

Intervening with Perpetrators of Intimate Partner Violence: A Global Perspective

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BACKGROUND

Nearly 50 population-based surveys from 36 nations around the world find that from 10 to over 50% of women are physically assaulted by intimate partners during their lifetimes (Heise, Ellsberg & Gottemoeller, 1999). Men's victimization by intimate partners has not been well studied, particularly cross-nationally, but in the United States of America (USA) men experience significantly less intimate partner physical assault than women; women in the USA are victims of intimate partner violence at a rate about five times that of men (Rennison & Welchans, 2000). While intimate partner violence against women has been documented as occurring in at least 42 nations (Heise, Ellsberg & Gottemoeller, 1999; Horne, 1999; Kozu, 1999; Subramaniam & Sivayogan, 2001; Adinkrah, 1999; Garcia-Moreno, 2000), it is unlikely that these nations are exceptional – more plausibly, intimate partner violence is a widespread phenomenon with devastating consequences for families, communities and societies in all parts of the world.

The causes of partner violence by intimates remain only partially clear and are often debated. Two theories have heavily influenced intimate partner etiology research; social learning theory, or the idea that violence may be transmitted from one generation to the

next, and feminist theory, or the idea that male dominance in society affects interpersonal relationships. The theory that stress may contribute to intimate violence perpetration has also been postulated (Jewkes, 2002). Due to the complexities of researching intimate partner violence, and maintaining victims' safety while doing so, it has been far easier for researchers to identify factors associated with the occurrence of intimate partner violence rather than those that are indisputably causal. Moreover, the majority of available research has defined intimate partner violence narrowly – as including only physical violence (or in some cases, physical and sexual assault). Restricting the definition of intimate partner violence in this way makes it easier to compare identified correlates of “intimate partner violence” across studies, but raises questions about whether a more expanded definition of the concept would be associated with the same, or additional, predictors.

Nonetheless, several factors have been found to be consistently associated with the physical assault of intimate partners, and as a result they are widely believed to play some causal role. At the societal level, these include poverty (Bachman & Saltzman, 1995; Hotelling & Sugarman, 1986; Aldorando & Sugarman, 1996) and

social norms that reflect male dominance (Levinson, 1989). At the individual level, it has been demonstrated that those who physically assault their female intimates are more likely to have witnessed interparental violence (Hotaling & Sugarman, 1986), experienced child abuse (Wekerle & Wolfe, 1998; Alexander, Moore & Alexander, 1991; Simonelli et al., 2002), have been raised in families with patriarchal values (Fagot, Loerber & Reid, 1998; Gwartney-Gibbs, Stockard & Bohmer, 1987; Riggs & O’Leary, 1989), subscribe to patriarchal values (Yllo & Straus, 1990), and use alcohol or drugs more than their non-abusive counterparts (Hotaling & Sugarman, 1986; Tolman & Bennett, 1990; Kantor & Straus, 1989).

In response to the problem of intimate partner violence, most nations have developed legal, medical and social resources to support victims and their children. For example, many developed nations have passed “restraining order” legislation, which entitles victims of intimate partner violence to protective orders against their abusers. In some Latin American and Asian nations, specialized women’s police stations, designed to improve the reporting of and response to violent crimes against women, have been established¹. Rape kits, one-stop centers, sexual assault response teams, special examination centers and sexual assault nurse examiner programmes, as well as sensitivity training for healthcare professionals, have been implemented in developing and developed nations alike.

Psychological counselling centers, legal literacy programmes, self-help groups, specialized shelters, supportive telephone hotlines, and peer advocacy programmes for intimate partner violence victims have been replicated in a wide variety of settings. International agencies, coalitions, and forums that promote victims’ support services – such as the Women Against Violence Europe, Communities Against Violence Network (CAVNET), or the United Nations Interagency Campaign on Women’s Human Rights in Latin America and the Caribbean – have been established and are expanding their membership base.

While the growth of victim advocacy and support services is an achievement, intervention with the perpetrators of intimate partner violence has received comparatively little attention from non-governmental, governmental and academic organizations outside the USA and Canada. Given that many abusers continue to terrorize their victims even after the relationship ends (Hart, 1996; Browne, 1987), providing support services to victims in the absence of intervention for perpetrators is a questionable practice. What is being done to change the beliefs, and actions, of intimate partner violence perpetrators worldwide?

“Batterer intervention programmes” are educational, therapeutic groups for intimate partner violence offenders. The first programmes were developed in the late 1970s in the United States; these included EMERGE in Boston, AMEND in Denver, and

¹ Some anecdotal reports indicate that specialized police stations may be ineffective or harmful for victims. The World Health Organization neither promotes nor discourages their development.

RAVEN in St. Louis. Shortly thereafter, the Duluth, Minnesota-based DAIP programme was created. Since that time, batterer intervention programmes have become a significant presence in the USA. Although national enrolment figures are unavailable, more than 3 000 men participate in batterer intervention groups in the state of Massachusetts alone every year (Massachusetts Department of Public Health, 2001). Most batterer intervention programmes in the USA represent partnerships between local criminal justice, mental health and victim advocacy professionals.

Evaluation research indicates that batterer intervention programmes are at least modestly successful at preventing further abuse by abusers (Gondolf, 2002; Saunders, 1996). Reviews of batterer intervention programme evaluations from the USA and UK have found that roughly 50 percent to 90 percent of people who complete the programmes remain non-violent for follow-up periods ranging from six months to three years (Eisikovits & Edleson, 1989; Rosenfeld 1992; Tolman & Bennet, 1990). The largest-scale evaluation to date found that those who completed the programmes were two-thirds less likely to physically re-assault their partners as those who dropped out of them, even controlling for demographic and behavioural factors that might otherwise explain this difference (Gondolf, 2002). It appears that intervention also inhibits renewed acts of non-physical abuse by participants, although these non-physical forms of abuse are prevalent among programme completers (e.g. 72% of men are verbally abusive

15 months after completing a programme) and are increasingly employed in the years following programme completion (Gondolf, 2002).

Critics of batterer intervention programme evaluations point out that abusers who participate in intervention programmes may simply become more skilful at concealing their renewed abuse from detection, and thus, evaluation results will reflect more positive change than truly occurs. Moreover, critics point out that the reported programme effects only pertain to men who complete the programmes, and that “programme drop-out” is a significant problem for programmes that serve court-mandated abusers. Indeed, it appears that 22–42% of abusers in US and Canadian programmes fail to complete their assigned programme (Rooney & Hanson, 2001; Saunders & Parker, 1989; DeMaris, 1989; Gondolf, 2002; Pirog-Good & Stets, 1986). These criticisms notwithstanding, it is possible to conclude on the basis of existing evaluations that batterer intervention programmes offer some hope for behaviour change among intimate partner violence offenders who are amenable to participation, though they are not a panacea.

Although there is variety across programmes, all batterer intervention programmes in the USA that operate according to available state standards offer 12–52 weeks of structured group intervention for approximately two hours each week (Healey, Smith & O’Sullivan, 1998). Groups are attended by adult males who acknowledge that they have perpetrated intimate partner violence. The group sessions are

dedicated to reviewing the abuse that the participants have perpetrated, learning about non-violent alternatives to resolving conflict, studying the ways in which social norms or gender roles influence behaviour, and examining ways in which substance abuse, stress, and negative attribution may exacerbate violent behaviour. The group facilitators are not necessarily mental health professionals; many programmes employ formerly battered women and some employ former batterers as group leaders (Massachusetts Department of Public Health, 2002). For many programmes, establishing and maintaining private contact with the victim of the abuser with whom they work is essential for ongoing monitoring of abusers' accountability.

Beginning in the mid-1980s, several USA states and Canadian provinces began to draft standards or guidelines for operating batterer intervention programmes in order to regulate the type and quality of service provided. As of 1997, 3 Canadian provinces had enacted standards (Dankwort & Austin, 1997) and 37 standards were in use in the USA (Austin & Dankwort, 1999). Critics of standards point out that requiring conformity among programmes may limit their ability to develop innovative

techniques, or compare the utility of various methods across programmes. Moreover, some criticize existing standards and guidelines for their lack of scientific basis and for their permissiveness towards staff members who are not licensed clinicians (Austin & Dankwort, 1999). Despite the fact that particular advocacy groups may take issue with the content of a specific set of standards, at the very least these standards do provide a mechanism through which funding or regulatory agencies can hold programmes accountable for the services they procure.

A small number of articles and books on intervention with men who batter in nations other than the USA exist. However, there is no international sourcebook that delineates the type of intervention occurring in different nations, that describes the approach and training of the interventionists, or communicates the results of evaluations. This report seeks to make the first contribution towards such a comprehensive resource. While not exhaustive, it indexes fifty-six programmes for men who batter from around the world, including programmes in high-, middle- and low-income nations.

METHODOLOGY

In September 2001, the World Health Organization Injuries and Violence Prevention Department developed a survey designed to capture service delivery information from batterer intervention programmes around the world. The survey was created with input from a variety of experts, including those with field experience in batterer intervention and victim advocacy, injury surveillance specialists, intimate partner violence researchers, and representatives of programmes in developing nations. The survey instrument, which included both quantitative (close-ended) and qualitative (open-ended) questions, was pilot-tested, modified, and retested before it was implemented.

Snowball sampling was used to locate and enrol participants in this descriptive study. “Snowball sampling” is a method of recruiting participants into research studies. It involves asking each new recruit to suggest several others who can be approached by the researcher for potential enrolment in the study. Almost every participant in this study was able to direct the researcher to three or more new participants. Towards the end of the data collection phase, it became more difficult for participants to recommend new interventionists who were not already enrolled in the study. As a result, it

became clear that the investigation had almost completely “uncovered” one particular, closed network of providers that spans all six global regions.

Four main sources provided the original cohort of participants:

- ***The Women’s Rights Network:*** The Women’s Rights Network (WRN) is a USA-based non-governmental, non-profit international human rights organization that works to address the root causes of intimate partner abuse in the USA and worldwide through the application of international human rights principles, strategies and laws. Based at the Wellesley Centers for Women, WRN (among other projects) sustains an international network of providers and practitioners who are working to end intimate partner abuse and related human rights violations. The WRN network was heavily utilized during the first phase of respondent recruitment.
- ***Emerge:*** Widely credited as the first batterer intervention programme in the world, this non-governmental organization has served people who batter in Massachusetts, USA since 1977. Emerge has conducted training in nations other than the USA. Emerge’s international contacts provided the basis for

enrolling several of the survey respondents, including Alternatives to Violence (ATV) in Norway, Harmony House in Hong Kong, and Swayam in India.

- **United Nations-INSTRAW:** In 2001, the United Nations agency for International Research and Training Institute for the Advancement of Women (UN-INSTRAW), developed an email list that was used by a diverse, international assemblage of intimate partner violence prevention professionals interested in men's roles and responsibilities in ending gender-based violence. Though it is now defunct, several of the subscribers to this online discussion group are interventionists who participated in this survey.
- **Amnesty International:** Each amnesty international office with an email address was contacted for referrals of potential survey participants. The batterer intervention programme in Iceland was referred to the study by Amnesty International.
- **Other Resources:** Several additional resources were utilized. These include the International Planned Parenthood Federation, the World Health Organization Headquarters and Regional Offices, and the City & Shelter organization in Belgium.

Since articles and books describing the methods of batterer intervention programmes located in the USA, Canada and United Kingdom are widely available (e.g. Pence & Paymer, 1993; Dobash et al., 1999; Minister of Health Canada, 1998), and given that data collection resources were limited,

the scope of the investigation excluded these three territories in order to focus more specifically on interventions and practitioners from less publicized programmes. One Scottish program was included in the analysis, because this program has been particularly influential internationally. One program in the Republic of Ireland was also included in the analysis. In addition, the authors selected to focus the investigation on interventions with perpetrators who had been already identified, rather than on universal programmes designed to *prevent* intimate partner violence. While in many locales prevention and intervention programmes may share the goal of changing the social acceptability of violence against women, previous research on prevention programmes has been conducted and the results are available elsewhere (e.g. Hayward, 2001). Thus, "White Ribbon Campaigns" and similar prevention initiatives aimed at increasing the global awareness of men's role in preventing violence against women were not assessed as part of this study.

For the purposes of this investigation, "batterer intervention" is defined as any action that has as its goal to change the abusive behaviour of a person who physically, sexually, emotionally or verbally controlled his or her intimate partner. Contact was sought with any individual or group – professional or informal – that directly participates in activities aimed at dissuading abusers from continuing that practice. The reason for using this broad definition was that descriptions of unstructured interventions, as well as those that fit the documented "psycho-educational" group model, were sought.

All participants were initially contacted by email or by telephone. Despite initial concerns that utilizing email for recruitment purposes would limit the study to programmes in high income nations, it was found that email coverage was sufficient to establish contact with informants in low- and middle-income countries in all six WHO world regions. A small number of practitioners without access to email were contacted by telephone. An informed consent form was distributed to, and collected from, all participants. This form was available in English, French and Spanish. Those who were unable to receive the form via email or fax were read the contents of the form over the telephone and gave their verbal consent to participate in the survey.

Each respondent was surveyed over the telephone, with the exception of two participants who completed the survey in writing and chose to email their

responses to the researcher. The survey was conducted by native speakers of English, French, Spanish, a non-native speaker of Russian, and a non-native speaker of Spanish. There were no known potential respondents who were unable to participate in the survey due to language barriers. It took approximately one hour to complete the survey over the telephone with each respondent. Two primary researchers conducted 90% of the survey interviews, thereby ensuring that the survey interview was highly standardized.

Data collected through the survey was coded, entered into an Access database, and analyzed using the statistical software program, STATA. The transcript of free responses made by participants was analyzed manually and data was coded, indexed, and linked to quantitative data for illustrative purposes.

RESULTS

Programme characteristics

Seventy-four programmes from 38 countries participated in the survey. Of these, 56 are classified as “batterer intervention programmes” (Table 1). The 22 programmes that have been excluded either participate in prevention-oriented efforts to end

Despite efforts to locate programmes in particular areas, none were found in places such as Central Africa, most areas of the Eastern Mediterranean region, and Eastern Europe. Multiple contacts with women’s rights agencies, law enforcement, health and other non governmental and governmental agencies in nations in

TABLE 1: Geographical distribution, duration and dimensions of batterer programmes*

WHO World Region	Percent of programmes by WHO Region	Year established (average)	Size of programme (average new cases per year)
Americas	34% (19)	1997	288
Europe	36% (20)	1994	233
Africa	11% (6)	1995	135
South-East Asia	5% (3)	1997	617
Eastern Mediterranean	2% (1)	2002	n/a
Western Pacific	13% (7)	1997	155

* Excludes programmes in the USA, Canada and England

gender-based violence, are sexual health educators, or are academics that study gender at universities. Forty-three percent (n=23) of the batterer interventionists who participated in this study are located in developing nations. Sixteen percent of the interventions are conducted as sidelines of private counselling psychology practices.

each of these regions failed to identify any individuals or programmes that could be described as working with men who beat or abuse their wives, girlfriends or dating partners. Possible reasons for the failure to locate programmes in these areas are discussed below.

Most batterer intervention programmes participating in this study were established during the mid-to-late 1990s. The longest-running programme is Men Against Male Violence in Germany, which was established in 1983. Following closely behind, Mannerberatung was established in Austria in 1985 and Alternatives to Violence in Norway in 1987. The first programme to be established in a developing country, as identified by this survey, was the Family and Marriage Association of South Africa (FAMSA) which began working with abusers in 1990. On average, the European and African programmes that participated in this survey have accumulated more years of operating experience than programmes in other regions.

The batterer intervention programmes that participated in this survey range widely in terms of size, from serving an average of 7–2 000 clients per year. Most of the programmes (70%) serve less than 100 abusers per year, but five serve upwards of 1 000. Programmes located in South and Central America tend to interact with a larger number of distinct individuals per year than programmes in other areas. The participating batterer intervention programmes with the largest client-

bases are Men Overcoming Violence (MOVE) in Ireland, Percy Cole's individual practice in Peru, and Kottayam in India. Six programmes serve as few as 10 clients per year.

Programme development

The survey indicates that the development of batterer intervention programmes around the world has been motivated by a number of different factors. Most commonly, programmes participating in this survey grew out of existing counselling or advocacy services for victims of intimate partner violence when staff at these agencies began feeling frustrated by their inability to stop intimate partner violence at what they felt to be the source. Other parent agencies include psychological counselling, addiction services, criminal justice programmes, men's programmes, child welfare services, religious programmes and sexual or reproductive health programmes (Table 2).

In Iceland, the programme grew out of a governmental programme designed to promote gender equality:

“The special men’s committee chose this topic, because they felt that as long as women feared men, there is no discussion of gender equality.”

TABLE 2: Parent agencies of batterer intervention programmes

Type of parent-agency	Proportion of all programmes (n=56)	Proportion of programmes in developed nations (n=33)	Proportion of programmes in developing nation (n=23)
Victim advocacy services	34% (19)	39% (13)	26% (6)
Psychological counselling	21% (12)	12% (4)	35% (8)
Criminal justice	5% (3)	9% (3)	0% (0)
Men's programme	4% (2)	3% (1)	4% (1)
Child welfare	11% (6)	9% (3)	13% (3)
Sexual or reproductive health	5% (3)	3% (1)	9% (2)
Addiction services	9% (5)	12% (4)	4% (1)
Religious	2% (1)	3% (1)	0% (0)
Missing data	9% (5)	9% (3)	9% (2)

Programme funding

Sixty-six percent (n=37) of the programmes surveyed reported that they receive some portion of their funding from a local or national governmental source, although only one such programme was located in a developing country. In some cases it was not possible to distinguish whether governmental funding specifically supported a programme's work with abusers, or if the governmental support for other types of services provided at the agency was relied upon to fund batterer interventions. Thirty-six percent of the programmes accept money from abusers in exchange for their services. These programmes generally charge men between US\$ 1 and US\$ 40 per session. One reason for charging this fee to clients, even in areas where clients are impoverished, is to add value to the service. As described by one interventionist from a low-income nation:

“People here believe that if something is free it isn't any good. Therefore, I believe the men should make a financial commitment. It motivates them, it will make them feel like it is worthwhile.”

Some interventionists, such as individuals in Peru, India, Costa Rica, and Honduras, volunteer their own time and receive no reimbursement for their work. Programmes have also been successful in obtaining funding from foundations and other private sources. Donors who, according to the practitioners, reportedly sponsor batterer intervention activities include; Phillip Morris, Bill and Melinda Gates Foundation, United Nations Development Fund for Women (UNIFEM), US Agency for International Development (USAID), the International Planned Parenthood Federation, International Red Cross, and a variety of churches, banks, and other local charities.

Client referrals

Interventionists meet their clients in a variety of ways. For just over half of the programmes surveyed (54%), men referred by the courts constitute a significant portion of their intervention population, although *referrals* made by court officers in many nations do not carry the same weight as “court-mandated referrals”. Developing country and developed country programmes appear to be equally likely to receive court referrals. One-third (36%) of all programmes have developed special relationships with the courts, such that intimate partner violence offenders can be mandated by the court to attend their programmes. In these cases, if offenders fail to comply with the intervention regulations, they must return to court and may be subject to additional penalties. In total, an average of 83% of the clients served by the programmes attend as volunteers. In other words, more than three-quarters of men who are currently attending the batterer intervention programmes surveyed in this report are doing so of their own volition.

Client demographics

The clients of batterer intervention programmes constitute a diverse population. Collectively, the programmes have served abusers as young as 12 years old and as old as 82. However, most abusers who attend the interventions are in their early thirties (mean age=33 years). At almost every site where batterer intervention takes place, practitioners serve both men who are native and those who are immigrants. For example, the “Beit-Noam”

programme in Israel is attended by Hebrew nationals, Arabs, Russians and Ethiopians. One-fifth of the programmes (n=12) serve abusers who are gay or lesbian and have battered same-sex partners. Sixteen percent of the programmes (n=9) serve females who have abused a male intimate partner. Programmes serving gay, lesbian and heterosexual female abusers were located exclusively in the American, western Pacific and European regions.

Definitions of intimate partner violence

Practitioners select to use particular models of intervention based on several factors, including knowledge of and access to particular curricula, reputation or “name-brand recognition” of the model, theoretical orientation, and the model’s definition of intimate partner violence. Disparate beliefs about the cause of intimate partner violence, and thus how to inhibit it, stem from the array of definitions in use. While every provider surveyed, without exception, considers physical abuse of an intimate partner to be a component of intimate partner violence, only 91% consider emotional abuse, 89% include sexual abuse, and 71% include economic control of a partner in the definition of intimate partner violence (Chart 1). Four percent of the providers (n=2) stated that they define intimate partner violence as including “spiritual abuse” (Chart 1).

The definition of intimate partner violence adopted by a practitioner has implications for his or her intervention techniques. One interventionist reported by a local women’s agency to be very

successful in reducing the prevalence of *physical* intimate partner violence in the community, said that his technique involves encouraging abusers to use other forms of control within the home.

“Men are the head of the family. Women should be submissive to men; women have to do the housework, cooking and taking care of children, women have to teach daughters to be good wives...I tell the women not to question their husbands when they come home late. The men should tell the women what to do and the women should listen [to avoid being physically battered].”

Moreover, most providers stated that they felt abuse was always solely the responsibility of one “perpetrator” within the relationship, whereas 20% (n=11) expressed a belief that the responsibility for abuse lies with both partners in an abusive relationship. Eight of the 11 programmes that expressed a belief that abuse may be

mutual are located in developed nations. For example, three of these practitioners stated:

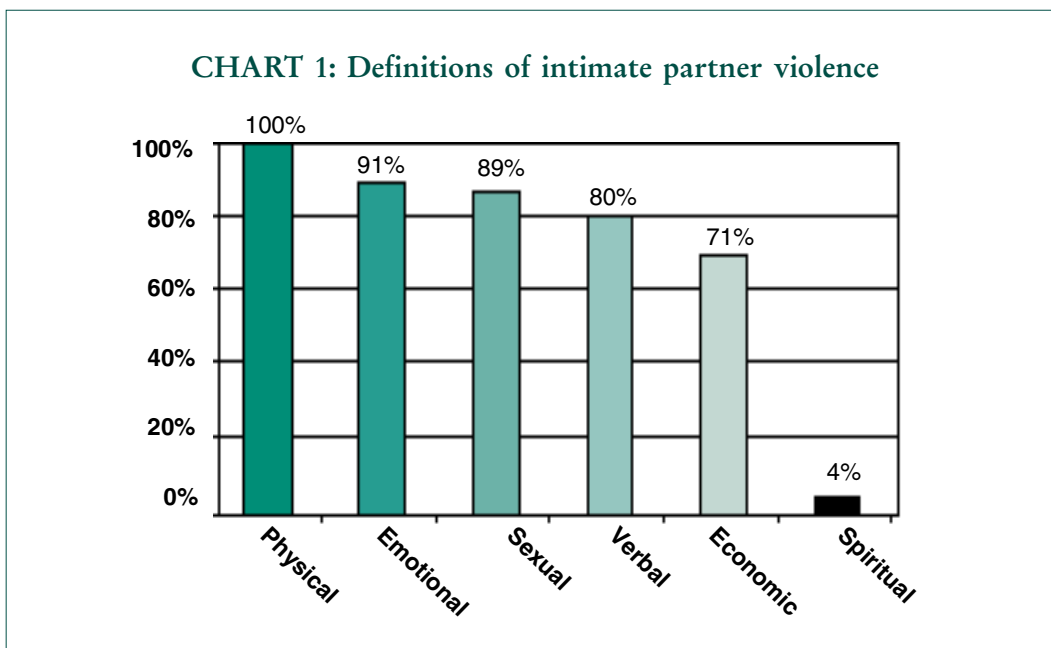
“The dichotomy between victim and perpetrator furthers the gap and stereotypes. The men become the bad guy so the victim automatically becomes the good guy.”

“We are practitioners. We don’t make a distinction between victims and perpetrators.”

“Women are responsible for their own safety. She isn’t a victim only. She has power and can keep herself safe.”

Yet another practitioner commented that supposed victims often use psychological abuse against abusers:

“Threatening the father that he won’t see his children any more if he does not cooperate [with treatment] is a form of psychological violence...This is misuse of one’s power as a mother.”



Programme theories on the cause of intimate partner violence

The theoretical orientation of the practitioners is correlated with their beliefs about what causes intimate partner violence, and heavily influences how they approach changing the behaviour of abusers. Thirty-four percent of those surveyed described themselves as “feminist” programmes; these programmes regard power differentials between males and females in society as a contributing or primary cause of intimate partner violence. This view is typified by the comments of three providers:

“We must view this [intimate partner violence] as a historical problem of patriarchy and not as a psychology problem.”

“Underlying intimate partner violence is the need for men who use the violence to have control and power over their intimate partner. This is entrenched in a patriarchal value system.”

“The underlying cause of intimate partner violence is the lack of value that women have, even before they are born. Men and women are both adversely affected by the lack of equality. Men must take on the role of head of the family, and can’t enjoy fulfilling relationships with partners because they don’t allow women to have inner strengths and talents. Therefore, he doesn’t have a partner with whom he can walk hand in hand.”

The programmes subscribing to the feminist model are significantly more likely to be located in developing nations. In addition, two representatives of programmes stated that they did not feel comfortable using a particular label, but that they believe the primary cause of intimate partner violence is gender-based power imbalance:

“Here you can’t say that you are a feminist. If you say that, then people think you are a man-hater or something similar to that. So we don’t use that word. I think it is differences in the way society treats men and women [that causes intimate partner violence].”

“Here you must preach feminism gradually...we are not like the U.S.”

By including any programme that mentioned a belief that gender roles play at least some part in fostering intimate partner violence as a ‘feminist’ programme, the total proportion of programmes surveyed with a ‘feminist’ theoretical orientation rose from 34% to 73%.

Twenty-seven percent of the programmes, including 4 that also subscribe to feminist theory, indicated that they believe intimate partner violence is caused by psychopathology on the part of the perpetrator or the victim. These programmes use psychological theories and techniques for counselling abusers. In general, those who subscribe to psychopathological explanations for intimate partner violence perpetration tend to believe that intimate partner violence is caused by child abuse, witnessing of domestic violence or stress, and that it

is unlikely to be caused by one person within an intimate partnership relationship. Rather, the roots of the violence and the responsibility for ending it lay with both partners. The perspective of practitioners who use the psychopathology approach is captured in the following quotations:

“Violence is a symptom of poor mental health. We must go deeply to the roots of men’s own trauma in order to change it.”

“It’s only abuse if it is intentional. We accept the explanations of men that it isn’t always intentional, sometimes it is just an emotional outburst.”

Some programmes integrate both theories into their approach:

“It is neither enough to focus on socio-cultural aspects of men’s violence, nor to focus only on their individual psychopathology. We need an approach that integrates both foci.”

Overall, those in developing nations were more likely to express a belief that gender differences cause intimate partner violence, as compared with those in developed nations; 88% of the surveyed providers in developing nations, as opposed to 63% of those in developed nations, view re-socialization with regard to “gender differences” as the basis of their work.

Intervention topics

It was anticipated that based on the theoretical model employed, providers would report differences with regard to the educational topics covered during their sessions. In fact, little variation was found. In essence, despite varied definitions of intimate partner violence or disparate perspectives on what causes it, practitioners reportedly introduce very similar topics of discussion during intervention sessions. It remains possible that what is taught, relative to each of the educational topics, varies among providers based on definitional or theoretical lines. That potential difference was not assessed by the current study.

To elucidate the educational content of intervention discussions, each provider was read a list of possible topics and asked to indicate whether, and to what extent, they cover each of them in client sessions. Providers were also asked to name additional topics that they address during their interventions that had not been listed. Six providers had insufficient time to complete this section of the survey and did not participate. The list of topics, and frequency with which topics are covered by providers, is presented in Table 3.

Table 3: Intervention topics

Topic	Proportion of providers that cover this topic during intervention (n=50)	Programmes in developed nations (n=31)	Programmes in developing nations (n=19)
Masculinity: Discussion of the ways in which social norms about gender affect the way that men behave in intimate partnerships	90% (45)	84% (26)	100% (19)
Intimate partnership: Discussion of the differences between healthy and unhealthy intimate partnerships	88% (44)	84% (26)	95% (18)
Conflict resolution: Ways to solve problems without using violence	86% (43)	84% (26)	89% (17)
Cultural traditions: Discussion of the extent to which the culture of the abuser supports or discourages intimate partner violence	78% (39)	81% (25)	74% (14)
Anger management: Techniques for managing anger that avert violence	76% (38)	71% (22)	84% (16)
Fatherhood skills: The importance of parenting in a non-abusive manner	76% (38)	77% (24)	74% (14)
Criminal sanctions for intimate partner violence perpetration: Explanation of local laws regarding intimate partner violence	64% (32)	58% (18)	74% (14)
Alcohol and Drug use: The effects of alcohol and drugs on one's moods and capacity for violence	58% (29)	58% (18)	58% (11)
Trauma: The effects of childhood traumatic experiences on one's behaviour as an adult.	50% (25)	61% (19)	32% (6)
Stress: The effects of stress on one's behaviour.	50% (25)	55% (17)	42% (8)
Sexual health: Sexually transmitted disease and their relationship to healthy intimate partnership.	44% (22)	55% (17)	26% (5)
Oppression: How racism, classism or other forms of oppression affect one's behaviour.	44% (22)	52% (16)	32% (6)
Spirituality: How faith and spirituality affect one's behaviour and capacity for violence	22% (11)	26% (8)	16% (3)
Community Organizing: Discussion of mobilizing others to join a political or social cause.	14% (7)	19% (6)	5% (1)

In addition, individual providers indicated that they cover the topics of self-esteem, suicide and the “constant fears of abusers about the world around them.” One provider mentioned that

their programme also offers participants debt-relief, job-skills training and employment assistance, and another offers free paternity testing.

Discussing the topics covered during intervention, practitioners commented:

“The subject of culture and values is fundamental, because men repeat the conduct acquired in their childhood homes. Masculinity is also important to discuss, because everything is respected for the man, but for the woman – everything is relative. What the husband demands the wife fulfils.”

“We discuss masculinity, certainly. In our society, intimate partner violence is still accepted. The view is that a man must do it to prove his manhood.”

One practitioner also passed on some advice about technique. In his words:

“We give people knowledge when they ask for it. If groups are too structured, it simply makes parrots out of men. There is no real change, they only adapt to the teacher’s demands. To avoid this, we let the men lead the discussion. I build an agenda based on what I see is important in the moment.”

Who is screened out of batterer intervention programmes?

Not all potential clients can be served by the programmes. Each survey respondent was asked to identify potential clients to whom their programme denies service. Almost universally, respondents indicated that abusers who are assessed as having psychiatric disorders are not suitable for their intervention. Additionally, abusers with active alcohol or drug addictions

are deemed inappropriate for participation in most programmes. Other types of abusers who may be screened out of programmes include those who become violent with counsellors, sex offenders, those who are suicidal, men who appear to be unafraid of the law, and those who are disruptive in group counselling sessions, or fail to attend the sessions regularly.

Victim contact

Contact with the victim is important to many of the practitioners. Seventy-one percent of those surveyed indicated that their programme makes an effort to communicate with the victim about her experiences with the abuser. In some cases, this contact occurs in person at joint counselling sessions with the abuser. In other cases, the contact occurs privately – either in person, over the telephone or by mail. Face-to-face contact with the victim is most common. In addition to making contact with the victim, 61% of practitioners have established formal links with local battered women’s advocacy services in order to facilitate case management and the exchange of information.

Providers made the following comments about establishing the victim-contact component of their interventions:

“Originally, we made no contact with victims. After one year of operation, we received a letter from a woman with criticism about how little information she had received about what was happening. So after that, we began to send an information letter to women. We take care to emphasize his responsibility [for his abusive behaviour] in these letters.”

“Cooperation with victims’ advocates, and contact with victims, is important. If we work only with the men, it’s dangerous, because they can tell you stories. We need to guarantee the safety of victims, and their versions of reality are quite different sometimes.”

“The safety of women comes first, so the challenge is not telling the men what she said. You can’t confront him with the information that she tells you, because it can become worse for her.”

Some of the practitioners stated that when they begin to work with an abuser, they also require the victim to attend a counselling programme. In some cases, the victim is required to attend joint counselling sessions with the abuser. In other cases, she is required to participate in separate counselling sessions. Programmatic differences with regard to couples counselling are explored below.

It should be noted that despite the fact that some programmes indicated that partner contact is vital, this may not always occur in a manner that is safe for victims. For example, one practitioner stated that their programme “communicates with the victim through the abuser”, which may place victims at increased risk for further abuse by increasing their isolation, masking the true behaviours of the abuser, or revealing safety plans to the abuser.

Intervention goals

Sixty-two percent of the programmes report that the over-

arching goal of their intervention is “ecologic” in nature. In other words, their mission is not simply to alter the behaviour of individual abusers with whom they intervene; instead, these practitioners are seeking to transform the attitudes and behaviours of abusers, families, communities and society with regard to violence and gender roles:

“Our goal is to change the person so that he will become a tutor to his friends and spread the message. He can speak in public and make the problem more visible. We change him, but we begin to change the society also.”

“There are ripple effects. If you change a batterer, things improve for that family and so on.”

Other practitioners reported that they focused more specifically on altering the abusive behaviour of the individuals who participate in their interventions.

Of those who attempt to alter the behaviour of individuals, some intervene in order to preserve family harmony, while others prioritize victim safety over family unity:

“If two people are married, our goal is to keep them together. Men come to us to ask us to explain to the woman how she can remedy the situation.”

“A successful treatment, from our perspective, might mean divorce. We are most concerned with the safety of the victim, and she may be safest without her husband.”

Staff training

Staff members involved in counselling abusers have diverse training experience (Table 4). While some programmes, such as CORIAC in Mexico, require men to participate first in the intervention programme and address their own capacity for exercising “male privilege” before counselling others, 7% of agencies report requiring no training before employees begin work with abusers. A significant proportion (34%) of programmes hire staff with academic degrees in social work or psychology, but do not necessarily require that these

to be mentored by more experienced counsellors before assuming responsibility for batterer intervention groups on their own.

Proper staff training may be essential for effective functioning of intervention programmes. Techniques that may be ineffective or inappropriate in particular settings may be effective and fitting in others. That fact notwithstanding, it is possible that some geographically isolated counsellors could benefit from a facilitated exchange of information regarding counselling methods. This may be particularly useful for practitioners who serve culturally congruous indigenous populations, such

Table 4: Staff training

Training requirement	Proportion of programmes
None	7% (4)
Academic criteria	34% (19)
Special training programme	25% (14)
Certificate or license of counsellors	0%
No response/don't know	34% (19)

staff receive specialized training in the dynamics of intimate partner violence, or laws pertaining to intimate partner violence offenders. One-quarter of the programmes require staff to undergo intimate partner violence-specific training offered at their own agency. Two of the programmes pay to send staff to Duluth, Minnesota, USA for training, and two others have paid to receive training from US and Australian batterer intervention experts on-site. Several of the programmes require new counsellors

as the Maori in New Zealand, and Native Americans, because curricular resources for these practitioners may be even more limited than for practitioners in general. Every participant surveyed expressed a clear interest in receiving more information about batterer intervention counselling techniques employed elsewhere, and almost all expressed an interest in travelling to participate in an international conference or training course on this topic.

Programme evaluation

One of the most pressing questions about batterer intervention is whether it has an effect, and if so, if the effect is the desired one. One-third (n=21) of the programmes surveyed are in the process of, or have been subjected to, evaluation by independent researchers. Of those evaluated, two-thirds (n=14) are located in developed nations and one-third (n=7) in developing nations. In addition, a small number of programmes described informal evaluation efforts that have taken place but were not completed by independent evaluators, failed to include outcome measures, used no systematic method for data collection, did not incorporate long-term follow-up, or relied upon self-reports of behaviour change from the abusers alone. Reportedly, none of the evaluations conducted made use of a comparison or control group. Some evaluations sponsored by governmental agencies are currently underway, and results are scheduled to be available during 2003.

Couples counselling

Most respondents had strong feelings about couples counselling and whether it was an appropriate method for resolving intimate partner abuse perpetration. Roughly 38% of the programmes do provide couples counselling to abusers and their victims – some with regularity and some only

under special circumstances such as at the victim's request. Eleven percent of the practitioners unambiguously denounced intimate partner violence-related couples counselling as detrimental, and even dangerous, to victims. Two of those who advocate couples counselling for abusive couples provided the following reasons for doing so:

“It is futile to leave [one partner] out of the [counselling] picture. It is gratifying for the women to hear the men's perspective, when you call them both in for a joint session.”

“We offer couples counselling after the batterer has done group work, so that she can learn to trust him again.”

“We provide couples counselling when we are convinced that the power balance had changed sufficiently, such that the women could speak up openly in the session without fear of the repercussions.”

A practitioner who dissuades others from using couples counselling with abusive couples provides the following justification:

“Counselling must be done separately, never together. Out of your sight, the victim is subjected to even more violence because [the batterer] thinks the counsellor has taken the woman's side and he feels blamed.”

The effects on staff

Participating in batterer intervention as a staff person is a unique, and oftentimes unconventional choice. Survey respondents were asked why they selected to enter the field of batterer intervention, and the effect it has had on their life. Due to time limitations not every respondent was asked this question. Most of those who answered this question revealed that their interest in the work stems from compassion for victims and for perpetrators of intimate partner violence. Consistently, staff reported that the life-altering nature of conducting interventions with men who batter was unanticipated. Most practitioners commented that counseling men who batter is a profound, occasionally heart-breaking experience, which has forced them to examine their own closely held assumptions about intimate partnerships. They were eager to share their hindsights:

“He had been in the group three weeks and then he hospitalized his wife. I said ‘Wow, I don’t believe this!’ All indications to us were that there would be a 100% success rate. I was just out of graduate school and I thought that I could make change for everyone, and I had had success with victims. It changed my whole belief. I can’t believe the programme will help everyone. There will be failures, and it has to do with those individuals themselves.”

“Before I started this job, I wish I had known it was all encompassing. It takes every part of you with it. You are no longer a private person. I am

recognized everywhere and I have no private space.”

“It’s easy to get sucked into the batterers’ denial and minimization of violence. Some facilitators might expect the clients to have relationships that function like their own do – so they can’t imagine what the relationships of their clients are like – that the men operate without any equality.”

“The reason I kept doing this work was that I saw some small changes, but they were incredible changes. Kids who used to hate their Dads would run down the street with open arms yelling ‘Daddy’, no longer in fear of him.”

“This is an issue that people want to turn their head away from, but don’t ever believe those who say it’s impossible work. I felt insecure starting out—[I wondered] why hasn’t this work been done earlier and more often?...I didn’t know how important it was to understand that men truly are 100% responsible for what they do, and it doesn’t matter how much he’s been provoked.”

“Men who batter are human, and we can’t forget them, even though the priority is victims.”

“I believe this work affects the staff – judges, social workers – in the way it affects victims! We become afraid of his threats, and we react the same way, by denying and minimizing his capacity for violence. We are in danger of hesitating and not reacting quickly enough.”

Intervention with boys/ young men

Several agencies that participated in this survey, and a few additional non-participating agencies, provide dating violence intervention and prevention services to young men and boys. The programmes with which the authors had contact are located in Australia, Germany, South Africa, Norway, Brazil, Nicaragua, Bulgaria, Zimbabwe, Mauritius, Fiji, Vanuatu and Singapore. The programming for young men is similar in a few ways across geographic locations; a) wilderness programming or camping is believed to be an effective strategy for intervening

with young men, b) teen-produced plays and dramatic presentations are also frequently used for outreach and educational purposes, and c) some practitioners are less inclined to confront young men about abuse directly, as compared with adult intimate partner violence offenders. As with most of the intervention programmes for adults, the adolescent prevention-oriented programmes have rarely been evaluated. Nonetheless, interventions with young people inspire hope that practitioners will find a variety of effective means for preventing the intergenerational cycle of intimate partner violence and for establishing new, health-promoting norms among youth.

DISCUSSION

Interventions with men who batter exist in developing and developed nations around the world. These programmes have originated out of victim advocacy service agencies, sexual health programmes, men’s counselling centres, religious organizations, family mental health centres, and individuals’ personal interest. In some nations, agencies have found that natural alliances exist between their own programme and law enforcement, battered women’s services, or mental health centres. In other locations, programme directors and their staff work in relative isolation.

There are several possibilities as to why it was not possible to make contact with interventionists in some regions or nations. Although unlikely, it could be that no intervention of any type – either formal and professional, or unstructured and informal – takes place. More plausible is that interventions do exist, but they are not the responsibility of any one individual or agency. For example, perhaps men who assault their partners in one nation are scolded by their partner’s family and publicly criticized by their neighbours – and this social control “intervention” is successful in inhibiting future acts of abuse. This investigation was not designed to capture social control interventions that occur routinely, and are enacted by an

entire family or community. Moreover, language and dependence on email and telephone for communication may have affected our ability to reach some practitioners in particular nations more so than in others. Finally, in some parts of the world, intervention for any reason may be infeasible. As one provider commented:

“The belief that any discussion of problems is bad luck hampers our progress here.”

“In our culture, it is thought that only crazy people go to therapy. So we have some difficulties [recruiting clients].”

It is also possible that in some societies prevention-oriented programmes and campaigns displace more targeted batterer intervention programmes. If a regional government grants funds to one community-based organization to conduct a campaign against men’s violence, they may not be able to devote additional resources to intervention with male abusers – nor feel that it to be necessary, given the presence of a “men’s campaign.” In other communities, the reputation and size of one social service agency may prevent others from forming a new one, because they do not want or feel unable to compete for funding, clients, or

recognition. Needs assessments, designed to help determine whether prevention campaigns or existing NGOs do in fact displace or delay the development of intervention programmes for abusers, should be conducted.

In the state of Massachusetts in the USA, 85% of abusers who attend intervention programmes do so because they are mandated by the courts. In sharp contrast, approximately 83% of the clients served by the programmes participating in this study attend the programmes willingly, as volunteers. The implications of this on practice and evaluation may be significant. The population of “court-mandated” abusers may differ substantially from those who are under no obligation to attend intervention programmes but select to do so anyway for periods of up to several years. Given the potential for underlying differences in the motivation to attend, learn and change behaviour that exists between USA batterer intervention clients and those in other nations – the practice of “exporting” US curriculum models to new settings seems questionable. The Emerge, Duluth, Manalive, and Raven approaches to working with men who batter were not developed for non-English speakers or for those in developing nations settings. As a result, practitioners who are seeking guidance, advice and materials to use in local settings with men who batter may need to turn to one another, and identified experts with experience in developing nations, in addition to the US, English and Canadian models that have been long-considered the “gold standard.”

One might argue that it is the batterer intervention programmes in the USA, Canada and United Kingdom that stand to learn from their colleagues with less publicized programmes. Batterer intervention programmes in the USA are noting that immigrants and refugees represent an increasing proportion of their clientele. Providing appropriate and effective services to men from Vietnam, Cambodia, Somalia, Haiti, Jamaica, Brazil, India, Nigeria and Russia – and who have lived in the USA for as little as one year – may be fundamentally different from providing the same service to native US citizens due to acculturation and linguistic factors. USA-, Canada- and UK-based programmes that serve immigrants and refugees should contact and solicit practical advice and materials from their colleagues in the nations-of-origin of their clients. International information sharing should be facilitated and made affordable for those in low- and middle-income nations.

As compared with providers of other services – such as HIV testing and counselling – batterer intervention counsellors are experiencing a relative dearth of factual information to use as the basis for their work. The providers expressed an interest in training, resources, materials, guidance, supervision, evaluation and a synthesis of scientific evidence about intimate partner violence. Currently, no international federation of batterer intervention programmes exists. If such a federation were established, it might serve to facilitate the exchange of information detailed above.

One area that highlighted the need for the exchange of ideas was the fact that a disappointingly low number of practitioners have established links with battered women's service agencies. Working in tandem with the advocates of intimate partner violence victims increases the amount of information that is available to the practitioners about the victims' experiences. Programmatic linkages also allow the staff – who are at risk for experiencing secondary trauma as a result of their work – to receive emotional, political, and even financial support from their partner agencies.

While there is some evidence that batterer intervention is effective with men who voluntarily attend it in the USA, the published evaluation studies do not address particular challenges currently faced by many batterer intervention programmes outside of the USA, Canada and the United Kingdom. For example, the lack of legal sanctions for intimate partner offences, cultural disinclination towards therapy of any type, or logistical barriers such as transportation, linguistic, literacy, or health needs of clients are not tackled by existing intervention programmes. There is urgent need for experimental evaluations of batterer intervention programmes that take place in developing nations. The rigour of the evaluation designs should not be overlooked; evaluations that fail to utilize a randomized or control group design, or evaluations that fail to assess victims' perceptions of batterers' behaviour change, will be of limited use.

The links between HIV, other sexually transmitted diseases, and intimate partner violence have been well

documented (see review by Maman et al., 2000; Wingood, DiClemente & Raj, 2000). Intimate partner violence inhibits women from negotiating condom use (Maman et al., 2000), and from seeking HIV testing or treatment (Heise, Ellsberg & Gottemoeller, 1999). The fact that less than half of the batterer intervention providers surveyed discuss sexual health with their clients is striking. It is unlikely that USA-, Canada- and UK-based batterer intervention programmes cover the topic of sexual health any more frequently, although clarification of this issue is needed.

Batterer intervention counsellors have the opportunity to provide information about reproductive and sexual health and to encourage their clients to respect their partners' rights to health-related self-determination. Initiatives that seek to educate sexual and reproductive health clients about intimate partner violence, such as those sponsored by the International Planned Parenthood Federation and Engender Health, are underway. To complement these initiatives, schemes to educate intimate partner violence clients about sexual and reproductive health should be introduced. Fostering links at the local level between intimate partner violence and health professionals would also benefit both parties.

Batterer intervention programme staff would also benefit from more extensive training on other topics. Currently, only one-third of the agencies provide their staff with intimate partner violence-specific training. For organizations that have branched out to batterer intervention work in response to the demand for service, without

previous experience in the area of intimate partner violence, basic information about intimate partner violence is essential. Basic training programmes should include evidence-based information about the causes of intimate partner violence, and knowledge about batterers, victims, and the effects of intimate partner violence on children. Training should also include area-specific information about local resources, such as the availability of legal advocacy services, shelter and counselling for victims and children, medical care, and the expected police response to intimate partner violence situations.

Even those practitioners who are well-informed about the dynamics of intimate partner violence and their local resources require training on how to conduct group or individual behaviour change intervention with batterers. Batterer intervention, for many providers, is distinctly different from providing psychotherapy. Techniques for improving participation in group sessions, holding abusers accountable for their abuse without alienating or humiliating them, honouring abusers' own experiences of oppression without colluding with them, and avoiding transferring one's own emotions on to abusers or victims are critical. Finally, the mental health status of practitioners is frequently affected by their professional duties. Staff training should include information that will help batterer intervention counsellors prepare for, and cope with, the explicit and frequently horrific content of their work.

Not all perpetrators of intimate partner violence are welcome to participate in the batterer intervention services provided through the programmes surveyed. In general, abusers with mental illnesses and active drug addictions are screened out of programmes. This investigation did not assess outcomes in clients who are turned away from batterer intervention programmes. It is possible that some receive specialized intervention services that address both intimate partner violence and their other healthcare needs. In areas where no specialized intervention of this type exists, particular attention should be devoted to how, and why, perpetrators of intimate partner violence are screened out of services and what happens to them and their partner when they are rejected from the programmes. The development of specialized services that are equipped for addicted abusers or those suffering would be a benefit.

Providing couples counselling to abusers and victims is a controversial practice. Battered women's advocates and many batterer intervention practitioners have expressed concern that victims who participate in couples counselling risk extenuated harm and that perpetrators are unlikely to be rehabilitated by this practice. The fact that many couples counsellors fail to distinguish a perpetrator and a victim when working with abusive couples, and prefer instead to view their clients as two victims each with equal responsibility for the dysfunction of the relationship, is particularly worrisome for many victims' advocates.

These criticisms notwithstanding, couples counselling has been demonstrated to reduce the use of physical violence by 56–90% among married men in the USA (Brown & O’Leary, 1997). Furthermore, it is noted that while couples counselling may endanger victims in certain settings, it may be the only, or the most effective, means of ameliorating abusive situations in others.

Continued evaluation of the utility and efficacy of couples counselling for perpetrators of intimate partner violence is needed. Until practitioners can be provided with clear evidence that couples counselling is either dangerous or beneficial in their own contexts, it is assumed that most will continue to provide or withhold the service as they have done historically. Given that abusers and their victims will be participating in couples counselling in some communities, the providers of that service should be equipped with an outline of possible dangers of that practice and effective techniques for minimizing the possibility of harm. Ongoing consultation with colleagues and battered women’s advocates, who may offer constructive critiques of the practice, will inform and enhance the providers’ ability to serve victims through their work.

Ongoing monitoring of programmes’ effectiveness is also important, given that there is a

possibility that participation in batterer intervention programmes may increase some forms of abusive behaviour on the part of the offender. At least two evaluations of USA-based batterer intervention programmes have found that abusers’ use of emotional abuse may remain constant subsequent to participation in an intervention programme, despite the fact that their use of physical abuse decreases (Edleson & Grusznski, 1988; Edleson & Syers, 1990). It is important to ascertain if some techniques or programme structures – particularly those that are “exported” from other nations – tend to have a deleterious effect on men’s relationship behaviour rather than producing the hoped-for, positive behavioural change. As Garcia-Moreno points out, risk factors for intimate partner violence vary across cultures. While victim’s empowerment may protect women in the USA from experiencing continued abuse, the same empowerment strategies employed in other settings may exacerbate abuse (Garcia-Moreno, 2000). Analogously, intervention strategies that inhibit abusers in one community may in fact encourage them in the next. Practitioners should share their own experiences freely with one another, and should not be afraid to develop new methodologies if borrowed models or techniques appear to be jeopardizing victims in the local setting.

LIMITATIONS

This investigation was not designed to be comprehensive or representative of all interventions with abusers that take place worldwide. Rather, it was our hope that this study would provide a starting point for future, more exhaustive investigations or more specific, targeted research projects in the area of batterer intervention in developing nations. Therefore, the results of the study are limited in several ways.

As mentioned, the results may not be generalized to all interventions with abusers. The recruitment of programmes may have systematically eliminated providers that are linguistically or technologically isolated. Moreover, “interventions” that are enacted by an entire neighborhood or community – and are not the responsibility of one individual or programme – were not captured by this investigation.

The sample size was small (n=56). As a result, it is possible that relationships exist that were undetected by this analysis. For example, it is

possible that providers who adhere to the pathology causation model are more likely to discuss experiences of childhood trauma than those who adhere to the gender-based power differential causation model. Future investigations that utilize larger samples may be able to clarify this and similar questions.

The validity and reliability of the data collected were not assessed. It is possible that the survey participants failed to accurately convey information about their organizations or their own work – or might have provided slightly different answers if asked on a different day. Due to resource limitations on the part of researchers and surveyed providers, repeated questioning of the respondents was not possible or practical. It is also possible that details about providers’ agencies and practice was improperly translated, miscoded or otherwise interpreted incorrectly by the researchers. Every effort was made to minimize these possible threats to the validity of the information reported here.

CONCLUSIONS

This descriptive study demonstrates that batterer intervention programmes exist in developing and developed nations alike. New programmes are being established and existing programmes are expanding. Given that this area of intervention appears to be on the brink of rapid growth, it is critical to quickly set in place process and outcome evaluations that will elucidate how programmes function effectively and in what ways they fall short of expectations. To prevent extenuating harm to victims, and minimize potential waste of financial and human resources, expertly-designed, independently-conducted programme evaluations are essential.

Several recommendations are put forth for consideration:

1) **Work towards the development of international best practices guidelines on batterer intervention.** A process for developing international best practices guidelines should be envisioned. This process should be informed by the results of programme evaluations and by batterer intervention practitioners who represent a wide range of philosophical standpoints and geographical experience. Those with the skills to critically evaluate

scientific literature and programme practice should play key roles in the guidelines development process. Once established, best practices guidelines could facilitate the funding process by highlighting areas of need among developing programmes and simultaneously providing baseline measures by which funding agencies could evaluate prospective grantees.

2) **The participation of battered women's and victims' rights organizations in the development of the batterer intervention field should be ensured.** The multiple benefits of cooperating with women's and victims' rights organizations, and the necessity of including women's and victims' advocates in the process of developing batterer intervention programmes, should be stressed to the international community of batterer intervention practitioners. Programmes that have not yet established productive relationships with local battered women's or victims' rights groups should be provided with the additional training, resources and incentive needed in order to foster solid, cooperative relationships.

- 3) **Assess the potential merits and burdens of introducing batterer intervention programmes to communities where violence prevention programmes exist.** In some communities, batterer intervention programmes may enhance existing violence prevention programming. In others, there may be insufficient resources or community capital to sustain two types of programmes with similar goals. Needs assessments that will articulate whether batterer intervention and violence prevention programmes will complement or hinder each other's efforts should be conducted in a variety of settings.
- 4) **Provide batterer intervention practitioners with simply written, translated syntheses of the empirical research on intimate partner violence causes and consequences.** Providers of batterer intervention services should be equipped with up-to-date and easily-understood summaries of the most current research on intimate partner violence.
- 5) **Model batterer intervention programmes based in the USA should be provided with the contact information of their international colleagues, so that they can collaborate to improve service for immigrant and refugee abusers.** The Duluth, Emerge, Manalive and other USA-based batterer intervention programmes that regularly train new providers should be linked with the international network of batterer intervention programme providers in order to develop new, effective materials and techniques for use with foreign abusers who attend programmes in the USA.
- 6) **Investigate informal social controls that inhibit intimate violence perpetration.** In some regions, no structured batterer intervention programmes exist. It is assumed that in these regions, as well as in some areas where formal programmes have been established, informal community-enacted interventions with abusers occur. Qualitative, descriptive investigation into the type, nature and efficacy of these social controls may enrich structured programmes, or may provide a basis upon which to develop effective, formal interventions where there are currently none.
- 7) **Enhance partnerships between sexual health and intimate partner violence perpetration programmes.** There is a clear need to foster linkages between sexual health programmes and the practitioners who are working with perpetrators of intimate partner violence. Models for creating and sustaining partnerships should be evaluated and disseminated.

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ATTACHMENT A

List of programme and individual provider participants:

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
Argentina	Grupo de Autoayuda para Hombres Violentos, Gobierno de la Ciudad de Buenos Aires	self-help group for violent men, some individual counselling for men after 3 or 6 months of group	PEEcV	✓	✓	—
Argentina	Centro Integral de Salud Psicologica Masculina	group sessions for men who batter, some individual sessions	PSEEcV	✓	✓	—
Argentina	Jenny Nievas	individual and group counselling for men who batter	PSEEc	✓	✓	—
Australia	No To Violence	agency is the umbrella organization for a network of 26 programmes for men who batter that hold group sessions and offer some individual counselling. The agency also operates a hotline for men who batter.	PSEEcV+ social and spiritual abuse, stalking, male privilege,	—	✓	—
Australia	Owning Up Programme	currently not operating groups, but formerly offered groups for men who batter	PSEEcV +Spiritual abuse	—	✓	—
Australia — Tiwi Islands	Family Violence Project	community-lead group for aboriginal men focused on their roles and health-related issues ; this is not a "perpetrator group" although issues of family violence arise; uses an "early intervention" approach	undefined	✓	—	—

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
Austria	Mannerberatung	Duluth-model and CHANGE-model (Scotland) influenced program; group sessions for men who batter	PSEEcV	✓	✓	in process
Barbados	The Crisis Center	groups for men who batter (pilot programme, planning for expansion)	PSEV	✓	✓	—
Barbados	Network Services Center	individual counselling for men and women who batter	PEV	✓	✓	—
Brazil	Pro Women, Family and Citizenship	individual, family and couples counselling and mediation for abusive men	PSEEcV	—	✓	—
Colombia	Fundacion Centro de Psicologia Clínica y de Familia	individual, family and couples counselling for abusive men	PSEEcV	—	✓	—
Costa Rica	Isela Lizano	individual and group counselling for men who batter	PSEEcV	—	✓	—
Democratic Republic of Congo	Protestant Church	Couples counselling	P	—	✓	—
Dominican Republic	Gregorio Marte	individual and group counselling for men who batter; anger management	PSE	✓	✓	—
Finland	Petteri Sveins	oversees 10 programmes that offer group and individual services to men who batter	PSEEcV	✓	✓	in process
France	AVAC	individual, family and couples counselling	PEV	—	✓	—
Germany	Men Against Male Violence "Maenner gegen Maenner-Gewalt"	agency is the umbrella for 22 programmes for men who batter across German-speaking Europe; 6 months individual counselling followed by 6 months of group sessions; uses offender-therapy methods of their own design	PS	no formal linkage, although occasional incidental contact with programmes for women)	—	✓ (conducted by German government in 1995)

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
Grenada	LACC	parenting programme, dispute resolution with couples, public education groups on IPV with men	PSE	no formal linkage with a battered women's advocacy agency, but works closely with CAFRA (a Caribbean, feminist organization)	depends on mode of service	—
Honduras	Edmundo Perez	groups for men who batter	PSEEcV	✓	✓	—
Hong Kong	Harmony House	individual and group treatment for men who batter; hotline for men; some training from EMERGE	PSEEcV	✓	✓	✓
Iceland	Center for Gender Equity—Men Taking Responsibility	group and individual counselling for men who batter	PSE	✓	✓	✓
India	Kottayam Social Service Society	self-help groups for women and men in abusive marriages; couples counselling	PSE	—	✓	✓
India	Swayam	agency primarily serves battered women. On occasion, staff will confront batterers of the women they serve.	PSEEc	✓	✓	—
India	Men Against Violence and Abuse (MAVA)	couples counselling, individual counselling, referrals and advocacy for victims	PSEEcV	—	✓	—
Ireland (Republic of)	MOVE Ireland	multi-agency network of programmes with varied practice; all sites offer 26 group sessions for men who batter; influenced by Wilson/Waring model.	PSEEcV	✓	✓	in process
Israel	Glickman Center	Duluth-model influenced group and individual counselling for men who batter	PSEEcV	✓	✓	—

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
Israel	Beit-Noam (Hannah Rosenberg co-founder)	live-in group home for men who batter; group counselling	PSEEcV	—	—	✓
Jamaica	Women, Inc.	agency does not offer batterer intervention services per se, but seeks to confront and resocialize men who batter through community workshops	PSEEcV	✓	—	—
Jamaica	FAMPLAN	programme has been adopted by the probation department and currently functions differently than it did 1998-2000. EMERGE-model influenced; group sessions for men who batter.	PSEEcV	—	not with regularity	✓
Mauritius	Daddies' Programme	outreach and counselling for married men with regard to sexual and reproductive health, some of the men are controlling and/or abusive and that is addressed	PSEEcV	✓	✓	—
Mexico	Coriac - Programa de Hombres Renunciando a su Violencia (PHRSV)	educational groups for men who batter	PSEEc	✓	✓	in process
Micronesia	Micronesian Legal Services	groups for men who batter	PSEV	✓	—	✓
Mongolia	National Centre Against Violence	police are trained to counsel and hold accountable male batterers	PSEEcV	✓	✓	in process
Netherlands	Probation Department/Sjef Rameakers	individual and group sessions; couples counselling optional after the abuser completes the group	PSEEcV	✓	✓	—
Netherlands	TransAct	individual and couples counselling for those in abusive relationships	PSEEcV	✓	✓	in process

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
New Zealand	Tim Metcalfe	group sessions for men who batter modeled on the Duluth programme	PSEECV	✓	✓	✓ (conducted by NZ Dept of Corrections in 1999)
Nevis	The Change Centre	individual and couples counselling for abusive couples	PSEECV	✓	✓	—
Norway	Alternatives to Violence	group and individual sessions for men who batter, modified US psycho-educational model, features of EMERGE-model programme used	PSEECV	✓	✓	✓ (conducted in 1996)
Pakistan	ROZAN	train male police officers to intervene more effectively with batterers and to become more sensitive towards women and children	PSEECV	✓	—	✓
Paraguay	CEDAI (Lic. Susana Torres)	individual counselling for men who batter; originally trained by Lic. Corsi	PSEECV	—	—	—
Peru	Percy Cole	groups for men who batter	PSEV	—	(missing data)	—
Peru	Carmen Torres Castro	groups and couples counselling for men who batter; uses cognitive-behavioural approach	undefined/ mutual and non-mutual	—	in couples counselling only	—
Peru	Nestor Vergara	group sessions for men who batter	PSEECV	✓	✓	—
Russia	Crisis Center for Men	groups for men who batter; individual counselling	PSEECV	✓	✓	—
Russia	Tyoply Dom (Warm House)	individual counselling with men who batter	PSEV	—	✓	—
Scotland	Change Programme	multi-agency network of programmes. Duluth-model influenced group sessions for men who batter. Also influenced by EMERGE and Manalive.	PSEECV	✓	✓	✓ (see Dobash, et al. 1999)

Nation	Programme name or director*	Type of programming offered to perpetrators of intimate partner violence	Definition of IPV**	Linked with battered women's agency	Makes contact with victims as component of programme	Formal programme evaluation results are available***
South Africa	ADAPT	family, group, couples and individual counselling sessions for men who batter; public seminars provided to men in informal settings such as taverns	PSEEcV+ spiritual	✓	✓	✓
South Africa	Family and Marriage Society of South Africa (FAMSA)	counselling for families, couples and individuals with relationship problems; groups for men who batter	PSEEcV	✓	✓	—
South Africa	Men for Change	individual, group, couples and telephone counselling for men who are violent against women	PSEEcV+ using the police to intimidate	—	not with regularity	—
Spain	Programme of Family Violence	individual treatment for men who batter	PSEV	✓	not with regularity	✓ (conducted by Echeburúa & Fernández-Montalvo in 1997)
Sweden	Safety Programme for Women Exposed to Men's Violence	Duluth-model influenced group sessions for men who batter	PSEEcV	✓	✓	—
Sweden	Manscentrum	individual and group sessions for men who batter	PSEEcV	—	not with regularity	—
Switzerland	Intervention Against Domestic Violence	group sessions for batterers, modeled after the Duluth program	PSEEcV + using children and male privilege	✓	✓	in process
Switzerland	Violence and the Family	21 group sessions for men who batter	PSEEcV	✓	—	—
Switzerland	Probation Department of Zurich	groups for men who batter; gather information for sentencing purposes	PS (illegal violence only)	✓	✓	in process
Zimbabwe	Family AIDS Support Organization (FASO)	group counselling for women and men in abusive partnerships	P	—	✓	—

* All programmes and individuals are listed with their permission

** P=physical abuse; S=sexual abuse; E=emotional abuse; Ec=economic abuse; V=verbal abuse

*** Programme evaluations conducted internally are not included

