Partner Abuse, Volume 7, Number 3, 2016

research

A Survey of Domestic Violence Perpetrator Programs in the United States and Canada: Findings and Implications for Policy and Intervention

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A 15-page questionnaire, the North American Domestic Violence Intervention Program Survey, was sent to directors of 3,246 domestic violence perpetrator programs (also known as *batterer intervention programs*, or BIPs) in the United States and Canada. Respondent contact information was obtained from state Coalitions Against Domestic Violence and from various government agencies (e.g., Attorney General) available on the Internet. Two hundred thirty-eight programs completed and returned the questionnaire, a response rate of 20%. The survey yielded descriptive data on respondent characteristics; program philosophy, structure, content, and service; client characteristics; treatment approach and adjunct services; and group facilitator views on intervention approaches and domestic violence policy and treatment standards. The programs varied in the extent to which they adhere to treatment approaches suggested by the empirical research literature. In addition, chi-square analyses were conducted on the associations between several factors. Significant correlations were found between respondent low level of education and adherence to a feminist-gendered program philosophy; respondent low level of education and use of a shorter assessment protocol; feminist-gendered program philosophy and

http://dx.doi.org/10.1891/1946-6560.7.3.226

incorrect facilitator knowledge about domestic violence; and feminist-gendered program philosophy and a program focus on power and control as the primary cause of domestic violence.

KEYWORDS: domestic violence; batterer intervention programs; policy; intimate partner violence

Partner abuse (PA), also known as *domestic violence*, is now recognized as a serious public health problem that includes physical as well as nonphysical forms of relationship aggression among dating, cohabitating, and married couples from all ethnic and cultural groups, of both opposite-sex and same-sex orientation (Hines, Malley-Morrison, & Dutton, 2013; West, 2012). Intervention policies are focused on providing services for victims, mostly women, coupled with a vigorous law enforcement response for perpetrators, mostly targeting men, that includes incarceration, probation, and mandatory participation in psychoeducational treatment programs commonly known as *batterer intervention programs*, or BIPs (Buzawa, Buzawa, & Stark, 2011; Shernock & Russell, 2012). On the whole, outcome research suggests that these perpetrator treatment programs are only moderately successful in reducing recidivism among offenders. Quasi-experimental design studies, using complex (but controversial) statistical tools such as Instrumental Variables Regression, have yielded the highest effect sizes (Gondolf, 2012). However, studies using a random assignment-to-conditions design indicate that although male perpetrators have a 40% chance of being nonviolent after treatment, this is only a 5% improvement over the 35% rate found among nontreated controls (Eckhardt et al., 2013). With very few exceptions (e.g., Carney & Buttell, 2006), outcome studies on programs for female perpetrators are virtually nonexistent.

Research scholars have suggested several explanations for the relatively modest reductions in recidivism rates. First, compared to related populations (such as general criminal populations and substance abusers), research on the treatment needs of partner-abusive individuals has been scant. Only recently has research moved away from outcome studies measuring overall program effectiveness to the particular characteristics of interventions across program models that may work for various client populations (Eckhardt et al., 2013), including, and most promising, the use of Motivational Interviewing and other client-centered approaches instead of harsh, authoritarian confrontations (Holmgren, Holma, & Seikkula, 2015). As the review by Babcock et al. (2016) indicates, there are numerous unanswered questions about BIPs and how they operate.

Second, the laws in most states that regulate perpetrator treatment programs are badly flawed, specifying intervention approaches not based on evidence from the social science research literature but rather on recommendations from victim advocacy organizations, such as the National Coalition Against Domestic Violence and affiliated organizations. Although no one disputes the importance of these groups in raising awareness about the problem of PA and advancing the needs of victims, their

understanding of perpetrator programs specifically—and the characteristics, causes, and consequences of PA as a whole—is limited at best and reflects a particularly rigid ideology which too often resists social science data that might challenge its basic premises (e.g., Corvo, Dutton, & Chen, 2008; Hines, 2014). Consequently, most state standards emphasize adherence to a "power and control" model of treatment, based on sociopolitical theories of patriarchy (e.g., the "Duluth" model), whereas discouraging alternative theories (e.g., cognitive-behavioral therapy [CBT] model) place equal or greater emphasis on a client's mental health issues and personality (Maiuro & Eberle, 2008). In addition, there is almost no consideration for ensuring that treatment is conducted in accordance to the treatment needs of each client, based on a thorough assessment. Rather, nearly all of the state standards specify one treatment approach of the same intensity and duration for all perpetrators regardless of abuse history, motivation, or other individual factors (Maiuro & Eberle, 2008), to be delivered within the mandated format of a same-sex group despite convincing evidence for the efficacy of couples therapy for low-moderate risk offenders (Eckhardt et al., 2013; Stith, McCollum, & Rosen, 2011). Clearly, intervention providers and policymakers involved with perpetrator programs would benefit from more accurate and reliable information on all aspects of PA, including perpetration rates, dynamics, effects on victims and families, in addition to treatment effectiveness.

SUMMARY OF RESEARCH ON PARTNER ABUSE

Rates of physical assaults among intimate partners have been measured extensively in the United States, occasionally as part of more general crime victimization surveys conducted by government agencies but mostly by social science research focused directly on family or relationship violence. Crime surveys find much lower rates of assaults overall, and a greater percentage involving female victims, and are not as reliable (Straus, 1999). According to the latest national crime survey conducted by the United States Department of Justice, in the year prior to the survey, 11% of men and 59% of women reported to have been victimized (Catalano, 2012). In comparison, the National Intimate Partner and Sexual Violence Survey, reporting on a sample of 5,365,000 men and 4,741,000 women, found past-year victimization rates for men to be at 4.5% for minor victimization (slapped, pushed, or shoved) and 2.0% for severe victimization (e.g., "hit with fist or something hard," "beaten"), and rates for women to be at 3.6% and 2.7%, respectively (Black et al., 2011), which translate to an annual rate of approximately 7.3 million male and 7.5 million female victims. In Canada, a national survey of cohabitating and married individuals determined that approximately 7% of women and 6% of men to have been victims of physical PA in the 5 years prior to 2004, with subsequent victimization rates remaining consistent, at 6% overall, between 2004 and 2009 (Sinha, 2013). Other research has found that in most abusive relationships, physical assaults are perpetrated by both partners (Langhinrichsen-Rohling, Misra, Selwyn, & Rohling, 2012) and initiated as frequently by the female as the male partner (Hamel, 2007).

Additional data on rates of physical partner violence (PV) in the United States, as well as a few from Canada and other English-speaking countries, comes from the literature review by Desmarais, Reeves, Nicholls, Telford, and Fiebert (2012a), who examined 249 peer-reviewed journal articles on PA victimization published between 1990 and 2012. Across all sample populations (national, regional, university, clinical, legal), on average, 24% of respondents said that they had been physically assaulted by an intimate partner at least once in their lifetime, with female victimization rates higher for females (23%) than males (19.3%). In a separate review, the same research team reported overall physical abuse perpetration rates of 25.3% (28% by females, 21.6% by males; Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012b). As expected, studies drawing on samples of clients enrolled in BIPs report higher rates than studies drawn from dating or general population surveys but with similarly comparable rates across gender (Elmquist et al., 2014; Feder & Henning, 2005).

The incidence rates of other forms of PA (emotional/psychological abuse, controlling and stalking behaviors, and sexual coercion) are far more frequent than those for physical assault, with 80% of individuals in the United States found to have experienced one or more of these during their lifetime based on studies from a variety of sample populations (Carney & Barner, 2012). As with rates of physical assaults, there are minimal differences across gender in incidence of emotional/psychological abuse and control, even among BIP samples (Hamel, Jones, Dutton, & Graham-Kevan, 2015; Kernsmith, 2005); however, women are significantly more likely to be victims of stalking and sexual coercion. When combined with physical assaults, a sustained pattern of emotional/psychological abuse and control is known alternatively as *battering* or *intimate terrorism* (IT). This type of abuse is far less prevalent than what Johnson (2008) termed *situational violence*. Based on Johnson's definitions, approximately 2% of men and 3% of women report to have been so victimized in Canada (Laroche, 2005). Gender differences for rates of IT appear to be less pronounced in the United States (Felson & Outlaw, 2007; Jasinski, Blumenstein, & Morgan, 2014). Nonetheless, the impact of physical PA, and to a lesser extent psychological/emotional PA, is greater on female victims, in terms of serious bodily injury requiring medical attention, fear, and mental health symptoms such as anxiety, posttraumatic stress disorder (PTSD), and clinical depression (Lawrence, Orengo-Aguayo, Langer, & Brock, 2012). Undoubtedly, the greater amount of fear experienced by female victims has some effect on abuse dynamics. However, the impact of female-perpetrated abuse on families, especially its correlation with aggression and other externalized symptoms among their children, should not be understated (MacDonnel, 2012; Sturge-Apple, Skibo, & Davies, 2012).

In sharp contradistinction to the gendered view of PA that currently informs policy and treatment, there is at best only a weak correlation with traditional gender-role beliefs and male-perpetrated relationship violence (Capaldi, Knoble, Shortt, & Kim, 2012; Sugarman & Frankel, 1996), although harboring attitudes supportive of violence are significantly correlated with physical PA by both genders. The risk factors most correlated with PV include low socioeconomic status, poor education, having experienced childhood abuse, current abuse of drugs and alcohol, and having

characteristics of an aggressive personality (Capaldi et al., 2012; Carney & Buttell, 2006; Henning, Jones, & Holford, 2003; Simmons, Lehmann, Cobb, & Fowler, 2005). These factors are essentially the same for men and women. Furthermore, research across sample populations, including BIPs, indicates that the need to dominate and control one's partner, widely assumed to be the major driving motive for perpetration of PA, is less significant than other motives, such as a desire to communicate and express feelings, retaliation, or self-defense, and differences across gender are quite minimal (Elmquist et al., 2014; Langhinrichsen-Rohling, McCullars, & Misra, 2012).

CHARACTERISTICS OF PERPETRATOR PROGRAMS

To account for the limited treatment effectiveness of BIPs, one must look for answers beyond the dearth of research and examine more carefully how perpetrator programs operate—both because of, and despite, the flawed standards imposed on them.

Previous surveys have investigated characteristics of perpetrator programs across the United States. The first of them, conducted in the early 1980s when BIPs were just beginning to proliferate, reported on small samples and low response rates, yielding data from 44 to 75 respondents (Eddy & Myers, 1984; Pirog-Good & Stets-Kealey, 1985; Roberts, 1982). These early studies provided very preliminary information, primarily on client demographics, intervention formats, and how and where programs operate (e.g., as a social service agency, private practice, or as part of a shelter). Two decades later, Dalton (2007) reported on a 44-item questionnaire of perpetrator programs administered in 36 states, including the District of Columbia. Completed questionnaires were received from 150 programs. The majority reported to be operating on their own and not part of a shelter, but 81% indicated that they found input from shelters to be "very" or "somewhat" helpful. The average program lasted a mean of 31.5 weeks, and the overwhelming majority of clients were referred through the judicial system. Of the 110 programs offering groups for women, 64 of them indicated that women made up less than 10% of their clientele. About a quarter (26%) of programs indicated that they provided differential treatment tracks based on an assessment of client history and risk analysis. Follow-up contact with clients, or attempts to track recidivism rates from any source, was made by a slim majority of programs, about 51.3%. A significant (and almost accidental) finding was

> the enthusiasm of the respondents, as evidenced by the many added comments on the questionnaires. Several wrote that research on this area was overdue and were eager to add their thoughts on the issue. Some were eager to use this survey as a means of sharing their knowledge with others. The lack of a national organization for BIP leaves each individuals program to solve problems on their own rather than learn from each other. (p. 69)

Subsequently, Price and Rosenbaum (2009) launched a more ambitious study, based on a database of 2,557 programs, of which 1,890 were contacted. Approximately 20% of

those contacted eventually responded, for a total completion rate of 276. The 57-item questionnaire covered program structure (modality, philosophy, length), facilitator characteristics, curriculum, confidentiality, victim contact, and program logistics (number of clients referred and gender, percentage of completers, relationship to the courts, how programs are financially supported, and outcome). Among the more notable findings,

- 82% of programs reported that more than 95% of their clients were served within the group modality.
- 53% described their philosophy as Duluth, 40% as CBT, and 26% as "therapeutic."
- Program length varied, with an average of 96-minute sessions over 31 weeks.
- Nearly three-quarters (71%) had at least one staff member with a master's degree, and 13% used reformed batterers as group facilitators.
- A third said that most of their groups were conducted by a male–female team.
- Only 10% provided treatment based on client needs, and 90% offered a one-size-fits-all curriculum.
- 55% included a substance abuse component in their curriculum, and 76% included anger management.
- Three-quarters contacted victims at least once over the course of treatment.
- Although 74% of programs reported to serve both male and female perpetrators, and 78% served lesbian, gay, bisexual, and transgender (LGBT) clients, the percentage of female clients actually served was only 10% and LGBT clients even less, at 1%.
- The percentage of court-mandated clients was between 89% (mean) and 96% (median).
- Slightly more than half of the programs said they collected outcome data, mostly at the conclusion of group.

THE PRESENT STUDY

The Price and Rosenbaum (2009) survey yielded a great deal of useful data, but we were interested in obtaining more in-depth information. For example, whatever their stated theoretical orientation, what specific interventions do they actually provide, and how do they deliver those services? Are the men and women who facilitate perpetrator groups adequately trained to treat a highly heterogeneous, resistant, and quite often pathological clientele? Are these treatment providers sufficiently knowledgeable about partner abuse? More important, how do they view their role as facilitators, and what is their relationship with the client? How many of these providers are satisfied with the limitations within which they operate, and what recommendations would they make if asked? The answer to these questions would be of enormous help in establishing more promising evidence-based policies.

METHOD

The North American Domestic Violence Intervention Program Survey (NADVIPS) was administered to BIPs across the United States and Canada. The survey was

administered electronically to 3,256 BIPs for which we have e-mail addresses and physical addresses. Any member over the age of 18 years was eligible to complete the survey. Because some BIPs have e-mail addresses and some physical addresses, we sent 546 e-mails and 2,710 letters of recruitment to each BIP. Programs were contacted using a recruitment letter asking whether they would like to participate by going online to complete the survey for which a link was provided. The survey was administered through the third party, Survey Monkey, to maintain anonymity of responses.

It is estimated that the number of noncontacts was approximately 64%. The response rate for mailings was 20%. Response rate was calculated using American Association for Public Opinion Research's (AAPOR) conservative estimate for noncontact rate for mailings, which is 65%. The rate could be higher given it took 3 years to compile our list of addresses and given the high turnover of BIPs, many may have already closed or moved (see Price & Rosenbaum, 2009). Using this conservative estimate, then, our survey garnered a 20% response rate (see AAPOR calculating guidelines). The response rate for e-mails was 45%. Of the 223 who opened the e-mail, 101 clicked on the link to the survey, resulting in a response rate of 45%. Three e-mails were sent in total over the course of the 3 months in which the survey was open online. Only those with the link were able to participate in the survey. Similar to the mailing addresses, although we sent 546 e-mails, it is probable that not all of them are active given the high rate of turnover in BIPs. In total, the survey was completed by 238 respondents.

The survey instrument (see Appendix A) was designed by the research team to ascertain what domestic violence BIPs were like across North America. To do this, the NADVIPS investigated facilitator demographics, client demographics, facilitator insights, and program logistics. The ultimate goal of this study was to improve our understanding of how BIPs operate on the ground. Equally important, we also hope that our findings will contribute to the development of policy recommendations intended to improve the quality and success of court-mandated interventions.

Quantitative data were analyzed to reveal descriptive statistics, whereas content analysis was performed on qualitative data to show key insights garnered from participants. Quantitative results are reported first, followed by qualitative results. All results are broken down into the following sections: program information, respondent demographics, program structure and content, program logistics, client demographics, facilitator characteristics, and facilitator insights.

We also conducted data analyses to determine the extent to which facilitator education requirements and respondent level of education are related to their understanding of research on domestic violence, their program philosophy, assessment and treatment approaches, and relationship to clients.

Quantitative Results

Results were broken down by section of the survey for ease of interpretation, as outlined earlier.

Program Information. Nearly half of the sample, or 48.4% of 238 respondents ($n = 93$) reported being part of a larger counseling or social service, followed by 28.6% ($n = 55$) who reported being part of an independent private practice, and 22.9% ($n = 44$) who reported being part of a battered women's shelter. Responses came from 36 different states. For a list of states and Canadian cities, see Appendix B.

Respondent Demographics. Among respondents, 45.0% ($n = 86$) were the director of the domestic violence perpetrator program, 43.4% ($n = 83$) were the director of the entire agency, and 41.9% ($n = 80$) were group facilitators. The mean age was 51.2 years ($SD = 13.38$), with the youngest respondent being 23 years of age and the oldest being 77 years of age; 61.8% ($n = 141$) were women and 38.2% ($n = 87$) were men. Respondents overwhelmingly self-identified as White (87.4%; $n = 188$). Another 6.5% ($n = 14$) identified as African American. Hispanic or Latino respondents accounted for 5.1% ($n = 11$), and American Indian or Alaska Natives made up 3.3% ($n = 7$). Asian was the least represented category at 0.5% ($n = 1$).

In terms of educational attainment, 59.4% ($n = 130$) of respondents had a Master of Arts (MA), Master of Social Work (MSW), or Master of Science (MS); 23.7% ($n = 52$) held a bachelor's degree; 7.3% ($n = 16$) had accumulated some college credits; and 5.0% ($n = 11$) held a Doctor of Philosophy (PhD), Doctor of Social Work (DSW), or Doctor of Psychology (PsyD). Respondents with associate degrees made up 3.2% ($n = 7$) of the sample.

Program Structure and Content. The vast majority of treatment for domestic violence perpetrators was delivered using group therapy 97.3% ($n = 183$), followed by 45.2% ($n = 85$) individual treatment, and 8.5% ($n = 16$) of programs reported using couples therapy. Only 4.3% ($n = 8$) of programs used family sessions and even less, 2.1% ($n = 4$), employed groups of couples to treat perpetrators.

Domestic violence perpetrator intervention programs provided several services and information for their clients attempting to provide a range of skills and tactics. Nearly all of the programs, 97.3% ($n = 181$), taught the effects of violence on children, followed by 94.6% of programs ($n = 176$) identified power/control tactics, developed communication skills, and related the impact of abuse on victims and 89.8% ($n = 176$) of programs attempted to teach clients to identify and manage emotions. The majority of programs taught conflict resolution skills with 88.7% ($n = 165$) focusing on this intervention, followed by changing proviolent and irrational thoughts 84.4% ($n = 157$), with raising consciousness about gender roles 83.9% ($n = 156$), and general coping skills 80.1% ($n = 149$). Furthermore, the majority of programs attempted to generate general self-awareness (78.5%; $n = 146$), to teach socialization factors (78%; $n = 146$), to develop anger and impulse control skills (75.3%; $n = 140$), and to cultivate an understanding of childhood experiences (70.4%; $n = 131$). Still important, but less than the earlier mentioned skills, programs identified a three-phase battering cycle (66.7%; $n = 124$), promoted assertiveness training (62.4%; $n = 116$), taught life skills (57.5%; $n = 107$), and provided meditation and relaxation exercises

(57.0%; $n = 106$). Finally, 48.4% ($n = 90$) of programs offered information and skills to heal from past trauma, identified mutual conflict cycles (40.9%; $n = 76$), and lastly, performed grief work (30.7%; $n = 57$).

The majority of the mentioned intervention services were usually provided through handouts and exercises (96.2%; $n = 178$) and/or during check-in time and discussion (94.1%; $n = 174$). Furthermore, services and information were disseminated 75.7% ($n = 140$) of the time through DVDs and/or audio files; 69.2% ($n = 128$) of the time in lectures; and 63.8% ($n = 118$) through role-play. Other services were also delivered through goal setting (58.9%; $n = 109$) and progress logs/journal writing (42.7%; $n = 79$).

The survey assessed the most important, primary treatment/intervention approaches to their program for their clients. Similar to Price and Rosenbaum's (2009) findings, we found that 35.6% ($n = 64$) of programs used the power and control, Duluth model, as their primary approach to treatment; followed closely by CBT as the primary mode of intervention among 29.1% ($n = 50$) of programs; and psychoeducational treatments as the primary mode of treatment was used by 16.7% ($n = 29$) of programs. None of the programs used 12-step, self-help/peer support, or psychodynamic approaches as their primary forms of intervention. The ability for respondents to rank 17 different treatment options provides a more nuanced view into the treatments they provide. For instance, 25% ($n = 42$) of programs used CBT as their second most used intervention, followed by 19% ($n = 33$) psychoeducational approaches as secondary approach, and 11.7% ($n = 21$) of programs reported using the power/control model secondarily. However, 10.5% ($n = 15$) of programs used narrative therapy secondarily (compared to 4.9% [$n = 7$] that used it primarily) and 8.4% ($n = 13$) of programs used client-centered approaches secondarily (compared to 5.8% [$n = 9$] that used it primarily). Moreover, Motivational Interviewing (7.6%; $n = 12$), solution-focused (7.1%; $n = 12$), and family systems (7.5%; $n = 11$) approaches were all used almost three times more in a secondary position to primary treatments.

The average length of the program was 30 weeks ($SD = 12.12$), ranging from 8 weeks to 78 weeks, with the mode for program duration being 26 weeks ($n = 178$). The average duration of each session was 103 minutes ($SD = 19.1$) with the mode for session duration being 120 minutes ($n = 184$); 96.7% ($n = 176$) of sessions met once a week. The average number of clients per session was 8 ($n = 166$). The number of clients per session ranged from 1 to 42, with the most frequent number of participants being 10. Nearly all of the programs in the sample (97.7%; $n = 166$) were outpatient-focused. Only 2.9% ($n = 5$) were inpatient, and 1.2% ($n = 2$) were located in prisons.

Average intake time took roughly 90–120 minutes. Programs surveyed have a range of intake/assessment procedures ($n = 180$). Some programs had a face-to-face interview, most programs did a risk assessment, reviewed documents from referrals, and went over the police reports (e.g., history of violence police report, a self-disclosure report). During such intake, often, programs assessed past incidents of violence, risk of substance abuse, family history, gathered information on lethality risk assessment, and ascertained motivation for treatment. At the same time, many programs informed the client about the program, logistics, curriculum, homework, and goals.

Some programs used the intake process developed in the Duluth model. Most programs discussed, in person or in written form, the events that brought the client to the program. Many programs used a "biopsychosocial" intake assessment process. Most respondents seemed to indicate a very thorough intake process in which as much information as possible was gathered about clients before they begin to group. Some respondents indicated a specific process or intake protocol (e.g., Duluth model, Arizona Department of Health Services intake form, Domestic Violence Inventory), whereas others wrote more generally of their program's process (e.g., biopsychosocial assessment). Only a handful of respondents ($n = 5$) said that their program only offered orientation to groups or otherwise provided a very limited intake.

Programs provided additional services to domestic violence perpetrators. Most commonly, programs provided crisis management (60.7%; $n = 91$), parenting classes (53.3%; $n = 80$), substance abuse counseling (50.7%; $n = 76$), educational resources (38.0%; $n = 57$), and community advocacy (24.7%; $n = 37$). Roughly 8%–12% of programs offered associated services such as mentoring, food, transportation, career services, housing, police/safety, and job training.

In more than half of programs, 56.4% ($n = 97$), facilitators of domestic violence perpetrator programs had contact with victims (e.g., at least once) before treatment begins. For 69.2% ($n = 119$) of programs, facilitators had contact with victims during treatment, 57.0% ($n = 98$) of programs reported facilitators had contact with victims after treatment was completed, and 47.6% ($n = 82$) of programs reported that facilitators of domestic violence perpetrator programs never had contact with victims. These programs, sometimes in conjunction with sister agencies, also offered services for victims. For instance, 73.8% ($n = 90$) of programs that responded offered mental health treatment, 62.3% ($n = 76$) offered peer support groups, 52.5% ($n = 64$) offered social service assistance (e.g., getting food stamps, child care), 47.5% ($n = 58$) offered some sort of legal assistance (e.g., obtaining restraining orders), 42.6% ($n = 52$) offered shelter beds, and 33.6% ($n = 41$) offered transitional housing.

Program Logistics and Client Demographics. Programs served on average 105 clients ($SD = 182.1$), with client totals ranging from 5 to 1,900. The majority of programs offered just English (40.3%; $n = 96$), followed by English and Spanish programs (13%; $n = 31$), and rounded out by only Spanish (2.1%; $n = 5$) and multilingual with more than three languages available (2.1%; $n = 5$). Still, other programs offered specific languages popular within the communities they serve (e.g., Russian, Turkish, Tagalog, Navajo).

Respondents were asked to provide percentages of the demographics of clients participating in their programs. Of all the programs that responded, 14% ($n = 122$) of clients were identified as female and 83% ($n = 130$) as male. In terms of sexual orientation, 3% ($n = 104$) of clients were identified as lesbian, 4% ($n = 98$) as gay, 1% ($n = 77$) as bisexual, 0% of transgender male to female and transgender female to male, and other sexuality, 90% ($n = 112$) of clients, were identified as heterosexual. Regarding race, 55% ($n = 123$) of clients were reported White, 20% ($n = 116$) reported

to be African American, 18% (n = 118) were Hispanic or Latino, 5% (n = 90) were Native American or Aboriginal, 3% (n = 91) were Asian, and 2% (n = 78) were identified as Other ethnicity. The majority, 75% (n = 95), of clients was located in urban areas. In terms of age, 2% (n = 96) of clients were identified as being younger than 18 years, followed by 20% (n = 115) of clients being between 18 and 24 years of age, 43% (n = 117) of clients are between the ages of 25 and 39 years, 21% (n = 114) of clients are between the ages of 40 and 54, 9% (n = 111) between the ages of 55 and 64 years, and 2% (n = 95) of clients are 65 years and older. Among programs that responded, they reported that clients that are unemployed made up 29% (n = 112) of their client population, 18% (n = 104) of clients worked part-time, 44% (n = 108) were employed full time, 3% (n = 88) were retired, 4% (n = 85) were students, and 2% (n = 88) were prisoners. Average annual income for clients were $23,962 ($SD$ = $11,110.573), with the lowest earning being no income and the highest being $70,000.

Clients were referred primarily through courts. Of the responding programs, 77% (n = 131) of clients were referred through the court system, 13% (n = 108) were referred through a social service agency or family court, 8% (n = 89) professionally referred, 6% (n = 95) enter voluntarily, 6% (n = 40) were referred through other means, and 4% (n = 73) were referred by family or friends.

Of the other service providers with which domestic violence intervention programs have relationships, responders rated the quality of that relationship: 75.2% (n = 106) of programs reported an excellent or very good relationship with the courts, with 14.9% (n = 21) of programs reporting a good relationship, and 9.9% (n = 14) reporting fair or poor relationships with the courts. Regarding social services, 68.9% (n = 93) of programs reported an excellent or very good relationship, 24.4% (n = 33) reported a good relationship, and 8.2% (n = 11) reported fair or poor relationships with social services. In terms of relationships with advocacy groups, 60.2% (n = 68) of programs reported an excellent or very good relationship with advocacy groups, 26.6% (n = 30) reported a good relationship, and 14.2% (n = 16) reported a fair or poor relationship with advocacy groups. Regarding behavioral health services, 54.3% (n = 63) of programs reported an excellent or very good relationship, with 31.9% (n = 37) reported a good relationship, and 13.4% (n = 16) of programs reported a fair or poor relationship with behavioral health services. The relationship breakdown for substance abuse programs was similar to behavioral health services with 56.6% (n = 67) of programs stating an excellent or very good relationship with substance abuse programs, 24.6% (n = 29) stating a good relationship, and 18.6% (n = 22) reporting a fair or poor relationship with substance abuse programs. In terms of relationships with shelters, 61.2% (n = 76) of programs reported having an excellent or very good relationship with shelters, 26.6% (n = 33) reported a good relationship, and 12.1% (n = 15) reported a fair or poor relationship. Relationship with law enforcement was comparable to that of advocacy groups with 58.3% (n = 74) of programs reporting an excellent or very good relationship with law enforcement, followed by 30.7% (n = 39) reporting a good relationship, and 11.8% (n = 15) of programs reporting a fair or poor relationship with law enforcement.

The frequency with which BIPs worked with these other social service agencies varied. For instance, 84.3% (n = 114) of programs responded that they always or often have contact with the courts. Similarly, 65.2% (n = 88) of programs responded that they always or often were in contact with social services, 43.6% (n = 51) reported they always or often have contact with advocacy groups, 40.8% (n = 49) are often or always in contact with behavioral health services, 40.7% (n = 50) are often or always in contact with substance abuse programs, 43.9% (n = 54) reported being in contact with shelters often or always, and finally, 51.9% (n = 68) of programs reported being in contact with law enforcement often or always.

Respondents approximated what percentage of program funding comes from different sources (e.g., funding from perpetrators, federal government, private funds). Of the programs that responded, the average estimate was 75% (n = 118) of funding came from the perpetrators themselves. Programs reported that approximately, on average, 20.1% (n = 68) came from state funding, 11.3% (n = 62) came from local government, 8.6% (n = 53) came from federal government, 7.0% (n = 51) came from private donations, 1.8% (n = 46) came from tribal governments, 1.3% (n = 46) came from foundations, and 14.8% (n = 52) came from other sources.

Facilitator Characteristics and Insights. Regarding educational requirements for facilitators at domestic violence perpetrator programs, 48.4% (n = 62) of programs responded that a bachelor's degree was required, 46.8% (n = 60) of programs responded that an MA or MSW was required to be a facilitator at the domestic violence perpetrator program. A minimum of an associate's degree 8.6% (n = 11), followed by 7.8% (n = 10) of programs requiring a high school degree, and 6.3% (n = 8) of programs required some college. Interestingly, less than 3.9% (n = 5) of programs required an advanced degree (e.g., PhD, DSW, or PsyD). Among the sample, 11.7% (n = 15) of responding programs had no educational requirements.

In terms of other specialized trainings typical of facilitators, respondents estimated that on average, typical facilitators had 30 hours of domestic violence training per year. Typical facilitators on average had 83 hours of mental health (not domestic violence related) training per year, 52 hours of case reviews and peer support, and 8 hours of other types of specialized training per year. On average, typical facilitators have 8 years of experience with a range from 0 to 30 years. Of programs that responded, the average number of female facilitators is four, and the average number of male facilitators is two. No other genders of facilitators were reported.

Facilitators were asked what they thought were the most important factors that cause domestic violence perpetration. From the results, 85.0% (n = 127) of programs indicated that the need to exercise power and control was very important and a factor resulting in domestic violence perpetration, followed by 73.2% (n = 93) of programs indicating violence and abuse in family of origin was a causal factor resulting in domestic violence. Fairly similar to the importance of family of origin was attitudes supportive of violence with 71.2% (n = 89) indicated as a factor resulting in domestic violence. Difficulty in managing emotions as a contributing factor of domestic violence

was 65.9% ($n = 83$), compared to 60.6% ($n = 77$) for poor communication and conflict resolution skills as cause of domestic violence. Similarly, coping skills was regarded by 52.8% ($n = 126$) of respondents as a very important cause of domestic violence. Just more than half of respondents (52.4%; $n = 66$) believe substance abuse is a very important factor in domestic violence perpetration. Linked with coping skills, 47.6% ($n = 60$) respondents said that poor anger management skills were a factor in domestic violence perpetration. Fairly close to poor anger management, 46.8% ($n = 59$) of programs reported that patriarchy was a very important factor. Just less than half of programs (45.6%; $n = 57$) responded that dependency on traditional gender roles was a very important factor. Past trauma as an important factor for domestic violence perpetration was reported by 41.3% ($n = 52$).

Interestingly, 54.8% ($n = 68$) of respondents believe that having an aggressive personality is somewhat important compared to 34.7% ($n = 43$) of programs that believe it is very important as a causal factor of domestic violence. Nearly one-third (33.6%; $n = 42$) indicated that having an abusive partner was a very important factor of domestic violence. Fairly similar is 32.5% ($n = 41$) that indicated that having mental health issues (such as depression) was a very important factor of perpetration, whereas 55.5% ($n = 70$) indicated that depression was somewhat important as a factor of domestic violence. Nearly one-fifth (21.6%; $n = 27$) of programs indicated that stress from unemployment or low income is a very important factor, whereas 58.4% ($n = 73$) reported that it was a somewhat important factor. Parenting stress as a factor of perpetration was regarded by 16.3% ($n = 20$) as a cause of domestic violence, whereas 60.2% ($n = 74$) reported it was somewhat important as a factor of domestic violence perpetration. Respondents indicated that 14.4% ($n = 18$) shaving faced oppression or discrimination was a very important factor, 57.6% ($n = 72$) reported that discrimination was somewhat important as a factor of domestic violence. Comparative to oppression, 13.6% ($n = 17$) of respondents believe poor education was a very important factor in domestic violence perpetration, with 48% ($n = 60$) signifying it was somewhat important. Work environment and work stress was reported as a causal factor by 10.5% ($n = 13$) as very important, with 51.6% ($n = 64$) indicating that it was somewhat important as a factor in domestic violence.

When asked whom they think most often initiates physical violence, 86.51% responded that men most often initiate physical intimate partner violence (IPV); 11.9% responded that males and females equally initiate physical IPV, whereas 0.79% responded that women most often initiate physical violence. When asked who initiates nonphysical forms of IPV most often, 42.74% responded that men most often initiate nonphysical forms of IPV, 33.87% responded that men and women equally initiate nonphysical forms of IPV, 18.55% responded that women most often initiate nonphysical forms of IPV; 71.17% responded that women felt the greatest impact of domestic violence, 27.93% reported that male and female victims equally felt the impact of domestic violence, whereas only 0.9% responded that men felt the greatest impact of domestic violence. When asked what is the most damaging kind of violence children can witness, 58.06% said that it did not matter which parent instigated violence,

whereas 37.0% reported it would be worse if a father hurt a mother and 0% said that it would be worse if a mother hurt a father. In the context of what persuades male perpetrators to abuse their partners, 80.3% (n = 94) of programs reported dominance and control; 17.1% (n = 20) responded the main reason for abuse is a way to express anger or other emotions or to communicate. A very small percentage indicated self-defense (1.7%; n = 2) as the major motivation for abuse. Interestingly, 0% of programs responded that retaliation was a motivating factor for men. When inquired what motivates women to perpetrate, 32.5% (n = 38) indicated self-defense, followed by 26.5% (n = 31) who believe women are motivated to abuse as a way to express anger or other emotions or as a means of communication. Domination and control was reported by 23.9% (n = 28) as a major motivation to abuse. Regarding retaliation, 13.7% (n = 16) indicated that women perpetrate IPV to retaliate for something their partner did.

Views on Program Improvement and State/Provincial Standards. Of those who responded, 84.1% (n = 95) of programs collected data on their domestic violence programs. Of these programs, 87.1% (n = 81) collected descriptive data (e.g., information from assessment such as age, ethnic background, crime history), 62.4% (n = 58) collected client satisfaction responses, and 45.2% (n = 42) collected outcome data on recidivism rates. Half (51.76%; n = 44) of the programs collected these data on a monthly basis. Just less than a third (32.9%; n = 28) of programs collected data quarterly, and another third of programs collected data yearly (31.7%; n = 27). Mostly, programs collected data on themselves (94.3%; n = 83), although 17.1% (n = 15) reported that outside researchers collected program data. When asked how satisfied with these data gathering processes, 27.7% (n = 28) of respondents indicated they were very satisfied compared to 13.7% (n = 14) as slightly satisfied.

Respondents, on average, estimated that 75.7% (SD = 17.68; n = 110) of clients completed the program after intake assessment. Respondents, on average, estimated that 10.6% (SD = 9.15; n = 85) of clients were arrested for domestic violence within 1 year of completion of the program.

Of those who responded, 86.1% (n = 93) indicated that treatment interventions were delivered according to a written curriculum, 63.9% (n = 69) of programs reported using treatment interventions adapted to fit the specific and various needs of their clients. Of these respondents, 41.7% (n = 45) responded that treatment interventions were the same for all clients regardless of ethnicity, race, gender, class, sexual orientation and identity, disability, religion, age, or religious status. Although the same percentage (41.7%; n = 45) reported that treatment interventions were developed specifically for various client needs and contexts, 18.5% (n = 20) responded that treatment interventions were not written but are used according to the agency's philosophy of treatment and expectations.

When asked how satisfied respondents are with the overall effectiveness of their program, 52.7% (n = 59) reported they were very satisfied, followed by 25.9% (n = 29) that stated they were moderately satisfied, and 20.5% (n = 23) said they were extremely satisfied.

When asked about their awareness of state standards, 83.9% ($n = 94$) responded that they had a very strong understanding of these standards. Interestingly, 4.5% ($n = 5$) responded that their state did not have any written standards. When asked about the adequacy of these state standards, 76.0% ($n = 60$) reported that they strongly agreed or agreed that the state standards adequately provided effective intervention for perpetrators; on the other side of the spectrum, 16.5% ($n = 13$) strongly disagree or disagree that state standards provided effective intervention for perpetrators. In terms of perpetration, 46.6% ($n = 34$) of respondents indicated that state standards provided effective intervention for female perpetrators, whereas 32.88% said they strongly disagree or disagree with state standards' ability to provide effective treatment intervention; 31.5% ($n = 23$) of respondents strongly agree or agree that state standards adequately provided effective treatment intervention for same-sex perpetrators, whereas 30.1% ($n = 22$) strongly disagree or disagree that same-sex perpetrators were adequately provided treatment interventions. For males, 82.8% ($n = 63$) of programs strongly agree or agree that state standards provided adequate intervention for male perpetrators, whereas only 11.8% ($n = 9$) strongly disagree or disagree with this assessment. When asked how faithfully respondents adhere to state standards, 59.6% ($n = 62$) reported they always adhere to these standards; 33.66% ($n = 35$) reported they often adhere to state standards. For more detailed analysis on views of state standards, see the results from content analysis performed on qualitative data in the following text.

Chi-Square Analysis. A set of chi-square tests was performed to test the differences between each of the four-study hypotheses. The *first research question* sought to examine the difference between the respondent's level of education, defined here as having less than a bachelor's degree, and which program frameworks he or she would employ (e.g., whether the respondent would endorse the "feminist approach" and "power control" [Duluth approach]; if they carried out a shorter intake/assessment procedure, endorse the "need to exercise power and control" and "patriarchy" as causes of domestic violence) as well as the respondent's viewpoint on who most often initiates IPV and why (e.g., who he or she thinks most often initiates physical violence against his or her intimate partner; who he or she thinks initiates nonphysical violence against his or her intimate partner; who he or she thinks is impacted the greatest by domestic violence; children who witness domestic violence are more likely to become perpetrators themselves later in life when they witnessed a certain type of violence; the reason they believe male perpetrators are motivated to abuse their partner; the reason they believe female perpetrators are motivated to abuse their partner; do the respondents agree that their current state standards on domestic violence provide effective treatment for perpetrators).

Results from the analysis indicated that when attitudes were measured (see previous text) against level of education, there were statistically significant differences between shorter intake assessment and views on patriarchy. Because respondents were able to choose multiple options for the frameworks and values they use within

TABLE 1. Chi-Square Results for Respondent's Level of Education

Variables	χ^2	*df*	Φ
Feminist approach	0.006	1	0.01
Power control (Duluth)	1.29	1	0.09
Intake assessment	4.464*	1	0.16
Need to exercise control	0.457	1	0.06
Patriarchy	8.282**	1	0.26
Initiate physical violence	0.228	1	0.04
Initiate nonphysical violence	0.235	1	0.04
Impacted greatest by domestic violence	3.936	1	0.19
Children who witness domestic violence	0.355	1	0.05
Reason males commit domestic violence	0.017	1	0.01
Reason females commit domestic violence	0.008	1	0.07
Support current state standards on treatment for perpetrators	0.773	1	0.10

*$p < .05$. **$p < .01$.

their treatment interventions, the following percentages do not add to 100%. The analytical strategy compared those without a bachelor's degree to those who have one (and more degrees) across different intervention attitudes and philosophies. At least 68% of respondents with less than a bachelor's degree had shorter intake assessment protocols (less than 90 minutes). This was compared to 45.3% of those with a bachelor's degree or higher that conducted a similarly shorter intake assessment protocol (less than 90 minutes). The difference is significant, $\chi^2 = 4.464$, $df = 1, p < .05$, $\Phi = .16$. The majority (90.9%) of respondents with less than a bachelor's degree endorse patriarchy as a cause of domestic violence compared to 45.4% of respondents with a bachelor's degree or higher endorsing patriarchy as a cause of domestic violence, $\chi^2 = 8.28$, $df = 1, p < .01$, $\Phi = .26$. By patriarchy, we mean the hierarchical advantage men have in our society and the ways that men access their dominant status in society to use power and control in their intimate partnerships (see Dobash, Dobash, Wilson, & Wilson, 1992). A detailed description of results is reported in Table 1.

In the *second research question*, we examined the difference between a respondent's level of education attainment, defined as less than a bachelor's degree, and motivations for IPV (e.g., whether one would endorse the feminist approach and power control [e.g., Duluth approach] carried out a shorter intake/assessment procedure; endorse patriarchy as causes of domestic violence; the respondent's viewpoint on who he or she thinks most often initiates physical violence against his or her intimate partner; who he or she thinks initiates nonphysical violence against his or her intimate partner; who he or she thinks is impacted the greatest by domestic violence; children who witness domestic violence are at risk to become perpetrators themselves later in life when they witnessed a certain type of violence; the reason they believe male

perpetrators are motivated to abuse their partner; the reason they believe female perpetrators are motivated to abuse their partner; and do the respondents agree that their current state standards provide effective treatment for perpetrators.

Results indicate that there were significant differences when a facilitators' education was measured against endorsing the feminist approach and reason for motivation among male perpetrators to abuse their partners. At least 71% of agencies where respondents have less than a bachelor's degree endorsed the feminist approach compared to 48.3% of agencies with facilitators with at least a bachelor's degree endorsed the feminist approach. The difference is significant, $\chi^2 = 3.547$, $df = 1$, $p < .05$, $\Phi = .22$. Nearly all respondents (93.8%) where the education attainment was less than a bachelor's degree at an agency reported they believed that males perpetrate as a form of domination and control. This is compared to 77.6% of facilitators at agencies where the educational attainment of facilitators are bachelor's degree or higher, $\chi^2 = 3.879$, $df = 1$, $p < .05$, $\Phi = .21$. See Table 2 for a detailed description of results.

With the *third research question*, we investigated the difference between facilitator endorsement of the feminist approach and other program logistics and philosophies (e.g., carried out a shorter intake/assessment procedure; endorse the need to exercise power and control and patriarchy as causes of domestic violence; the respondent's approach to (a) who he or she thinks most often initiates physical violence against his or her intimate partner; (b) who he or she thinks initiates nonphysical violence against his or her intimate partner; (c) who he or she thinks is impacted the greatest by domestic violence; (d) children who witness domestic violence are more likely to become perpetrators themselves later in life when they witnessed a certain type of violence; (e) the reason they believe male perpetrators are motivated to abuse their

TABLE 2. Chi-Square Results for Agency's Level of Education

Variables	χ^2	*df*	Φ
Feminist approach	3.547*	1	0.22
Power control (Duluth)	1.782	1	0.14
Intake assessment	0.345	1	0.07
Patriarchy	0.163	1	0.04
Initiate physical violence	0.057	1	0.03
Initiate nonphysical violence	0.978	1	0.10
Impacted greatest by domestic violence	0.491	1	0.08
Children who witness domestic violence	0.016	1	0.01
Reason males commit domestic violence	3.879*	1	0.21
Reason females commit domestic violence	1.453	1	0.13
Support current state standards on treatment for perpetrators	0.164	1	0.05

*$p < .05$.

partner; (f) the reason they believe female perpetrators are motivated to abuse their partner; and (g) do the respondents agree that their current state standards provide effective treatment for perpetrators).

Results indicate that there were significant differences when endorsement of the feminist approach was measured against endorsement of the power control (Duluth approach) and impact of violence on children when either "father on mother or mother on father violence is committed." Among respondents who supported the feminist approach, 89.3% of respondents also endorse the power control (Duluth approach) compared to 77.1% who do not endorse the feminist approach as their first approach. The difference is significant, $\chi^2 = 3.896$, $df = 1$, $p < .05$, $\Phi = .16$. Among those respondents who endorsed the feminist approach, 48% believe that the impact of violence on children is the greatest if they witness either partner initiating violence. Nearly three quarters (71.7%) of respondents who did not endorse the feminist approach as their first approach believe that the impact of violence on children is the greatest when they witness either father on mother or mother on father domestic violence. The difference is significant, $\chi^2 = 5.597$, $df = 1$, $p < .05$, $\Phi = .24$. See Table 3 for a detailed description of results.

In the *fourth research question*, we examined the difference between facilitator endorsement of the "power control approach" (Duluth approach) and attitudes (e.g., carried out a shorter intake/assessment procedure; endorse the need to exercise power and control and patriarchy as causes of domestic violence; the respondents approach to (a) who he or she thinks most often initiates physical violence against his or her intimate partner; (b) who he or she thinks initiates nonphysical violence against his or her intimate partner; (c) who he or she thinks is impacted the greatest by domestic

TABLE 3. Chi-Square Results for Respondent's Endorsement of the Feminist Approach

Variables	χ^2	*df*	Φ
Power control (Duluth)	3.896*	1	0.16
Intake assessment	1.694	1	0.13
Need to exercise control	0.731	1	0.09
Patriarchy	1.607	1	0.13
Initiate physical violence	0.004	1	0.01
Initiate nonphysical violence	0.010	1	0.01
Impacted greatest by domestic violence	0.022	1	0.02
Children who witness domestic violence	5.597*	1	0.24
Reason males commit domestic violence	2.679	1	0.17
Reason females commit domestic violence	0.063	1	0.03
Support current state standards on treatment for perpetrators	0.57	1	0.10

*$p < .05$.

violence; (d) children who witness domestic violence are at risk to become perpetrators themselves later in life when they witness a certain type of violence; (e) the reason they believe male perpetrators are motivated to abuse their partner; (f) the reason they believe female perpetrators are motivated to abuse their partner; and (g) do the respondents agree that their current state standards provide effective treatment for perpetrators).

Results from the analysis indicate statistically significant differences when respondents endorsed the power control (Duluth approach) and was measured against the respondent's (a) endorsement of the feminist approach, (b) respondent's view that males perpetrate as a need to exercise power and control, (c) respondent's view that the "impact of domestic violence is the greatest on females," (d) respondent's view that the "impact of domestic violence is greatest on children when they witness," and (e) respondent's view that "the reason males commit domestic violence." Among respondents who endorsed the power control (Duluth approach) as the primary method of treatment, 55.4% endorsed the feminist approach compared to 33.3% of those who did not use the power control approach as their primary approach who endorsed the feminist approach, $\chi^2 = 3.896$, $df = 1$, $p < .05$, $\Phi = .16$. The majority (89.3%) of respondents who chose the power control approach viewed the need to exercise power and control as a very important cause of domestic violence compared to 50% of respondents who did not select power control approach as their primary approach, $\chi^2 = 15.958$, $df = 1$, $p < .001$, $\Phi = .366$. Among respondents who ascribe to the power control paradigm, more than three quarters (77.0%) believe that the impact of domestic violence is the greatest on females compared to 40% of respondents who did not select power control paradigm as a primary approach, $\chi^2 = 8.652$, $df = 1$, $p < .01$, $\Phi = .29$. More than half of (53%) respondents who endorse the power control approach believe that the impact of violence on children is the greatest if they witness either father on mother or mother on father domestic violence. More than 81% of respondents who did not use power control approach as a primary approach believe that the impact of violence on children is the greatest when they witness either father on mother or mother on father domestic violence, $\chi^2 = 4.357$, $df = 1$, $p < .05$, $\Phi = .19$. The majority (85%) of respondents endorsing the power control approach answered men commit domestic violence to dominate and control. Those who used a different approach believed that 46% of men commit domestic violence as a mode to dominate and control, $\chi^2 = 10.555$, $df = 1$, $p < .01$, $\Phi = .31$. For more detailed description of results, see Table 4.

Qualitative Results

Facilitator Insights. When asked, "How would you deal with a client in your group who seems to be cooperating with the program but who remains quiet and rarely talks?" respondents gave varied responses ($N = 119$). The two most common suggestions were to schedule individual sessions and to ask participants direct, open-ended questions during group sessions. Another strategy was to ask clients why they were not talking during group, while respecting boundaries and defenses, developing trust,

TABLE 4. Chi-Square Results for Respondent's Endorsement of the Power Control (Duluth Approach)

Variables	χ^2	*df*	Φ
Feminist approach	3.896*	1	0.16
Intake assessment	0.038	1	0.02
Need to exercise control	15.958***	1	0.37
Patriarchy	2.837	1	0.16
Initiate physical violence	0.608	1	0.07
Initiate nonphysical violence	0.086	1	0.03
Impacted greatest by domestic violence	8.652**	1	0.29
Children who witness domestic violence	4.357*	1	0.19
Reason males commit domestic violence	10.555**	1	0.31
Reason females commit domestic violence	0.034	1	0.02
Support current state standards on treatment for perpetrators	3.490	1	0.21

*$p < .05$. **$p < .01$. ***$p < .001$.

and encouraging them to talk more. One strategy was to explain the importance of participating and talking during group to the rehabilitation process. Another strategy focused on the attitudes and beliefs of each member of the group. One respondent wrote, "We ask questions about attitudes and beliefs of everyone in the class, 'What's your opinion? Why did he say that? Why did he do that? What do you think he wanted the outcome to be?' etc." Yet, another tactic was to ask participants to share parts of their journal or other written material. Many respondents alluded to these written materials, making it seem that many programs require journal keeping among other written tools. Some used Motivational Interviewing techniques or a participation agreement. Although most reported that participants who do not speak up are subject to suspension, dismissal, homework, or a note is made in their file to the court about their lack of participation, others reported to have no consequences for quiet members. These responses indicate that facilitators have great discretion over how they handle such a situation.

When asked, "How do you deal with a client who is dominating the group by always wanting to talk, giving others his or her opinions without being asked?" respondents ($N = 119$) used key words such as *redirect*, *feedback*, and *encourage*. The most popular strategy was to redirect the client. The next most popular response was to model assertive behavior to show clients how to interact with others in the group, such that all parties' needs may be met while building boundaries and setting limits. Another common response was to schedule individual sessions to discuss the client's behavior. Another technique was to ask others in the group what they think and to encourage listening. One response was to call the client's attention to how talking a

lot during group can be a form of power and controlling behavior. They write, "Reflect on the tactic of flooding as a thinking error that can avoid responsibility and/or avoid being kind and loving, ask how that fits into controlling/hurtful behavior in a relationship. Perhaps have a direct confrontation in the group to address the issue and ask other class participants to give feedback on ways to be respectful and healthy in discussions." Similar to clients who do not talk very much, those who dominate the conversation were also subject to participation agreements and may be subject to suspension or dismissal from the group.

When asked, "How would you deal with a client who questions your program's approach or material or your position as group facilitator?" respondents ($N = 118$) answered most often that they provided the rationale for the program and curriculum, empirical evidence, and the benefits and successes of these approaches. Respondents shared many strategies with dealing with client questions. One strategy was to redirect the client's questions to the group and have the group respond to his or her concerns. Another one was to set up individual sessions to "strengthen understanding and connectivity." One approach was to remind the client that the sessions are not about the program or the facilitator but about the clients themselves. Respondents emphasized the research findings that support treatment philosophy. Other respondents redirected clients suggesting that such questions may be a form of power and control similar to the behavior that landed clients in the group. Another common strategy was to use a motivational interview interaction style in which the facilitator did not engage in power struggles but offered that the client can take or leave the material used in the course. Several respondents noted that clients' questions diminished after a few sessions (usually four to six) once the respondents believe they began to see the value in the program and curriculum. Respondents also said they would see the client in individual sessions. One facilitator commented that they asked the client what he or she does not like about the approach and what would be better for him or her. Some refer the client to the fact that often, materials were mandated by the state and the facilitator was required to cover certain topics and concerns. Sometimes, clients were encouraged to find another group that might be a better fit, although specifics on why the group fit and what group might be better were not provided. Another approach was to offer to meet clients before or after group to further discuss their concerns. In response to this survey question, multiple respondents gave their qualifications and professional requirements for leading the groups.

When asked, "How would you deal with a group where the members show support for a member who appears to not be taking responsibility for his or her behavior?" respondents ($N = 118$) answered that they would ask the group to hold each member accountable for their actions as a necessary and critical part of the therapeutic intervention. One strategy was to use taking responsibility as a topic of group discussion. Another strategy was to relate how being accountable was part of the program. Some facilitators addressed the group highlighting the negative consequences that can come from people not taking responsibility for their actions and being held accountable for their bad decisions. Similar to previous questions, one

common approach was that facilitators would have individual sessions, redirect the comment to other members of the group, and use an accountability contract.

When asked, "If a client tells you that the accusations against him or her were either false or exaggerated (e.g., says that his or her partner started the fight and that he or she was only acting in self-defense), what percentage of the time do you think the client is being truthful as opposed to minimizing/blaming the victim? Why?" respondents gave varied answers ($N = 118$). Respondents answered that they thought clients were being truthful from 4% to 20% of the time, with most respondents agreeing 5% of the time. Most respondents said that minimizing was always, at least a part, of this type of client behavior because it is for most people who attempt to rationalize their bad behavior. Strategies to address this issue involved redirecting clients' attention to their own behavior, thoughts, and feelings and focusing on what they could change (themselves). Another strategy was to remind clients of their accountability agreements or that accountability was one of the tactics they are to learn over the course of the program. One approach involved the group reminding each other of promoting change through accountability, although facilitators reminded the group that the program is not a court, and clients were encouraged to face their abusive behaviors without consequences associated with the courts.

To connect with a sense of accountability, another approach was to have clients recount the incident that brought them to group from the perspective of a partner or a child if present. Many respondents agreed that more clients denied accusations at the beginning of group and came to accept more responsibility for domestic violence incidents as the course progressed. Often, facilitators saw this form of denial as a means for the client to understand himself or herself as a victim in the process. One approach respondents identified was to use the client's narrative in combination with other sources of information, such as police reports, probation, child welfare information, and information from the client on other incidences. Several respondents ($N = 9$) thought the client could be telling the truth 50% of the time. One such respondent mentioned that they believe the client 50% of the time because of the "legal system around domestic violence and the sexism involved leaves no equality in some cases." Another noted that in their county, police exercise bias and assumed men were always the perpetrators of domestic violence. One respondent answered that this question was irrelevant because facilitators do not collude with clients in their victim blaming and always redirect the client to their own behavior and their part in the situation. Similarly, another respondent put it aptly,

> In the abuser's perspective, 100% accurate. That being the case, the goal is to inflict critical thinking about personal choice, patterns of harm leading to an incident, attitudes contributing to an event, and when/how the relationship started going downhill and how the abuse contributed to that. I am not a polygraph; I do not determine deception, my goal as a facilitator is to facilitate awareness, health, and respect. How I navigate that process is critical to creating safety and potential repairs to partners and children.

Views on State/Provincial Standards. When asked, "If interventions and/or programs are adapted or developed to fit the needs of clients, please specify for what population(s) and the specific ways they have been adapted or developed for these population(s)," respondents ($N = 77$) reported on several specific populations, including women; lesbian, gay, bisexual, transgender, and queer (LGBTQ); Spanish speakers; the illiterate; the deaf; as well as age-related groups (e.g., teenagers). Sometimes, religion was mentioned, in which case, programs attempted to use the language and lessons of religions to connect with clients. LGBTQ populations were the most common population for which specific interventions were made. Respondents said they created these specific interventions because LGBTQ groups may be far away or the population maybe relatively small. The most endorsed strategy was to make language of their program materials more gender inclusive. However, many respondents used the term men, male, and associated pronouns when discussing clients, revealing a de facto assumption about perpetrators as well as the majority of clients they assist. The second most common adaptation was to translate course materials into Spanish. Several respondents commented that the curriculum may be the same for everyone but that difference occurs within group meetings to address the specific concerns brought to group.

The most common approach to LGBTQ batterers was to meet individually with them instead of a group setting. Taken together, respondents' answers to this question revealed that depending on where the program was located greatly influenced what specific interventions they created. For example, one respondent answered that working with Native American populations, their program incorporated "native cultural traditions, beliefs, and strategies that do not include violence or abuse." Most respondents indicated that when there were groups available for women, groups were segregated by gender. In addition, some clients were required to attend other groups, such as Alcoholics Anonymous (AA). Some respondents mentioned they would incorporate fatherhood and parenting skills in their groups. One respondent commented that his or her group identified the typology of abuser and purpose of abuse to help the client deal with underlying emotional and personality issues. The majority of respondents indicated that all course materials were written to be very accessible so that all people, regardless of educational attainment level, could understand the principles and goals.

When asked, "Describe any training or strategies that facilitators receive/use to make treatment interventions culturally sensitive to the given population," respondents ($N = 81$) indicated a range of training of facilitators from annual training designed to promote cultural sensitivity to no additional training. Only a few respondents indicated that additional training was required to lead women and LGBTQ groups. One respondent said that they have a "Spanish men's program conducted by a Spanish facilitator." Respondents commented that because different cultures arise either in-group or as a group, then specific training would be conducted for that particular facilitator. The data indicated that there was strong support for cultural sensitivity with a wide range of responses to dealing with it, revealing that many agree

that cultural sensitivity was an important aspect of effective intervention. However, it was not clear what was meant by cultural sensitivity. Moreover, cultural interventions were not developed from a systematic model but rather were program- and context-specific. For those who mentioned they use the Duluth model, they noted there was a section on cultural sensitivity. Some states (e.g., Washington, Iowa) required cultural sensitive training to address sexism, racism, and homophobia and how these ideologies of oppression are related to domestic violence. Some cultural training came from the program itself, whereas other trainings occurred with other advocacy groups, probation departments, or the Association of Batterer Intervention Programs (http://www.abips.com).

When asked, "Describe any challenges facilitators have experience in making interventions relevant to treatment populations with respect to ethnicity and/or race, gender, class, sexual orientation and identity, disability, religion, age, or citizenship status," respondents provided a variety of answers ($N = 73$). Rural programs have consulted urban programs to help with issues of incarceration that their client populations have experienced. Programs acknowledged that sometimes they get Spanish translators to help with Spanish-speaking populations. Some programs referred gay and lesbian clients elsewhere because they did not have the resources to treat this population. Many respondents said that LGBTQ people were a challenge. One respondent put it thusly, "LGTB being in a heterosexual groups is hard for them to express openly." Respondents also mentioned that undocumented people posed a challenge. A respondent wrote, "With nondocumented, they qualify for less help and are less likely to come forward and seek help." One challenge identified by many respondents was to have a lot of diversity, along lines of race, class, sexual orientation, religion, age, and so forth, in the same group. Another challenge faced was inadequate resources to serve female perpetrators. One respondent mentioned wheelchair access. There was strong endorsement of the intergenerational cycle of violence being a major challenge in group work. Respondents commented that they used state-mandated curriculum with no variation across cultures. There was strong endorsement for financial resources being one of the greatest challenges. One respondent reported getting a batterer to accept responsibility for their actions. Another respondent noted that poor people frequently have great challenges with legal and child protective services. One respondent said the greatest challenge were cultural, religious ones (e.g., Muslim, different Christian denominations).

When asked, "Do you provide any LGBTQ-specific services? Please describe," ($N = 91$) most respondents said no ($n = 80$). Several programs would treat LGBTQ people in individual sessions; otherwise, LGBTQ people would be in the gender-segregated groups. Several respondents reported their programs adapted their curriculum to the LGBTQ population. Two programs were specially trained for LGBTQ populations.

When asked, "What LGBTQ-specific services would you like to see implemented?" respondents had several suggestions ($N = 67$). Most respondents said they would do nothing to create LGBTQ-specific services because it was "not realistic to create individual services for specific client populations." However, several respondents

offered strategies for dealing with LGBTQ-specific needs and services. One identified need and strategy was for greater outreach to the LGBTQ community to inform the community of the services available to them. Another need was for more aftercase services to help prevent reoffense. A couple of respondents mentioned a need for gender-neutral documents. The majority of respondents commented that the LGBTQ population was not large enough to warrant a group of its own and that there were no resources available to have such a group even if it were large enough. One respondent said that it was not safe enough in their particular location. Some programs refer LGBTQ clients to groups in bigger cities nearby (e.g., Portland, Chicago). A few respondents said that no specific services were necessary because violence was still about power and control. One respondent said LGBTQ facilitators would be a helpful service.

When asked, "What specific needs do you think LGBTQ clients need apart from the standard intervention?" ($N = 69$) the majority of respondents wrote none, too many, or do not deal with the population. A few respondents offered more specific suggestions. These included gender-neutral documents; a different curriculum; an LGBTQ-specific group; social support and support dealing with issues related to family of origin; more culturally diverse staff; address safety issues at the family, systems, and community levels; a need for facilitators to address and critique instances of homophobia and oppression by group members; acknowledgment that LGBTQ relationship dynamics were different from heterosexual ones; community response training for police and courts of the domestic violence that occurs in this community; addressing issues of judgments, stereotypes, stigmas, and societal oppressions more generally; ensure confidentiality; and address concerns and issues of safety.

When asked, "What do you think is most effective about your state's current standards?" respondents offered a range of viewpoints ($N = 82$). Several respondents said specifying what should be covered in the curriculum (e.g., standardization). There was strong support for enacting effective other requirements, including consistency in programs (e.g., mandated 52-week session), a multidisciplinary approach for containing perpetrators while promoting empowerment among victims, having to be kept informed of new interventions, conducting sound evaluations (not subjective), only counselors and therapists trained in batterer intervention are allowed to facilitate groups, a committee that reviews current standards and best practices, transitional housing funds, collaboration and communication between the BIP and referring agent, clear curriculum, focus on dynamics of power and control, evidence-based treatments, clearly define family violence law, use strengths-based approach, state standards are just a guide to developing responsive interventions, Duluth model, alternative treatment options, monitoring department of clients, and consistent reports. There was moderate support for making no changes to state standards.

When asked, "What do you think is least effective about your state's current standards?" answers varied ($N = 76$). Many responses included the singular focus on power and control, "which ignores research and female perpetrators." There was weak

to moderate support for the following aspects of treatment: Court monitors, or those assigned by the court to monitor client progress, did not know how batterer intervention works in practice, only in theory, and lacked the fundamental belief that abusers can change; did not take account the needs of female clients; 26-week program was too short; not recognizing that violence has multiple motivations; not recognizing the more varied populations (e.g., LGBTQ and prisoners) who need different curricula; extreme gender bias and lack of competency at the state level; not enough accountability of the providers; does not address female or same-sex perpetrators; lack of training of police officers, judges, and referring agents; lack of thorough assessment; one-size-fits-all approach; a failure to realize that funding goes to the agency not the perpetrators; not requiring victims to attend a victims class; neglects parenting; lack of focus of trauma as a cause; lack of understanding of the effectiveness of CBT; enforcement of state laws; challenges with compliance with standards; failure to counsel both perpetrator and victim together in addition to the BIP curriculum; judges do not have to follow the same guidelines; no consistent application of standards; length of treatment; lack of training; and does not consider typologies of abusers.

When asked, "What changes do you think should be made to your state's standards?" respondents offered several key suggestions ($N = 70$). Most respondents argued for gender-neutral language; getting rid of the one-size-fits-all models; reduce punitive tone of standards and not to treat program workers like criminals; and addressing co-occurring issues such as mental health, substance abuse, trauma, and communication. Aggregated responses indicated moderate to weak endorsement for the following: regular meetings between judges, program directors, probation department officials, and BIP personnel; more emphasis on female clients; 52-week minimum program length; increased prosecution rates; more absences to work with clients; more training hours (e.g., more than 40) for facilitators; make standards more flexible; address lack of standards; update standards to address new evidence, interventions, and female and same-sex perpetrators; develop a governing body for accrediting BIPs; make standards gender-neutral; better reporting and training; provide specialized treatment groups to address specific needs; get rid of standards and focus on training requirements for providers; required parenting and family/couples counseling; peer review and only professionally trained clinicians can facilitate groups; uniform court responses; better typology assessments; standards should be upheld and enforced by the courts; decrease emphasis on patriarchal models; and evaluation period after 16 weeks.

When asked, "Please describe how you supplement state standards," responses ($N = 73$) included add relevant topics, use a different model and supplement with state standards in a cursory way, and provide extra time as needed by clients. Most respondents supplemented state standards through educational materials used with clients; identifying, providing, or referring additional services needed by clients; discussion topics and activities created around concerns raised in group; discussion of trauma and Motivational Interviewing; and address co-occurring issues such as mental health disorders, substance abuse, anger/stress management, and

coping and communication skills. Aggregated responses indicate moderate support for the following supplements: use culturally appropriate ceremonies/rituals/traditions; use a variety of evidence-based, scientifically approved interventions; attend state meetings on domestic violence standards; providing progress reports to courts; bringing in other materials and theories (e.g., the Good Lives model or narrative strategies) that facilitator thinks may help; individual plans based on assessment needs; and because standards do not address same-sex perpetrators and adolescents, programs make their own choices regarding these populations. The least endorsed response was none; choice theory; embed parenting module in the curriculum; follow-up sessions with no added cost; allow clients to attend more than once a week depending on their work schedule; add parenting skills and cultural look at roots of violence beyond power and control; offer case management services; and attempt to accommodate economic needs with a sliding scale and referrals to programs for housing, employment, and substance abuse recovery. Several respondents reported their programs were not allowed to supplement state standards.

When asked, "Describe any ways this intervention program could be improved," respondents offered many suggestions ($N = 73$) ranging from Spanish-speaking facilitators, more grant money, greater integration for different models of adult learning, different motivations for domestic violence, and emotional regulation skills. The most common suggestion was more financial assistance and resources. Other suggestions included having subsidies other than from client fees; more female cofacilitators; couples counseling after completion of BIP; include female offender work; 52-week minimum, mandatory concurrent substance abuse counseling; better tracking recidivism rates; cooperation of the local supervising authority; develop female and LGBTQ curriculum; more interactions with other BIPs and more unified approaches for the state; increased victim advocacy and services for LGBT victims and survivors; better communication with victims and victims agencies; database of new information available to access for group ideas; different levels of treatment for different levels of domestic violence risk depending on the assessment; stronger negative consequences if not in compliance with program requirements; need both male and female facilitators as cofacilitators to model equality; provide victim classes in addition to perpetration classes; coed groups; state provided ongoing trainings and state-sponsored research and evaluation; enough funding for individual and group sessions; ending one-size-fits-all approach; having law enforcement, district, and county attorneys and judges attend sessions to see impact of program; more community involvement and holding legal system accountable; better referral system (e.g., "Better referral understanding. DA's still refer clients that they think 'aren't that bad' to anger management for 10 weeks"); judges enforce sentencing; more outreach education and awareness to referral sources; and better data collection and analysis.

When asked, "If you had unlimited resources, how would you design the most effective intervention program for domestic violence? Some questions to consider include the following: Would it be group/family/couple/individual focused? What, if any, other programs would be included? What would be the treatment approach and/

or intervention?" respondents offered many ideas (N = 86). Aggregated responses yielded strong support for the following suggestions including couples therapy, aftercare groups, a group for those who abuse their children; parenting classes specifically to domestic violence impact on family and community; CBT-based group and individual sessions with culturally specific responsive modules; group treatment focused on trauma, mental health, substance abuse, power and control, and relationship skills; and multidisciplinary approach with individual, group, and couples work. Aggregated responses showed weak support for the following suggestions to improve domestic violence intervention programs: housing; treat learning disabilities; offer lifestyle education, including food and exercise; more audiovisual aids; after successful BIP completion then couples and family counseling; have funding for indigent abusers; allow people to pay with community service hours (e.g., such as Emerge); stronger coordinated community response and more collaboration; graduate degree of MSW with focus in domestic violence; continue Duluth model with integrated substance abuse education into the curriculum; evaluate each client's risk and gather and incorporate more information from various law enforcement departments to develop a motivational evaluation; develop family systems program; specialized groups; case management; work readiness and life skills component; child care for parenting seeking treatment; same-sex groups; groups for victims; additional follow-up services for perpetrators as well as family services; Spanish-speaking groups; Motivational Interviewing training for all counselors; longer class; fatherhood program for offenders; and formal study of recidivism rates.

DISCUSSION AND CONCLUSIONS

This study has generated a great deal of data on BIPs across the United States and Canada. When comparing responses to items similar to those previously included in the survey by Price and Rosenbaum (2009), we found some changes in program philosophy and intervention approaches over the intervening 16 years between the two studies. Group remains by far the predominant treatment modality, despite research finding rates of mutual abuse around 60%, and the demonstrated safety and efficacy of couples counseling. However, current programs are somewhat less likely to endorse a feminist or Duluth model and less rigidly wedded to a one-size-fits-all curriculum. Still, the scope of our survey was broader than our predecessors', and our additional findings suggest that although there has been some progress toward evidence-based practice, that progress has been uneven because we make clear in answering the questions posed earlier in the introductory part of this article:

Whatever their stated theoretical orientation, what specific interventions do they actually provide, and how do they deliver those services? A high percentage of respondents endorsed interventions that have some support in the research literature. For example, although the most popular intervention, endorsed by 94.6% of programs, is helping clients identify power and control tactics, 89.8% teach clients ways to identify and manage their emotions, 88.7% teach conflict resolutions skills, and 84.4% help

clients change proviolent and irrational thoughts. Unfortunately, only 40.9% teach clients about mutual abuse cycles. As previously noted, respondents provide services almost exclusively in the modality of group. Nonetheless, the majority or programs deliver their services in a variety of ways besides the usual "check-in" and discussion time, for example, handouts and exercises, progress logs and journal writing, use of media, and role-play.

Are the men and women who facilitate perpetrator groups adequately trained to treat a highly heterogeneous, resistant, and quite often pathological clientele? Respondents, on average, have had 8 years conducting perpetrator groups and obtain 30 hours of continuing education training annually. The number of training hours is impressive, which is not necessarily indicative of the quality of training or its relevance to BIPs.

Are these treatment providers sufficiently knowledgeable about partner abuse? The short answer would appear to be "no." Nearly 50% of respondents believe that patriarchy is "very important" causal factor for IPV (it is not), whereas only about a third think that having an aggressive personality or being in an abusive relationship is very important; even less (21.6%) cite stress from low income or unemployment—all of which have been found to be among the most significant IPV risk factors. Although respondents correctly believe that women are more impacted than men by IPV and are mostly in agreement that violence by either parent on the other is harmful to child witnesses (both correct assumptions), respondents are far more predisposed to view men as the initiators of physical and psychological abuse and to assume that men's violence is driven by an intent to exercise power and control, whereas female-perpetrated violence is motivated in self-defense or as a means of expressing feelings—assumptions that are not supported by research. Such ignorance may have deleterious effects on treatment success.

A provider who, for example, facilitates female perpetrator groups and thinks women are generally victims, or that they are not motivated to control their partners, is at risk of colluding with his or her clients and putting her victims at further risk. The facilitator who is fixated on patriarchal views of IPV and its corollary assumptions about the instrumental nature of men's violence, and who minimizes the importance of unemployment stress, may be inclined to incorrectly view incidents of situational violence as evidence of typical power and control battering behavior. Similarly, the facilitator who is ignorant about mutual abuse is doing clients a disservice when he or she limits the discussion to Walker's three-phase battering cycle. Walker's model adequately explains unilateral IPV by an individual with traits of borderline personality disorder but fails to explain unilateral violence by antisocial batterers or is it useful for understanding bidirectional IPV. A client whose partner is equally abusive needs to understand the various ways that conflicts escalate *and especially needs to understand his or her own unique cycle*, because the skills needed to address each cycle are different (e.g., ending mutual abuse cycles requires practice in metacommunication) and because failure to properly assess a client's type of abuse jeopardizes the facilitator–client alliance (the client feels disrespected and misunderstood).

How do they view their role as facilitators, and what is their relationship with the client? Qualitative data from questions 20a–20e (how to deal with clients who don't talk, dominate, question the facilitator's role, support irresponsible behavior by other members, or dispute the IPV charges against them) indicate that, on the whole, respondents are capable of appropriately handling a variety of problems typical to groups. Respondents seem sincere in seeing clients as people rather than as criminals and favor an approach balances a need to maintain order while at the same time flexible enough to allow a variety of viewpoints and attitudes. A notable exception is the inclination of most respondents not to believe a client who insists he acted in self-defense. This finding is in line with the assumption, as stated earlier, that men are usually the initiators of IPV. Certainly, it might reflect a lack of knowledge about IPV rather than disrespect or insensitivity to client feelings. Nevertheless, this lack of knowledge does have the potential to undermine the therapist–client alliance, which has been proven to be one of the key factors predicting good treatment outcomes.

How many of these providers are satisfied with the limitations within which they operate, and what recommendations would they make if asked? We found a variety of views. About three quarters of respondents said they were "very satisfied" or "extremely satisfied" with the effectiveness of their programs, even though a high number of respondents (41.7%) deliver interventions that are the same for all clients regardless of ethnicity and/or race, gender, class, sexual orientation, and so forth. Most respondents, when asked, "What changes do you think should be made to your state's standards?" said they would like to see more use of gender-neutral language, an elimination of the one-size-fits-all models, a softening of the punitive tone of standards, and a more serious emphasis on co-occurring issues such as mental health, substance abuse, and trauma. On the other hand, 59.6% say they "always" faithfully follow state standards for intervention. Still, about half say they "often" or "always" supplement those standards.

Results of the data analysis are also revealing. In finding a statistically significant difference between respondent educational attainment and endorsement of patriarchy as the principal cause of IPV as well as endorsement of shorter assessment protocols, we argue that without advanced training in holistic social science, psychopathology and therapeutic approaches (e.g., learned in MSW or PhD programs), facilitators will default to the prevailing IPV paradigm—one that offers a simplistic set of interventions for which a proper assessment is regarded as superfluous and unnecessary. Treatment based on causal theory of patriarchy flies in the face of the empirical research literature. By failing to account for other causal mechanisms, such treatment is inherently limited, a dismissive of the needs of diverse treatment populations. This is apparent, for example, when assessing BIP treatment for LGBTQ clients because several facilitators argued for more inclusive, wider ranging approaches to same-sex IPV specifically, and all forms of IPV generally (see "Qualitative Results" section).

Relatedly, respondents in programs where the education requirement for facilitators is a bachelor's degree or less were more likely to embrace the feminist paradigm

and to believe that men, but not women, use power and control to dominate their partners. Our results indicate that this percentage dropped by almost half when facilitators held advanced degrees. Taken together, these two major findings highlight the importance of educational attainment on the program philosophy, and by extension assessment and intervention approaches, of BIPs across North America.

We found that those who subscribe to a feminist theory of IPV, like most other respondents regardless of theoretical orientation, agreed on the negative effects on children of witnessing any type of parental IPV. Put another way, facilitators believe that it does not matter which partner initiates violence to have a negative effect on children. These respondents, however, were also found to endorse the need to exercise power and control as the primary cause of IPV. As discussed here and elsewhere (see Cannon & Buttell, 2015; White & Dutton, 2013), this orientation limits providers ability to address most IPV, often known as *situational violence*, which is driven not by a power and control motive but rather by anger and poor impulse control, typically leading to mutual, escalated conflict.

In conclusion, this study has generated a wealth of data on domestic violence perpetrator programs as they currently operate in the United States and Canada. Although a large number of treatment providers do provide interventions that are supported by empirical research, treat clients with concern and respect, and are open to learning and applying new approaches, many are stymied by an insufficient knowledge base and adherence to outdated theories. Because BIPs serve as the primary treatment option for many individuals, and for nearly all individuals mandated by a criminal court, our findings deserve serious consideration by policymakers, intervention providers, and others involved in the collective efforts to create more effective programs holding perpetrators accountable and keeping victims safe. Readers interested in discussion of how our findings may inform the creation of evidence-based national standards of intervention may want to read Babcock et al. (2016). Accurate, up-to-date research on IPV can be accessed for free at www.domesticviolence.org. Treatment providers may wish to join the Association of Domestic Violence Intervention Programs, an international organization dedicated to evidence-based practice (www.battererintervention.org).

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Acknowledgments. We would like to thank the Wisner Center of Tulane School of Social Work, directed by Dr. Fred Buttell, for supporting this research.

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APPENDIX A. Tulane University/Association of Domestic Violence Intervention Programs

National Survey for Domestic Violence Intervention Programs Draft

Please fill out all the questions to the best of your ability. This survey is confidential. By using this survey, we seek to better understand the types of services provided so as to help in the effort to reduce domestic violence in our communities and keep victims safe. By returning this survey, you consent to this study. By filling out this survey you are automatically entered to win either an iPad mini, a gift card for $400, a book of your choice on family violence, or 7 continuing education hours from an online domestic violence course. Thank you for your participation. For any questions or comments please contact Fred Buttell (buttell@tulane.edu).

State/Province _____ County _____ Zip Code _____

1a. Please specify what type of agency you work for and where the domestic violence perpetrator treatment program fits into the agency.

a. Solo private practice ___
b. Part of a larger counseling or social service agency ___
c. Part of a battered women shelter ___
d. Other (specify) _____

1b. What is your position? *Check all that apply*.

a. Director of the entire agency ___
b. Director of the domestic violence perpetrator programs ___
c. A group facilitator ___
d. Other (specify) _____

Demographics of Respondent

2. What is your age?

a. 18–24 ___
b. 25–39 ___
c. 40–54 ___
d. 55–64 ___
e. 65+ ___

3. What is your gender?

a. Female ___
b. Male ___
c. Other ___

4. What is the highest level of education you have attained?

   a. Less than high school ___
   b. High school degree ___
   c. Some college ___
   d. Associate degree ___
   e. Bachelor degree ___
   f. Technical degree ___
   g. MA/MSW/MS ___
   h. PhD/DSW/PsyD ___
   i. MD ___
   j. Other (specify) _____

5. With which ethnicity do you identify?

   a. White ___
   b. African American ___
   c. Asian ___
   d. American Indian or Alaska Native ___
   e. Hispanic or Latino ___
   f. Other (*please indicate ethnicity*) _____

Program Structure and Content

6a. What modalities do you use to deliver treatment to domestic violence perpetrators? Please check all that apply.

   a. Group
   b. Individual
   c. Couples
   d. Couples groups
   e. Family

6b. What types of services and information does your program provide to domestic violence perpetrators? *Please check all that apply*.

Anger/impulse control skills ___	Identifying/ managing emotions ___	Meditation/ relaxation exercises ___	Identifying power/ control tactics ___
Communication skills ___	Conflict resolution skills ___	Assertiveness training ___	Identifying three-phase battering cycle ___
Identifying mutual conflict cycles ___	Changing proviolent/ irrational thoughts ___	Consciousness raising about gender roles ___	Socialization factors ___

Impact of abuse on victims ___	Effects of violence on children ___	Grief work ___	Understanding of childhood experiences ___
Healing from past trauma ___	General self-awareness ___	General coping skills ___	Life skills ___

6c. How are these services and information provided? *Check all that apply*.

a. Check-in time and discussion ___
b. Lectures
c. Handouts and exercises ___
d. Role-play ___
e. DVDs and/or audio
f. Goal setting ___
g. Progress logs/journal writing ___
h. Other (specify) _____

6d. What do you consider the primary treatment/intervention approach(s) that your program uses for perpetrators? *Please check all that apply and rank them in the order of their importance to your program (1 = most important, 2 = second important, 3 = third important, and so on)*.

Narrative therapy ___	Family systems ____	Cognitive behavioral therapy ___	Feminist ___
Power/control (Duluth) ___	Client-centered___	Psychodynamic ___	Solution-focused ___
Psycho educational ___	Motivational Interviewing ___	Trauma-focused ___	Strengths-based ___
12-step ___	Self-help/peer support ___	Social learning ___	Do not know ___
Other			

7a. How many sessions is the perpetrator treatment program? _____

7b. What is the average duration of each session?

a. 30–60 minutes ___
b. 60–90 minutes ___
c. 90–120 minutes ___
d. 120–150 minutes ___
e. 1501 minutes ___

7c. How often do sessions meet?

a. Twice a week ___
b. Once a week ___
c. Twice a month ___
d. Once a month ___
e. Other (specify) _____

7d. On average, how many clients are in a session? _____

7e. What is the setting of sessions?

a. Inpatient ___
b. Outpatient ___
c. Prison ___
d. Other (specify) ___

8a. How long is your intake/assessment procedure on average?

a. Less than 15 minutes ___
b. 16–30 minutes ___
c. 31–59 minutes ___
d. 60 minutes or more ___

8b. What does your intake/assessment procedure consist of? *Check all that apply*.

a. Oral interview ___
b. Administration of standardized questionnaires (please describe):

_____
_____
_____

9. What additional services do you provide to domestic violence perpetrators? *Check all that apply*.

Crisis management ___	Parenting classes ___	Substance abuse counseling ___	Mentoring ___
Career services ___	Transportation ___	Housing ___	Financial ___
Food ___	Clothing ___	Police/safety ___	Educational resources ___
Job training ___	Employment ___	Community advocacy ___	

10a. What services does your agency offer for victims? *Check all that apply*.

a. Shelter beds ___
b. Peer support groups ___
c. Mental health treatment ___
d. Legal assistance (e.g., with restraining orders) ___
e. Transitional housing ___
f. Social service assistance (e.g., in getting food stamps, child care) ___
g. Other (specify) _____

10b. Please indicate the approximate number of occasions perpetrator program facilitators have contact with victims during the following treatment periods (e.g., one time).

a. Never ___
b. Before treatment ___
c. During treatment ___
d. After treatment ___

Program Logistics

11a. Approximately, how many perpetrators does your program serve?_____

11b. Please list the languages in which you provide services. _____

12. Please provide *percentages* for the demographics of client population.

Gender: a. Female ____% b. Male ____% c. Other ____%
Sexuality: a. Heterosexual ____% b. Lesbian ____% c. Gay ____% d. Bisexual ____% e. Transgender male to female ____% f. Transgender female to male ____% g. Other _____%
Ethnicity: a. White ____% b. African American ____% c. Asian ____% d. Native American/Aboriginal ____% e. Hispanic or Latino ____% f. Other (specify) _____%

Locale: a. Rural ____% b. Urban ____%
Age: a. Younger than 18 ____% b. 18–24 ____% c. 25–39 ____% d. 40–54 ____% e. 55–64 ____% f. 65+ ____%
Employment: a. Unemployed ____% b. Part time ____% c. Full time ____% d. Retired ____% e. Students ____% f. Prisoners ____%
Please estimate average annual income of client population $_____ per year

13. Approximately what percentage of clients is referred to services through the following methods?

    a. Professional referral ____%
    b. Family/friend referral ____%
    c. Voluntary ____%
    d. Court-mandated ____%
    e. Social service agency or Family Court ____%
    f. Other (specify) _____%

14. Which other services do you have relationships with? *Please check all that apply*.

Service	**Quality of relationship**	**Frequency of contact**
Courts ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___
Social services ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___

Advocacy groups ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___
Behavioral health ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___
Substance abuse counseling ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___
Shelters ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___
Law enforcement ___	a. Poor ___ b. Fair ___ c. Good ___ d. Very good ___ e. Excellent ___	a. Never ___ b. Rarely ___ c. Sometimes ___ d. Often ___ e. Always ___

15. Approximately what percentage of program funding comes from the following sources?

    a. Perpetrator ____%
    b. Government: Federal ____% State ____% Local ____% Tribal ____%
    c. Private donations ____%
    d. Foundations ____%
    e. Other (specify) _____%

Facilitator Characteristics

16a. What are the educational requirements for facilitators of domestic violence perpetrator treatment at your agency? *Please check all that apply*.

a. No educational requirements ___
b. Less than high school ___
c. High school degree ___
d. Some college ___
e. Associate degree ___
f. Bachelor degree ___
j. Technical degree ___
h. MA/MSW ___
i. PhD/DSW/PsyD ___
j. MD ___
k. Other (specify) _____

16b. What is the typical level of educational attainment for facilitators? *Please check all that apply*.

a. Less than high school ___
b. High school degree ___
c. Some college ___
d. Associate degree ___
e. Bachelor degree ___
f. Technical degree ___
g. MA/MSW ___
h. PhD/DSW/PsyD ___
i. MD ___
j. Other (specify) _____

16c. What other specialized trainings does the typical facilitator have? *Please indicate number of hours per year. If none, write "0."*

a. Domestic violence specific. Hours per year ____
b. Mental health—not domestic violence related. Hours per year ____
c. Case reviews and peer support. Hours per year ____
d. Other (specify) _____

16d. How many years of experience does the typical facilitator(s) in your program have? _____

17. Please identify the number of intervention facilitators by gender.

    a. Female ____
    b. Male ____
    c. Other ____
    d. Not applicable ____

Facilitator Insights

18. When thinking about causes of domestic violence, what do you think are important factors? *Rate each according to their importance*:
    1 = Not all important
    2 = Somewhat important
    3 = Very important

Poor self-esteem ___	Need to exercise power and control ___	Poor anger management skills ___	Difficulty managing emotions ___
Patriarchy ___	Dependency on others ___	Traditional gender roles ___	Past trauma ___
Violence/abuse in family of origin ___	Mental health issues (e.g., depression) ___	Poor self-awareness ___	Having an aggressive personality ___
Other personality issues___	Poor communication/ conflict resolution skills ___	Poor general coping skills ___	Exposure to negative peer influences ___
Substance abuse ___	Attitudes supportive of violence ___	Having an abusive partner ___	Work/environmental stress ___
Having faced oppression/ discrimination ___	Poor education ___	Unemployment/ low-income stress ___	Parenting stress ___
Other _____			

19a. Who do you think most often initiates physical violence against their intimate partners?

    a. Males ___
    b. Females ___
    c. Males and females about equally ___
    d. Don't know ___

19b. Who do you think most often initiates nonphysical forms of violence against their intimate partners?

a. Males ___
b. Females ___
c. Males and females about equally ___
d. Don't know ___

19c. The impact of domestic violence is greatest on who?

a. Male victims ___
b. Female victims ___
c. Male and female victims about equally ___
d. Don't know ___

19d. Children who witness domestic violence are more likely to become perpetrators themselves later in life when they witnessed what type of violence?

a. Father on mother ___
b. Mother on father ___
c. Either father on mother or mother on father ___
d. Don't know ___

19e. In general, male perpetrators are motivated to abuse their partners for what reason?

a. To dominate and control ___
b. As a way to express anger or other emotions or communicate ___
c. In self-defense ___
d. To retaliate for something their partner did ___
e. Don't know ___

19f. In general, female perpetrators are motivated to abuse their partners for what reason?

a. To dominate and control ___
b. As a way to express anger or other emotions or communicate ___
c. In self-defense ___
d. To retaliate for something their partner did ___
e. Don't know ___

20a. How would you deal with a client in your group who seems to be cooperating with the program but who remains quiet and rarely talks? _____

20b. How do you deal with a client who is dominating the group by always wanting to talk, giving others his or her opinions without being asked? _____

20c. How would you deal with a client who questions your program's approach or material or your position as group facilitator?

_____
_____
_____

20d. How would you deal a group where the members show support for a member who appears to not be taking responsibility for his or her behavior?

_____
_____
_____

20e. If a client tells you that the accusations against him or her were either false or exaggerated (e.g., says that his or her partner started the fight and that he or she was only acting in self-defense), what percentage of the time do you think the client is being truthful as opposed to minimizing/blaming the victim? Why?

_____
_____
_____

Views on State/Provincial Standards and Program Improvement

21a. Is data collected on your domestic violence perpetrator program?

a. Yes ___
b. No ___

21b. If yes, what kind of data does this program collect?

a. Descriptive data (e.g., information from assessment such as age, ethnic background, crime history, whether voluntary or court-referred) ___
b. Client satisfaction survey ___
c. Outcome data on recidivism rates (who reoffends during or after the program) ___

21c. How often is this data collected?

a. Monthly ___
b. Quarterly ___
c. Semiannually ___
d. Yearly ___
e. Other (specify) _____

21d. Who collects the data and evaluates the program?

a. The agency ___
b. Researchers outside of the agency ___
c. Other (specify) _____

21e. How satisfied are you with your program's data gathering?

a. Not at all ___
b. Slightly ___
c. Moderately ___
d. Very ___
e. Completely ___

22a. Please estimate the percentage of clients who complete the program after having completed the intake/assessment: ____%

22b. Please estimate the percentage of clients who go and are arrested for domestic violence within one year after program completion: ____%

23. Are treatment interventions (*check all that apply*)

a. Used according to the written curriculum? ___
b. If no written curriculum, used according to agency's philosophy of treatment and expectations? ___
c. The same for all clients? ___
d. Adapted to fit the various needs of clients? ___
e. Developed specifically for various client needs and contexts? ___
f. Don't know ___

24. If interventions and/or programs are adapted or developed to fit the needs of clients, please specify for what population(s) and the specific ways they have been adapted or developed for these population(s). _____

25. Describe any training or strategies that facilitators receive/use to make treatment interventions culturally sensitive to the given population. _____

26. Describe any challenges facilitators have experienced in making interventions relevant to treatment populations with respect to ethnicity and/or race, gender, class, sexual orientation and identity, disability, religion, age, or citizenship status. _____

27. Describe any training or educational needs facilitators may have related to cultural sensitivity and providing relevant cultural services to populations. _____

28a. Do you provide any LGBTQ specific services? Please describe.
_____

28b. What LGBTQ-specific services would you like to see implemented?
_____

28c. What specific needs do you think LGBTQ clients need apart from the standard intervention? _____

29. How satisfied are you overall with the effectiveness of the program?

    a. Not at all satisfied ___
    b. Slightly satisfied ___
    c. Moderately satisfied ___
    d. Very satisfied ___
    e. Extremely satisfied ___

30a. How aware are you of state/province standards for perpetrator treatment programs?

    a. My state/province does not have any written standards ___
    b. Not sure whether or not my state/province has standards or do not know what they consist of ___
    c. Have a poor understanding of these standards ___
    d. Have a moderate understanding of these standards ___
    e. Have a very strong understanding of these standards ___

ATTENTION!

If you checked either "a" or "b" in question 30a and you live in a state/province that does not have written standards or you are not familiar with them, then please answer all the questions in 30b–30i according to the standards or expectations of *the agency you work for*.

30b. Do you think your state's standards adequately provide effective intervention for perpetrators?

    a. Strongly disagree ___
    b. Disagree ___
    c. Neither agree nor disagree ___
    d. Agree ___
    e. Strongly agree ___

30c. Do you think your state's standards adequately provide effective intervention for female perpetrators?

    a. Strongly disagree ___
    b. Disagree ___
    c. Neither agree nor disagree ___
    d. Agree ___
    e. Strongly agree ___

30d. Do you think your state's standards adequately provide effective intervention for same-sex perpetrators?

a. Strongly disagree ___
b. Disagree ___
c. Neither agree nor disagree ___
d. Agree ___
e. Strongly agree ___

30e. Do you think your state's standards adequately provide effective intervention for male perpetrators?

a. Strongly disagree ___
b. Disagree ___
c. Neither agree nor disagree ___
d. Agree ___
e. Strongly agree ___

30f. Previously you were asked to rate what you believe are the most important causes of domestic violence. Here is the list again. To what extent do current state/province perpetrator intervention standards address each of these possible causes?

Poor self-esteem a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Need to exercise power and control a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Poor anger management skills a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Difficulty managing emotions a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___
Patriarchy a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Dependency on others a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Traditional gender roles a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Past trauma a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___
Violence/abuse in family of origin a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Mental health issues (e.g., depression) a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Poor self-awareness a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Having an aggressive personality a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___

Other personality issues a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Poor communication/conflict resolution skills a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Poor general coping skills a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Exposure to negative peer influences a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___
Substance abuse a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Attitudes supportive of violence a. Not at all ____ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Having an abusive partner a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Work/environmental stress a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___
Having faced oppression/discrimination a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Poor education a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Unemployment/low-income stress a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___	Parenting stress a. Not at all ___ b. Slightly ___ c. Moderately ___ d. Very ___ e. Completely ___

30g. What do you think is most effective about your state's current standards? (*If you do not know, write "do not know."*)

_____
_____
_____

30h. What do you think is least effective about your state's current standards?

_____
_____
_____

30i. What changes do you think should be made to your state's standards?

_____
_____
_____

31a. How often do you faithfully follow state standards?

a. Never ___
b. Rarely ___
c. Sometimes ___
d. Often ___
e. Always ___

31b. How often do you supplement state standards?

a. Never ___
b. Rarely ___
c. Sometimes ___
d. Often ___
e. Always ___

31c. Please describe how you supplement state standards.

_____
_____
_____

32. Describe any ways this intervention program could be improved. _____

33. If you had unlimited resources, how would you design the most effective intervention program for domestic violence? Some questions to consider include the following: Would it be group/family/couple/individual focused? What, if any, other programs would be included? What would be the treatment approach and/or intervention? _____

APPENDIX B. States and Canadian Cities Represented by Respondents

State

AR
AZ
CA
CO
FL
GA
IA
ID
IL
IN
KS
KY
MA
MD
ME
MI
MO
NC
NE
NH
NV
NY
OH
OR
PA
RI
SC
TN
TX
UT
VA
VT
WA
WI
WV
WY

Canadian City

Toronto
North Bay
Burlington
Ontario
Kemmerer
Surrey
Yorkton
Thunder Bay
Edmonton