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What Services Exist for LGBTQ Perpetrators of Intimate Partner Violence in Batterer Intervention Programs Across North America? A Qualitative Study

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Objective: The purpose of this study was to determine available services for LGBTQ clients in domestic violence batterer intervention programs across North America and to ascertain which theoretical models informed these services. **Method:** Data collected from the *North American Survey of Domestic Violence Intervention Programs* were analyzed using deductive and inductive coding. Using guidelines established by the American Association for Public Opinion Research, the response rate for mailings was 20% and for e-mails was 45%. **Results:** Respondents indicated a range of approaches to LGBTQ clients from doing nothing specific to serving LGBTQ clients with one-on-one sessions. **Conclusions:** Recommendations include more LGBTQ facilitators, developing curricula that addresses homophobia, issues related to family of origin, and foster methods of outreach to the LGBTQ community to make those affected aware of treatment possibilities. Moreover, evidence suggests a disconnect between practitioners and researchers when it comes to defining and treating the problem of intimate partner violence in LGBTQ relationships. **Implications:** Practitioners should not only undergo cultural training and provide LGBTQ-specific curricula, but also engage how and why such social inequality exists and persists. Further implications for policy and treatment are discussed.

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

INTRODUCTION

Although historically an under-researched area, recent scholarship has focused on intimate partner violence (IPV) in same-sex relationships providing evidence that IPV occurs at comparable or greater rates than opposite-sex relationships (e.g., Blosnich &

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Bossarte, 2009; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2004; Hellemans, Loeys, Buysse, Dewaele, & Smet, 2015; Mason et al., 2014; Messinger, 2011; Walters, Chen, & Breiding, 2013; West, 2012). For instance, Walters et al. (2013) using the National Intimate Partner and Sexual Violence Survey (NIPSVS) find that 43.8% of self-identified lesbians report having been physically victimized, stalked, or raped by an intimate partner in their lifetime. The survey shows 35.0% of heterosexual women, 29.0% of heterosexual men, and 26.0% of gay men report having experienced a form of IPV. Bisexual women experience the highest rates of IPV with 61.1% (Hamel, 2014). (For a more in-depth analysis of breakdown in types of IPV perpetration by sexual orientation see Walters et al., 2013 and Hamel, 2014). It is important to note that the question of sexual orientation did not include transgender (trans)-identified people, leaving data on this population uncollected.

Such instances of IPV lead to ongoing health issues. Per the NIPSVS, 27% of women and 12% of men experience posttraumatic stress disorder among other short-term and long-term negative health consequences (Black et al., 2011). Given the newness of this information and the pervasiveness of IPV for LGBTQ relationships, it seems evident that greater attention should be given to studying IPV in LGBTQ populations. Furthermore, although increasingly the subject of study, IPV in LGBTQ relationships, specifically same-sex identified perpetrators, has still not been thoroughly studied or analyzed (see for review Langhinrichsen-Rohling, Misra, Selwyn, & Rohling, 2012; West, 2012). Moreover, since batterer intervention programs (BIPs), are the prime mechanism for delivering treatment to IPV perpetrators (Price & Rosenbaum, 2009), the current study focuses on identifying what, if any, services exist for LGBTQ perpetrators of IPV across the United States and Canada.

To this end, primary data collected from practitioners at BIPs are analyzed using deductive and inductive coding to ascertain what resources exist for LGBTQ perpetrators of IPV who attend or may attend BIPs. Second, this research aims to identify the necessary resources those on the front lines suggest are needed for the understudied population of LGBTQ perpetrators of IPV. Lastly, this study endeavors to reduce inequality experienced by LGBTQ batterers by making this population the focus of important research that aims to shed further light on the problem of IPV in LGBTQ populations.

Batterer Intervention Programs

BIPs have become the most likely type of intervention after a domestic violence plea or conviction (Price & Rosenbaum, 2009). BIPs are an important site of study not only because of their predominance among treatment options but also because they employ a range of theoretical frameworks, such as the Duluth model or cognitive behavioral therapy. BIPs tend to meet with a group of same-sex clients for 12–26 weeks. There is variation across BIPs due to program philosophy, available resources, and state guidelines (see Babcock et al., 2016; Cannon, Hamel, Buttell, & Ferreira, 2016). An exhaustive review of the literature on BIPs finds that some studies have resulted in mixed findings (Eckhardt et al., 2013). This may be due in part to flawed research

design, however several recent studies show cautious optimism about the positive intervention some BIPs provide (Eckhardt et al., 2013; Feder & Wilson, 2005). Importantly, Eckhardt et al.'s review collected no specific data on LGBTQ partnerships.

In response to a growing chorus of scholars who call for culturally relevant treatment interventions (e.g., Burnette et al., 2017; Cannon & Buttell, 2015; Ferreira & Buttell, 2016; Hamel, 2014; Hines & Douglas, 2009; Kernsmith & Kernsmith, 2009; Maiuro & Eberle, 2008), scholars set out to identify leadership characteristics, guiding philosophy, program structure, and demographics of BIPs across North America (Cannon et al., 2016; Price & Rosenbaum, 2009). For instance, in their study of 276 BIPs in 45 states, Price and Rosenbaum (2009) find that although batterers are not a homogenous group, interventions are based on a "one-size-fits-all" model.

Furthermore, according to Eckhardt et al.'s (2013) review of research on BIPs, gender reeducation continues to be the principal focus of treatment interventions due to the assumption that IPV is an extension of male dominance and control. Even though same-sex couples are less likely to call the police (see more broadly, Buzawa, Buzawa, & Stark, 2015; Pattavina, Hirschel, Buzawa, Faggiani, & Bentley, 2007), Price and Rosenbaum (2009) find that although 78% of BIPs surveyed were willing to provide services to "homosexual batterers," only approximately 1% of clientele openly identified as LGBTQ. This finding reveals two key issues. First, it indicates lack of program visibility and ability to guarantee an LGBTQ person's safety and comfort. Secondly, this result indicates a lack of outreach to the LGBTQ community such that LGBTQ people may not know about possible treatment options (see Ford, Slavin, Hilton, & Holt, 2013). These results reveal the gap between the needs of the LGBTQ community with respect to IPV and the services necessary to combat the problem. The current study seeks to better identify what treatment options through BIPs are available to LGBTQ identified batterers.

Beyond Patriarchal Models of IPV

Many BIPs utilize models such as the Duluth model for treatment intervention (see Cannon et al., 2016), which is based, in part, on patriarchal models of IPV (see Pence & Paymar, 1993). Patriarchal models of IPV are models that tend to theorize violence between intimate partners as an extension of patriarchal hierarchy of society in which men dominate women (for critique and explanation, see Dutton & Corvo, 2007; Ferreira & Buttell, 2016). Importantly, they have advanced scholarship on IPV. Such models were designed heteronormatively with a man-as-perpetrator and woman-as-victim arrangement. These models, coupled with changing laws (e.g., Violence Against Women Act), have especially contributed in the criminalization of domestic violence. However, such a model is not without its limitations. This one-size-fits-all model, in which batterers are assumed to be male and their victims' female, limits the ability of researchers and practitioners to frame and understand aspects that arise from instances of IPV in LGBTQ relationships (Baker, Buick, Kim, Moniz, & Nava, 2013).

In considering gender identity and sexual orientation as important social, personal, and cultural markers in recognizing and discussing a person's relationship to violence rather than solely as an explanation, some scholars aim to cultivate greater awareness of the importance of cultural contexts in which people experience IPV (Baker et al., 2013; Cannon & Buttell, 2015, 2016; Coleman, 2002; Kernsmith, 2006). For example, applying intersectionalitya–feminist theory that posits it is the intersecting axes of oppression along lines of race, class, gender, sexual orientation, ethnicity, citizenship status, and so on, that informs one's life chances (see Smooth, 2013)–to the problem of IPV in LGBTQ populations extends the ability of both practitioners and researchers to understand the various cultural and social impacts on clients. Such a theory provides a framework to ask specific questions regarding one's social location and use of violence. For example, "In what ways might minority stresses function in a perpetrators' decision to use violence in an intimate relationship?" Considering the cultural and social milieu of LGBTQ people and how such context might positively and/or negatively affect their life and by extension their use of violence in intimate relationships is one way of expanding a theoretical framework necessary to better identify services for and motivations of LGBTQ perpetrators (see as examples, Cannon & Buttell, 2016; Cannon, Lauve-Moon, & Buttell, 2016). Broadening the lens with which clients are viewed holistically in the context of their lives better enables assessment of drivers and protective factors of IPV perpetrators.

And, as Cannon & Buttell (2015) argue, the throwaway acknowledgement of IPV as a serious problem in the LGBTQ community limits the development of effective policy to provide better treatment options to affected communities. To elaborate, if the theoretical framework researchers employ inhibits the ability to accurately view the problem of IPV in LGBTQ relationships, then collectively we will be unable to adequately develop policy that informs better treatment interventions (Cannon & Buttell, 2016). For instance, scholars who study female perpetrators in heterosexual relationships have found limitations in effectiveness with heteronormative, patriarchal models that have been designed for male perpetrators and female victims (e.g., Duke & Davidson, 2009; Hamel, 2014; Hassouneh & Glass, 2008; Russell, 2015; Stanley, Bartholomew, Taylor, Oram, & Landolt, 2006). Similar limitations have emerged with recent studies that have found the predominance of the bidirectional use of IPV (see Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012). Additionally, those researching the problem of IPV in LGBTQ populations must move beyond heteronormative, patriarchal models to include more diverse and inclusive theoretical models, such as intersectionality, to better develop policy and more acute treatment interventions (e.g., Langhinrichsen-rohling, 2010; Smooth, 2013).

Similarly, Baker et al. (2013) argue examining same-sex IPV provides important insights into two significant aspects of IPV. First, studying same-sex IPV informs us of the dynamics and needs of this community, and in turn the services practitioners should provide. Secondly, such research promotes a critical examination of the ways IPV is framed. For instance, research that focuses on same-sex IPV provides a pathway to analyze the means by which we construct and understand factors (e.g., motivations, events, outcomes, treatment, etc.) of domestic violence that are most often

associated with gendered roles and sex-based biological differences. Analyzing IPV in same-sex relationships is an opportunity to develop strategies of theorizing and intervention that serves to promote social justice and to learn more about the problem of IPV itself.

This latter point is of particular importance. As a strict interpretation of the heteronormative, patriarchal explanation of IPV, in which men access patriarchy in order to express power and control in their intimate partnerships, it would appear to prohibit, by definition, IPV from occurring in lesbian relationships (e.g., for examples on heteronormative scripts in women's same-sex relationships, see Sanger & Lynch, 2018). Following the strict logical application of this theory, men access their dominant status as men to batter their female partners, who have less power precisely because they are women. In this instance, the theory allows that men use violence as a form of power and control that is as an extension of their power and authority as men in a society that values men more than women (e.g., a patriarchal one). However, in this scenario, how would we understand a lesbian identified woman battering her female partner? Is she accessing the same patriarchal status as the male batterer? Such a strict interpretation of a patriarchal model of IPV reveals a need to include different kinds of theories across the field in order to address IPV in both opposite and same-sex relationships. To this end, the data analyzed here aims to identify which theoretical models are employed in rendering services to LGBTQ perpetrators in BIPs across the United States and Canada.

Purpose of the Study

The purpose of this study is to answer the following research questions: (a) what treatments and services are provided to LGBTQ identified batterers at BIPs across North America? And, (b) which theoretical models are used by BIPs in treatment of LGBTQ identified batterers?

METHODOLOGY

Data Collection

Building on the work of Price and Rosenbaum (2009), the *North American Survey on Domestic Violence Intervention Programs* (NASDVIP), was developed to ascertain practitioners' perspectives on treatment philosophies (i.e., cognitive behavioral therapy, Duluth model, etc.) and logistics (i.e., frequency of meetings, group setting, etc.). Cover letters with a brief description and electronic link to the survey were distributed to 3,256 BIPs across the United States and Canada for which the research team had hard and electronic addresses.

Response Rate

Given the high turnover in BIPs (roughly every 3 years) and the time it took to compile the list (3 years) in conjunction with using the standards employed by the American

Association for Public Opinion Research (AAPOR), a conservative estimate of 65% noncontact rate was calculated (see AAPOR noncontact rate estimates). Put another way, an estimated 65% of BIPs for which there were hard addresses never received mailed communications. There were 238 total responses to the survey. Using AAPOR standards, a response rate of 20% for mailings was calculated. The response rate for email was 45%, which is calculated by how many people completed the survey divided by the number of people who opened the email link (see Cannon et al., 2016 for further methodology). It is important to note that the response rate, although defensible, is lower than desirable and is a limitation to the current study.

Participants

Any employee at a contacted BIP, over the age of 18 was eligible to complete the survey. Demographics of respondents can be found in Table 1. Programs were contacted using a recruitment letter asking whether they would participate by going online to complete the survey for which a link was provided. The survey was administered through the third party site, Survey Monkey. No identifying information was collected in order to maintain anonymonity of responses. This research was approved by the primary researchers' sociobehavioral university institutional review board (IRB). Of these communications, 2,710 were mailed, and 546 were e-mailed.

Measures

A mixed-method design was employed for the survey, NASDVIP, using forced-answer choice questions (e.g., demographics, theories, and group length) and open-ended responses (e.g., "What would you change if you could?"; "Describe challenges facilitators face."). The NASDVIP asked participants questions related to facilitator demographics (i.e., age, gender, educational attainment, ethnicity, etc.); client demographics (i.e., gender, sexuality, ethnicity, employment, etc.); facilitator insights (i.e., rate factors that contribute to IPV, frequency of inciting violence by gender, motivations for perpetration, etc.); program logistics (i.e., number of clients served, languages in which services are offered, funding sources, etc.); and treatment philosophy (i.e., "What do you consider the primary treatment/intervention approach that your program uses for perpetrators?"). For a list of all survey questions see Cannon et al., 2016.

Analytic Strategy

These data were analyzed both deductively and inductively. Open-ended survey data were coded into general themes that were both prespecified (i.e., recommendations for improving BIPs) and emergent. Codes were segments of text that range from several sentences to several paragraphs and address a specific theme (i.e., "Practitioner Recommendations for BIPs Improvement"). The first phase of coding resulted in a list of broad themes found in the text to better understand the ways in which practitioners think about challenges and opportunities related to treating LGBTQ clients. Secondly, the data were analyzed inductively. The data were reviewed upward of

three times for important themes or narratives that emerged in relation to the two research questions stated earlier. Both analytic processes were conducted in order to answer the above research questions (see for extensive research methodology, Creswell & Creswell, 2017). Results from each analytic process was checked by two other researchers in order to ensure reliability of the findings. This strategy is appropriate given the data collected. The themes that emerged from this process illustrate the limitations, challenges, and improvements identified by surveyed practitioners. See Figure 1 for the list of these themes, findings, and resulting recommendations.

RESULTS

The following results are organized by themes generated from the analytic strategy described earlier. For respondent demographics see Table 1.

Percentages of client population by sexual orientation estimated by respondents are reported in Table 2.

The importance of these results within the context of the literature reviewed earlier, as well as implications for policy and treatment, are discussed in the "Discussion" section (see Figure 1).

TABLE 1. Characteristics of Respondents

Demographic	Percent (*N*)
Agency position (*N* = 191)	
Director of the domestic violence perpetrator program	45.0 (86)
Director of entire agency	43.4 (83)
Domestic violence group facilitator	41.9 (80)
Gender (*N* = 228)	
Female	61.8 (141)
Male	38.2 (87)
Race (*N* = 215)	
Caucasian	87.4 (188)
African American	6.5 (14)
Hispanic or Latino	5.1 (11)
American Indian or Alaska Native	3.3 (7)
Asian	.5% (1)
Educational attainment of respondents (*N* = 219)	
PhD/DSW/PsyD	5 (11)
Master of Arts/Social Work/Science	59.4 (130)
Bachelor's degree	23.7 (52)
Associate degree	3.2 (7)
Some college	7.3 (16)
High school degree	1.4 (3)

TABLE 2. Estimated Percentage of Clients by Sexual Orientation Based on Responses From Practitioners

Sexual Orientation (*N* = 131)	**Percentage (*N*)**
Lesbian	3.0 (104)
Gay	4.0 (98)
Bisexual	1.0 (77)
Transgender (M to F; F to M)	0.0 (0)
Heterosexual	90.0 (112)

Do LGBTQ Clients Have Specific Needs?

In order to determine what treatments and services are provided to LGBTQ identified batterers at BIPs across North America, the survey asks whether LGBTQ clients have specific, differing needs from a heterosexual perpetrator population. Practitioners surveyed differ on whether or not LGBTQ clients have specific needs apart from the standard intervention (e.g., "What specific needs do you think LGBTQ clients need apart from the standard intervention?" [*N* = 69]). Responses range from doing nothing different to specified groups for LGBTQ clients only. Practitioners offer specific suggestions such as gender-neutral documents; a different curriculum entirely; and, social support dealing with issues related to family of origin. Additional recommendations include more culturally diverse staff (e.g., LGBTQ facilitators); address safety issues at the family, systems, and community levels; and, a need for facilitators to address and critique instances of homophobia and oppression by group members. Further recommendations are to acknowledge that LGBTQ relationship dynamics are different from heterosexual ones; community response training for police and courts of the domestic violence that occurs in this community; and, addressing issues of judgments, stereotypes, and stigmas, as well as societal oppressions, more generally. Although several respondents report not working with this population (at least knowingly) and several respondents report that no changes are needed, the above recommendations make clear the diversity of perspective of practitioners. These recommendations offer a range of possibilities for BIPs that treat LGBTQ clients and may improve treatment options.

Specific Challenges BIPs Face With Respect to LGBTQ Clients

Many BIPs face challenges in general, such as maintaining and acquiring enough resources. In order to ascertain what treatments and services are provided to LGBTQ batterers at BIPs, it is necessary to understand what challenges might exist. Those surveyed expressed that BIPs experience challenges with respect to specific populations within their clientele. 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 range of answers ($N = 73$). For example, rural programs may consult urban programs to help with issues of incarceration that their client populations experience. Some programs refer gay and lesbian clients to other BIPs because they report not having resources to treat this population. Of the responses, professionals mention that LGBTQ clients pose a significant challenge. One respondent put it thusly, "LGTB being in heterosexual groups is hard for them to express openly." This perception of a practitioner may contribute to the lack of resources available to LGBTQ perpetrators.

One challenge identified by respondents is to have diversity, along lines of race, class, sexual orientation, religion, age, and so on, in the same group. Other challenges include lack of financial resources, disadvantages poor people face with respect to legal challenges and child protective services, and the use of state mandated curricula with no variation across cultures. This finding indicates the intersectionality of oppressions and disadvantages that people face when perpetrating IPV.

Specific Interventions for LGBTQ Clients

To determine what services are available for LGBTQ perpetrators of IPV, practitioners at BIPs are asked whether or not specific interventions are used for this client population (i.e., "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 report that they made a variety of interventions when certain client populations had specific needs. Participants report what services and treatments the BIPs offered to LGBTQ clients. Participants ($N = 77$) respond that specific populations for which programs have been adapted were illiterate, deaf, age-related (e.g., teenagers), Spanish-speaking, women, and LGBTQ identified people. Due to the scope of this study, I treat only responses that involve LGBTQ populations.

LGBTQ populations are the most common population for which specific interventions are made. These specific interventions are made due to constraints of geography (e.g., LGBTQ groups may be far away) or size (e.g., the population maybe relatively small). According to the perceptions of service providers, the two most common specific interventions for LGBTQ clients are to make language of program materials more gender inclusive or to treat LGBTQ clients in one-on-one sessions. For example, several respondents report that although their curricula are for men, they change the gender pronouns when they hold female groups. However, given the responses throughout the survey, many respondents use male and male associated pronouns when discussing clients. This de facto use of male pronouns reveals an implicit assumption that batterers are always male.

Respondents hold various views on whether or not different curricula are necessary for different client populations. For instance, several respondents note that different curricula are developed for female batterers to better address specific issues they experience. At the same time, still other respondents comment that the curricula may

be the same for everyone but that within group meetings, members address their specific concerns brought to the group.

The second most common approach to LGBTQ batterers is to meet individually instead of in a group setting. Taken together, respondents' answers to this question reveal that depending on where the program is located greatly influences what specific interventions are created. For example, some programs refer LGBTQ clients to groups in bigger cities nearby (e.g., Portland, Chicago). Most respondents indicate that when there are groups available for women, groups are segregated by gender.

LGBTQ-Specific Services: At Present and Future Possibilities

Approximately 88% of practitioners surveyed (N = 80) report that they do not offer LGBTQ-specific services (e.g., "Do you provide any LGBTQ-specific services? Please describe." [N = 91]). Some respondents report treating LGBTQ people in individual sessions. Otherwise, LGBTQ people would be in gender-specific, male or female, groups. Some programs adapt their curricula to the LGBTQ population, although specific changes are not reported. Of all programs surveyed, 2.1% of programs (N = 2) are specially trained for LGBTQ populations.

Respondents provide several suggestions on how to improve LGBTQ-specific services (e.g., "What LGBTQ-specific services would you like to see implemented?" [N = 67]). Respondents indicate that greater outreach to the LGBTQ community is needed to inform them of available services. Several respondents state that gender-neutral documents would be helpful in addressing specific needs of LGBTQ clients. One respondent suggests LGBTQ facilitators would be a helpful service.

Some practitioners offer they would do nothing to create LGBTQ-specific services because it is "not realistic to create individual services for specific client populations." Respondents offer several reasons—such as size of the population, safety, and lack of resources—for why LGBTQ-specific interventions are not necessary or feasible. However, this statement contradicts the findings that IPV occurs in LGBTQ relationships as often or more frequently than opposite-sex couples (see Walters et al., 2013). In assessing which theoretical models are used in BIPs in treatment of LGBTQ clients, several practitioners report that no specific services are necessary because violence is still always about power and control.

Additional Training and Cultural Sensitivity for BIP Practitioners

There are no national standards in the United States for BIPs. In determining which theoretical models are employed in treatment of LGBTQ clients, the need for cultural sensitivity and further training varied among participants. When asked, "Describe any training or strategies that facilitators receive/use to make treatment interventions culturally sensitive to the given population"; respondents (N = 81) indicate a range of training of facilitators. These trainings range from annual trainings designed to promote cultural sensitivity to no additional training. Several respondents report that additional training is required to lead female perpetrator and LGBTQ groups. Most respondents agree that cultural sensitivity is an important aspect of effective

intervention. However, it was not clear what was meant by cultural sensitivity. Moreover, there is not a systematic model for developing such cultural interventions, but instead each intervention is program and context specific. For example, many participants comment that as different cultures arise either in-group or as a group, then specific training would be conducted by that particular facilitator.

For those service providers who report they employ the Domestic Abuse Intervention Program of Duluth, Minnesota (commonly referred to as the Duluth model), they note there is a section on cultural sensitivity. Some states (e.g., Washington, Iowa) require cultural sensitivity training to address sexism, racism, and homophobia and how these ideologies of oppression relate to domestic violence. Programs may receive training from multiple sources. For instance, some cultural training comes from the program itself, while other trainings occur with other advocacy groups, probation departments, or the Association of Batterer Intervention Programs (ABIP).

Practitioner Recommendations for Improvements of BIPs

Practitioners surveyed provide a comprehensive list of improvements to intervention programs (e.g., "Describe any ways this intervention program could be improved." [$N = 73$]). Although not all of their recommendations are specific to the LGBTQ client population, these recommendations could also serve LGBTQ identified clients. Suggestions to improve BIPs include facilitators who identify as LGBTQ; increased grant money; greater integration for different models of adult learning, different motivations for domestic violence, and emotional regulation skills. The most common suggestion is for greater financial assistance and resources. Other recommendations include generating funding subsidies from sources other than client fees. There are several recommendations on personnel (e.g., more female cofacilitators; LGBTQ identified facilitators) as well as call for additional counseling, such as couples counseling. Practitioners identify and call for development of female and LGBTQ-specific curricula; ending the one-size-fits-all approach; more interactions with other BIPs and more unified approaches for the state. Some practitioners recommend coed groups. BIPs also need increased victim advocacy and services for LGBT victims and survivors, and/or to closely partner with victim services organizations. In addition to practical changes, practitioners recommend changes that will provide greater information and knowledge for practitioners and clients alike. For instance, a database of new information that may be accessed for group ideas. Another recommendation is creating different levels of treatment for different levels of domestic violence risk identified during assessment.

Many respondents offer that stronger negative consequences are needed for noncompliance with program requirements. Additional training is a recurring recommendation from practitioners. For instance, practitioners mention that states need to provide ongoing trainings as well as sponsor research and evaluation into IPV, treatment interventions, and program effectiveness. Data-driven research, such as this, may help improve program interventions. Working across relevant government agencies and entities, practitioners suggest law enforcement, district and county

attorneys, and judges attend sessions to gain valuable insight into the impact of programs. Such implementation would integrate the court systems with treatment interventions. More generally, practitioners suggest greater community involvement and a better referral system. One respondent writes, "Better referral understanding [is needed]. DAs still refer clients that they think 'aren't that bad' to anger management for 10 weeks." Furthermore, practitioners suggest more outreach education and awareness to referral sources and communities are needed for at-risk populations.

DISCUSSION AND RECOMMENDATIONS

This section is organized around major themes that resulted from the deductive and inductive coding analysis of primary data from the NASDVIPS reported earlier. Figure 1 illustrates relationships among themes, findings, and recommendations.

Treatment Options for LGBTQ People in North American BIPs

Respondents provide a frontline look at whether or not LGBTQ clients require specific services, what these specific services could be, and improvements to their programs. In answering the first research question, what treatment services are provided to

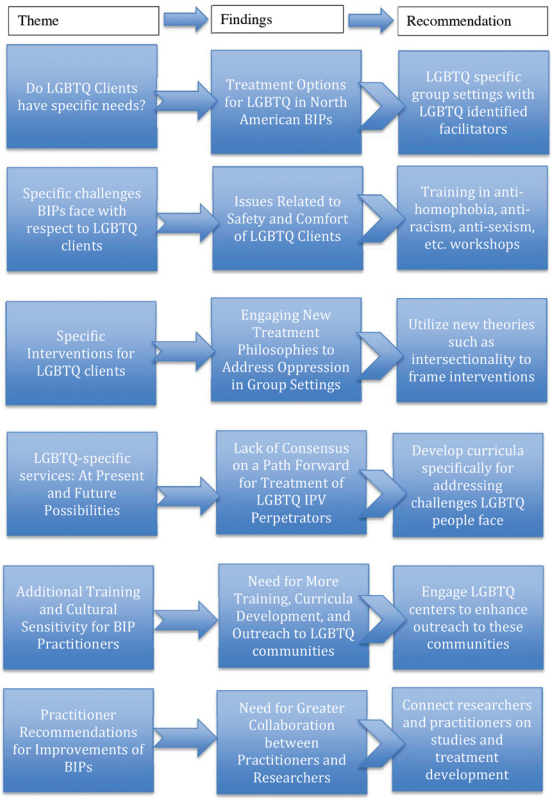

Figure 1. Identified themes from deductive and inductive coding with findings and recommendations derived from analysis.

LGBTQ clients, this study shows that LGBTQ populations are either not served or are underserved by many BIPs in North America. Since no practitioner indicated that LGBTQ people receive their own group services, best circumstances are that LGBTQ people are culled out of group therapy and given one-on-one treatment. Unfortunately, this strategy negates benefits of the group dynamic and may further consolidate a sense of isolation and disenfranchisement (see Russell, 2015) from mainstream BIP programming. Furthermore, given the CDC reports (2014) show that IPV occurs in LGB relationships at similar or greater rates than opposite-sex relationships, the lack of treatment options for LGB people evidences a bias that potentially obfuscates the needs of people in this community. This disconnect between the identified need of the LGBTQ community for treating IPV and the lack of reported LGBTQ attendance further invisibilizes the LGBTQ community (Cannon & Buttell, 2015). While many respondents indicate the need for better programming for the LGBTQ community and as they attempt to provide what services they could, practitioners are greatly limited by resources and policy that is designed with male batterers and female victims in mind (see Hamel, 2014; Price & Rosenbaum, 2009). This finding provides further support for those calling on treatment models beyond the one-size-fits-all model (e.g., Burnette et al., 2017). Specifically, such philosophical treatment models should incorporate nonheteronormative assumptions and should reference specific concerns of LGBTQ folks (i.e., safety and comfort).

Issues Related to Safety and Comfort of LGBTQ Clients

Another major concern of service providers is the emotional and physical safety of LGBTQ clients. Due to the perceptions and explanations reported by professionals, these findings add further support to scholars who argue that LGBTQ people may not feel safe, emotionally or physically, and may feel repressed in heteronormative groups (Hamel, 2014; Russell, 2015). The very perceptions reported here provides illuminating insight into the potentially hostile or unsafe environment in which LGBTQ people are inhabiting. Even in the wake of the Supreme Court's decision in Obergefell v. Hodges (2015), in which same-sex marriages became nationally legalized, such a finding stresses the continued necessity and importance for combatting homophobia and ensuring the safety of LGBTQ people.

Safety is not only a major concern, but also a major challenge to treating this population. One important means for creating safe space is to address instances of homophobia, sexism, and racism in all group settings regardless of whether perpetrators are part of same-sex or opposite-sex relationships. One important avenue for professional development is to provide practitioners with anti-homophobia, anti-racism, and anti-misogyny trainings such that they can apply this knowledge in group therapy. For instance, professionals who participated in this survey reveal their own assumptions of experiences of alienation and safety for LGBTQ people. Such data indicate the necessity for training of facilitators in order to reduce homophobic bias. This training could take place as part of social work and psychological education curriculum,

or as part of the standards of practice for the program itself. Furthermore, trainings that have been developed and adapted for female perpetrators (see for analysis, Carney, Buttell, & Dutton, 2007; Maiuro & Eberle, 2008) may be a starting place for implementing improvements for services directed toward LGBTQ clients. Training in one such theoretical and analytical framework, intersectionality, in which the intersection of racism, sexism, and heteronormativity serve to reinforce one another (see Smooth, 2013), may provide an opportunity to benefit all participants of BIPs.

Engaging New Treatment Philosophies to Address Oppression in Group Settings

In answering the second research question, which treatment philosophies guide the treatment of LGBTQ people in BIPs, this study evidenced, through surveying practitioners, most LGBTQ people experienced the Duluth model of treatment. Since the Duluth model is most widely used in treating the LGBTQ population, there are some key recommendations that may aid in the efficacy of using this treatment philosophy. If, as many respondents suggest, IPV is first and foremost about power and control, regardless of the sexual orientation and gender identity of the perpetrator and victim, then it is necessary to address the systems of privilege and domination that allow some people to dominate more easily than others (Cannon & Buttell, 2015; Smooth, 2013). Addressing such issues of domination and subordination across all group settings not only assists in treatment of each perpetrator regardless of their identity, it also serves to create greater equity. Otherwise, to only address homophobia in treatments for LGBTQ perpetrators is to reinforce the notion that it is *their* problem, not everyone's problem.

Furthermore, in order to create more inclusive and safe spaces for everyone within treatment, it is necessary to address instances of sexism, homophobia, and racism. To provide such services, however, scholars and practitioners must employ a variety of theoretical frameworks, such as intersectionality, and skills, such as therapeutically, confronting homophobia. Such an intervention creates new spaces for understanding IPV differently as Baker et al. (2013) suggest. A better understanding of IPV in LGBTQ relationships may yield insights into occurrences of IPV in heterosexual relationships.

Lack of Consensus on a Path Forward for Treatment of LGBTQ IPV Perpetrators

Respondents' insights into the problem of IPV in LGBTQ relationships reflect a spectrum of positions. Findings from this study support scholarly calls for culturally specific treatment interventions (e.g., Burnette et al., 2017; Cannon & Buttell, 2015; Hamel, 2014; Kernsmith & Kernsmith, 2009; Maiuro & Eberle, 2008; National Institute of Justice, 2010). On one end of the spectrum are those that contend no differences to curricula are needed because IPV is always about power and control, and thus the gender of the person battering and the victim are irrelevant. On the other

end of the spectrum, professionals argue LGBTQ-only groups, led by LGBTQ identified facilitators, with culturally specific curricula, are necessary to provide a safe space for these perpetrators to be effectively treated. Still other practitioners argue that making the already approved curricula gender-inclusive, or changing pronouns, would be an effective practice in treating IPV in LGBTQ relationships. However, as Cannon and Buttell (2015, 2016), persuasively argue, changing gender pronouns in curricula designed for male batterers and female victims only serves to obscure the particular motivations and experiences of all perpetrators and victims.

The current study found supporting evidence for this argument. Surveyed professionals reason that changing pronouns of current curricula does not adequately address both the circumstances of LGBTQ people's lives, such as, the prejudices they potentially face at home, work, public, as well as their motivations and experiences of IPV. Based on their responses, most surveyed practitioners advocate support for culturally sensitive curricula. Although no respondent explicitly stated what culturally sensitive curricula includes, responses taken together point toward additional modules that address life circumstances of LGBTQ people (e.g., encounters with homophobia, issues with family of origin, harassment, and trauma). Therefore, LGBTQ culturally relevant curricula should address these specific circumstances of encounters with homophobia, issues related to family of origin, harassment, and trauma. Moreover, such curricula should most likely take into account specific experiences related to each identity separately. For instance, trans people may have different needs than lesbian identified clients. Rather than being taken together, practitioners may need to provide specific group services for lesbian, bisexual, gay, trans, and queer folks according to their sexual identity in addressing their particular needs and contexts.

Although throughout this article LGBTQ is mentioned as one community, it is more accurate to discuss it as several communities that often come together for common goals. Furthermore, scholars do not have an accurate understanding of the needs of trans-identified people in the United States since most national surveys, such as the NIPSVS, do not collect information on this population. A necessary first step to identify the scope of IPV perpetration for trans people, is for the NIPSVS to collect specific information on this population. Doing so enables researchers and practitioners to begin to analyze further the needs of this community and how they are specifically affected by IPV. Similarly, in the survey used in this study, although scholars asked for specific percentages of trans F to M and trans M to F clients, respondents reported no trans clients. Furthermore, the qualitative questions of this survey grouped the LGBTQ community together as a whole.

Need for More Training and Curricula Development

Although the Duluth curricula has a specific module for LGBTQ people that focuses on power and control, most respondents indicate that more training and flexibility of theoretical approaches are necessary. Given the predominance of the Duluth model, and the insights of practitioners who advocate for more culturally inclusive curricula,

it seems imperative that researchers and practitioners implement these changes. It is important to teach practitioners not only culturally relevant means for dealing with diverse populations, but also to teach those on the frontlines why such inequality exists and persists in our society (Russell, 2015). One such strategy that could be used as a model for culturally specific curricula for LGBTQ people is the Alcoholics Anonymous (AA) batterer intervention approach. AA forms its batterer curriculum from those who experience firsthand the difficulties of managing both alcohol abuse and intimate partner abuse. This model offers a potential blue print for developing a curriculum by including input by affected LGBTQ people to better specify the needs and concerns of this population.

Need for Outreach to LGBTQ Communities

According to professionals in the field, one problem with delivering effective treatment that emerges from the data is the lack of community outreach. One important step in combatting this problem is developing greater outreach with local LGBTQ communities. Doing so alerts the community to resources available to them. It stands to reason, with greater outreach and awareness, greater numbers of LGBTQ people would participate in treatment programs, such as BIPs. Such logic negates practitioners' responses that no changes need to be made given the current low numbers of LGBTQ participants in BIPs across North America. This point of view fails to recognize the structural ways in which the problem of IPV in LGBTQ communities is invisibilized (see, for instance, Baker et al., 2013; Cannon & Buttell, 2015; Cannon et al., 2015; Russell, 2015; West, 2012). Furthermore, additional theoretical frameworks may be brought to bear to further understanding of the structural violence faced by LGBTQ people. For instance, an epidemiological framework (e.g., Okuda et al., 2015) may be used to identify areas of special concern for LGBTQ people and to support victims and perpetrators specifically.

Need for Collaboration Between Practitioners and Researchers

Curiously, future interventions professionals would like to see implemented lack the need for LGBTQ-specific interventions. While several respondents reiterated that LGBTQ-specific interventions are not necessary due to the smallness of the population, their responses also illuminate why there might be such small numbers of openly out LGBTQ people in BIPs in the first place. Evidence cited earlier suggests that IPV occurs at the same rate or greater rates in same-sex relationships as opposite-sex relationships (see for example Hamel, 2014; Walters et al., 2013). Yet, LGBTQ populations remain small in BIPs. These two points indicate disconnection between the problem of IPV in same-sex relationships and treatment services. Such incongruity also may be due to the lack of arrests and convictions of LGBTQ identified people. In order to address such issues, many respondents provide suggestions on how to improve services for LGBTQ clients (see above results for theme, Recommendations for Improvements for BIPs).

This study shows the disconnect between trends identified by researchers and the interventions practiced by practitioners. For instance, researchers have found that IPV occurs in LGBTQ relationships at similar or more prevalent rates than heterosexual relationships (Hamel, 2014). Taken together, professionals surveyed estimate that roughly 8% of their clients identified as LGBTQ, yet no respondent reported that there were enough LGBTQ people to warrant their own group. The one-size-fits all approach, encouraged by current policies, to the treatment setting in which LGBTQ people participate, hinders practitioners' abilities to employ multiple theories and approaches to connect the various social locations of their clients. This finding reveals not only that LGBTQ perpetrators of IPV go to BIPs to receive treatment, but it also shows the necessity for treatment that is better suited to the specific needs, concerns, and challenges they face as LGBTQ identified persons. Moreover, this study shows the importance of future collaboration between practitioners, such as the ones surveyed here, and researchers to better bridge the gap between the deployment of treatment interventions and the philosophies, drivers, and trends of the population of interest. This collaboration should take the form of practitioners sharing their insights with researchers so that together they can inform the research community of these practices, concerns, and challenges. Additionally, researchers should work with practitioners to better communicate their cutting-edge findings and develop, in collaboration, policy recommendations and treatment interventions that fit within the current infrastructure.

Limitations

There are several limitations with the current study. First, as a qualitative study, this research cannot provide analysis of generalizable data to a representative sample that a cross-sectional quantitative study might be able to provide. Rather, the strength of this research relies precisely on the perceptions of those on the frontlines treating LGBTQ perpetrators of IPV in BIPs across North America. Secondly, these data are constrained by the data collection strategy. Future research should entail interviews and focus groups to follow up with findings presented here. Such additional data will enable researchers to better tease out discrepancies in the data and further pinpoint and define recommendations, such as what elements and modules need to be included in culturally relevant curricula.

CONCLUSIONS AND IMPLICATIONS

Practitioners on the frontlines of IPV intervention across North America propose several recommendations for addressing the lack of treatment options for LGBTQ perpetrators of IPV. First, outreach to LGBTQ communities is necessary to alert people of the kinds of services available to them. Second, policy must, at best, set the tone for culturally relevant curricula and training for practiticioners of BIPs and, at worst, provide a flexible framework to allow individual programs to better address the problems faced by the LGBTQ community. Culturally relevant curricula must be

developed to address the particular experiences LGBTQ have (e.g., encounters with homophobia) that may impact how they mediate interpersonal relationships. Such innovations may be modeled after recent interventions developed for female perpetrators and male victims. Furthermore, LGBTQ facilitators would be helpful in addressing group instances of homophobia as well as being better equipped to create a safe space for all clients. Better policy, utilizing such data-driven studies as this, could serve to encourage and support these treatment recommendations. Such policy advancements will serve to close the inequality gap for LGBTQ people and may help reduce the problem of IPV.

Providing equal access to treatment services to such a widespread problem as IPV in LGBTQ relationships is part of a larger push for equality. Especially in the wake of the current Federal Administration limiting the CDC and other institutions under the preview of the Department of Health and Human Services from using "LGBTQ," "vulnerable," "transgender," "diversity," among other words from their budget reports (see Washington Post, 2017), such research is more necessary than ever. Each of these recommendations begin with socially responsible scholars and practitioners utilizing multiple theoretical frameworks to develop culturally relevant curricula and to address instances of homophobia, racism, and misogyny. Furthermore, such practitioners should engage community outreach skills and coalition building to communicate the services available to the underserved LGBTQ population. Such an approach benefits not just LGBTQ clients nor perpetrators of IPV, but all clients.

Future research should take into account LGBTQ clients as part of their own individual groups (e.g., along lines of lesbian, gay, bisexual, trans, and queer identified people). Researchers should continue to focus their energies on this community, and the specific public health and social justice issues that it faces. In service to this end, an array of theoretical frameworks and empirical methodologies may be used in service of these goals to better understand the problem of IPV and to improve policy development and treatment interventions.

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