

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.