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A Pilot Evaluation of the STOP Intimate Partner Violence Intervention Program

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This pilot study examines the impacts of a 12-week community-based intimate partner violence intervention program delivered in British Columbia, Canada. The Stop Taking it Out on your Partner (STOP) program targets males who have engaged in abusive behaviors toward their intimate partners; most are voluntary participants. The STOP program was evaluated in three sites across the province (once program per cycle), with a total of 39 enrollees. Thirty-seven men completed the pretest survey; analyses focus on the 22 participants who completed pretest and posttest questions regarding knowledge and skills learned, and the 15 participants who completed the Abusive Behavior Inventory (Shepard & Campbell, 1992) regarding psychologically and physically abusive behaviors. Results suggest that participation in STOP contributed to significant decreases in both physical and psychological abuse. Further, program participants increased in their use of cognitive behavioral strategies to avoid violence. Implications for intimate partner violence intervention and future research are discussed.

KEYWORDS: individual; couples and family interventions; partner abuse and socialcognitive processes; BIPs: characteristics; process and outcome studies

INTRODUCTION

In many parts of the world, intimate partner violence (IPV) is the leading type of violence experienced by women (World Health Organization [WHO], 2017). IPV refers to actual or threatened harm that occurs between current and former spouses and dating partners, and includes types of harm such as physical, psychological, sexual, and economic abuse. The global prevalence of violence experienced by women in intimate partner relationships has been estimated at nearly 30% (WHO, 2017). Similarly, the magnitude of IPV in Canada and the United States is alarmingly high. In the United States, results from the National Intimate Partner and Sexual Violence

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Survey indicate that more than one in three women have experienced some form of IPV in their lifetime (Smith et al., 2018). In Canada, police-reported violent crime data show that 28% of victims over the age of 14 have been victimized by an intimate partner, and 79% of the over 93,000 victims of IPV across the country are female (Statistics Canada, 2018).

The individual, societal, and economic ramifications of IPV are severe, and research suggests that survivors of partner violence often suffer significant consequences long after the violence has stopped (WHO, 2017). On the individual level, IPV is related to a range of physical injuries (e.g., fractured bones, head injury, back and neck pain), psychological trauma (e.g., depression, anxiety, posttraumatic stress, suicidal thoughts), economic instability (e.g., job/wage loss, homelessness), and sexual health problems (e.g., unintended pregnancy, induced abortions, sexually transmitted infections; Dillon et al., 2013; Jordan et al., 2010; Wong & Mellor, 2014).

Given the pervasiveness of IPV and the vast personal costs associated with this violence, there is a pressing need to prevent this behavior among individuals who have previously used or are at risk of using violence in their intimate relationships. The current study presents the results of a pilot investigation of a community-based IPV intervention program operating in several cities across British Columbia (BC), Canada. The Stop Taking it Out on your Partner (STOP) program primarily targets nonadjudicated men who have engaged in harmful behaviors toward their intimate partners. Specifically, the evaluation seeks to examine short-term changes in participant abusive behaviors, and skills/knowledge learned in the program.

IPV Intervention Programs

Treatment Approach. One of the most prominent approaches to treating perpetrators of IPV in a community organization setting is a group-based method using cognitive behavioral therapy (CBT). CBT is a widely used form of psychotherapy that focuses on the thought processes, beliefs, attitudes, and values that underlie how participants think (Clark, 2011). In this approach, abusive men examine the circumstances surrounding their violent behaviors; for example, how emotions underlie their violence and how they may use anger to empower themselves and/or to gain compliance from others. Participants typically learn communication skills, how to be assertive without using violence, and how to manage anger (Babcock et al., 2004). Despite its widespread use, results from several meta-analytic studies have failed to find significant treatment impacts for recidivism among IPV perpetrators who participated in CBT interventions (i.e., Arias et al., 2013; Babcock et al., 2004; Nesset et al., 2019).

Other prominent treatment approaches to IPV intervention include the Duluth model (a psychoeducational/feminist approach which proposes that male privilege and patriarchal ideology is the underlying cause of IPV; Herman et al., 2014) and Acceptance and Commitment Therapy (ACT; which focuses on experiential learning and does not attempt to correct participant thoughts, cognitions, or beliefs; Zarling et al., 2019). Motivational Interviewing is another promising approach to IPV, in

which program facilitators help participants who may not yet be ready for active behavioral change, to reflect and move toward a commitment to change (see Soleymani et al., 2018). Although the primary focus of each approach to treating IPV differs, in practice, most programs use a combination of treatment approaches (rather than a single modality). As such, it is not uncommon for programs to incorporate therapeutic elements from different treatment approaches (Babcock et al., 2016). Consequently, the distinction between programmatic approaches is often not clear. For example, although the STOP program evaluated herein is primarily CBT-oriented, the program curriculum has some overlap with other treatment approaches (e.g., trauma-informed, humanistic, social learning).

Referral Status of Participants. Typically, participants in IPV programs are court-mandated to attend. A recent finding from the North American Domestic Violence Intervention Program Survey estimates that court-mandated offenders make up approximately 90% of IPV program participants, while 5% are voluntary clients (Cannon et al., 2016). Some studies have compared recidivism outcomes of voluntary and court-mandated perpetrators who have participated in an IPV intervention; the results of these studies have been mixed. While some studies suggest that men who are mandated to attend an IPV treatment program demonstrate lower rates of recidivism than men who attend the program voluntarily (e.g., Rosenbaum et al., 2001), opposing findings suggest that court-mandated men show an increased risk of recidivism (e.g., Hanson & Wallace-Capretta, 2004; Shepard et al., 2002). Further, a more recent study suggests no significant differences in recidivism outcomes between mandated and voluntary IPV program participants (Tutty et al., 2019). As existing evidence finds varied levels of IPV intervention effectiveness depending on the referral status of an offender (see also Stoops et al., 2010), debates have ensued concerning the mixing of voluntary and mandated participants in IPV intervention programs (Radatz & Wright, 2016; Scott et al., 2017; Tutty et al., 2019). As STOP combines both mandated and voluntary participants in their program (described below), the current study contributes to the limited knowledge on the effectiveness of IPV interventions that deliver their programs to a mixed cohort of voluntary and mandated participants.

Effectiveness of IPV Intervention Programs

Recidivism is the most commonly used outcome measure to assess IPV intervention effectiveness. To date, systematic reviews and meta-analyses on IPV interventions (not limited to CBT approaches) have largely failed to reliably conclude that programs are effective at reducing abusive behavior. For example, a recent meta-analysis by Arias et al. (2013) pooled effect sizes across 19 IPV program evaluations and found a positive but nonsignificant treatment effect ($\delta = 0.41$). Similarly, a 2013 systematic review of 20 IPV intervention programs reported 9 studies showing positive and significant effects in reducing IPV, 6 studies reporting no differences, while 5 studies provided insufficient data (Eckhardt et al., 2013).

Relying on recidivism measures alone to draw conclusions about IPV program effectiveness, however, is likely to be misleading as recidivism measures often fail to

capture other important indicators of program success. Although considerably less common, some studies have evaluated the impact of IPV programs using nonrecidivism outcomes. For example, Crockett et al. (2015) used outcomes *associated with* abusive behaviors to evaluate the effectiveness of a psychoeducational program for IPV offenders. The authors found significant improvement in participant skillsets from pretest to posttest such as "taking responsibility for violent behaviors" ($p < .001$), "managing anger" ($p = .01$), and "desire for change in their violent behaviors" ($p < .01$). Similarly, Cranwell Schmidt et al. (2007) evaluated short-term changes in attitudes toward abusive behavior of male participants in a group-based IPV intervention program, with participants demonstrating significantly positive changes ($p < .01$) following program completion. Qualitative analyses have also been used to examine participants' perceptions of change throughout a program (e.g., Kilgore et al., 2019; Smith, 2011), as well as key themes relating to the change process (e.g., accountability for past behavior, communication skills, nonviolence strategies, motivation to change; see Smith, 2011).

The Current Study

The current study uses mixed methods to conduct a pilot evaluation of the STOP IPV intervention program. The program is described in detail below; in brief, STOP uses a primarily CBT approach and combines both mandated and voluntary participants. The evaluation design incorporates recidivism outcomes on a validated scale as well as open-ended knowledge and skills questions.

The STOP Program. Created in 1991, STOP is a cognitive behavioral group-based program that provides an opportunity for men who are involved in abusive/violent behaviors to access information on how to control their emotions, communicate better with their partners, and change the thoughts and beliefs that enable abusive behavior (John Howard Society of BC, n.d.). The long-term goal of the program is to eliminate all forms of violence and abusive behavior by male offenders. Although STOP is primarily a voluntary program and many men self-refer (i.e., they or their families/friends recognize they need help) or are referred from sources including the police, the Ministry of Children and Family Development, community corrections agencies, health agencies, treatment centers, and law offices, other participants are mandated by the courts or by their probation officer to register. STOP is delivered by the John Howard Society of British Columbia (JHSBC), a nonprofit charitable organization with an over 80-year history of delivering programs and services to assist individuals who have come into contact with the law or who may be at risk of conflict with the law (e.g., persons facing multiple cultural, economic, and/or social barriers).

Initial intake screenings of participants are done via a phone consultation with JHSBC staff; the second level of screening occurs during a one-to-one in-person intake session during which participants complete a questionnaire concerning their risk of violent behavior. These screenings assess willingness to change, and potential barriers to participation in the group such as severe mental health issues, violent behavior, and active substance use. In addition, program staff check in with the partners of

participants to assess their safety (if partners agree to be contacted; they are then invited to attend a separate group for information about the content being delivered in the men's group). The men's program is 12 weeks in duration, with weekly 3-hour sessions cofacilitated by a male/female team. Following completion, participants are encouraged to repeat the program when appropriate or requested. The STOP program is primarily based on CBT strategies; the curriculum includes psychoeducational components (e.g., cognitive restructuring, changing negative patterns of thought), cognitive behavioral teachings such as anger management techniques (e.g., timeouts, relaxation, breathing exercises), and skills for effective communication (e.g., active listening, conflict resolution). Program facilitators have a minimum education of a bachelor's degree, experience working with male perpetrators of domestic violence/abuse and experience with group therapy processes. Table 1 provides a brief overview of the 12 curriculum sessions; the STOP facilitator's manual is comprehensive, detailed, and intended for ease of implementation and replication by facilitators in different JSHBC sites and other community-based organizations.

TABLE 1. Curriculum Content

Curriculum Session	Content/Activities
(1) What is abuse?	Introductions, check-in guidelines, what is domestic violence, different types of abuse, Power and Control Wheel, checkout guidelines
(2) Emotional literacy	Breathing exercise, discussing emotions, range of emotions, expressing emotions in a healthy way
(3) Anger and emotions	Relaxation exercise, increase awareness and understanding regarding anger and emotions, strategies for dealing with anger, anger volcano
(4) Anger and stress	Anger log, the three R's of communication, brain cutoff point, the anger scale, self-talk, how to talk yourself down, time out techniques, common thinking errors, defensive behaviors, expressing anger respectfully
(5) Communication: Self-talk	Mindfulness exercise, the voice inside our head, types of self-talk, self-talk techniques, affirmations, anger diffusing technique
(6) Communication: Nonviolent communication	Four elements of nonviolent communication: (1) observations, (2) feeling, (3) needs, (4) request, taking responsibility
(7) Communication: Interpersonal	Relaxation exercise, elements of respectful communication, two-way communication, guidelines for active or reflective listening, conflict resolution, effective communication techniques, obstacles to listening

(Continued)

TABLE 1. Curriculum Content *(Continued)*

Curriculum Session	Content/Activities
(8) Self-esteem	Increased understanding and awareness regarding self-esteem, the ABCs of core beliefs, gratitude, being assertive
(9) The partner's perspective	Developing empathy for those who have been victims of domestic violence, why she doesn't leave, power and control, the five stages of grief
(10) Accountability	Letter of responsibility: reasons for writing, statement of apology, statement of responsibility, statement of understanding of impact, statement of what you are doing about it, recurrences, statement of future intent
(11) Toxic shame	What is shame, shame as identity, shame and guilt, understanding shame and pride, shame in unhealthy families, shame within upbringing, understanding the role of shame in family healing
(12) Plan overview/ celebration	Relapse plan; promises for future

METHODS

Research Design and Data Collection

The evaluation of STOP was conducted as part of a larger study of 12 domestic violence intervention programs operating throughout the province of BC in 2017–2018. The STOP program was evaluated across three geographically disperse JHSBC program sites from October 2017 to June 2018. The evaluation was designed as a single group pretest/posttest with a 6-month follow-up (due to resource and logistical constraints a comparison group design was not possible). Prior to the start of the program, the evaluation team (consisting of the study authors) reviewed the pretest and posttest questionnaire items with STOP program staff and instructed staff on survey administration procedures. Program staff administered paper-and-pencil pretest questionnaires to participants on either the first day of the program or during program intake prior to the first day; similarly, staff administered posttests in-person on the last day of the program. Participants were informed of the purpose of the evaluation, voluntary participation, the risks and benefits of participation, confidentiality of responses, and phone numbers to call for additional support. Respondents were given the option of including their personal contact information on their surveys or using a unique identification number; all respondents opted to include their contact information. Respondents were assured confidentiality of responses, and that the surveys would not be read or retained by program staff and instead given directly to the evaluation team. To incentivize participation in the evaluation, the consent form specified that all respondents who completed the 6-month follow-up questionnaire

would be provided a $50 payment in their choice of an Amazon e-gift card, a check, or cash. Completed surveys were collected by program staff and mailed to the evaluation team; surveys were not viewed or retained by program staff or the organization. The follow-up questionnaires were administered online approximately 6 months following program completion. Across the three cycles of the STOP program, a total of 39 men enrolled and 37 participants completed the pretest survey (95%); of the pretest respondents 23 completed the posttest survey (62%). Response rates to the follow-up survey were very low (n = 10); results are not presented here.

Measures and Instrumentation

Knowledge and Skills (Qualitative). In order for an intervention program to successfully alter behaviors, participants must gain and retain knowledge that is taught throughout the program. The pretest and posttest surveys contained two open-ended questions assessing respondent knowledge of the STOP curriculum content and key concepts of change. Specifically, the questions assessed knowledge regarding (a) skills to deescalate emotions and (b) healthy ways to express emotion. These measures were developed in collaboration with the program developer and are based on specific content delivered in the program curriculum.

Recidivism (Quantitative). Participant abusive behaviors were assessed using the Abusive Behavior Inventory—Partner Form (ABI; Shepard & Campbell, 1992). The validated instrument is a self-report questionnaire containing 29 items and encompassing two subscales: Physical Abuse (9 items) and Psychological Abuse (20 items). Both ABI subscales have demonstrated strong internal consistency in prior research, with alphas ranging from .70 to .92 (Shepard & Campbell, 1992; Zink et al., 2007). The 29 ABI items are measured using a 5-point Likert scale with answers ranging from 1 (never) to 5 (very often). The questions are designed for respondents who are currently or recently involved in an intimate relationship; a lead-in question asks "at any point during the past 3 months, did you have a partner/significant other? (e.g., girlfriend, fiancée, wife)?" Respondents who did not have a partner during this time were asked to skip the ABI portion of the questionnaire.

Analytic Approach

Sample Characteristics. Frequency counts/percentages were calculated for background questionnaire items for the full sample of participants who completed the pretest (n = 37), as well as the subsample who completed the ABI at both pretest and posttest (n = 15). Fisher's exact chi-square tests were used to compare the groups; no significant differences were found.

Nonrecidivism Outcomes (Knowledge and Skills). Two stages were involved in the analysis of the open-ended questions. In the first stage, textual analysis was used to identify the dominant themes across participant responses for each question, and to organize responses into thematic categories. To be included as a "category," items had to display a minimum level of saturation with mentions at least four times at one time point. Two coders reviewed all categories and coded participant responses

accordingly. Discourse analysis was used in the second stage of the analysis to examine how often the categories identified in stage 1 were mentioned by participants, and whether any differences could be identified over time. McNemar tests for paired data were used to compare pre- to posttest results; statistical significance was examined with the Exact McNemar significance probability (a conservative *p*-value for small samples).

Recidivism Outcomes (ABI). Mean scores and standard deviations at each time point were computed for each of the ABI questionnaire items. The 20 items reflecting psychological abuse were summed and averaged to obtain a Psychological Abuse subscale score; similarly, the nine items reflecting physical abuse were summed and averaged to obtain a Physical Abuse subscale score. Difference scores (between posttest and pretest) were computed for both subscales and a Shapiro–Wilk test was used to test for normality in the scores. Normally distributed difference scores were examined using paired-samples *t* tests; otherwise, Wilcoxon signed-rank tests were used as a nonparametric alternative.

FINDINGS

Pretest and posttest response rates across the three program sites for the various outcome measures are shown in Table 2.

TABLE 2. Enrollment and Response Rates

Site	# Enrolled	# Completing Pretest (% of Enrollees)	# Completing Posttest (% of Pretest Completers)
A	13	# completing pretest ABI: 11 (85%) # completing qual #1 pre: 12 (92%) # completing qual #2 pre: 12 (92%)	# completing post-test ABI: 8 (73%) # completing qual #1 post: 9 (75%) # completing qual #2 post: 9 (75%)
B	11	# completing pretest ABI: 10 (91%) # completing qual #1 pre: 10 (91%) # completing qual #2 pre: 10 (91%)	# completing posttest ABI: 3 (30%) # completing qual #1 post: 3 (30%) # completing qual #2 post: 2 (20%)
C	15	# completing pretest ABI: 6 (40%) # completing qual #1 pre: 14 (93%) # completing qual #2 pre: 11 (73%)	# completing posttest ABI: 4 (66%) # completing qual #1 post: 10 (93%) # completing qual #2 post: 11 (100%)

(Continued)

TABLE 2. Enrollment and Response Rates *(Continued)*

Site	# Enrolled	# Completing Pretest (% of Enrollees)	# Completing Posttest (% of Pretest Completers)
Total	39	# completing any question: 37 (95%) # completing pretest ABI: 27 (69%) # completing qual #1: 36 (92%) # completing qual #2: 33 (85%)	# completing any question: 23 (62%) # completing posttest ABI: 15 (56%) # completing qual #1 post: 22 (69%) # completing qual #2 post: 22 (67%)

Note. ABI = Abusive Behavior Inventory; qual = qualitative open-ended question.

Characteristics of Full Sample

The 37 men who completed the pretest survey are described here and shown in Table 3. The average age of the sample was 42.5 years, with 30% of the respondents identifying as Aboriginal and 46% as White. More than half of the respondents had at least some postsecondary education (60%), and most of the participants were currently employed (62%). Thirty participants (81%) had children; of the fathers, 28% indicated that at least some of their children were currently living with them. Over two-thirds of the respondents (66%) indicated that they were attending the program voluntarily, and 9 of the participants (24%) had previously participated in a domestic violence intervention program (it is unknown whether this was the STOP program or a different program). With respect to criminal history and other risk factors, the participants identified as a moderate risk group with 16 men (44%) having previously been arrested for spousal assault and 20 men (57%) having received other charges or convictions (such as threats, trafficking a controlled substance, break and enter). Twelve men indicated that a protection order was in place for him concerning his partner/or their children (32%). Twenty of the respondents reported that, as a child, they had been exposed to domestic violence at home (56%), while 16 respondents (46%) had been a direct victim of domestic violence as a child. Nearly two-thirds of the respondents indicated that they suffered from anxiety (64%), and 64% (n = 23) reported experiencing depression.

Nonrecidivism Outcomes (Knowledge and Skills)

Table 4 displays the response category as well as example responses provided by participants for each of the two open-ended questions. The table also shows pretest and posttest counts and percentages for responses per category (a given respondent's answer may have been categorized in more than one category), and the McNemar's chi-square and p-value for the differences in category counts between pretest and posttest.

TABLE 3. Sample Characteristics

Item Response	Full Sample (n = 37) N (%)	ABI Completers (n = 15) N (%)
Age (mean)	42.49 years (19–70)	41.73 years (24–59)
Ethnicity		
White	17 (46%)	4 (27%)
Aboriginal	11 (30%)	6 (40%)
Other	4 (11%)	2 (13%)
No response	5 (14%)	3 (20%)
Immigrant status		
I was born in Canada	31 (84%)	14 (93%)
I immigrated to Canada	5 (13%)	1 (7%)
No response	1 (3%)	0
Education		
Elementary or some high school	9 (24%)	6 (40%)
Graduated high school	6 (16%)	1 (7%)
Some college, vocational, technical, or trade school	17 (46%)	6 (40%)
Undergraduate degree or diploma	5 (14%)	2 (13%)
Employment status		
Full time	15 (41%)	8 (53%)
Part time	5 (14%)	2 (14%)
Self-employed	2 (5%)	1 (7%)
Seasonal	1 (3%)	1 (7%)
Unemployed	5 (14%)	1 (7%)
Disability	4 (11%)	1 (7%)
Income assistance	3 (8%)	1 (7%)
Retired	2 (5%)	0
Marital status		
Single	10 (28%)	3 (21%)
Living common-law	6 (17%)	3 (21%)
Married	6 (17%)	4 (29%)
Separated	10 (28%)	4 (29%)
Divorced	3 (8%)	0
Widowed	1 (3%)	0
No response	1 (3%)	1 (7%)
Do you have children? (Yes)	30 (81%)	13 (87%)
If yes, are any of them living at home with you? (Yes)	8 (28%)	6 (50%)
Criminal history Ever been…		
Arrested for spousal assault?	16 (44%)	6 (40%)
Charged for spousal assault?	14 (39%)	4 (27%)

(Continued)

TABLE 3. Sample Characteristics *(Continued)*

Item Response	Full Sample (n = 37) N (%)	ABI Completers (n = 15) N (%)
Convicted of spousal assault?	8 (22%)	3 (20%)
Charged or convicted of any other offense?	20 (57%)	7 (54%)
Protection services		
Child protection services currently involved with your family?	12 (32%)	5 (33%)
Protection order in place with your partner and/or children?	18 (49%)	6 (40%)
History of domestic violence		
Exposed to domestic violence at home as a child?	20 (56%)	11 (73%)
Direct victim of domestic violence as a child?	16 (46%)	8 (57%)
History of substance use in past 3 months		
Alcohol	19 (53%)	8 (53%)
Marijuana	10 (28%)	8 (53%)
Street (illicit) drugs	3 (8%)	2 (13%)
Mental health		
Suffer from anxiety	23 (64%)	7 (47%)
Suffer from depression	23 (64%)	8 (53%)
Program history		
Prior participation in a domestic violence intervention/prevention program?	9 (24%)	4 (27%)
Mandated to attend	12 (33%)	4 (29%)

Note. ABI = Abusive Behavior Inventory.

Question 1. Skills to Deescalate Emotions. Using the CBT model, participants are taught a number of ways to understand and manage their emotions, such as self-awareness, recognizing triggers and cues, taking a time out, self-talk, and mindfulness/relaxation exercises. The participants are taught that by changing their self-talk when angry, they can deescalate their anger and regain self-control. Participant responses regarding deescalation fell into four thematic categories: (a) stay calm, relax, (b) cognitive behavioral strategies, (c) think of the bigger picture, and (d) take a positive perspective on life (e.g., *"focus on the positive," "it's a beautiful day"*). At pretest, respondents showed some degree of knowledge regarding emotional control, with most responses falling within the categories of "stay calm, relax" (55%; e.g., *"Take a deep breath. Walk away"; Think about it, leave the house for some time"*) and "think of the bigger picture" (50%; e.g., *"Nothing is worth going back to jail for"; "Is it a hill*

TABLE 4. Open-Ended Knowledge and Skills Questions (n = 22)

Category	Example Responses	Pretest Count (%)[a]	Posttest Count (%)[a]	McNemar's Chi-Square (p-Value)
Self-Talk Kills to Deescalate Emotions				
Stay calm, relax, take time to think	Breathe, calm down, relax, cool down, walk away, do breathing exercises	12 (55%)	15 (68%)	1.80 (.375)
Cognitive behavioral awareness	Anger causes unclear thinking, it takes 2 to argue so what is my role in this, how do I feel, think before speaking	7 (32%)	13 (59%)	4.50 (.070)*
Think of the bigger picture	I really don't think this is a big deal, is this worth it, life is too short to live in anger, don't sweat the small stuff, will it matter a day/a week/a month from now?	11 (50%)	9 (41%)	0.50 (0.727)
Take a positive perspective	You are better than that, this will pass, everything will be okay	7 (32%)	6 (27%)	0.20 (1.000)
Knowledge Regarding Healthy Ways to Express Emotion				
Category	**Example responses**	**Pretest Count (%)[a]**	**Posttest Count (%)[a]**	**McNemar's Chi-Square(p-Value)**
Talking with partner (general)	Talk, communication, use your words	11 (50%)	6 (27%)	2.78 (.180)
Specific communication techniques with partner	Calmly assertive communication, listen to her, using "I" statements, "I feel that . . .I need"	6 (27%)	12 (55%)	4.50 (.070)*
Writing/reflecting	Writing, writing and analysis of result; taking a personal time out to gather thoughts to precisely know why you are feeling a certain way; letter to the person and thendestroying it	4 (18%)	1 (5%)	3.00 (.250)
Talking to a third party	Venting with somebody you trust, counseling, talk to friends to see what they think	4 (18%)	2 (9%)	0.67 (.688)
Affection	Showing you care, being compassionate, smile, hugs, be kind; telling her how happy you are; laugh, love	4 (18%)	7 (32%)	3.00 (.250)
Self-care	Listen to music, be calm and quiet, reading, working out, meditation	4 (18%)	3 (14%)	0.20 (1.00)

*$p < .10$.

[a]Total responses sum to >22 because some respondents provided an answer that fell into more than one category; percentages represent proportion of the 22 participants who provided an answer in the given category.

you want to die on. How big a deal is this problem"). Few participants discussed solutions/perspectives that would help in deescalating anger in the longer term, such as practicing self-awareness or realizing that one cannot force a partner to behave a certain way.

Participant responses at posttest demonstrate a marginally significant gain in knowledge for the category of "cognitive behavioral strategies" (from 32% at pretest to 59% at posttest; $\chi^2 = 4.50$, $p = .07$). For example, one respondent noted he considers the following: *"What my primary feelings are, what are my secondary feelings. What filters I am using to blurr my communication with my partner. How am I feeling physically, what can I do physically to feel differently"*. Another respondent noted *"Anger and the possible result of losing control is on me, no one can make me mad / angry. As such I focus on grounding myself: what do I see, what do I hear, what do I feel physically, what do I smell and taste. This may only take a moment or two, but will get me out of my head space and focus on what I am allowing to get the better of me."* Altogether, following completion of STOP, participant responses suggest a clearer understanding of the connection between thoughts, feelings, and behaviors, signaling recognition that the ability to control their thoughts and emotions can enable them to deescalate feelings of anger.

Question 2. Knowledge Regarding Healthy Ways to Express Emotion. Learning effective communication techniques and expressing emotion in healthy ways are important nonviolence skills. In the STOP curriculum, participants are taught that achieving healthy emotional expression requires them to first become aware of what they are feeling before trying to communicate it. As demonstrated in Table 4, at pretest most responses (50%) were centered around the theme of general talking with their partner (Theme 1), for example, *"talk about it," "use your words,"* and *"communication."* Just over one-quarter of the responses (27%) focused on more specific communication techniques (Theme 2; e.g., *"verbalize your feeling, frustration, act in a clam manner," "communication without anger,"* and *"write a note."*) Other categories identified through the thematic analysis included (3) writing/reflecting, (4) talking to a third party, (5) displaying affection to their partner, and (6) practicing self-care (18% each).

Notably, following completion of the program, participant responses were less focused on general communication with their partner (27% at posttest vs. 50% at pretest) and instead were marginally significantly more likely to discuss specific communication techniques (55% at post-test versus 27% at pretest, $\chi^2 = 4.50$, $p = .07$). For example, one response concerning specific techniques included the following: "*Using "I" language. Being concise with primary feelings and explaining in calm manner. Lessening physical posture, tone, volume when communicating*", suggesting that the participant had learned and retained a range of healthy communication strategies. Another participant indicated that healthy emotion should be done *"In a calm manner. Respond to your emotions don't react to them"; "I feel that . . . I need . . . ,"* while another noted the importance of asking for clarification, that is, *"Asking honest questions about how your partner feels and perceives the same situation."*

TABLE 5. Abusive Behavior Inventory Pre- and Posttest Scores (n = 15)

	Pretest	Posttest	Sig.	
	Mean (*SD*)	Mean (*SD*)	Z/*t* score (*p* value)	**Effect Size (*d*)**
Physical Abuse subscale	1.25 (.35)	1.04 (.08)	$Z = 2.53$ ($p < .05$)	0.82
Psychological Abuse subscale	1.75 (.62)	1.20 (.24)	$t = 4.23$ ($p < .001$)	1.18

Note. *SD* = standard deviation.

Recidivism Outcomes (ABI)

Of the total respondents, 15 completed the ABI section of the survey at both pretest and posttest. Only those men who reported having had an intimate partner within the past 3 months were eligible to complete the ABI, which may account for some of the nonresponse to the instrument (i.e., 23 men completed both surveys but only 65% of these respondents completed the ABI). Fisher's exact chi-square tests were conducted to assess differences between the full sample of participants and participants who completed the ABI on any of the background items. No statistically significant differences were observed.

Table 5 presents the mean scores for the Physical Abuse and Psychological Abuse subscales at pretest and posttest (range 1–5). Findings for both scales show a statistically significant decrease in abusive behavior from pretest to posttest. Specifically, on the Physical Abuse subscale the mean of 1.25 (standard deviation [*SD*] = .35) at pretest dropped to 1.04 (*SD* = .08) at posttest ($Z = 2.53$, $p < .05$, $d = 0.82$). Similar findings are demonstrated for the Psychological Abuse subscale, where the mean score of 1.75 (*SD* = .62) at pretest decreased to 1.20 (*SD* = .24) at posttest ($t(14) = 4.23$, $p < .001$, $d = 1.18$). Altogether, the results from the ABI suggest that participation in STOP contributed to a significant decrease in physical and psychological abuse.

DISCUSSION

Despite the widespread use of CBT approaches in IPV intervention programs, there has been little reliable evidence that using this approach consistently contributes to reductions in abusive behaviors (e.g., Arias et al., 2013; Nesset et al., 2019). Nonetheless, IPV intervention programs delivered by community-based organizations are common and a key alternative to the criminal justice system for perpetrators of IPV (Abraham & Tastsoglou, 2016; Heise, 2011). As such, continuing to evaluate their effectiveness is important. In this pilot study, we examined the impact of the STOP program that serves a mix of voluntary/mandated men who have used violence in their intimate relationships. Using a mixed methods approach, positive program impacts were found for measures of recidivism, and some promising outcomes for gains in program-specific knowledge and skills.

As distorted thinking patterns and creating awareness of thoughts and behaviors are central to CBT-oriented interventions, participants are typically encouraged to examine the context of their abusive behaviors, examine the connection between emotions and maladaptive thinking patterns, and consider failures of self-regulation (Clark, 2011). Consistently, objectives of CBT interventions for perpetrators of IPV typically involve teaching participants healthy communication skills, assertiveness (without using violence), and anger management techniques (Babcock et al., 2004). With respect to the qualitative analysis of open-ended questions regarding the acquisition of knowledge and skills, participant responses at posttest suggest an increased awareness and understanding of their emotions, as well as the connection between emotions and maladaptive thought processes. In addition, several participants showed an enhanced understanding of their intrapersonal patterns of thought and cognitive processes, including the ability to identify the causes of their anger, the circumstances surrounding their violent behaviors, and how emotions underlie their violent tendencies. In particular, participant responses reflected growth with respect to cognitive behavioral awareness and learning to respond to a situation rationally (rather than responding instinctually with anger).

This finding is important because although many CBT-oriented interventions for perpetrators of IPV include discussions about emotions (particularly anger) and anger management strategies, the inclusion of such components have been met with some criticism (see Healey et al., 2009 for a full explanation). While the effectiveness of CBT-informed anger management strategies for general criminal rehabilitation has been demonstrated (Henwood et al., 2015), there is currently limited evidence to support this approach for perpetrators of IPV (Gilchrist et al., 2015). Further, these gains in knowledge and skills are important indicators of positive program outcomes and overall effectiveness, as "addressing external factors that contribute to violence by teaching skill sets, such as anger and stress management, . . . is an essential element of an effective [Batterer Intervention Program]" (Crockett et al., 2015, p. 490). Consistent with existing literature, our findings suggest that nonrecidivism outcomes are important measures of program success and are linked to a number of positive outcomes that are associated with reducing abusive behaviors (e.g., helping participants avoid situational violence, empowering men to take control of their violent behaviors, fostering healthier relationships with their partners).

With respect to the quantitative recidivism outcomes examined in this study, the findings suggest that participation in STOP contributed to a significant decrease in psychological abuse (31% decrease). Although this is a pilot study with limitations noted below, this finding is important for two primary reasons. First, extant research suggests that the adverse effects of psychological abuse (e.g., depression, anxiety, posttraumatic stress) may last longer and be more destructive to women's day-to-day lives than the impacts of physical abuse or sexual abuse (Follingstad, 2009; Ludermir et al., 2010). Second, the literature suggests that psychological abuse is a strong indicator of later physical abuse (O'Leary, 1999; Schumacher & Leonard, 2005). As such, the significant reduction in psychological abuse is encouraging. In addition, the findings also suggest that participation in STOP contributed to a significant decrease in

physical abuse (17% decrease). These findings lend further support for the teaching of CBT techniques and skills (e.g., emotion/anger management, communication, conflict resolution) in IPV intervention programs (Miller et al., 2013). Notably, low rates of abuse perpetration were reported by participants at both time points. However, as STOP is an early intervention program that primarily targets self-referred/non-court-mandated participants, it is likely that the majority of participants were not violent offenders (i.e., few men had a criminal history of IPV-related offences or other violent offences). Further, it is possible that the particularly low self-reported rates of physical abuse are the result of men engaging in early intervention, and that their abusive behaviors may not yet have escalated to physical abuse (see O'Leary, 1999; Schumacher & Leonard, 2005). Regardless, when it comes to reducing the perpetration of abusive behaviors, any decrease in violent behaviors is meaningful (Crockett et al., 2015).

While it is not uncommon for IPV offenders of varying levels of risk and/or different sources of referral (i.e., mandated or voluntary) to be grouped together in intervention programs (Scott et al., 2017), some literature questions the possible negative impacts of mixing voluntary and court-mandated IPV offenders (Radatz & Wright, 2016; Scott et al., 2017; Tutty et al., 2019). Some of these concerns include, for example, significant differences in participant level of risk and severity of criminal history, and the possibility that mixing participants may lead to criminogenic peer associations. Similar concerns have been discussed with respect to the possible detrimental impact to group cohesion and how this may negatively impact participant learning (Radatz & Wright, 2016; Scott et al., 2017; Tutty et al., 2019). While some literature on general criminal rehabilitation supports the negative impacts of mixing low-risk and high-risk offenders (Bonta et al., 2000; Marlowe et al., 2006), evidence is currently lacking to substantiate these concerns for the treatment of IPV offenders (Scott et al., 2017). Although the current study did not test for any effects of mixing of voluntary and court-mandated participants, it is possible that some findings may have differed had voluntary and court-mandated men participated in separate programs. Based on our preliminary positive and promising findings for both recidivism and nonrecidivism outcomes, mixing participant types does not seem to have thwarted the overall impact of the program.

Perhaps due to the overwhelming focus on court-mandated participation in IPV intervention programs, the effectiveness of IPV interventions on voluntary participants appears to be largely overlooked in the academic literature. Consistently, many systematic reviews and meta-analyses of IPV intervention programs (e.g., Babcock et al., 2004; Eckhardt et al., 2013; Smedslund et al., 2011) have neglected to differentiate findings between voluntary and mandated participants. This lack of differentiation between participants is noteworthy as treatment mandate has been shown to be an important moderator of correctional treatment effectiveness on general recidivism. For instance, in their meta-analysis of treatment mandate, Parhar et al. (2008) compared the effectiveness of mandated, coerced, and voluntary correctional treatment on reducing general recidivism. Significant differences were found among all three levels of treatment mandate ($F = 3.12$, $p < .05$), and post hoc comparison

analyses showed that voluntary treatment was significantly more effective at reducing general recidivism than was mandated treatment. Given this finding, the lack of empirical evidence surrounding IPV intervention programs for voluntary participants is a substantial limitation of the available literature on effectiveness. Further, the lack of differentiation between program participants means that very little of the existing research on IPV intervention effectiveness can be used as a benchmark for the effectiveness of intervention programs for voluntary participants.

Based on our preliminary findings for the STOP program on both recidivism and nonrecidivism outcomes, the use of CBT as a primary intervention for men who have used or are at risk of using violence in their intimate relationships seems to have a positive and promising overall impact on its participants. Altogether, given that the current findings are based on a small sample size and associated low levels of statistical power, results should be considered preliminary evidence of STOP program effectiveness. However, the fact that positive outcomes were observed in the analysis of open-ended questions, and that significant effects were found for both ABI subscales despite the small sample size, lends further support for program impacts. Given the limited existing research on the effects of IPV intervention programs on voluntary, nonjustice involved offenders, as well as the examination of nonrecidivism outcomes, this study offers a valuable contribution to the IPV evaluation research literature. Future studies are encouraged to consider the importance of more comprehensive measures of "effectiveness" and "success" (i.e., beyond measures of recidivism outcomes alone), and integrate measures of nonrecidivism outcomes into their evaluations of IPV programs. In addition, future evaluations of IPV program effects should continue to integrate quantitative and qualitative methods, as this mixed methods approach may offer a greater understanding of what participants are learning and how this information can be used to improve the overall effectiveness of IPV interventions.

Limitations. There are several limitations to consider in this pilot evaluation. First, due to the small sample size of respondents, our conclusions about the impacts of STOP may be an artifact of the particular set of respondents who completed the surveys, or other variables such as facilitator experience, program logistics, and so forth. Despite collecting data across three cycles of STOP, the small sample was due to small numbers of participants in each group, low posttest response rates, and only a portion of the men (65%) having intimate partners within the past 3 months and being eligible to complete the ABI. It is possible that response rates were impacted by respondents opting to include their contact information as opposed to an ID number. Second, with respect to the planned 6-month follow-up data, only 10 program participants completed a follow-up survey. The lack of follow-up data prevented an assessment of the program's attainment of its longer term outcomes. Third are the standard internal validity limitations associated with a single-group before-and-after evaluation design. Pretest and posttest designs without a comparison group are generally considered to overestimate effect sizes; endogenous changes cannot be ruled out without the use of a comparison group.

There are also some general limitations concerning the nature of the data collected. Given resource constraints, official measures of recidivism (i.e., police contact, arrests, charges, and convictions for assault) were not feasible to collect. Instead, we used self-report participant surveys. Limitations of self-report surveys include that they can be subject to inaccurate recollection, purposeful deception/withholding of information, and social desirability (i.e., respondents answering in a way they believe will reflect well on them). Last, the perspective of the partner is an important consideration when evaluating the effectiveness of IPV intervention programs; without her feedback to corroborate/validate reports regarding his abusive attitudes and behaviors, the dependence on perpetrator data to be accurate/reliable is precarious (Kelly & Westmarland, 2016). While attempts to contact partners were a part of the evaluation plan in the current study, only one partner responded to the posttest survey and data are not included here.

CONCLUSION

IPV is a prevalent occurrence with well-known negative outcomes for survivors and victims. Previous research suggests mixed findings regarding program effectiveness; the need to determine best practices for IPV intervention programs is urgent given the high personal and social costs associated with this violence. The STOP program offers a promising approach to reducing violent and abusive behaviors, an important finding given the program's target clientele of voluntary and nonadjudicated participants. Future research on STOP should be extended to larger samples in additional program sites, enabling researchers to examine moderators of program effectiveness such as facilitator and participant characteristics. Overall, further research is needed to develop a solid evidence base for community-based responses to IPV, ensuring that effective services are provided so that the adverse and destructive impacts of IPV are reduced.

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