

# RESULTS

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## 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:

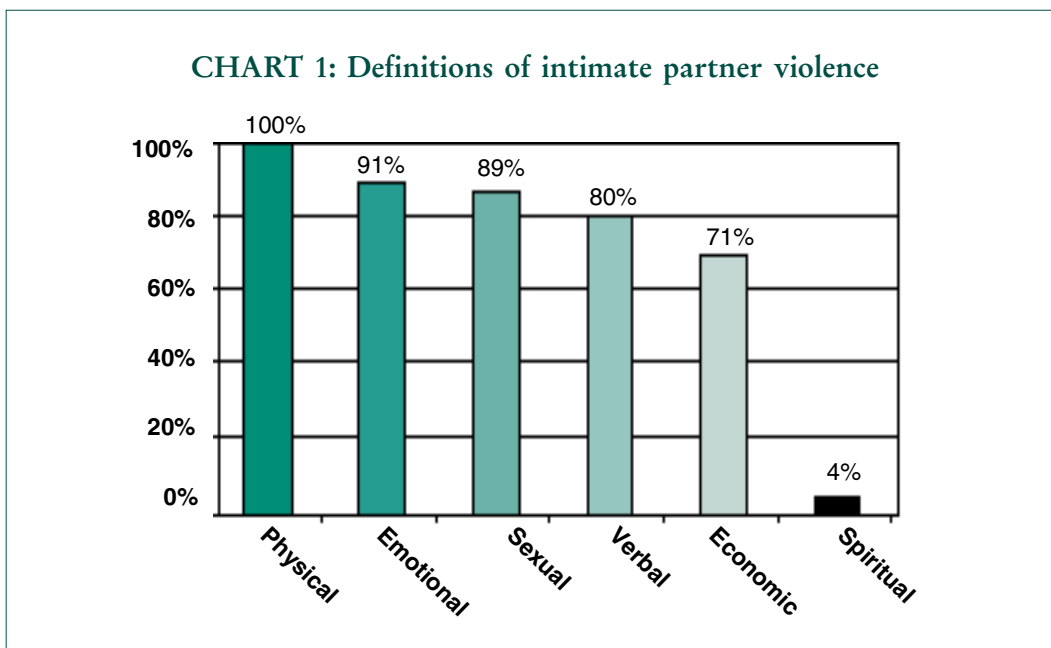
*“The dichotomy between victim and perpetrator furthers the gap and stereotypes. The men become the bad guy so the victim automatically becomes the good guy.”*

*“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)
<b>Masculinity:</b> 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)
<b>Intimate partnership:</b> Discussion of the differences between healthy and unhealthy intimate partnerships	88% (44)	84% (26)	95% (18)
<b>Conflict resolution:</b> Ways to solve problems without using violence	86% (43)	84% (26)	89% (17)
<b>Cultural traditions:</b> Discussion of the extent to which the culture of the abuser supports or discourages intimate partner violence	78% (39)	81% (25)	74% (14)
<b>Anger management:</b> Techniques for managing anger that avert violence	76% (38)	71% (22)	84% (16)
<b>Fatherhood skills:</b> The importance of parenting in a non-abusive manner	76% (38)	77% (24)	74% (14)
<b>Criminal sanctions for intimate partner violence perpetration:</b> Explanation of local laws regarding intimate partner violence	64% (32)	58% (18)	74% (14)
<b>Alcohol and Drug use:</b> The effects of alcohol and drugs on one's moods and capacity for violence	58% (29)	58% (18)	58% (11)
<b>Trauma:</b> The effects of childhood traumatic experiences on one's behaviour as an adult.	50% (25)	61% (19)	32% (6)
<b>Stress:</b> The effects of stress on one's behaviour.	50% (25)	55% (17)	42% (8)
<b>Sexual health:</b> Sexually transmitted disease and their relationship to healthy intimate partnership.	44% (22)	55% (17)	26% (5)
<b>Oppression:</b> How racism, classism or other forms of oppression affect one's behaviour.	44% (22)	52% (16)	32% (6)
<b>Spirituality:</b> How faith and spirituality affect one's behaviour and capacity for violence	22% (11)	26% (8)	16% (3)
<b>Community Organizing:</b> 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.