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Chapter 2

Policy Discussions on LGBTQ Intimate Partner Violence in North America

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Additional information is available at the end of the chapter

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Abstract

This chapter delves into social policy and welfare regarding intimate partner violence (IPV) across North America, specifically around research, policies, and treatment interventions for the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. In this chapter, we outline the problem of intimate partner violence, or IPV, in the USA; analyze IPV policies at the state and national levels; and advocate for more specific treatment interventions to address the unique needs of this community.

Keywords: social policy, LGBTQ, intimate partner violence, social justice

1. Introduction

Intimate partner violence (IPV), defined as emotional and/or physical abuse in an intimate relationship, is a pernicious social problem with wide-ranging causes and consequences for individuals, families, and communities. Although comparatively little scholarship has focused on IPV in same-sex relationships, relative to heterosexual couples, there is clear empirical evidence that IPV in lesbian, gay, bisexual, and transgender (LGBTQ) relationships occurs at comparable or greater rates than opposite sex relationships (see [1, 2]). For instance, Walters et al. [1] using the National Intimate Partner and Sexual Violence Survey (NIPSVS) found that 43.8% of self-identified lesbians reported having been physically victimized, stalked, or raped by an intimate partner in their lifetime, compared to 35.0% of heterosexual women, 29.0% of heterosexual men, and 26.0% of gay men. Bisexual women experienced the highest rates of IPV with 61.1% [2]. (For a more in-depth analysis of the breakdown in types of IPV perpetration by sexual orientation, see [1, 2].) It is important to note that the question of sexual orientation did not include trans* identified people, leaving information on this population uncollected and the

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depth of the problem undefined. Recent studies have attempted to identify what resources if any are available for the treatment of LGBTQ perpetrators (see, for instance [3]).

In this chapter, we further develop these nascent discussions by providing an overview of recent IPV research and policy in the USA. We then delve into limited existing research on LGBTQ programming and views on policy standards and treatment interventions provided by batterer intervention programs (BIPs) across the USA and Canada. Since batterer intervention programs are a primary source of treatment intervention for IPV in North America, and since these programs reside at the nexus of research, policy, and treatment, our research provides insight into the problem of IPV as well as social policies and welfare in the USA.

2. Addressing social policies: analysing LGBTQ IPV policy in the USA

Given the prevalence of the problem, scholars have begun to employ an array of theoretical frameworks and research methodologies to further understand the problem of IPV in LGBTQ relationships (e.g., [4, 5]) in order to better inform policymakers (e.g., [2, 3]) and to develop more acute treatment interventions (e.g., [2, 6]). For instance, Cannon et al. [4] apply a post-structural feminist approach to occurrences of IPV, to show that women cannot be understood as powerless and men cannot be depicted as having all the power as assumed in a US traditional feminist paradigm. Women can and do exercise power; sometimes in forms similar to how men use power (such as to perpetrate IPV) [4, 12]. However, because we live in a society that privileges men and heterosexual people, how we understand the use of this power is both important and different.

Therefore, scholars have begun to argue that policy proscriptions and treatment interventions should reflect these differences in order to better account for the various experiences, motivations, meanings, and contexts of perpetrators and victims (see [4, 7, 8, 5]). As Cannon and Buttell [8] argued, IPV policy in the US perpetuates an illusion of inclusion" through inclusive language that pays lip service to non-heterosexual relationships (e.g., the use of the term "partner") but has the unintended consequence of serving to obfuscate key dynamics of IPV. In terms of treatment of IPV in the USA, scholars applying a post-structuralist feminist framework to IPV add to the growing chorus of scholars that argue that a one-size-fits-all treatment model for IPV perpetrators (e.g., the Duluth Model) should be replaced by culturally relevant and specific treatment options for different categories of perpetrators (e.g., heterosexual women, LGBTQ) (see [9, 7, 3]). The most compelling point these scholars advance is that all treatment interventions should address issues of sexism, homophobia, racism, and classism in order to address not only personal motivations of perpetrators but also the ways society materially disadvantages some while privileging others (e.g., [4]).

3. Methods and data

Much of what is known about batterer intervention programming nationally is derived from Price and Rosenbaum's [10] analysis of 276 batterer intervention programs (BIPs) in 45 states.

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They found that although 74% of programs reported that they served both male and female perpetrators, and 78% reported that they would serve LGBT clients, the percentage of female clients actually served was only 10% and LGBT clients 1% [10]. In order to further explore how policy affects LGBTQ clients in BIPS, we developed the first North American survey of its kind, distributing cover letters to 3256 BIPs across the USA and Canada. Our study employed a mixed-method design for the survey, the *North American Survey on Domestic Violence Intervention Programs* (NASDVIP), employing 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 survey instrument was designed by the research team with certain aims in mind, most importantly, to ascertain what domestic violence BIPs were like across North America. To do this, the NADVIPS investigated facilitator demographics, client demographics, facilitator insights, and program logistics. We studied not only philosophy and structure of these programs but also the demographics of both facilitators and clients. Data were then analyzed using content analysis to better understand the needs and services of the LGBTQ community and to gauge the frontlines of IPV interventions across the USA and Canada.

The NASDVIP was sent to 3256 batterer intervention programs across North America for which we had hard and electronic addresses. Any member over the age of 18 was eligible to complete the survey. Programs were contacted using a recruitment letter asking whether they would like to participate by going online to complete the survey for which a link was provided. The survey was administered through the third party, Survey Monkey, in order to maintain anonymity of responses. Of these communications, 2710 were mailed and 546 were emailed. 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), we calculated a conservative estimate of 65% non-contact rate (see AAPOR non-contact rate estimates). This means that we estimate 65% of BIPs for which we had hard addresses never received our mailed communications. There were 238 total responses. Thus, using AAPOR standards, we calculate a response rate of 20% for mailings. The response rate for email was 45% calculated by how many people completed the survey divided by the number of people who clicked on the email link.

4. Discussion of results

4.1. Program logistics

In order to analyze practitioners' views on policies and their effects on LGBTQ communities, we review program logistics. The average length of a BIP was 30 weeks (SD = 12.12), ranging from 8 to 78 weeks, with the mode for program duration was 26 weeks (N = 178). The average duration of each session was 103 minutes (SD = 19.1) with the mode for session duration being 120 minutes (N = 184). 96.7% (N = 176) of sessions met once a week. The average number of clients per session was 8 (N = 166). The number of clients per session ranged from 1 to 42, with the most frequent number of participants being 10. Nearly all of the programs in the sample

(97.7%; *N* = 166) were outpatient focused. Only 2.9% (*n* = 5) were inpatient and 1.2% (*N* = 2) were located in prisons. Programs provided additional services to domestic violence perpetrators. Most commonly, programs provided crisis management (60.7%; *N* = 91), parenting classes (53.3%; *N* = 80), substance abuse counseling (50.7%; *N* = 76), educational resources (38.0%; *N* = 57), and community advocacy (24.7%; *N* = 37). Roughly 8–12% of programs offered associated services such as mentoring, food, transportation, career services, housing, police/safety, and job training. These programs, sometimes in conjunction with sister agencies, also offered services for victims. For instance, 73.8% (*N* = 90) of programs that responded offered mental health treatment; 62.3% (*N* = 76) offered peer support groups; 52.5% (*N* = 64) offered social service assistance (e.g., getting food stamps, child care, etc.); 47.5% (*N* = 58) offered some sort of legal assistance (e.g., obtaining restraining orders); 42.6% (*N* = 52) offered shelter beds; 33.6% (*N* = 41) offered transitional housing.

4.2. Program demographics

Respondents were asked to provide percentages of the demographics of clients participating in their programs. Of all the programs that responded, 14% (*N* = 122) of clients were identified as female and 83% (*N* = 130) as male. In terms of sexual orientation 3% (*N* = 104) of clients were identified as lesbian, 4% (*N* = 98) as gay, 1% (*N* = 77) as bisexual, 0% of trans M to F, Trans F to M, and other sexuality, and 90% (*N* = 112) of clients were identified as heterosexual.

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

4.3. Respondents' views of treatment

Results are reported in **Table 1** and discussed here. Of those who responded, 86.1% (*N* = 93) indicated that treatment interventions were delivered according to a written curriculum; 63.9% (*N* = 69) of programs reported using treatment interventions adapted to fit the specific and various needs of their clients. Of these respondents, 41.7% (*N* = 45) responded that treatment interventions were the same for all clients regardless of ethnicity, race, gender, class, sexual orientation and identity, disability, religion, age, or religious status. While the same percentage (41.7%; *N* = 45) reported that treatment interventions were developed specifically for various client needs and contexts. Of these respondents, 18.5% (*N* = 20) responded that treatment interventions were not written but are used according to the agency's philosophy of treatment and expectations.

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

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In terms of perpetration, 46.6% ($N = 34$) of respondents indicated that state standards provided effective intervention for female perpetrators, whereas 32.88% said they strongly disagree or disagree with state standards' ability to provide effective treatment intervention. 31.5% ($N = 23$) of respondents strongly agree or agree that state standards adequately provided effective treatment intervention for same-sex perpetrators, whereas 30.1% ($N = 22$) strongly disagree or disagree that same-sex perpetrators were adequately provided treatment interventions. For males, 82.8% ($N = 63$) of programs strongly agree or agree that state standards provided adequate intervention for male perpetrators, while only 11.8% ($N = 9$) strongly disagree or disagree with this assessment. When asked how faithfully respondents adhere to state standards, 59.6% ($N = 62$) reported they always adhere to these standards; 33.66% ($N = 35$) reported they often adhere to state standards.

Key findings	**Percentage of respondents (N*N*)**
Treatment interventions were delivered according to a written curriculum;	86.1% (93)
Programs reported using treatment interventions adapted to fit the specific and various needs of their clients	63.9% (69)
Treatment interventions were the same for all clients regardless of ethnicity, race, gender, class, sexual orientation and identity, disability, religion, age, or religious status	41.7% (45)
Treatment interventions were developed specifically for various client needs and contexts	41.7% (45)
Treatment interventions were not written but are used according to the agency's philosophy of treatment and expectations	18.5% (20)
• 80 respondents said they do not provide any LGBTQ specific services.	(91)
• Several programs opted to treat LGBTQ people in individual sessions	
• A few respondents reported their programs adapted their curriculum for the LGBTQ populations	
Indicated that state standards provided effective intervention for female perpetrators	46.6% (34)
Strongly disagree or disagree with state standards' ability to provide effective treatment intervention	32.88% (24)
Strongly agree or agree that state standards adequately provided effective treatment intervention for same-sex perpetrators	31.5% (23)
Strongly disagree or disagree that same-sex perpetrators were adequately provided treatment interventions	30.1% (22)
Strongly agree or agree that state standards provided adequate intervention for male perpetrators	82.8% (63)
Strongly disagree or disagree with the assessment that state standards provide adequate intervention for male perpetrators	11.8% (9)
When asked how faithfully respondents adhere to state standards, reported they always adhere to these standards	59.6% (62)
Reported they often adhere to state standards	33.66% (35)

Table 1. Key findings and percentage of respondents for North American Domestic Violence Batterer Intervention Program Survey.

As indicated in the results here, many BIPS offer a range of services besides group therapy in an effort that recognizes and supports the multiple dimensions that affect one's use of violence. In this way, BIPs have shown their effectiveness in addressing a host of co-factors (e.g., offering parenting classes, transportation, substance abuse counseling, community advocacy, etc.). In doing does, BIPs have proven their ability to work with other services and community partners in order to holistically address the range of issues faced by perpetrators. However, no respondent indicated work with specifically LGBTQ organizations to identify and address the needs of this community. Research has shown that IPV occurs in the LGBTQ relationships at similar or greater rates than heterosexual couples (see, for instance, [1, 2]) but BIPs surveyed here have yet to make inroads into well-established community organizations to work to address these disparities.

Although policy language has mostly shifted to discuss domestic violence between "partners," as Cannon and Buttell [8] note, this language has papered over the need for policy to adequately legislate treatment options that directly address the needs of the underserved LGBTQ populations. For instance, 69% of respondents did not agree that state standards adequately legislates treatment options for LGBTQ populations. Given the pervasiveness of the problem of LGBTQ IPV and the pernicious of the personal and social effects of this, it is necessary for policymakers to use evidence-based practices to generate policies that adequately protect and regulate treatment options for all perpetrators and victims of IPV. To this end, respondents offered several key recommendations for better addressing treatment interventions for LGBTQ people. Furthermore, it was clear from the survey that practitioners thought that the state standards adequately legislated treatment for male batterers. This finding lends support to scholars who have argued that most policies do a good job of helping male batterers but that there is a gap in policy that does not explicitly and directly support female batterers or LGBTQ batterers. Specifically, policy that directly structures culturally relevant treatments now being called for by leading scholars (see, e.g., [7, 11, 3, 2, 12, 5]).

5. Conclusions

Practitioners on the frontlines of IPV intervention across the USA and Canada proposed several recommendations for addressing the lack of treatment options for LGBTQ perpetrators of IPV. These recommendations are important for creating equal access and opportunity for all people afflicted by IPV. First, outreach to LGBTQ communities is necessary to alert people to the kinds of services available for them. Second, policy must, at best, set the tone for culturally relevant curriculum and training for practitioners of BIPs and, at worst, provide a flexible framework to allow individual programs to better address the problems faced by the LGBTQ community. Additionally, as this research shows BIPs have been able to provide similar types of services (e.g., parenting classes, substance abuse counseling, education classes). Along similar lines, 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. Furthermore, LGBTQ facilitators would be helpful in addressing group instances of homophobia as well as being better equipped to create a safe space for clients.

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Providing equal access to treatment services to such a widespread problem as IPV in LGBTQ relationships is part of a larger push for equality. These insights coupled with the fight for social justice have widespread implications across the field of social work, not just for those who research and treat perpetrators and victims of IPV. All of these recommendations begin with socially responsible scholars and practitioners—utilizing multiple theoretical frameworks with which to develop culturally relevant curricula, community outreach skills, and coalition building, as well as how to identify and address instances of homophobia, racism, and sexism. Such an approach benefits not just LGBTQ clients nor perpetrators of IPV but all clients.

Current policy is limiting in that it simply privileges a certain kind of relationship over others (e.g., heteronormativity). Broadening our thinking about who is violent in intimate relationships and why it helps us to better understand the complexities of IPV itself (see [5]). Following the recommendations elaborated above would improve treatment services for this population. Given the Supreme Court's ruling for marriage equality in *USA v. Windsor* (2015) and President Obama's latest extension of protection for transgendered employees of the Federal government (2016), there is a reason to hope that more policies will be put into place that provide greater resources and treatment for the LGBTQ community with respect to IPV. Expanding our ideas about how and why different groups of people initiate IPV in their relationships allows us to treat abusers and victims as whole people and takes seriously the notion that our society is rife with inequalities and power differentials.

Any effort to right such inequalities begins by acknowledging they exist and that they create *differences* that matter; that need to be addressed in policies that affect both perpetrators and victims. Treatment options, then, must be available that deal with different people's social contexts and opportunities (or lack thereof) as well as their identities, since both these macro and micro issues affect *how* and *why* people use violence to mediate their intimate relationships (e.g., [9, 3, 7]).

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