of participants with ADUPs, and encouraging them to set goals related to their ADUPs that will be worked on throughout the intervention in both individual and group formats, could help improve participants' intervention outcomes (Lila et al., 2018; Romero-Martínez et al., 2019c; Santirso, Lila, et al., 2020). However, integrated approaches to address both IPV and ADUPs are surprisingly scarce (Mootz et al., 2022). Further research is needed to evaluate whether the implementation of individualized motivational plans, tailored to ADUPs and their associated risk factors, could improve treatment outcomes in these participants, thereby increasing the effectiveness of intervention programs for IPV perpetrators.

Moreover, specific evidence-based strategies should be developed and implemented in intervention programs for IPV perpetrators to address the identified risks and needs of each participant beyond their substance use. For example, given that a history of trauma has been identified as a risk factor for IPV among perpetrators with ADUPs, trauma-informed approaches that focus on exploring trauma history, re-scripting childhood experiences, and expressing repressed emotional needs to promote self-regulation and trauma healing, may improve intervention outcomes (McKenna & Holtfreter, 2021; Gilchrist et al., 2022; Travers et al., 2022). In this regard, Karakurt et al. (2019), showed in their meta-analysis and systematic review that interventions that included trauma-informed approaches and substance-use components had improved results in reducing IPV recidivism than interventions without these components.

The most salient risk factors identified among IPV perpetrators with ADUPs were higher levels of anger and impulsivity. Specific intervention strategies could be implemented for those participants with higher levels of anger and impulsivity to improve their outcomes. For example, participants could be given cognitive rehabilitation homework to address their impulsivity (Romero-Martínez et al., 2021). Promising results have been shown in intervention programs that integrate anger management components and work on emotional distress, thereby promoting self-control and self-regulation (Gilchrist et al., 2015, 2021). In this vein, a study conducted by Finkel et al. (2009) showed that individuals with low self-regulatory resources who engaged in self-regulation-based activities, such as learning to recognize internal signs of anger and impulsivity, reduced their IPV perpetration. Homework activities aimed at reflecting

on how their aggressive behavior prevents them from meeting their own needs and desires may also be helpful for individuals with high levels of aggressive or antisocial personality disorders (Babcock et al., 2016).

With regard to social-relational risk factors, individuals with low social support may find value in engaging in activities that foster intimate environments conducive to sharing meaningful experiences within their social circles. In addition, mindfulness-based stress reduction activities may help participants cope with stress and increase their sense of calm (Nesset et al., 2020). In terms of attitudinal risk factors, individuals who hold sexist beliefs or excuse their violent behavior based on personal circumstances, such as their ADUPs or jealousy, may benefit from interventions aimed at reframing gender ideals and gendered power dynamics that perpetuate violence against women (Gilchrist et al., 2019).

Our findings can further inform policymakers about effective strategies to reduce IPV perpetration. This includes advocating for public funding of evidence-based intervention programs tailored to address the specific risk factors and treatment needs of IPV perpetrators. These programs should use evidence-based strategies, such as motivational strategies and goal setting, to help men develop skills to build healthy relationships free from IPV (Expósito-Álvarez, Gilchrist et al., 2024).

Overall, our findings have important treatment implications because they could help inform researchers, professionals and policymakers about the risk factors underlying IPV among participants with ADUPs, a high-risk and highly resistant group of IPV perpetrators who represent approximately 50% of all participants, thereby helping to reduce the risk of IPV recidivism and promote healthy, nonviolent relationships. Further, identified risk factors and treatment needs of participants with ADUPs can be translated into intervention targets that could be addressed through evidence-based strategies in intervention programs for IPV perpetrators (Leonard & Quigley, 2017). Tailoring such interventions to the participants' risk and needs has shown promising results over standard approaches (Travers et al., 2021). Integrating substance use components or strategies aimed at reducing ADUPs and their associated risk factors may also hold promise for increasing intervention effectiveness (Karakurt et al., 2019). In addition, while only 8.9% of program sessions of intervention programs for IPV perpetrators are focused on goal setting (Wong & Bouchard, 2021), our findings highlight the importance of incorporating goal setting as a key strategy to reduce dropout rates among IPV perpetrators, including those with ADUPs. This approach may

facilitate the design of evidence-based treatment plans tailored to individual risks and needs, thereby increasing intervention effectiveness (Lila et al., 2018).

3. Limitations

This doctoral thesis has certain limitations. First, Studies 1 and 3 used a sample of men convicted of IPV crimes to less than two years in prison, and with a suspended sentence on the condition that they attend an intervention program for IPV perpetrators in Spain. Therefore, results cannot be generalized to other populations, such as imprisoned men or men from different ethnic backgrounds. Moreover, the focus of this doctoral thesis was men who perpetrated IPV against a female partner, as this was the sample population recruited in the program. However, other types of partnerships may involve IPV (e.g., LGBTIQ+; Gilchrist et al., 2023; Liu et al., 2021), so that future research should be conducted that reduces heteronormative bias.

Second, Studies 1 and 3 mostly relied on self-reported measures, where social desirability may play a role in their responses. Due to Spanish legislation restrictions, intervention programs for IPV perpetrators are restricted from obtaining information that could identify victims and contact them (Lila et al., 2018). Consequently, this limitation hampered the ability of this doctoral thesis to incorporate victim-related data. Notably, information from the victim, such as participants' risk of recidivism, further IPV incidents, and any potential risk to children, could have offered valuable insights and enriched the risk assessment of the participants. Notwithstanding this limitation, a strength of this doctoral thesis is that it also relied on measures assessed by facilitators, such as participants' risk of recidivism, participants' stage of change, and their motivation to change.

Third, several methodological constraints require a cautious interpretation of results. For instance, both Studies 1 and 3 conducted several tests to assess the differences between participants with and without ADUPs or to examine the association between participants' characteristics and a dependent variable (goal setting or dropout). Although several statistical analyses were conducted to reduce the probability of Type I error (e.g., adjusted p-value, effect size estimators, Cohen's U_3 as a measure of practical significance, Bonferroni correction, and multiple regressions), further research should be conducted that mitigates the probability of both false positives (i.e., Type I error) and false negatives (i.e., Type II error) by carefully considering appropriate statistical approaches (Benjamini, 2010). Further, it is important to note that the analyses of risk factors for IPV among participants with ADUPs or regression analyses

predicting dropout do not necessarily imply causation. Instead, the identified risk or protective factors account for the likelihood of an event occurring. Future research is necessary to further explore the potential interactions between identified risk factors and ADUPs to understand how they may exacerbate IPV in the context of substance use. Furthermore, future studies should effectively address and control for any missing data.

Finally, the systematic review (Study 2) included studies with heterogeneous methodologies for identifying risk factors in IPV perpetrators with ADUPs (e.g., path analysis, simple comparisons, regressions). In addition, there was considerable variation in how ADUPs were defined and measured (e.g., ADAPs, alcohol use, and drug abuse) across studies. Therefore, caution should be exercised in interpreting the results, particularly when only a limited number of studies assessed a particular risk factor. In addition, future studies should be conducted that employ well-validated measures and adopt consistent definitions when investigating identified risk factors for IPV among participants with ADUPs. Despite these limitations, this doctoral thesis provides insight into the risk factors present in IPV perpetrators with ADUPs at a multilevel scale, which may help design evidence-based intervention strategies to address identified risk factors and encourage the use of goal setting as an effective intervention strategy to reduce dropout rates, thereby contributing to increasing the effectiveness of intervention programs for IPV perpetrators.

4. Future research directions

Studies 1 and 2 shed light on the risk factors present in men with ADUPs court-mandated to attend intervention programs for IPV perpetrators. Both studies were conducted within the framework of the ecological model (Heise, 2011), which allowed a multifactorial study of the risk factors (e.g., socio-demographic, individual, social-relational, and attitudinal factors). The systematic review demonstrated that while individual risk factors have received substantial attention (e.g., personality disorders, mental health issues, clinical symptomatology), other categories remain understudied, such as social-relational risk factors and those related to attitudes toward women and IPV. Therefore, more research is needed to improve our understanding of how several factors, such as victim-blaming attitudes, or lack of social support, play a role in exacerbating IPV among men with ADUPs (Martín-Fernández et al., 2018). Moreover, additional efforts are required to assess the effectiveness of intervention strategies tailored to address identified risk factors among high-risk and highly resistant participants, particularly those with ADUPs (Travers et al., 2021). This would help improve the

effectiveness of intervention programs for IPV perpetrators by making them more sensitive and responsive to participants' risk factors and treatment needs, aligning with the principles of the RNR model (Andrews & Bonta, 2010).

In Study 3, goal setting emerged as a promising motivational strategy for reducing dropout rates among IPV perpetrators, including those with ADUPs. While this finding contributes to the "what works best for whom" knowledge, further research is warranted to ascertain which intervention strategies, including goal setting and other motivational strategies, are effective in improving other treatment outcomes (e.g., motivation to change, risk of recidivism), as well as reducing IPV official recidivism. In this vein, rigorous research methodologies, such as RCTs, are needed to evaluate the effectiveness of integrated interventions targeting the reduction of ADUPs and their associated risk factors (e.g., anger, trauma, social support) among men participating in court-mandated intervention programs for IPV perpetrators (Expósito-Álvarez, Roldán-Pardo et al., 2024). Such efforts should be directed towards refining intervention models, that move beyond a "one-size-fits-all" approach to prioritize individualized treatments that resonate with participants, thus fostering meaningful engagement with program objectives (Butters et al., 2021; Cunha et al., 2024).

5. Conclusions

This doctoral thesis aimed at analyzing the risk factors and treatment needs of men with ADUPs court-mandated to attend intervention programs for IPV perpetrators and examined whether a specific motivational strategy (i.e., goal setting) helped reduce their higher likelihood of dropping out of the intervention program. As expected, participants with ADUPs, who represent approximately 50% of all participants, had a higher presence of risk factors at a multilevel scale, including risk factors at the socio-demographic, individual, social-relational, and attitudinal levels. Participants with ADUPs were also more likely to dropout, recidivate, and perpetrate more severe violence. Therefore, this group of IPV perpetrators require special attention, as improving their treatment outcomes could contribute to improving the effectiveness of intervention programs for IPV perpetrators.

Studies 1 and 2 aimed at answering the first research question on the main risk factors and treatment needs that court-mandated participants with ADUPs have in contrast to those without. Study 1 used a sample of 1,039 participants court-mandated to attend an intervention program for IPV perpetrators, while Study 2 was a systematic review which included studies analyzing potential risk factors in this high-risk and highly resistant population.

Taking both results together, at the socio-demographic level, mixed results were found for age, immigrant status, unemployment, and marital status, so further research is needed to evaluate the presence of specific socio-demographic risk factors in IPV perpetrators with ADUPs. The most salient risk factors at the individual level were higher anger and impulsivity levels. In addition, participants with ADUPs exhibited heightened clinical symptomatology and trauma-related symptoms and scored higher on several personality disorder scales, including antisocial, borderline, narcissist, aggressive, anxiety, depressive, and paranoid personality disorders. Additionally, this group of participants demonstrated lower empathy and self-esteem, and poorer executive functioning, when compared to those without ADUPs. At the social-relational level, participants with ADUPs presented lower intimate support, experienced more stressful life events, and were more likely to have a childhood trauma history than those without. At the attitudinal level, participants with ADUPs tended to place the responsibility for their violent behavior on their ADUPs (Expósito-Álvarez et al., 2021, 2023). Moreover, participants with ADUPs reported perpetrating higher psychological IPV and presented a higher risk of IPV recidivism toward partners and non-partners. This result is consistent with literature showing that IPV perpetrators with ADUPs are more likely to recidivate and perpetrate more severe violence (Cafferky et al., 2018; Lila et al., 2020; Jewell & Wormith, 2010).

Recent literature highlights the need to conduct risk assessments to tailor intervention programs to the specific needs and risks of IPV perpetrators, since this approach is showing promising results in intervention programs for IPV perpetrators (Butters et al., 2021; Massa et al., 2020; Travers et al., 2021). Our findings have important treatment implications as identified risk factors could be translated into relevant intervention targets that, if addressed, could improve the intervention outcomes of participants with ADUPs, thereby contributing to increasing the effectiveness of intervention programs for IPV perpetrators.

Study 3 aimed to answer the second objective, and investigated goal setting, a motivational strategy, in which participants voluntarily chose to set a relevant intervention target that could be worked on both in individual and group formats throughout the intervention program. Several participant characteristics were found to predict a higher likelihood of participants setting goals, including being younger, scoring higher on the hypomanic personality disorder scale, exhibiting higher empathetic perspective-taking, and experiencing greater community support. Moreover, this study showed that the main predictors for dropout were goal setting (e.g., goal setting predicted lower dropout) and ADUPs (e.g., having an ADUP predicted a higher likelihood of dropping out) in a sample of men who participated in an

intervention program for IPV perpetrators. Considering that IPV perpetrators often attend intervention programs as a result of a court-order or pressure from other services or the partner, thus with a low motivation to engage in treatment and change, this result may indicate that participants who set goals meaningful to them may have found an internal motive to change that, when guided and supported by facilitators and other group members, may have resulted in a higher treatment engagement and lower dropout rates. Moreover, as expected, IPV perpetrators with ADUPs were more likely to dropout, which highlights the importance of implementing strategies to promote engagement in this high-risk group of participants. When only those participants with ADUPs were selected in the analyses, the most salient predictors for dropout (i.e., protective factors) were setting goals and perceiving greater informal support. Notably, results demonstrated that those participants who set goals, including participants with ADUPs, were less likely to dropout, even after adjusting for relevant socio-demographic, individual, social-relational, and attitudinal variables. These findings have important practical implications as dropout has been consistently identified in the literature as one of the major risk factors for IPV recidivism, especially among perpetrators with ADUPs, who comprise approximately 50% of all participants (Olver et al., 2011).

Therefore, findings from this doctoral thesis encourage professionals working in intervention programs for IPV perpetrators to conduct risk assessments and tailor the intervention to the specific needs of high-risk perpetrators, such as those with ADUPs. Individualizing group-based interventions so that they resonate with participants' needs may improve their treatment outcomes. In addition, our results encourage professionals to include goal setting as a core strategy to reduce resistance to the intervention and reduce the likelihood of participants dropping out, which have been identified as two of the major challenges that interventions should address to increase their effectiveness. Further, goal setting may serve as a motivational strategy to address not only the reduction of ADUPs, but also the reduction of identified, associated risk factors, including trauma, impulsivity and anger management, social support and any other risk factor relevant to the participant. Thus, goal setting may serve as a tool to promote participants' internal desire to change in alignment with their values, which appears to be key to reducing their resistance towards the court-mandated intervention and increasing treatment engagement. Overall, these insights provide valuable guidance for intervention design and facilitation, ultimately contributing to more effective strategies for preventing IPV against women and promoting safer and healthier relationships.

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