

# DISCUSSION

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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.