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Sandra M. Stith
Chelsea M. Spencer *Editors*

International Perspectives on Intimate Partner Violence

Challenges and Opportunities

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Series Editor's Foreword

The AFTA Springer Briefs in Family Therapy is an official publication of the American Family Therapy Academy. Each volume focuses on the practice and policy implications of innovative systemic research and theory in family therapy and allied fields. Our goal is to make information about families and systemic practices in societal contexts widely accessible in a reader friendly, conversational, and practical style. AFTA's core commitment to equality, social responsibility, and justice are represented in each volume.

In this volume, *International Perspectives on Intimate Partner Violence: Challenges and Opportunities,* editors Sandra Stith and Chelsea Spencer, renowned IPV scholars from the United States, took an explicitly decolonizing stance to address this world-wide phenomenon through the voices of researchers and practitioners intimately familiar with their local contexts. As each chapter author describes their own work and the sociocultural, legal, and professional contexts of IPV awareness, prevention, and treatment in their communities, readers begin to see both the many similarities attendant to IPV and the influence of unique differences arising out of varying sociopolitical contexts.

Reading the whole volume cover to cover, I was particularly struck by the persistence of IPV even in countries like Finland where gender equity is rated one of the highest in the world. I was also caught by the tensions between the pulls to maintain family stability and reputation and the need to promote safety and well-being for individual partners. Addressing IPV clearly challenges written and unwritten gender and cultural norms and is thus part of ongoing societal change. What this means, as well as who is studied and the focus of intervention, looks different in different social contexts. Like all good scholarly accomplishments, this book raises as many questions as answers. By bringing together so many different international perspectives, the volume offers hope and direction for increased understanding of the causes, challenges, and opportunities for addressing intimate partner violence through a genuinely collaborative exchange.

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AFTA Springer Briefs in Family Therapy

A publication of the American Family Therapy Academy
Founded in 1977, the **American Family Therapy Academy** is a non-profit organization of leading family therapy teachers, clinicians, program directors, policymakers, researchers, and social scientists dedicated to advancing systemic thinking and practices for families in their social context.

Vision

AFTA envisions a just world by transforming social contexts that promote health, safety, and well-being of all families and communities.

Mission

AFTA's mission is developing, researching, teaching, and disseminating progressive, just family therapy and family-centered practices and policies.

Acknowledgments

We (Sandi and Chelsea) have many people and organizations to thank for making this book happen. First, we acknowledge the contributions the National Council on Family Relations (NCFR) made to this book. In 2017, we attended the NCFR and they announced the theme for the 2018 conference: "Families and Cultural Intersections in a Global Context: Innovations in Research, Practice, and Policies." We knew that we wanted to put together a symposium for the Family Therapy Section for the conference. Most of the authors of chapters for this book presented with us at NCFR. When we decided to turn our symposium into a book, all of the presenters agreed to join us. We are so grateful for the contribution of these colleagues, both in the symposium and in this book: Karen Ripoll-Nunez and Anna Jaramillo-Sierra are professors in Bogota' Colombia, South America; Fatemeh Nikparvar, originally from Iran, now serving as clinical director of the University of Central Missouri; Jingshuai Du was originally from China, but is now earning her Ph.D. from the University of Maryland; Sandi, Chelsea, Fatemeh, and Jingshuai worked together on a domestic violence research team at Kansas State University when Fatemeh and Jingshuai were students; Tatiana Glebova, originally from Russia, but is now a professor at Alliant University in California; Mona Motal, originally from India, is a professor at the University of Maryland, and her colleague, Manjushree Palit, professor at Jindal Global University in India co-authored the chapter on IPV in India. We loved the symposium and learned so much from this team, but we realized we had some gaps in our ability to examine domestic violence from a global perspective without expanding the list of authors. We invited friends from the United Kingdom, Arlene Vetere and Jan Cooper, who provide services to families and couples after experiencing domestic violence and are internationally known domestic violence scholars we have gotten to know from the International Family Therapy Association (IFTA). We also knew Heli Siltala, Helena Päivinen, and Juha Holma, University of Jyväskylä, Finland, from IFTA. As the author list was coming together, I (Sandi) was invited to make a presentation on my work with couples experiencing situational intimate partner violence in Turkey. At dinner, the evening after the presentation, Senem Zeytinoğlu Saydam, from Ozyegin University, Istanbul, and Nesteren Gazioğlu, from Maltepe University, Istanbul, Turkey, agreed

to write a chapter. At that point, we realized we were missing a scholar from Africa and from Australia/New Zealand and searched recent publications on domestic violence from scholars in those continents. We were able to collaborate with Kolawonyole Oyediran, a scholar publishing work on IPV in Nigeria, Andrew Day and Stuart Ross from the University of Melbourne, Australia, and Devon Polaschek, from Waikato University, New Zealand.

We are also grateful to the American Family Therapy Academy for highlighting the importance of social justice and context and for sponsoring the AFTA Springer Briefs in Family Therapy which allowed us to share our work with a community who "envision a just world by transforming social contexts that promote health, safety and well-being of all families and communities" (AFTA vision statement). We are grateful for the guidance and support we received from our friend, Carmen Knudsen Martin, series editor from the AFTA Springer Briefs in Family Therapy. We are both committed members of AFTA, and the focus on social justice fits with our work, which seeks to eliminate violence in the family.

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About the Editors

Sandra M. Stith is a university distinguished professor, emeritus in the couple and family therapy program at Kansas State University. She is also a licensed marriage and family therapist and an approved supervisor. Her research focuses on partner violence. In 1997, she received NIMH funding to develop and test the effectiveness of a couple's treatment program for partner violence. She has published 4 books and has co-authored over 130 articles and book chapters on the topic, including a newly published article (co-authored with Dr. Spencer and some other contributors to this brief) which describes how the program developed from NIMH funding for treating IPV has been adapted and delivered in Mexico, Iran, and Finland: Stith, Spencer, Ripoll-Núñez, Jaramillo-Sierra, Khodadadi, Nikparvar, Oksman, & Metelinen (2019). International adaptation of a treatment program for situational couple violence. *Journal of Marital and Family Therapy.1-17.* In 2004, Dr. Stith received the American Association for Marriage and Family Therapy's Outstanding Contribution to Marriage and Family Therapy award, in 2007 she received the American Family Therapy Association's Distinguished Contribution to Family Systems Research award. In 2012, she was named Fellow of the National Council on Family Relations.

Chelsea M. Spencer is a research assistant professor in the couple and family therapy program at Kansas State University. Dr. Spencer researches intimate partner violence, intimate partner homicide, and sexual violence. She has worked on papers and presentations that have focused on risk for intimate partner violence perpetration and victimization, as well as treatment for couples who have experienced situational couple violence in their relationship. Her overarching goal is to examine factors that could aid in violence prevention and intervention efforts. Dr. Spencer has authored or co-authored 34 journal articles, 7 book chapters/encyclopedia articles, and 71 presentations. Additionally, she is also a licensed marriage and family therapist who specializes in working with individuals who have experienced trauma, including individuals who have experience intimate partner violence.

Chapter 1
Intimate Partner Violence Risk and Intervention: Need for an International Lens

Sandra M. Stith

For much of my life, I have been passionate about making a difference in people's lives and about understanding and experiencing life beyond the United States (US). On my file cabinet is a quote attributed to John F Kennedy, "One person can make a difference and everyone should try," which keeps me grounded. My husband and I married young and after completing college; we spent 2 years in Venezuela in the Peace Corps, which fueled my passion for both making a difference and understanding perspectives beyond the United States. This book, and my academic career, focusing on preventing and treating intimate partner violence (IPV), comes out of this passion.

I earned my PhD in Couple and Family Therapy (CFT) at Kansas State University (KSU) in 1986 and sought to understand police response to IPV for my dissertation (Stith, 1990). I taught courses in understanding and preventing IPV in numerous settings and echoed the prevailing view that "it is never appropriate to treat couples together when there had been IPV." When I was program director in the CFT program at Virginia Tech, we worked with high conflict couples. Frequently, we found that clients reported to us that they had experienced physical, psychological, or sexual IPV in their relationship only after we had established a therapeutic alliance with them. My first reaction, as a supervisor, was that the offender needed to go to a batterer intervention program. However, these voluntary clients typically did not want to go to a batterer intervention program. If we chose not to treat them, they found a different couples' therapist who may have no understanding of IPV. This made me rethink the idea of whether it might be appropriate to treat carefully screened couples conjointly.

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In 1997, my Virginia Tech colleagues, Eric McCollum and Karen Rosen, and I received a grant from the National Institute of Mental Health to develop and test a treatment model for couples who have experienced IPV. At the time, very little had been written about treating couples experiencing violence conjointly. Not long after we began presenting and publishing research from our program (e.g., Stith et al., 2003, 2011, 2012), we began being invited to provide training on the program internationally. When I moved to KSU and Chelsea Spencer (co-editor of this brief) became a student and then a faculty member, we worked together and, in 2019, published an article (Stith et al., 2019) in the *Journal of Marital and Family Therapy* on how our couples' treatment program for IPV has been adapted in Colombia, Iran, and Finland. Several of our co-authors in that paper are co-authors in this brief. The more I have had the opportunity to provide training on IPV treatment internationally, the more I recognized that although IPV is a worldwide phenomenon, our understanding of IPV differs substantially. This was especially clear when two of our chapter authors for this brief, Karen Ripoll-Núñez and Ana Jaramillo-Sierra, asked me to speak at the Universidad de los Andes, Bogotá, Colombia. Karen and Ana spent almost a day helping me understand the Colombian response to IPV before I presented our work in Bogota. This discussion was amazingly helpful and added to my passion to edit this brief for AFTA.

One early question I had, and continue to have, is as follows: "Are there factors that might lead a clinician to expect that IPV may be occurring in a relationship?" In 2004, my Virginia Tech students and I (Stith, Smith, Penn, and Ward) published a meta-analysis on risk markers for IPV perpetration and victimization. When I moved to KSU, I moved the data set with me, and my students and I have continued to add to the data set.

1.1 Risk Markers for IPV

Chelsea Spencer and I have conducted many studies seeking to identify risk markers for physical IPV perpetration and victimization. This work is important for clinicians working with couples because knowing what variables are associated with an increased (or decreased) risk of IPV perpetration or victimization can allow for improved screening for IPV, as well as help identify areas to address in therapy for IPV prevention or intervention purposes. In 2020, we (Spencer et al., 2020b) conducted a meta-analysis examining risk marker for IPV perpetration among men and women. We included data from 503 studies on the topic and were able to examine 60 risk markers for IPV perpetration. We found that the strongest risk markers were related to other forms of violence perpetration and victimization within the couple relationship, followed by demand/withdraw relationship patterns and mental health issues (e.g., borderline personality disorder, anger, controlling behaviors). These results are important for therapists, because they suggest that we may target co-occurring issues for IPV prevention and intervention work. This highlights the

importance of clinical work in the prevention, identification, reduction, or elimination of IPV in relationships.

We have also conducted meta-analyses examining topics that specifically relate to therapy (Spencer et al., 2019a). For example, we (Spencer et al., 2020a) examined attachment styles as risk markers for IPV perpetration and victimization. In this study, we found that avoidant attachment, anxious attachment, and disorganized attachment were significantly related to both IPV perpetration and victimization among men and women. Since some therapists focus on building secure attachment among couples in their practice, these are additional important factors to consider. We also found that an avoidant attachment style was a significantly stronger risk marker for IPV victimization for women than it was for men, which is an important finding for therapists working with a couple where the woman has an avoidant attachment style. Of course, we do not know if the avoidant attachment style is the cause or result of IPV, but it should be a warning signal. We (Kimmes et al., 2019) have also examined risk markers for IPV perpetration and victimization among same-sex couples. We identified some unique risk markers for same-sex couples that therapists should be aware of, such as internalized homophobia. The growing body of literature regarding risk for IPV can allow clinicians and researchers to have an understanding of factors to examine when working with couples who may have experienced violence in their relationship.

We have also sought to understand how culture influences the strength of IPV risk markers. In our 2016 study (Mallory et al., 2016), we used Hofstede's dimensional model of culture (Hofstede, 2011) to understand how variation among cultural values across different countries influences the strength of risk markers. We focused this study on two types of societies Hofstede identified. He suggests that individualist societies have "loose ties between individuals" (p. 11) and tend to privilege "I consciousness" versus collectivist societies, in which "…people from birth onward are integrated into strong cohesive groups, often extended families…that continue protecting them in exchange for unquestioning loyalty" (p. 11) and tend to focus on "we consciousness." Developed and western countries tended to be higher on individualism. Japan scored a 50 on the scale. In this meta-analysis, we divided our sample into three groups: US sample (because it included the largest number of studies, but according to Hofstede's scale, 0 = the strongest collectivist country and 100 = strongest individualistic country, the United States scored 91). Collectivist countries were 107/799 studies (studies published from China were the largest in this group). International individualist countries were 92/799 studies (studies published from Canada were the largest in this group). Studies published in the United States were 580 out of 799 studies. We tested 11 risk markers for male IPV perpetration, and 7 did not differ between the three groups. Overall, young age and low relationship satisfaction were stronger risk markers for men in the United States compared to men in the other two groups. However, witnessing parental IPV and perpetrating emotional abuse were stronger risk markers in collectivist societies compared to other two groups. Although we expected that cultural values would be an important distinguishing factor between the strengths of various risk markers in predicting IPV, we found that the only risk marker that might be related to

individualist cultural values was "witnessing IPV in childhood.". Witnessing IPV in childhood in collectivist countries was a stronger risk marker than it was in individualistic countries. Next, we decided to look at another factor in our international meta-analysis data set that might lead to differential risk markers, i.e., the country's level of income inequality.

Income inequality tends to contribute to social disorganization and to acts of violence within a community. Wilkinson (2004) found that increased rates of homicide are linked to higher levels of income inequality. He suggested that income inequality leads to additional stress in poorer families, which can lead to increased violence. In our research (Spencer et al., 2019b), we looked at how income inequality can influence risk markers in countries rated as high- or low-income inequality via the Gini index. The Gini index came from the World Bank Development Indicator (World Bank, 2017). Perfect equality is rated as 0, and perfect inequality is rated as 1. We divided the countries in half with the studies from countries with the highest income inequality rated as high-income inequality and the studies from the countries in the lowest half rated as low-income inequality. A total of 367 studies and 1492 effect sizes were used in this paper. Of the countries represented in this brief, China, Turkey, and the United States were considered to have high-income inequality. Australia, India, and Iran were considered to have low-income inequality. Only countries that had data published in English examining the risk markers we were studying were included in the analysis. We compared the strength of 29 risk markers between high- and low-income inequality countries. We found that young age, relationship dissatisfaction, violence toward others, and emotional abuse perpetration were stronger risk markers in countries rated as high-income inequality. We also found that having experienced trauma was a significantly stronger risk marker for men in low-income inequality countries. Although we learned from all of these studies, it became increasingly clear that it was not possible to generalize data to an entire country. For example, if the data were collected from a low-income community in a country rated as having low-income inequality, the data might be more representative of data from a high-income inequality country, regardless of how the country was rated on the Gini index. A country might be rated as individualistic, but if the data were collected from a primary Moslem community or an indigenous community, it might be more representative of a collectivist country. We also began examining risk markers in individual countries from the growing data set. For example, Fatemeh Nikparvar, an author of a chapter in this brief and former student, who is from Iran, examined risk markers for IPV in Iran (Nikparvar et al., 2020). She looked at 14 studies and found that women who experienced emotional abuse, depression, poor mental health, and poor physical health, whose partners used illegal drugs, who lived in a patriarchal household, and whose partner had experienced child abuse were more likely to experience physical IPV. While understanding IPV risk markers in various countries is important and useful, I really wanted to know more and to understand how individual countries responded to IPV.

When I thought about what I wanted to do next, I reviewed an earlier Springer Brief written by Teresa McDowell, focusing on applying critical social theories in family therapy practice. A theory discussed in the Brief which really stood out to

me, was that of "colonization". "Colonizing is sometimes exemplified in the practice of family therapy via the privleging of evidence-based manualized models for broad cross-cultural application, the transplantation of Western family therapy concepts and techniques to non-Western countries" (McDowell, 2015, p. 3). The brief made me think about how my speaking in countries all over the world about our manualized treatment for couples experiencing situational IPV and how my sitting in an office in Kansas, using data collected in countries all over the world, trying to explain or improve understandings of IPV internationally are types of colonization. In an effort to learn more about challenges and successes in preventing and/or treating IPV from an international perspective, this AFTA Springer Brief was born. It was clear to us that we did not want to expand on our roles as colonizers; therefore, each of the authors who we invited to write chapters had lived most of their lives in the country about which they were writing. We invited authors from all over the world to contribute. Each of the authors we invited agreed to contribute and was pleased to be a part of this AFTA Springer Brief. We asked them to first introduce themselves and then to help us understand more about their country (e.g., size, population, religious orientation, etc.). We asked them to share information about IPV in their country and the legal and clinical response to IPV in their country. We are excited to share this Springer Brief with you.

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Chapter 2
Intimate Partner Violence in the United Kingdom

Arlene Vetere and Jan Cooper

2.1 Introducing Ourselves to You

I, Arlene, am a clinical psychologist, and I, Jan, am a former psychiatric social worker. We are both systemic psychotherapists, trainers, and supervisors. Later in this chapter, we describe our independent family violence intervention service, founded in 1996, in the town of Reading, in the south of England. Here we shall say a little bit about ourselves and how we met. Prior to this, we knew each other for years, meeting at the annual conference of the UK Association for Family Therapy. During that time, I, Arlene, was working as a clinical psychologist in adult mental health services in the National Health Service, and I, Jan, was working for a major children's charity. So we would meet up at the conference and talk about our frustration at not being able to persuade our respective employers to let us focus on working directly with violence in family relationships. We could see the intergenerational impacts on child and adult development and in particular the impact in family culture of unresolved complex trauma. Thus, in 1996, we said to each other, "enough is enough, we need to do something about this!" So we stepped outside our paid employment to establish and work together in an independent service. As the reader of this chapter, you will not be surprised to hear that once we had taken this step, our previous employers looked at our service with interest and invited us back to work for them. We looked at each other in this moment, as it was tempting to go back to paid employment, but we decided to continue as two women, working in our local community. Looking back, we are both grateful we did this. We had to learn fast as we did not have an agency to protect us. We had to be highly visible, transparent,

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and completely accountable for our beliefs and practices around safety in family relationships (Cooper & Vetere, 2005; Sammut Scerri et al., 2017). We shall write more about this later in this chapter.

2.2 United Kingdom (UK) Overview

The United Kingdom of Great Britain and Northern Ireland is an island nation in NW Europe, which includes the four nations of England, Scotland, Wales, and the province of Northern Ireland. The UK population totals nearly 67 million and is considered an aging population as 18% are over the age of 65. London, the capital city, is in England and has a population of 8,800,000 in Greater London. It was in London, during the 1970s and early 1980s, that Erin Pizzey's work established the need to take domestic violence generally, and IPV in particular, seriously in how we as a society, in our social, health, political, and economic organizations, responded to the need (1974). In 1971, she established the first domestic violence shelter in modern times, Chiswick Women's Aid, now called Refuge.

Currently, Refuge provides a UK wide helpline. Locally, in the town of Reading, in the south of England, our first shelter was established in 1974 with Jan Cooper as one of the founding members.

2.3 Intimate Partner Violence in the United Kingdom

Walby (2009) estimated the economic and social costs of domestic violence for 2008 in the United Kingdom to be £16 billion. The UK Department of Health (1995) estimated that over 750,000 children a year witness domestic violence in England. The Crime Survey for England and Wales (Home Office, 2019) estimated that at least one third of all violent crime was domestic assault, with women much more likely to be assaulted and harmed by their male partners. The survey for 2019 recorded that 5.7% of 16–74-year-old people (2.4 million) experienced domestic abuse in the past year, with little change reported from the previous year. However, the recent Covid-19 pandemic has seen a rise in divorce rates and reported incidents of IPV, probably as a result of increased internal and external stressors for couples, as reported by commentators, but at the time of writing, accurate data are not available. The most common age at which women experience domestic violence is 18–24 years (38.6%), followed by age 11–17 years. For men who experience domestic violence, the most common age is 18–24 (47.1%) followed by age 25–34 (30.6%). Such findings led the Home Office for England and Wales to include 16–17 year olds in the definition of domestic violence and to enlarge the definition further to include coercive control. Earlier, in 2005, the definition had been expanded to include forced marriage, "honor crimes," and female genital mutilation. Interestingly, it is important to note that all the definitions of the UK nations speak

of what people do to harm others, i.e., acts, whereas they do not include omissions. The original Council of Europe's Council of Ministers (1986) definition of physical violence in the family is still the only definition that speaks of both acts and omissions. When considering safety in families and working toward safety in family life, it is important to consider what people do as well as what they do not do.

In 2004, the UK government via the Department of Health and Department of Education and Skills published the National Service Framework for Children, Young People and Maternity Services. The report emphasized that IPV starts or escalates during pregnancy and is associated with a greater incidence of miscarriage, fetal injury, and prematurity. In addition, the report called for domestic violence awareness training to be delivered within these public sector services to all staff, including the identification of appropriate referral pathways. However, therapeutic provision remains patchy, as discussed below. In 2005, the child protection category of emotional abuse was expanded to include seeing or hearing the ill treatment of another. This change was based in van der Kolk's (2005) developmental trauma research that showed that children were as adversely affected when they were exposed to other's violence as when they were physically assaulted themselves.

The Domestic Violence and Matrimonial Proceedings Act (1976) provided police with the powers of arrest for breaches of injunctions in circumstances of IPV and gave women the legal right to stay in the marital home. The Family Law Act 1996 Part IV provided remedies under civil law criminal offences, including sexual and physical assault, harassment, and homicide. The government strategy toward domestic violence and IPV is built on the three pillars of prevention, protection and justice, and support (Blunkett, 2003). In practice this means that police domestic violence units, housing services, probation, health and social care services, legal professionals, and voluntary agencies all work together at a local level. The Domestic Violence, Crime and Victims Act (2004) was enacted to aid in providing resources and legal protection to victims of IPV across the United Kingdom. Broadly speaking, there are few notable differences between the four nations in their definitions of IPV and provision of support, although, the North of Ireland was the first to include financial abuse in their definition, and Scotland was the first to include marital rape in law. The Women's Aid Federation is one of a group of charities in the United Kingdom that provides safety, assistance, and support to women and children. There are four main federations for each nation in the United Kingdom. Their main aim is to end domestic violence against women and children. They address the main needs of women through providing shelter and outreach work, for example, with housing, health, finance, and their children (Women's Aid Charity, England, 2020). The Women's Aid service is widely advertised throughout the United Kingdom, with all family doctor services, hospital departments, social work departments, etc. displaying posters, with leaflets and online links. In England, the Samaritans organization provides a phone link to the Women's Aid service. Shelters are available in all UK counties, and many in our metropolitan centers are organized to reflect the needs of women and children from different cultural and ethnic groups.

2.4 Challenges and Issues in IPV Services in the United Kingdom

A number of challenges confront us at this time of austerity politics and deep funding cuts in our public sector services. Research and practice identify a number of issues for our consideration here. The long-standing and mainstream focus on violence against women in intimate partner relationships has inadvertently downplayed the violence perpetrated by women in both same and different gender relationships. Downplaying violence against men strengthens some heteronormative assumptions in the gender paradigm and risks overlooking the needs of LGBTI+ couples (Eckhardt et al., 2013). The tendency to focus on single explanations for IPV, such as how it is rooted in patriarchal assumptions and entitlements to treat women, has meant that integrative formulations for the causation, maintenance, and cessation of IPV, which also include trauma theory, attachment theory, family psychology and sociology, etc., have been slower to develop. Similarly, dominant paradigms such as patriarchy do not help us explain women's violence, and for us it is an ethical position to draw on all available theory and research. Finally, the focus on men as perpetrators of IPV against their partners somewhat overshadows men's other roles in the family and community, such as fathers, sons, brothers, etc. This raises a level of analysis issue, i.e., how explanations for IPV can fit and adapt to the level of the individual, the couple, the family, community groups, and wider social institutions.

Therapeutic responses to IPV in the United Kingdom, as opposed to or in conjunction with legal responses, are still patchy (Hester & Westmarland, 2006). Probation services have traditionally offered perpetrator group programs to men and partner groups to women. Forensic psychologists and forensic services based in prisons provide individual and group therapeutic treatments for those people incarcerated as a result of perpetrating violent crime. Charities, such as the Women's Aid Federation, provide support and outreach to women as victims, as described above. They rely on grants and external funding, rather than a central government core funding program. Adult psychiatric and psychological services in the UK National Health Service are still diagnostically organized, and although staff may be aware of unresolved trauma responses as a result of IPV, they are often uncertain how best to respond, and the interventions offered generally follow the diagnostic categories (Turner et al., 2017). IPV in the relationships of older couples is addressed less frequently. Despite some notable exceptions, relationship-based therapeutic services, grounded in safety methodologies, are rarer still (Sammut Scerri et al., 2017). The impact of deep government funding cuts to the public sector services these past 10 years has made the provision deficit worse.

2.5 Situating Ourselves: The Reading Safer Families Service

The Reading Safer Families independent family violence intervention service, established in 1996, in the south of England, is an example of a community-based practice that did not need additional funding from the statutory sector (Cooper & Vetere, 2005). Reading Safer Families provided an affordable family violence prevention service, which was accessible for all family members and those living in close relationships, across the family life cycle, where violence was of concern. With this project, we aimed to explore both how systemic thinking and practice could make a contribution to family safety and to establish a safety methodology for safe relationship therapy practice. The question of how to make therapy safe enough to meet family members together, and to offer relationship support and therapy when violence has taken place, has vexed the field for decades. The Reading Safer Families systemic safety methodology is published extensively (see Sammut Scerri et al., 2017, for a full list of references). The methodology is based in the triangular relationship between the assessment of the risk of future violence, helping people take responsibility for safety and for behavior that harms others, and collaborative practice. The risk of future violence is managed from the outset of a referral with a no-violence contract and a careful, tailored safety plan to help predict, prevent, and de-escalate unhelpful arousal during relationship conflicts. The safety plan explores the internal and external relationship factors that trigger unhelpful arousal into dangerous arousal, such as attachment fears, relational traumas, etc. on the one hand and, on the other, stresses arising from debt, employment, wider family and community conflict, etc. It also explores resources, i.e., confiding relationships, those times when relationship conflict did not become dangerous, etc. The safety plan is supported with the help of a "stable third" person who knows the family and, if children are involved, can visit the family home. The "stable third" could be the referrer but needs to be someone who can think about the likely success of the safety plan, can help corroborate what family members are saying about the ending of their violent behavior toward others, and can participate in regular reviews of the safety plan. If the safety plan is effective, then it can be considered sufficiently safe to continue with relationship therapy, including the exploration of the developmental impact of the traumas and legacies of intergenerational violence and abuse (Vetere, 2015). We are writing this chapter in the post-Covid-19 world of online therapeutic work and are pleased to report that, thus far, safety planning with the help and support of the stable third person can be managed online.

The management of risk takes place alongside the assessment of the risk of future violence and includes consideration of the contexts of violent behavior, severity, frequency, etc., empathy for the victim, reflective functioning, and internal motivation for change. Commonly used psychometric measures include as follows: the Spousal Assault Risk Assessment (Kropp & Hart, 2000), the Conflict Tactics Scale 2 (Straus et al., 1996), and the Controlling Behavior 32 scale (Sleath et al., 2017). Responsibility for safety and for behavior that harms others is addressed at all times and involves the deconstruction of the use of language that minimizes

violent behavior and its impact and that blames others. If, in our opinion, a family member has an untreated substance use problem, we insist on them using our local addiction service, with consent for liaison, in parallel with our work. Collaborative practices include the use of reflecting processes; in-room consultation; transparency at every level about our thinking, intentions, and actions; recognition of our own moral dilemmas around the use of violence; and our commitment to help families find and maintain a resolution to the violence.

2.6 Defining Success and Good Outcomes

An interesting challenge is how we define success and good outcomes in IPV perpetrator programs and, in particular, from the perspectives of the different stakeholders, for example, the men and women who behave with violence, the funders and commissioners of perpetrator programs, and the practitioners. In the United Kingdom, commonly used outcome measures include the Couple Satisfaction Index 32 (Funk & Rogge, 2007) and the SCORE 15 (Carr & Stratton, 2017). A pilot study by Westmarland and Kelly (2013) attempted to map the complexity of successful outcomes from the four different perspectives, described above. Although the meaning of success held similarities across all the four perspectives, such as safety and empowerment, enhanced awareness of self and others, respectful/improved relationships, and so on, the differences for the funders and practitioners resided in safer parenting practices and increased well-being for all family members and their communities and, for the funders, quantifiable measures of success. Herein lies the rub, as a successful outcome can be defined as a safe separation, and this is where the theory-research gaps loom larger (Sammut Scerri et al., 2017). There is a higher risk of physical violence for women during the processes of separation, divorce, and contact handover when safety is not being monitored or maintained within public sector services (Johnson & Hotton, 2003).

2.7 Working in Multicultural Contexts

Multicultural work in the context of IPV continues to be a focus. The challenges lie in the integration of developed understandings of cultural differences with the need to work through language translators. Many local authorities, particularly in London, aim to meet the cultural diversity of their communities. There is often an educational focus to their work, which is based on the differing beliefs and understandings that their client population may hold based on their gendered roles in their country of origin, yet living within the context of UK legislation. There are very few specialist units; however, an exception is the NEWday Project in the London Borough of Newham where they work toward effective and sustained change with a culturally diverse community (Infanti-Milne & Walton, 2020). The NEWday

domestic abuse intervention project was funded through the Department of Education Innovation Fund in 2017 to assist families where domestic violence, including couple violence, was the main reason for Children's Services involvement in the family across the contexts they live in – home, school, and community. The NEWday team consists of social workers, family therapists, teachers, and parent support practitioners. They adapted the Reading Safer Families model and the work of Alan Jenkins (1990) for the development of social work practice in their urban context where they often rely on the help of interpreters

2.8 The Future

The challenges for the United Kingdom and for services in the future remain as above, including the further development of online practice, but in addition, there is a need to develop services for women who behave with violence in their intimate relationships, such that they receive help with understanding and managing their dangerous arousal. The evaluation of domestic violence perpetrator programs continues to be a vexing methodological issue, and early findings suggest that these programs continue to need improvement by tailoring the programs to the characteristics of the participants and their family and community contexts (Akoensi et al., 2012).

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Chapter 3
Intimate Partner Violence in Iran

Fatemeh Nikparvar

3.1 Author Background

I was born in Iran and attended the Shahid Beheshti University in Iran. After earning my graduate degree in Iran, I worked as a couple therapist. After seeing the challenges couples faced in Iran more clearly in my work, I decided to go to the United States, earn my PhD in Couple and Family Therapy, and conduct research on IPV in Iran. My major professor was one of the editors of this book, Dr. Sandra Stith. During my PhD program, I conducted quantitative research looking at violence against both men and women in Iran (Nikparvar et al., 2018a; Nikparvar et al., 2018b). I also conducted qualitative research, where we interviewed women from Iran who left their abusive marriages (Nikparvar et al., 2017) and sought to understand the process Iranian women faced adjusting to divorce after leaving their violent marriage (Nikparvar et al., 2018c). Finally, for my dissertation, I interviewed therapists in the United States who worked primarily with Iranian IPV clients in the United States (Nikparvar, 2019). This chapter was heavily influenced by my own experience and my ongoing research on IPV in Iran.

3.2 Introduction

Islamic Republic of Iran is one of the oldest civilizations in the world dating back to 3200–2800 BC (Kamali, 2018). Iran is the 18th largest country in the world with a population of over 82 million in 2018. There are seven major ethnic groups: Persian,

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Azeri, Kurd, Lur, Baloch, Arab, and Turkmen. Most of the population in Iran are Shi'a Muslim (89%), 10% are Sunni Muslim, and the remaining 1% are Christian, Zoroastrian, Baha'i, and Jewish (Aghajanian, 2001). Iran is in the Middle East region, and it has a collectivistic and patriarchal culture like all Middle Eastern countries. In a collectivistic culture, family is viewed as a highly important social institution and the main part of every person's social identity (Amin, 2000). Individuals living in collectivistic cultures often seek to keep family issues inside the family and not talk about them publicly. In addition, the marital bond must be preserved at all costs (Kagitcibasi, 2005; Ghahari et al., 2006; Nikparvar, 2019).

One of the worldwide family issues is intimate partner violence (IPV). Although the prevalence of IPV in Iran is reported to be high, it has not received enough attention through the legal system, the government, nor in the scholarly field. In a study with 1600 women in six different areas of Iran, 64% had experienced emotional abuse, 28% physical abuse, and 18% sexual aggression in their marriage (Saffari et al., 2017). Another study with 2091 Iranian women indicated that 57% had suffered psychological aggression, 28% physical abuse, 27% sexual abuse, and 7% injury (Ahmadi et al., 2017). Regarding IPV against men, there are only two studies, which reported that men also experience different types of IPV in Iran (Faramarzi, 2005; Nikparvar et al., 2018), and due to the illegality of homosexuality, there is no information about violence in same-sex relationships in Iran.

3.3 Challenges and Obstacles

Iran has a patriarchal system, which suggests that women are subordinate to men, both structurally and ideologically. The patriarchal values and practices and the concept of "family honor" in Iranian culture strongly influence the way women deal with IPV (Nikparvar, 2019; Nikparvar et al., 2017; Rizo & Macy, 2011). Family loyalty in collectivistic cultures reflects the importance of family connection and interpersonal relationship between family members, and it leads to a strong sense of belonging between them. In collectivistic societies, individuals get their self-image and self-perception from their family, and they invest a lot emotionally and socially to improve and present a positive reputation of their family.

In my research (Nikparvar et al., 2017; Nikparvar, 2019), we found that women who are in a violent marriage are generally advised to forgive their husbands, and they are committed to keep their family reputation/family honor by maintaining their marriage and sacrificing for the sake of their family, their marriage, and their children. Additionally, "using law to stop violence and putting husbands in jail can lead to stigma and embarrassment, which can make these women and their family feel shame and that breaking up their family can be counter to their value system" (Nikparvar, 2019, p. 29). In my dissertation, I interviewed therapists who worked with Iranian IPV clients in the United States to see what their experience had been working with this population, and they said: "The notion of [Abero] family face or family honor is huge among Iranian people. It's not just a concept, it's an

impenetrable wall in their lives, so that if something is going to threaten their family name, or sense of Abero, there is no moving forward. Inter-generationally they are used to thinking about what people think about them, I need to stay in this relationship. What do people say if I leave?"

On one hand, culturally, women's rights are under the control and power of men, brothers, and husbands, and sometimes, an aggressive man is known as the one who cares about his spouse. Many Iranians think it is acceptable for men to get aggressive. On the other hand, they think women are responsible for men's violence, and women are often blamed for men's violence (Nikparvar, 2019, p. 29). Another therapist said: "Most of the time men and sometimes even women define IPV as: 'if she doesn't aggravate him and she doesn't do all kinds of controlling behavior, then he wouldn't be aggressive' and he didn't have any other way of convincing her to listen to him therefore, he uses force. That is how they describe it and it is a woman who does something and makes him angry."

Battered women who use the law to remove violent husbands from the home may be ostracized by their community and blamed for undermining family stability and unity (Ezazi, 2007; Nikparvar et al., 2017). This can be attributed to the prevailing belief that divorce is against children's best interests and the woman's personal reputation and the reputation of her family of origin is damaged by divorce. Many women fear living alone, and stigmas around divorced women take precedence over their own well-being and safety (Nikparvar, 2019). There are shared rumors and judgments around divorced women, and divorced women may not have a secure life in society. These fears and concerns regarding stigma attributed to divorce affected participants at the individual level and how they saw themselves as divorced women and reduced their likelihood of leaving violent marriages (Nikparvar et al., 2017, p.14): "Getting divorce is a shame and negative label, which impacts a divorced woman and her family greatly. A divorced woman is blamed as not being a good wife to keep her family together. It is a failure for women because they think there is always something wrong with a woman who left a marriage. People think she is a maladjusted woman and she should have worked harder on her marriage."

One issue that increased this stigma is that, in Iran, birth certificates are required to be updated when individuals marry and divorce. Therefore, when individuals are required to present legal documentation (e.g., when they apply for a job or to rent a house), they are required to show their birth certificates, which indicates that they are divorced which often leads to experiencing sexual harassment (Nikparvar et al., 2017, p. 23): "I thought as I started this marriage, I should stay in it because I liked my life. Every year on our anniversary, I just was thankful that we were continuing our marriage while some of our friends got divorced. I hated being a divorced woman. I hated to have the data about the divorce on my birth certificate because when you have that data on your birth certificate, men take advantage of you and they might think you are available to fill their sexual needs."

These women experience and hear prejudices about divorce and how the culture and the legal system treat divorced women. These messages made women afraid of leaving their violent marriages. They had heard from other divorced women that it is not easy to deal with the stigma, and they reported that they were afraid of the

stigma around divorce and around being a divorced woman. They grew up in families and in a society that offered negative messages about getting divorced and shared rumors and judgments around divorced women. Participants knew that, in many cases, divorced women may not have a secure life in the society (Nikparvar et al., 2017, p. 13): "My family told me that if you divorce, people talk behind your back. Your divorce will ruin our reputation, or our friends will judge us. I heard from my parents many times that we should not be in contact with someone who is divorced because being a divorced woman is a negative thing and it is bad to be a friend with a woman who has gotten a divorce."

Financial dependency is another factor that impacts how women respond to IPV. Battered women who are financially dependent on their husbands stay longer in their marriages, especially those who do not have skills or education degrees. They are worried that if they leave their marriage, they would be unable to manage their lives (Nikparvar, 2019, p. 24; Nikparvar et al., 2017, p. 12): "Economic resources have so much to do with what people do and don't do in the relationship. If you are economically dependent on your husband, it impacts on how you look at the domestic violence and even calling it domestic violence. I thought to myself that I am almost 30 years old, without a job and no income, and no idea what I wanted to do in this society. The idea of being alone was so scary for me, I preferred to stay."

One of the most important points about IPV in Iran is the lack of language and knowledge about it. It is very common that people do not use the word "IPV" or "domestic violence" in their language. They say that "it is just conflict," "this is just a disagreement," or "only physical violence counts as violence." Many IPV clients did not count financial and emotional abuse as violence, and behaviors such as cursing or name-calling are considered part of conflict and fighting. The lack of knowledge about IPV led women to ignore red flags (Nikparvar, 2019, p.34 & p. 23). Two therapists shared: "They identify physical abuse as it is visible and tangible, and they do not want to face legal consequences, but they do not identify financial, isolation, verbal and emotional abuse. No one talks about it until it's really bad."

When that language does not exist in Farsi, it makes it much more difficult for victims to be able to relay their experience or recognize that this is something more than an argument. Iranians often have difficulty recognizing IPV as a violation of human rights, so they may deny or ignore it. Our research supports the idea that only counting severe physical violence as IPV may come from growing up in a violent family and witnessing parent's violence or experiencing violence between their parents or by their brothers against them (Kim & Gray, 2008; Sylaska & Edwards, 2014). It may also come from the way women view men as the dominant person in their relationships (Zand, 2008). Expecting men to be dominant leads some Iranian IPV victims to not recognize abusive behavior as being anything other than the cultural norm.

Beside the cultural factors that affect how women respond to IPV, the lack of laws addressing IPV is a big barrier if women decide to use the legal system to stop

violence or leave their marriage. In Iran, the laws remain very broad and ambiguous, and the punishment and consequences for the abuser are not clear. Two Iranian laws that can impact IPV are Code 1103, which states that "the couple is required to offer good companionship," and Code 1115 of the civil law that states that "if a woman in a shared home is at risk of losing her life, honor, and finances, she can leave the home and alimony is awarded to her" (Safaee & Emamei, 2012, p. 122). In 2015, a group of lawyers and women's rights advocates drafted a bill to prevent and protect Iranian women against violence, which included the criminalization of all types of violence against women, the emphasis on the need for shelters, and a focus on violence against women as a public issue and not a private family issue. So far, the bill has not been passed.

In addition, there are legal barriers regarding the custody of children. Based on the civil law in Iran, the full custody of children, until the age of 7, goes to the mother, and after that the custody of a boy until the age of 15 and a girl until the age 9 goes to the father if parents get a divorce. The only reason the father would not get custody during this time is if it is proven that the father is an addict and a gambler, is diagnosed with severe psychological disorders, or has an illegal job. If he forces his children to do illegal work (such as selling drugs or stealing) or is violent toward his children frequently and has caused them severe physical harm, it is also possible that a wife would get custody. If a woman wants to get full custody of her children after divorce, she must waive her financial rights. Therefore, many women prefer to stay in their marriages rather than getting a divorce and losing the custody of their children (Taherkhani et al., 2014; Nikparvar et al. 2017).

Another finding in my study about a serious barrier discussed by participants involved requirements by the legal system to get a divorce. When participants took the complaint to court to end violence, when they called the police to ask for help, or when they filed for divorce, they had difficulty proving that they had experienced violence (Nikparvar, et al., 2017, p.14): "It was disappointing to see that even the police did not take me seriously and just told me all couples fight and it is not something important that you want to end your marriage because of it. My experience with the judge in the court was the same, that as long as violence does not cause serious damage or injury they did not take it seriously."

According to Iranian law, only if a husband is violent repeatedly, and if life is hard and impossible for women, would divorce be legally justified (Safaee & Emamei, 2012). Otherwise, the justice system tries to encourage couples to get back together and continue their marriage.

3.4 Solutions

Making paradigm shifts and cultural changes in a society is a long-term process, and it takes time and effort. Since in Iran we do not have a language for IPV, it makes sense that it is hard for people to recognize it. Most people, regardless of education level, do not recognize psychological abuse, and they see it as the way

men communicate. Educating not only women but also men about what IPV is, the cycle of violence, different forms of IPV in couple's relationship, and how they can prevent it is the most important first step. Not knowing about the examples of IPV makes women justify it by taking responsibility and blaming themselves for aggravating their husband, or they even may normalize it if they had the same experience in their family of origin and no one ever reported it. The lack of knowledge about the cycle of violence and different forms of violence in couple's relationship can lead some women to stay in violent marriages with the hope that their husbands' behavior will change in the future. For some of them, micro-aggressions or psychological violence is acceptable. Given the ever-increasing number of people accessing the Internet and social media, and the widespread use of search engines, social activists and human rights advocates have a great opportunity to use this resource to educate people, serve IPV victims, educate people about safety plans, and even create cultural movements.

Men's lack of understanding of how they should use power appropriately in a healthy relationship is a big issue, which may lead them to use violence and aggression as a way to communicate with their spouse (Holtzworth-Munroe et al., 2010). Most men in Iran grew up in a context where effective communication skills and conflict resolution skills have never been considered as important skills to learn. Therefore, increasing relational skills, communication skills, and anger management skills is critical.

Educating families about peaceful parenting may be a way to help raise children who, when they become adults, they know how to communicate when they are in intimate relationship and not resort to violence. Another way the family system can help to stop IPV is using the kinship system intervention as a resource for couples when they experience violence. In kinship system interventions, older family members gather and speak with the couple about their relational problems and try to help them resolve conflicts and solve problems, which have led to violence. These interventions can be in the form of advice on how the couples should treat each other or, if couple's conflict comes in the form of financial stress, they can help them financially.

Gender discrimination and cultural myths lead to a cultural delay in accepting women's rights. The patriarchal culture in Iran has an influence on rejecting women's rights and creating unrealistic and unfair expectations of women encouraging them to keep their experiences of violence at home a family secret. As violence against women has a strong root in mistaken religious and cultural beliefs, religious leaders can help to educate society and change these beliefs.

Most Iranians also need education about legal rights. It would be helpful to offer trainings about lawful rights as a part of the Iranian education system to increase awareness for both genders about the importance of this subject. Women can ask for the right to divorce and custody of their children and add it to their marriage certificate before officially signing it, which would allow them to leave their marriage, when it comes to violence, without being concerned about financial rights and losing custody of their children. It is essential that changes be made in the justice system and the police system to meet the needs of victims. There is a lack of effective

laws punishing perpetrators or holding them accountable for the abuse. Laws need to be effective and up-to-date. IPV should be criminalized, and a strong connection between the law and the police is needed. The slow process of legislation and a lack of coordination between the law and police intervention do not allow police to enter a house where violence is happening, and even if the police come inside the house, they try to reconcile and often do not take the issue of violence seriously. Clear identification of the responsibility of different organization such as the police can provide the basis for more effective interventions and create more legal consequences for IPV.

Expansion of social services in public and private sectors to help women access these services is also needed. A national plan to protect vulnerable women and victims of violence, and to collect data regarding the incidence of IPV, is necessary. To facilitate the process of recording the information required by law, it would be important for health centers and clinics to document IPV and to provide this documentation to the police. Cooperation between health centers, social service agencies, the judicial system, and police is needed to enhance protection for victims.

At the institutional level, providing and extending the services by increased government funding and nongovernmental organizations (NGOs) and collaboration among experts are what we need in Iran. Although the social work system has a long history in Iran, it is not functioning at the optimal level, especially when it comes to IPV. The social service system does not have adequate knowledge and the appropriate services to intervene, so they need to educate their staff to be able to identify populations to target and give needed services.

Although there is currently little help for domestic violence victims in Iran, sometimes even when resources are available, there is no proper information about available services. For example, the judiciary and some legal counseling clinics have provided free phone counseling services to individuals, and the social welfare organization has provided 24-hour telephone numbers to individuals in case of danger and has allocated cars with the logo of 123 in different location of each city which gives people free emergency counseling. There are also shelters available in a few big cities, but unfortunately, not only are these services not advertised but also sometimes they are even hidden.

The issue of IPV is not taken seriously at the government level, and sufficient funding is not allocated for doing research and/or providing services for preventing or intervening in cases of IPV. Since research has not been conducted with a large sample in different parts of Iran, the information about the prevalence of IPV in Iran is not comprehensive. Further, because of the lack of research on the topic of IPV in Iran, the healthcare system does not educate their staff to screen and assess their patients for IPV and does not know how to respond and find resources for patients.

Addressing IPV in Iran requires the coordination and participation of many organizations and institutions. There are many shortcomings and challenges in this path. The first and most important step is to change the attitudes and beliefs of people at various levels, especially political leaders. This goal cannot be accomplished without taking small steps to inform and sensitize citizens, authorities, and politicians.

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Chapter 4
Intimate Partner Violence in Russia

Tatiana Glebova, Natalia Kravtsova, and Natalia Bolotina

4.1 Introducing Ourselves to You

I, Tatiana, am a couple and family therapist, supervisor, educator, and researcher residing and working in the USA. I was born and grew up in the then Soviet Union, present-day Russia. I was educated in family counseling in Russia and then moved to the USA in 1998 for a doctoral program in family therapy. I consider myself a bicultural person, having lived in the USA for more than 20 years and staying connected with Russia personally and professionally. I am acutely aware of the high prevalence of intimate partner violence (IPV) in Russia across social classes and ethnic groups. Currently, I work clinically with Russian-speaking immigrant families, some of them experiencing IPV or domestic violence. We (Natalia K., Natalia B., and I) met in the early 2000s through our work with the organization "Children of Russia," which was helping to develop a program of psychosocial rehabilitation for children with cancer and their families in Vladivostok, the regional capital of the Russian Far East. I (Tatiana) joined this project because I wanted to help families in Russia, especially in the region with fewer resources due to its remoteness from the Russia's economically dominating European region (particularly its capital, Moscow). From my personal experience as a Muscovite, I knew how privileged Russia's capital and its dwellers were in having access to resources—including intellectual ones, such as connections to European and American institutions—that most other Russian locations lacked.

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I, Natalia K., am an educator, psychotherapist, researcher, and head of the Department of Clinical Psychology, Pacific State Medical University, in Vladivostok. Originally trained as an MD general practitioner, during my clinical practice, I have realized the importance of the quality of life in childhood for the health of adults as well as that of healthy family relationships for children's mental and physical development. After professional retraining in psychiatry and postgraduate psychological education, I embarked on the career of a clinical psychologist and systemic family psychotherapist. In the 1990s, I participated, as part of a volunteer group, in opening the Regional Center for the Protection of the Psychosomatic Health of Children and Teenagers in Khabarovsk in the Russian Far East and then became its director. Education about family relations became both a profession and a life passion for me. I provided various educational programs for parents through radio and school presentations. There was a significant shortage, and a need for training, of qualified mental health professionals in the region at that time. My main goal was to give proper training to future psychologists and to shape systemic thinking. I have been working at the only Department of Clinical Psychology in the Russian Far East since 2000. There, the topic of domestic violence is a part of courses of family and forensic evaluation, as well as practicum for pathopsychological assessment and evaluation. In my clinical practice, I see individuals and couples with the primary focus on intimate relationship issues, which often include IPV.

I, Natalia B., am an educator, a lecturer at the Department of Clinical Psychology, Pacific State Medical University, and a psychotherapist. A psychiatrist by education, in the beginning of the 2000s, I worked with children and their parents at the Oncological Division of the Vladivostok Children's Hospital. I sought additional training in psychodrama, psychoanalysis, and family therapy. One of my strongest interests is the process of transgenerational trauma, including domestic violence and IPV. I have been working clinically with individuals, mostly women, couples, and families for 20 years. My clinical practice provided me with the evidence that not just the intrapersonal issues but also the broader socioeconomic context has a huge impact on the well-being of my clients.

The three of us, despite our very different professional experiences and backgrounds, share common interest and passion to support families facing various struggles. We see the training of competent professionals as a venue for that. Our common professional interests became the foundation of many professional collaborations including this chapter. IPV and domestic violence have been critical problems in Russia. Our chapter will provide an overview of the situation, its legal aspects, and the existing system of help across the country.

4.2 Country Overview

Russia (officially the Russian Federation, a successor state of the former Soviet Union since 1991) is the largest country in the world by territory (spans 11 time zones) and the ninth most populous (almost 147 million people) with a ratio of

about seven women for every six men (Federal State Statistics Service, 2017). Although 81% of the population are ethnically Russian, over 160 other ethnic groups and indigenous peoples compose the country's population. According to the Constitution (Art. 1), the Russian Federation is a democratic federative law-governed state with a republican form of government. The dominant religion is Russian Orthodox with the state alliance supporting conservative views. While legal and social equality of men and women was proclaimed after the Bolshevik Revolution in 1917, Russia still is ranked #53 (out of 189 countries) on the Gender Inequality Index (United Nations Development Programme, 2017). The divorce rate is around 60% (Federal State Statistics Service, 2017), mostly due to drug or alcohol use.

4.3 Intimate Partner Violence in Russia

Violent behavior within the family has a long history in European societies including Russia. Spousal violence was present across all social groups, from peasantry to nobility, with men being the absolute majority of offenders for centuries (Muravyeva, 2013). Specific gender roles and power inequality characterized the patriarchal social system that supported victimization of women during tsarist times. The 1917 Revolution brought profound social changes, including the emancipation of women. The 1936 Union of Soviet Socialist Republics (USSR) Constitution (Art. 35) proclaimed gender equality. However, IPV against women continued to be widespread in the USSR (Sperling, 1990). After the collapse of the Soviet Union in 1991, Russia has experienced drastic economic and social changes, which resulted in a profound crisis of the institution of the family (Mustaefa, 2010). While the current Constitution of the Russian Federation declares gender equality (Art. 19.3), gender inequality has increased in all spheres of life (Rimashevskaia, 2011).

Although current statistics on IPV in Russia are difficult to obtain, IPV is a serious social issue in modern Russia. Overall, some type of IPV is estimated to be present in every fourth family; two thirds of preconceived murders happen within the family. While men are also victims of IPV, the majority (75%) of IPV victims are women, and each year husbands or other intimate partners kill about 14,000 women (ANNA, 2018). Even less is known about IPV among LBGTQ+ partners. According to the first Russian study of partner violence in LBGT+ relationships (Resource Center, 2019) conducted in Ekaterinburg with a sample of 1539 people, 25.8% participants reported serious physical violence from a partner, and 52% experienced some type of sexual coercion.

4.4 Challenges and Issues in IPV Services in Russia

Russia remains one of only two countries in Europe and Central Asia which does not have a law criminalizing IPV. Currently, the Russian Criminal Code does not recognize IPV as a separate offense. The only applicable criminal provisions are those related to bodily injuries or other crimes against any person regardless of relational status. Nonphysical forms of IPV, such as psychological or economic violence, are not punishable under the current Criminal Code. There are no existing protective measures in case of stalking or harassment. IPV is considered a private family matter by the state and traditional public opinion. This fact is reflected in limited requests for police intervention. Almost 72% of women who turned to the National IPV Helpline never sought help from the police. Of those women who did, 80% were unsatisfied with police response (ANNA, 2015). In 2017, legislation was signed to decriminalize many types of IPV. The new law classifies only repeated instances of battery as a criminal offense, making the situation for victims of IPV in Russia even worse. This was reflected in the drastically increased number of calls for help to social services agencies (Bakin, 2018).

4.5 Therapeutic Response to Victims and Offenders

While psychology and psychotherapy in Russia have a long history going back to the beginning of the twentieth century, seeking professional help for family or couple relational issues is not a well-accepted social practice due to multiple factors, such as past totalitarian regime, religious, and cultural norms. There are existing and growing resources for various types of mental health issues, as well as for various psychology-related educational programs, but they are mostly concentrated in the central urban regions of Russia. Mental health professionals such as psychotherapists and clinical psychologists are trained at medical schools and various universities. Each program is regulated by a relevant state educational body with a unified state educational standard; however, there are no unified curricula or state certification and licensure for most of mental health professionals such as clinical psychologists or family therapists across the country. Practitioners utilize a broad range of approaches such as psychodrama, psychoanalysis, group therapy, family therapy, and many other models that were transplanted from the West. This diversity and eclecticism, on the one hand, provide a wide range of options suitable for diverse consumers. On the other hand, it increases risks of unqualified practitioners, especially because there are no legal regulations of the practice. Within some professional organizations such as Professional Psychotherapeutic League and Organization of Psychoanalytical Psychotherapy (which includes a Department of Couple and Family Therapy), their own ethics committees developed ethical codes for their members.

The state provides some mental health services at hospitals, social security institutions, and schools. For the general public, some services are available via nonprofit organizations and private practice that is often not affordable for people with low SES. However, "The availability of this type of care in public institutions and private psychotherapy …is virtually absent in the medium, small towns and rural areas" (Bebtschuk et al., 2012) since socioeconomic inequalities are exacerbated by huge regional inequalities.

There are no available statistics, but it appears that most of mental health requests are related to child's or adult's, mostly women's, individual issues. Couple therapy is not a very popular modality. In general, there is still "mass psychophobia" (Bebtschuk et al., 2012) rooted in the legacy of punitive psychiatry in the USSR and social stigma. This is especially relevant to therapy specializing in LGBTQ+ individual and relational issues. Nonprofit and private practice resources, as well as some training for professionals, are available, but they are limited. All existing challenges of getting help for heteronormative partners are further exacerbated for LGBTQ+ partners since homophobia is widespread in the Russian society (Podlyzhnyak, 2020) and there is no legal acknowledgement of a LG relationship (marriage). Being aware of this, crisis centers for LGBT, besides the legal and psychological assistance, also offer the so-called social escort (i.e., a person who would be available to accompany one for a visit to a psychologist, a doctor, or police).

The leader in IPV against women advocacy and interventions in Russia is the nonprofit nongovernmental organization (NGO), the ANNA Centre for the Prevention of Violence established in 1993. The center provides legal resources and education, professional trainings, dissemination of best practices, monitoring of violations, and compilation of reports on women's rights in Russia, including alternative reports to the United Nations. The ANNA Center received 8000 calls for help in 2014 and 26,000 in 2017 (Bakin, 2018).

In 2013, there were 1333 social services providing assistance to women in a "difficult life situation" with only 42 shelters in Russia that offer specialized assistance to IPV victims (ANNA, 2015). In 2018 there were 95 such shelters (Bakin, 2018) for about 147 million people. Services provided by state, nonprofit, or charity organizations vary across the Russian regions and may include crisis consultations, safety recommendations and shelter, legal support, medical referrals, and psychological counseling, as well as phone hotlines. Counseling includes individual and group therapy. There is a growing movement to include psychological counseling not only for victims but also for offenders (men).

There is an increasing awareness of the significance of IPV in Russia among the general public, especially through social media. Nongovernmental shelters work in Moscow, Nizhniy Novgorod, Pskov, and Vologda. Progressive representatives of the Russian Orthodox Church are taking an active stand on the movement against domestic violence and developing an approach aimed at encouraging zero tolerance attitudes toward violence in Christian families. Private companies in Russia in cooperation with the ANNA Center started to provide support to nongovernmental shelters both in kind and financially. New programs aimed at the involvement of

men into the movements on combating violence against women are being launched in different regions of Russia and contribute to gender equality.

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Chapter 5
Intimate Partner Violence in China

Jingshuai Du

5.1 Author Background

Currently I am a second-year PhD student in the Department of Family Science at University of Maryland in the USA. I am from China and grew up in a rural area in Northeast China, where traditional beliefs about gender roles are more accepted. After graduating from the Master's program of Social Work in Peking University of China, I decided to pursue a degree in Couple and Family Therapy (CFT) at Kansas State University (K-State) in the USA. At the CFT program of K-State, I was fortunate to work with Dr. Sandra Stith as my advisor on research projects related with intimate partner violence (IPV). For my thesis, I looked at the phenomenon of female perpetration of IPV in dating relationships among Chinese college students, a topic rarely discussed in the Chinese IPV literature. This idea occurred to me because in my personal experience, I have realized that IPV is often bidirectional and it is not uncommon for Chinese women to be abusive toward their partners, especially verbally and emotionally. Specifically, in my thesis, I looked at how relationship factors are associated with IPV perpetration among female college students in China. Besides my current PhD studies, I also work as a couple and family therapist in a counseling organization in China. Most of my clients shared with me their traumatic experiences of witnessing their parents' violence when they were young. IPV in China continues to be a research interest of mine, and I hope I can introduce and adapt some of the evidence-based IPV therapy models to China in the future.

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5.2 Country Overview

The People's Republic of China (China) is the world's most populous country and the third largest country by size in the world. There are 56 ethnic groups in China with 91.5% being Han and the remaining 55 being minority groups. China, officially the People's Republic of China (PRC), is a one-party sovereign state. The country is ruled under the leadership of the Communist Party of China. Since economic reforms in 1978, China's economy has been one of the fastest growing in the world, and this has dramatically changed family structure and people's lives. To be a member of the Communist Party of China, an individual must not have a religious affiliation. However, Confucianism, Taoism, and Buddhism (Chinese Buddhism) significantly shape Chinese culture, and these beliefs still deeply and widely influence Chinese families and society despite the recent dramatic changes in people's lives (Zhang & Zhao, 2018). Another important feature of China is that it has a sharp rural-urban divide in terms of income, education, job opportunities, healthcare, housing, and values. Due to this divide, and the rapid economic development in China in the past 30 years, China has witnessed an increase in population mobility from rural to urban areas for job opportunities. In most cases, the traditional breadwinners of households, men, migrate to big cities, such as Beijing, Shanghai, and Guangzhou, and leave their wives and children at home. The long distance and long-time separation also put family structure and unity into risk (Tang & Lai, 2008).

5.3 Intimate Partner Violence in China

Domestic violence in China is an enormous and multi-faceted issue. It is intertwined with traditional Chinese beliefs favoring gender inequality and family unity and with societal beliefs that devalue women (Zhao, 2000). It is also compounded by current political and economic challenges in China. Currently, there is a lack of systematically collected official and national data on the prevalence of domestic violence in China (Zhang & Zhao, 2018). According to a review of 19 empirical studies with a total of 49,201 adult respondents in China between 1987 and 2006, on average, 19.7% of women in China had experienced violence perpetrated by their male intimate partners in their lifetime, and prevalence of past year violence was 16.8% (Tang & Lai, 2008). Among various types of IPV, psychological violence was the most common (42.6% for lifetime and 37.3% for in the last year), followed by physical violence (14.2% and 6.7%) and sexual violence (9.8% and 5.4%) (Tang & Lai, 2008). A recent review of the literature examining the prevalence of domestic violence in China from 1997 to 2016 revealed slightly different results from Tang and Lai's 2008 study. This review found a range of 17.4–24.5% for lifetime psychological violence against women, 2.3–5.5% for physical violence, and 0.3–1.7% for sexual violence against women using national survey data (Yang et al., 2019). It was reported that approximately 24.7% of married women had

experienced some form of domestic violence by All China Women's Federation (ACWF) in 2011 (Zhang & Zhao, 2018).

In China, the concept of "domestic violence" (*Jia ting bao li*) was first introduced in 1995 in an official government report. Before that, it was long known as "wife beating" (Zhao, 2000). Historically, laws against "domestic violence" in China tended to be limited within the context of family, based on formally registered marriage. Therefore, legal protection was not available for women who lived with their intimate partners without the official marital status (Zhang & Zhao, 2018). Therefore, this concept is more commonly referred to as "domestic violence" instead of "intimate relationship violence" in China, reflecting a narrow view of abuse in the setting of "domestic" environment. In this chapter, I will mainly use the term of "domestic violence" to refer to the violence between intimate partners, as this is what is mainly used in the current law, policy, and public in China.

Similarly, women who suffer from domestic violence from their former husbands, which has been a major source of abuse in China, are also excluded from the legal protection. Internationally, it is believed that domestic violence is composed of not only physical abuse but also emotional and sexual abuse. However, it appears that China has adopted a narrow view of "violence" as mainly acts of physical violence, overlooking or even excluding emotional and sexual abuse in the definition of domestic violence. In addition, many Chinese people dispute the concept of marital rape because they think it is an intrinsic part of being "virtuous wives" to always be sexually available to their husbands (Zhao, 2000). Under this strict definition, many women may find their subjective experiences minimized or invalid, thus adding more difficulties to seeking assistance from police and other social service organizations, which can also lead to the problem under-reporting (Tang & Lai, 2008).

5.3.1 Traditional Cultural Beliefs, Values, and Practices in China

Throughout China's long history, domestic violence used to be seen neither as a crime nor as a social problem to be addressed by the government or public, as it was wrongly perceived as acceptable (Tang & Lai, 2008; Zhao, 2000). Largely, these beliefs about domestic violence were heavily influenced by traditional cultural beliefs and ongoing economic and political changes. Culturally, China has a long history of traditional male-dominated culture, and it has been heavily influenced by Confucian philosophy that advocates for patriarchal beliefs and rigid gender roles (Zhao, 2000). China has developed various doctrines succinctly reflecting men's dominating and women's inferior roles. For example, "Xian qi liang mu" specifies that a model woman should be a virtuous wife and a good mother, and "Nu zi wu cai bian shi de" further prescribes that women are virtuous when they stay at home and do not waste their time in pursuing their education and career (Tang & Lai, 2008). A man also was entitled to beat his wife to discipline her. There are old

Chinese sayings that depict wife beating as reasonable and even necessary, for example, "I bought my horse and married my wife. I can ride them and beat them as I like" and "If you go three days without beating your wife, she will climb up on the roof and move away all the tiles" (Xu et al., 2001). This kind of violence is often defended as men are executing "rules of family" (*jia fa*) in order to put women in the right place in the family (Tang & Lai, 2008). With the above rigid gender norms and beliefs, both men and women are socialized to believe that men are entitled to use violence over women to assert power and authority in the family and women are supposed to be submissive to their husbands. Domestic violence is generally believed to be a "private matter" (Zhao, 2000).

Multiple regional surveys have shown that domestic violence is more serious in rural areas where traditional attitudes toward women are more deeply and widely accepted (Zhao, 2000). Liu and Chan (1999) conducted a study of domestic violence in China and looked at stories of battered women in rural China and found that "enduring violent situations is the major theme that summarizes the lives of the participants" (p. 1475) and that women passively accepted wife abuse under the influences of cultural values. For example, one woman said, "If I do something wrong, my husband can beat me. I have my husband to discipline me, so it is not my mother-in-law and brother-in-law's business to beat me" (Liu & Chan, 1999, p. 1477); "How can you apply for divorce when you quarrel and fight with your husband? In the village, what couple does not quarrel? It is impossible for them to get divorced"; and "Divorce must have appropriate grounds, beating is not a good one" (Liu & Chan, 1999, p. 1478). Based on these stories, we can see that these women believed that their husbands are entitled to beat them if they "misbehave," and violence is a small thing, whereas divorce is a big issue.

5.3.2 Economic and Social Changes in China

There have been rapid economic and social changes in China since the 1980s, and it has brought increased educational and employment opportunities for its citizens. With greater access to education and employment, Chinese women started to challenge the power structure in traditional Chinese families, and this may have increased levels of anger in husbands and conflict within couples, and couples may use violence to resolve this conflict (Tang & Lai, 2008). In addition, Western ideas of gender equality and feminism have been introduced into China, and modern Chinese women are influenced to become more assertive to fight for what they need from their relationships. For example, more women are initiating divorce applications when they realize they are not happy in the current relationship, which challenges male authority in the family and overall society (Tang & Lai, 2008). Another important social change was the introduction of the one-child policy in the 1950s.

Influenced by this policy, the younger generation grew up in a single-child family environment where they received undivided attention and love from their parents and grandparents. For young women specifically, seen as precious and as "a pear in the palm," they are even more confident to embrace their power and rights in their intimate relationships and are less tolerant of violence from their partners (Wang & Petula, 2007).

Under this context, I looked at the female perpetration of violence in Chinese college dating relationships and its relationship risk and protective factors (Du et al., 2020). Traditionally, men are the primary perpetrators of IPV, yet females also perpetrate IPV against their male partners (Chen & Chan, 2019). For example, in my study, I found that 40.8% of the female Chinese college students reported perpetrating minor physical IPV, 19.6% reported perpetrating severe physical IPV, 65.6% reported perpetrating minor psychological IPV, and 44.1% reported perpetrating severe psychological IPV against current or former partners (Du et al., 2020). In addition, my research also suggested that lack of anger management skills, communication problems, and lack of conflict resolution skills play an important role in college women's experiences of perpetrating violence toward their partners. I encourage future studies to include male victimization into their studies and to develop gender-based intervention programs to address these problems related to female IPV perpetration (Du et al., 2020).

Additionally, due to the rising social tension and conflict resulting from China's rapid economic growth and widening income inequality, China's government has prioritized its political goal to maintain social stability. Family stability has long been seen as basic and fundamental to maintain control over society's stability (Han, 2017). In order to maintain family stability, the Chinese government is promoting "family harmony" as a virtue all over the country. For example, the All Women's Federation held events such as "look for the most beautiful family" and advertised "family harmony" as "family virtue" and moral values for citizens to learn. Therefore, in family disputes, even when domestic violence is present, in order to maintain and promote family and social harmony, mediation is a preferred method to handle domestic violence (Han, 2017). In China, the role of "mediator" is mostly played by people's informal support system including family members, employers, and village and neighborhood committees. The content of the "mediation" is usually focused on saving and repairing the marital relationship instead of representing the best interests of victims. As a popular saying goes in China, "It is better to persuade the couples to stay together instead of persuading them to be separate" (*quan he bu quan li*). Recently, even though the court and policy start to intervene by legal means, mediation remains a fundamental response of their intervention strategy. As a result, police officers usually resolve domestic violence through "criticism and education," instead of taking legal actions over abusers (Han, 2017).

5.4 Opportunities and Challenges in IPV Services in China

Since the 1980s, there has been a growing movement of activism that began to break the silence on domestic violence and campaigned for laws and services to protect and support survivors' rights and lives. The Fourth World Conference on Women was held in Beijing in 1995 and marked progressive development in the prevention and intervention on domestic violence in China. The widespread social media exposure of multiple high-profile incidents of partner abuse also raised attention from institutions and public. The issue of domestic violence has become more visible in public discourse (Tam et al., 2012).

5.4.1 Legal Response to Domestic Violence in China

In 2001, the revision of the Marriage Law prohibited domestic violence explicitly for the first time, which made physical abuse grounds for divorce (Palmer, 2017). In 2015, the Chinese parliament finally passed its first domestic violence law, legally defining domestic violence as both physical and emotional abuse of family members and cohabitating non-family members. The Law also introduced one of the most important protective mechanisms, i.e., the restraining order. This new Law is widely regarded as a landmark of anti-domestic violence in China and has a significant meaning to China (Han, 2017).

Though the Law was celebrated as a milestone in the development of legal protection against domestic violence, it has received wide criticism for its actual implementation (Han, 2017; Jiang, 2019). Some believe the new Law tries to achieve two potentially conflicting objectives by aiming to "stop and prevent domestic violence" while advocating for "promoting family harmony and social stability." By emphasizing "family harmony," the new Law still calls for informal mediation by "people's mediation organizations," such as village and neighborhood committees, to reduce and prevent incidents of domestic violence. Doing so, the new Law limits and undermines the full application of enforcement, thus continuing to put the victim in a serious risk (Han, 2017).

Moreover, though the new Law defines domestic violence as physical abuse and emotional abuse, it does not include sexual abuse or economic control. In addition, while the Law includes cohabiting and dating couples for the first time, it does not explicitly address issues arising from former partners (Palmer, 2017). There also are no legal protections for same-sex couples. At the implementation level, the new legislation is almost exclusively confined to married couples only. The protection toward these unmarried couples, divorced couples, and LGBTQ+ populations are still largely excluded from responsive law intervention (Yang et al., 2019).

5.4.2 *Social Response to Domestic Violence in China and Its Challenges*

5.4.2.1 Founding of the All Women's Federation

The All Women's Federation in China, established in 1949, is the largest women-centered organization in China. It is a semi-governmental organization which has branch organizations at each level of government (nation, province, city, town, and village) throughout the entire country (Tam et al., 2012; Zhao, 2000). It is responsible for promoting government policies on women, and protecting women's rights within the government, while liberating them from traditional norms within society and promoting women's overall status and welfare in the society. Since its founding, it has established legal aid centers, hotlines, and domestic violence report centers in every provincial and community branch (Tam et al., 2012). In addition, it also has been actively involved in the process of policy-making and law-making of anti-domestic violence (Zhao, 2000). With the new Law, the official Women's Federation, ACWF, has been increasingly vocal as an advocate for victims and provider of support services for Chinese women (Han, 2017).

However, due to the governmental nature of the Women's Federation, they are mainly responsible to the central government, instead of independently representing the growing women's needs and interests. Seen as an extension of the government and an agent for social control, the general public is often hesitant to reach them for assistance; instead, they mostly rely on their family members for support. However, due to the recent changes to the family structure because of the one-child policy, increasing number of women grew up in families without siblings or extended family network. Afraid of adding extra burdens to their aging parents, abused women are hesitant to reach out for help from their parents (Tam et al., 2012). In addition, influenced by the deeply rooted traditional beliefs about gender roles and family unity, staff members in the Women's Federation at different levels of branches, especially in the rural and small-town areas, can still hold these values when working with women. Mediation or lectures are normally used as an intervention (Tam et al., 2012).

5.4.2.2 NGOs, Social Work Development

An unprecedented growth of women's domestic violence activism and women's NGOs took off in China, especially after the fourth UN World Conference on women in 1995. They have been active in empowering women by informing, educating, and training women about their rights and necessary skills. The "Beijing-based Network/Research Center for Combating Domestic Violence (DVN)", the first women's NGO in China organized exclusively against the issue of domestic violence, was launched in Beijing in 2000 (Zhang, 2009). The women's Psychological Counseling Center, set up by a retired female Chinese journalist, has also been

active in addressing domestic violence since 1995. They provided psychological counseling to women, as well as advocated for social and policy change to provide women with legal protection from domestic violence (Zhang, 2009). Recently, social work services have been increasingly developing in China, which also presents new opportunities for anti-domestic violence in China.

However, these NGOs face a number of challenges ranging from the government's control and monitoring, limited funding, to a lack of professionally trained staff members (Tam et al., 2012). In addition, most support services are developed in urban areas, while women from rural areas have limited access to these resources (Yang et al., 2019).

5.4.2.3 Women's Shelter Development

Multiple initiatives have been made to promote the development of women's shelters. Women's groups set up the first shelters and hotlines for battered wives in the 1980s in mainland China and Hong Kong (Tang & Lai, 2008). However, overall the emergency shelters are underdeveloped and underutilized throughout the country. In 2009, less than 20 women's shelters existed in 33 provinces, and they are mostly underutilized due to a lack of follow-up service and trained staff; a limitation of allowable length of the stay; and traditional beliefs of keeping "family face" (Tam et al., 2012). Based on Tam and their colleagues' research, they suggested that the length of allowable stay is quite short, ranging from 3 days to a week. In addition, survivors are worried where they can go after the stay in the emergency shelter since usually there is not a longer-term shelter that can be provided (Tam et al., 2012).

5.4.2.4 Advocacy Intervention and Psychotherapy Treatments

Introduced from the West, the practice of counseling or psychotherapy is a relatively new phenomenon in China. The concept of "couple therapy" has only recently began to emerge and gain some exposure in the mental health field in China. While these Western-based psychotherapy models were adopted by mental health professionals in China, rarely new models of therapy congruent to Chinese families and culture were developed (Epstein et al., 2012). Specific to therapy treatments of domestic violence in China, currently, there is no mandatory psychotherapy treatment for offenders of IPV in China. Research studies about specific evidence-based systemic therapy treatment or models for couples who experience IPV and want to stay together are not available in China to the author's knowledge. Based on literature search, I only found two peer-reviewed studies about their interventions working with this population, one being on advocacy intervention for Chinese women survivors of IPV in Hong Kong (Tiwari et al., 2018) and the other one being on using expressive arts-based therapy for domestic violence survivors to cope with trauma and improve mother-child relationship in Taiwan (Lai, 2011). There are a serious lack and a high need of domestic violence therapy treatments in Mainland

China, as well as culturally congruent psychotherapy, or specific couple therapy models in China.

5.5 Conclusion

China has achieved considerable progress in the prevention and intervention of domestic violence. The new Law in 2015 was a significant breakthrough in the history of anti-domestic violence in China. Domestic violence has gradually gained attention from both the public and the government. However, China's efforts and responses to prevent and intervene in IPV are far from adequate due to a number of limitations. These limitations include traditional beliefs and values about gender roles, a narrow definition of domestic violence, over-reliance on informal mediation as an intervention strategy, limited coordination among government and social organizations, a lack of emergency shelter support for victims and professional training on IPV among service providers, and a lack of culturally congruent therapy programs or models designed for Chinese population (Tam et al., 2012). The issue of domestic violence in China continues to remain a legal, cultural, political, and social challenge in the future.

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Chapter 6
Intimate Partner Violence in India

Manjushree Palit and Mona Mittal

6.1 Country Overview

India is the seventh-largest and the second-most populous country in the world. It is the largest democracy in the world and has a unique mix of tradition and modernization. India ranks fifth among nations, with the most skewed ratio of girls to boys at birth, due to cultural preference for a son (USAID, 2019). The divorce rate was 1 in 1000 10 years ago and is still relatively low, 12 per 1000. However, the number of divorce applications has doubled and even tripled in some cities over the past 5 years (Dutt, 2015). I (Manjushree) was raised in India, but left the country briefly to attain a doctorate in Family Therapy in the United States. Now back in India, I am an academician and clinical practitioner. I was raised in a small town, exposed to the intersectionality of gender, caste-based stratification, and gender-based violence, which has inspired my research and clinical interest in intimate partner violence (IPV). I (Mona) grew up in India, but left the country to pursue higher education in the United States in my early 20s. I was acutely aware of my gender and also of the marginalized status of women in India at an early age. My awareness of the status of girls and women and personal experiences instilled a passion in me to work in the field of gender-based violence.

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6.2 Intimate Partner Violence in India

IPV is a significant public health issue in India. The National Health Survey (NFHS) data shows an IPV prevalence rate of 29–37% among Indian women (International Institute for Population Sciences, 2016). Estimates show that 4 in 10 Indian women report lifetime IPV and 3 in 10 report IPV in the last year. Recognizing the enormity of the problem, the Indian government issued the Protection of Women from Domestic Violence Act in 2005 (Kalokhe et al., 2017). There is a dearth of literature on violence against men and on violence against individuals in same-sex partnerships in India. A recent study on violence against men estimated that nearly 52% of their sample of men had experienced violence. Emotional violence was the most commonly reported form of violence (51.6%), followed by physical violence (6%; Malik & Nadda, 2019). A population-based, cross-sectional survey data of men who have sex with men (MSM) showed that nearly 25% of their MSM sample reported either physical or sexual victimization in the last 12 months (Chakrapani et al., 2019).

6.3 IPV Risk and Protective Factors

There is a growing body of literature on risk factors for IPV against women across different levels of the socio-ecological model in India. Individual-level factors include low education and socioeconomic status, young age at marriage, divorce, working outside the home, exposure to parental IPV, childlessness and giving birth to female children only, and ever having terminated a pregnancy (Ler et al., 2017; Sabri et al., 2014). At the relationship level, husband's jealous and controlling behaviors, his alcohol consumption, women's experience of forced sex, and their acceptance of IPV are correlated with risk for victimization (Ler et al., 2017; Sabri et al., 2014; Saggurti et al., 2014). Further, patriarchy, poverty, cultural and religious beliefs that further the subordinate position of women, and community crime rates have also been shown to influence women's risk for IPV (Kalokhe et al., 2017; Ler et al., 2017). In India, violence is also perpetrated by the husband's family, such as mother-in-law and sister-in-law (Krishnan et al., 2012). There is some literature on regional variations in IPV and associated risk factors in India. For example, poorly educated and low socioeconomic status women in Uttar Pradesh and Bihar report high levels of physical violence (Jejeebhoy et al., 2017). In contrast, psychological and sexual violence were more prevalent in educated women from Karnataka (Kundapur et al., 2017).

A few studies have examined protective and resilience factors among IPV survivors at individual, relational, and community levels. While several studies have identified greater education among husbands and wives and higher socioeconomic status to be a protective factor against IPV, this association is strongest for physical IPV (Kundapur et al., 2017). Individual factors that build resilience include personal attributes such as courage, patience, confidence, self-esteem, dignity, and worth due

to financial and psychological independence (Shanthakumari et al., 2014). One's belief system, such as religiosity/spirituality, believing in the Indian women's tenacity to survive IPV, and the overpowering need to protect their children, has also affected women's resilience. Relational resilience stems from knowing other women IPV survivors. Supportive colleagues, friends, and relatives serve as a protective factor and also help build resilience. Support from male family members belonging to one's family of origin and/or husband's family has also shown to be a buffer against IPV (Shanthakumari et al., 2014). Overall, these studies highlight a wide range of IPV risk and protective factors and the need for culturally relevant and region-specific IPV interventions in India.

6.4 Challenges and Issues Related to Help-Seeking in India

Current trends suggest that Indian women who have experienced both physical and sexual violence are more likely to seek help than women who have experienced physical violence only (International Institute for Population Sciences, 2016). Further, women experiencing physical IPV are more likely to seek mental health counseling than women who have experienced only emotional violence (Vranda et al., 2018). Most common sources of help-seeking include members of family of origin, husband's family, and close friends. Institutional support, if sought, is provided by police, religious organizations, medical personnel, lawyers, and non-governmental organizations (International Institute for Population Sciences, 2016; Shanthakumari et al., 2014).

There are many barriers to help-seeking among abused women. These include feelings of embarrassment or shame, fear of retaliation by husband and in-laws, fear that nobody will believe them, fear of re-traumatization or confinement, and fear of restricted access to care. Other barriers include the presence of one's partner or son at the healthcare settings, inability to recognize the presence of emotional violence in the absence of physical violence, belief that nothing will change, and lack of agency in making a change (Poreddi et al., 2020). India's high IPV rates point to the urgent need for multilevel and culturally tailored prevention interventions that target victims and perpetrators. Despite continued and sustained efforts, progress has been slow. Most of the prevention and intervention literature is from specific states where customized interventions target particular sections of the population. Below, we highlight some important initiatives.

6.5 Advocacy and Legal-Based Interventions

Nari Adalats (women's courts), an informal grassroots initiative by women's empowerment groups, promotes timely and affordable justice for women with limited access to justice in rural areas (Kethineni et al., 2016). Women from the

community who staff these courts receive basic legal information about women's rights, divorce, marriage customs, dowry, child marriage, and property issues. Despite offering an alternative conflict resolution system, these Adalats have several shortcomings. Lack of funding and stigma have rendered Nari Adalats less accessible to victims (Joshi et al., 2009).

Efforts are being made to make police stations more accessible to women and to encourage victims to report crimes. The state of Haryana has made tremendous progress in this area; they have 21 such police stations staffed by women officers. There is also a special women's helpline number in this state to address crisis situations (Verma et al., 2017). Furthermore, Haryana has appointed 21 protection-cum-child marriage prohibition officers (PPOs) under the domestic violence law and the prohibition of child marriage law, a state government's unique initiative. The PPOs operate from the Women's Police station; they are supported by a network of government bodies, hospitals, non-governmental organizations, and other support services. Haryana has developed a systematic action plan to implement women empowerment and decrease gender-based violence (HSHRC, n.d.). Such institutional and governmental efforts need to be replicated in other states of India.

The Special Cell to Stop Violence against Women, a community-based organization, initiated 25 years ago in Maharashtra was a collaborative effort between the Indian Central Social Welfare Board (CSWB) and the Tata Institute of Social Science (TISS), an academic institution. These special cells are based in police stations and provide services to abused women (Dave, 2013). They have two social workers (a male and a female) in each unit and one coordinator supervising ten units (Dave, 2013). Over the past 25 years, these cells have successfully sensitized police officers; advocated for the prevention of violence against women; advocated for legal and policy changes; enabled women's access to legal, medical, and counseling support services; and changed women's perspective on help-seeking behavior. Because of this initiative's success, seven more Indian states have started special cells in police stations (Dave, 2013).

6.6 Community-Based Interventions

Bell Bajao (Ring a bell), a nationwide community and media campaign against IPV, was launched in 2008. It targeted men and boys as proactive bystanders to intervene and halt domestic violence incidents in their vicinity by ringing the household's bell where a couple was fighting. The intervention aims to reduce IPV by disrupting the couple's fight and informing the perpetrator that someone is watching his actions. An evaluation study conducted in three states, Karnataka, Maharashtra, and Uttar Pradesh, demonstrated that the campaign effectively transformed bystanders' response to abuse, at home or in the community (Breakthrough, 2013).

Men's Action to Stop Violence Against Women (MASVAW) was initiated in 2002 in the state of Uttar Pradesh to involve men in reducing violence against women (Das et al., 2012). This statewide campaign promotes awareness and

instigates gender-related changes at both individual and community levels. Evaluations of MASVAW initiatives show that they have helped change men's gendered attitude and abusive practices toward women. Moreover, Coaching Boys Into Men, an evidence-based program that addresses gender-based violence, has been adapted for middle-school-age adolescent cricket athletes in Mumbai. The results of the intervention are promising (Miller et al., 2014).

Another intervention called the Horizon program had shown promising results in addressing the relationship between prevalent gender-inequitable norms and men's sexual and reproductive behavior in India. A non-governmental organization developed this program, and it was implemented in multiple countries (Pulerwitz et al., 2010). The Horizon program was tailored to the Indian cultural context and administered in two formats, small-group education sessions and behavior change communication sessions, like street theatre. Longitudinal evaluation of the intervention showed changes in men's gender attitudes toward women, increased condom usage, reduced IPV, increased sexual communication with the partner, and decreased sexual health issues and HIV and STI risk (Pulerwitz et al., 2010).

Since the 1990s, the Indian government has supported community initiatives based on the Self-Help Group (SHG) model to promote rural women's economic and social empowerment (Jejeebhoy et al., 2017). "Do Kadam Barabari Ki Aur" (i.e., Two steps towards equality) is a community initiative that taps into the existing SHG support group network in Nawada, a district of Bihar, to target both individual- and community-level transformation of gender attitudes toward violence against women (Jejeebhoy et al., 2017). Bihar has a high rate of child marriages and gender-based discrimination. This objective was to empower women, reduce IPV, induce individual- and community-level changes in the normative beliefs that favor violence against women and girls, and promote egalitarian attitudes among men and women. This intervention had mixed results; the most notable changes were the increase in egalitarian attitudes, decreased physical violence, and increased help-seeking behaviors among women, while there was no decrease in emotional and sexual violence (Jejeebhoy et al., 2017).

6.7 Community-Based Interventions in Healthcare Settings

Increasingly organizations and researchers have recognized that public health settings can play an important role in IPV prevention and intervention. They serve as the entry point for screening for IPV (International Center for Research on Women, 2000). Substantial efforts are being made to integrate IPV screening among economically disadvantaged women seeking services from community health centers and hospitals (Kamimura et al., 2015; Vranda et al., 2018). Such a program has been initiated in Maharashtra by a non-governmental organization called CEHAT. CEHAT in collaboration with the Brihanmumbai Municipal Corporation (BMC), the local civic body in Maharashtra, has developed a center called Dilaasa. Dilaasa is a public hospital-based crisis center that provides medical and referral support, counseling,

legal aid, and shelter to women. It also conducts mandatory IPV training and sensitization for medical professionals and hospital staff (Deosthali et al., 2005). Given its success, CEHAT and BMC are planning on replicating this model and creating additional Dilaasa centers in other government hospitals in Mumbai. Similarly, in Haryana, 12 Sukoon centers offer one-stop crisis intervention in the form of medico-legal and counseling support services to women with IPV experiences (Mona, 2020).

Mental health professionals and nursing staff are essential frontline healthcare providers who play a significant role in IPV screening and delivery of support services (Gandhi et al., 2018; Vranda et al., 2018). As part of a community-based initiative in Somali, Karnataka, nurses in the mental health settings were trained using a violence against women module. This module was developed by the National Institute of Mental Health and Neuroscience (NIMHANS) Bangalore, a premier mental health institute of India. The module focused on changing gender attitudes that favored abuse and encouraging nurses to have positive attitudes toward abused women with mental illness (Poreddi et al., 2020). Prior work by NIMHANS had indicated that women experienced stigma from healthcare staff, which prevented them from disclosing about their IPV experiences in tertiary care settings. Additionally, women also reported a lack of privacy as another reason for not disclosing IPV. Therefore, the module also emphasized the need to create safe spaces for IPV screening and talking about IPV with women seeking help (Vranda, et al., 2018). Studies have highlighted that even when nurses have positive attitudes and screen for IPV, they can benefit from continuing education programs (Gandhi et al., 2018). These programs need to focus on increasing nurses' efficacy in handling abusive situations, providing privacy to IPV women, and updating their knowledge about support and referral services (Gandhi et al., 2018; Vranda et al., 2018).

6.8 Dyad-Level Interventions

An intervention called Dil Mil (Hearts Together), daughter-in-law (DIL), and mother-in-law (MIL) was developed to address the issue of IPV and its impact on maternal and child health. Female family educators delivered this unique customized and culturally grounded intervention to urban low socioeconomic women in Bengaluru in their local language (Krishnan et al., 2012). Pregnant women and their MIL were recruited for this intervention. The intervention involved separate MIL sessions (five 3-hour sessions) and DIL (three 3-hour sessions) and a joint 3-hour session with MIL and DIL. This intervention promoted awareness about IPV, gender inequity, healthcare outcomes, intergenerational relationship conflict between MIL and DIL, and the MIL's role in perpetuating IPV on DIL. This family-based intervention approach promoted awareness about the interconnections between violence, gender disparity, health, and relationships. It also successfully reduced intergenerational conflicts, empowered the DIL-MIL dyad, improved relational and mental health outcomes for both, and reduced IPV in the spousal relationship (Krishnan et al., 2012).

Ghya Bharari Ekatra (take a flight together) is a couple-based intervention conducted over 6 weeks by a pair of trained male and female community educators. "Take a flight together" intervention was culturally tailored to address IPV among low socioeconomic status women living in slums in Pune. The intervention was delivered in small groups, with three to five newly married couples in each group. The intervention addressed six topics: relationship quality, individual resilience, communication and conflict management skills, planning and setting couple goals, improving sexual communication and relationship, and exploring and redefining gender norms and cultural practices that favored attitudes toward IPV (Kalokhe et al., 2019). Except for the fifth module, the rest of the sessions were conducted as a couple because educators recognized that women did not feel empowered to talk about their sexual needs in their spouses' presence (Kalokhe et al., 2019). This intervention is in the preliminary stages, and its outcomes are currently being tested.

Counseling Husbands to Achieve Reproductive Health and Marital Equity (CHARM) is another couple-based intervention aimed at empowering husbands' active engagement in family planning and promoting gender equity in the couple relationship. Though CHARM is a couple-based intervention, the focus was primarily on improving married men's awareness and engagement in improving women's reproductive health and maintaining gender-equitable norms (Raj et al., 2016). This multi-session intervention was delivered by male village health providers (VHP) in rural Maharashtra in the clinical healthcare setting. The first two sessions were on family planning and gender-equitable norms and were delivered to men only, and the third was a session with the couple. Benefits of this intervention were manifold: increased awareness about family planning methods and gender-equitable norms, positive changes in couple's family planning communication contraceptive usage, decreased sexual violence, and gendered attitudes toward IPV. These changes were sustained at 9-month and 18-month follow-ups (Raj et al., 2016).

6.9 Individual- and Group-Based IPV Interventions

A blended individual- and group-based intervention titled "Reducing HIV among the non-infected" (RHANI) wives was developed for low socioeconomic women experiencing physical and sexual violence perpetrated by their alcoholic husbands in the slums of Mumbai (Saggurti et al., 2014). The RHANI wives' intervention included four individual- and two group-based sessions that were delivered by trained counselors over 6–9 weeks. The individual and group sessions served different purposes; the individual sessions were focused on empowerment, improved assertiveness, and negotiation skills in the marital relationship, whereas the group sessions increased social cohesiveness, problem-solving, knowledge, and access to community resources (Saggurti et al., 2014). The outcome evaluation revealed significant reductions in marital conflict, physical violence, and sexual coercion. Moreover, there was a significant increase in women's ability to negotiate marital

sex, contraceptive usage, access formal and informal support networks, and reduced HIV risk (Saggurti et al., 2014).

Healthy Activity Program (HAP) is a culturally adapted, behavioral activation treatment for depression among women experiencing IPV in Goa. HAP consists of six to eight sessions of 30 to 45 minutes in length. The behavioral and psychological treatment is delivered by trained lay counselors over 3 to 4 months (Patel et al., 2019). Results indicate that the intervention helped women develop pleasure-seeking behaviors to increase their activation and these new behaviors replaced their previous withdrawal symptoms. The outcome evaluation of HAP also revealed that the intervention reduced depressive symptoms at 12-month follow-up. However, the presence of IPV at the 3-month follow-up strongly predicted low activation behaviors and severe depression at 12-month. IPV was strongly associated with depressive symptoms in women (Patel et al., 2019).

Satyanarayana et al. (2016) tested an integrated cognitive behavioral intervention (ICBI) in reducing IPV perpetration among alcohol-dependent men and improving mental health outcomes among their wives and children. Participants for this study were recruited from inpatient psychiatry services of a hospital in Bangalore and had been diagnosed with alcohol dependence. The participants in the intervention group received eight individual sessions that were 45–60 minutes long. Results show that the alcoholic male patients with a history of IPV in their couple relationship benefitted from this treatment. Participants in the intervention group showed greater reductions in alcohol abuse, less IPV in the couple relationship, and reductions in depression in the wives at the 6-month follow-up compared to the control group participants.

Hartman and colleagues (2020) tested a combined behavioral economics and cognitive behavioral therapy intervention to reduce hazardous alcohol use and IPV in Bengaluru. They randomized couples to one of three arms – incentives-only, incentives plus counseling intervention, and control group. The incentives plus counseling couples group showed significantly higher reductions in alcohol abuse and IPV, improved couple communication, financial decision-making, and increased husband's emotional regulation than the other two groups. The incentive-only group showed some reductions in alcohol abuse and IPV, but they were not substantial. Couple counseling was considered a critical factor in addressing the IPV risk factors, such as husband's alcohol abuse and low emotional regulation, and marital conflicts (Hartman et al., 2020). Couple counseling was highly recommended in reducing IPV. Similar recommendations were provided by Shah (2002), a clinician at the National Institute of Medical Sciences (NIMHANS). She provided a case study approach to examine the benefits of couple therapy for IPV. She proposed therapeutic intervention guidelines for better outcomes with the conjoint couple compared to individual therapy. The benefits include addressing systemic issues, identifying IPV patterns, and implementing IPV-related couple interventions (Shah, 2002). There is still a dearth of literature on couple and family therapy-based interventions in India.

6.10 Conclusion

Even though IPV is recognized as a serious public health issue in India, the literature on risk and protective factors and IPV interventions is still nascent, particularly at the national level. Most of the literature on risk and protective factors is focused on married women's experiences of IPV. There is negligible literature on violence experienced by men and individuals in same-sex relationships (Chakrapani et al., 2019; Malik & Nadda, 2019). Most regional studies have contributed to a multifaceted, yet inconsistent, understanding of IPV in India. For example, in some regions of India, education and socioeconomic factors were considered as protective factors. However, these findings are inconsistent with findings from other regional studies (Kundapur et al., 2017). Finally, a review of IPV interventions using the socio-ecological lens reveals a good impact of culturally tailored structural, advocacy, and community interventions, but there are few nationwide initiatives to prevent IPV (Dave, 2013; HSHRC, n.d.). There were more interventions at the community level, whereas there was only a sprinkling of individual and relational interventions, and the lack of trained professionals has hindered the progress. Lay counselors, healthcare workers, and health educators provided majority of the counseling services (Hartman et al., 2020; Patel et al., 2019; Raj et al., 2016). Overall, there is a need for individual- and relational-level intervention to promote safety for IPV women. Much has been accomplished in this field in India, but there is a greater need for multilevel services for the prevention and intervention of IPV in India.

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Chapter 7
Intimate Partner Violence in Colombia

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7.1 Our Background on This Topic

We are female scholars working at Universidad de los Andes in Colombia. We are both psychologists, with postgraduate studies in family therapy and family science in the USA. Since 2015, we have collaborated on different research projects focused on therapeutic treatments for family violence. We culturally adapted a version of Domestic Violence Focused Couple Treatment (DVFCT; Stith et al., 2011) for its use with Colombian couples (Jaramillo-Sierra & Ripoll-Núñez, 2018). Currently, we are working on developing a treatment program for families that targets both intimate partner violence (IPV) and child abuse.

I (Karen) started doing research on change processes in family therapy for family violence early in my career. I was engaged in a 2-year project in which my colleagues and I explored therapists' and mandated clients' perspectives on change in family therapy. This research project led to a number of interesting findings regarding the contrasting ways in which clients and therapists understand therapy effectiveness. Later, I worked with colleagues adapting clinical interventions for IPV described above. Another project involved the development of a brief group intervention for women dealing with IPV-related trauma symptoms, based on Compassion-Focused Therapy (Naismith et al., 2020).

I (Ana) became interested in research regarding IPV from a larger interest in gender relations in couples and families. I am particularly interested in better understanding the limits and overlaps between gender-based violence (GBV), IPV, and child abuse and its consequences on prevention and treatment. I am also interested in GBV beyond the family, particularly, sexual violence in universities (Pérez

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Trujillo et al., 2019). As a clinician and clinical supervisor, I see a number of clients who have been victims or perpetrators of these types of violence. Clinical practice and supervision reminds me of the complexity of these phenomena, the suffering, as well as the strength and resilience of victims (and others involved).

7.2 Colombia: A Brief Country Overview

More than 48 million people live in 1,141,748 square kilometers, making Colombia the seventh largest country in the Americas (DANE, 2020). Eighty-six percent of the population identify as White and *mestizo* (i.e., of mixed race), 10.6% identify as of African descent, and 3.4% identify as Indigenous (DANE, 2020). Colombia is a representative democracy with a President, two chambers of Congress, and Supreme and Constitutional Courts. Colombia is considered an *emergent economy*. It has the fourth highest GDP in Latin America, but second largest GINI (economic inequality) in the region (The World Bank, 2020). Approximately 89% of Colombians are Catholic, and 11% belong to other Christian churches (Cely, 2013). Predominant cultural beliefs are sexist (*machismo*) and privilege the family unity (*familism*) (Puyana Villamizar, 2007). However, urban, middle-class families demonstrate diverse patterns of gender organization (traditional, transitional, gender egalitarian; Puyana Villamizar, 2003).

Colombia has a history of socio-political violence that has expanded over six decades. This context of political violence has been associated with increased risks for IPV and other forms of familial and community violence such as sexual assault (Colombian Institute for Family Welfare & International Organization for Migrations, 2013). One important factor that increases women's vulnerability to violence victimization is forced displacement by guerrilla and other illegally armed groups. Women and children represent 50% of victims of forced displacement in Colombia. Forced displacement is associated with risk factors for IPV and an increased risk for traumatic experiences, broken family relationships, poverty, and limited access to health services (Colombian Institute for Family Welfare & International Organization for Migrations, 2013).

7.3 Gender-Based Violence and Intimate Partner Violence

As will be discussed later, there are two bodies of laws and social policies that deal with IPV victimization in Colombia: one that focuses on violence within the family and another that is centered on women's victimization due to gender-based inequalities. Therefore, it is important to differentiate between these concepts: GBV and IPV.

GBV is "violence directed against a person because of that person's gender or violence that affects persons of a particular gender disproportionately" (European Commission, 2020). It includes "any act that results in, or is likely to result in,

physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (WHO, 2020). GBV includes a wide range of violence in diverse contexts, beyond couple and family ties.

IPV "refers to behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors" (WHO, 2020). Within the IPV literature, there is an ongoing discussion regarding the role of gender in explaining all or some types of IPV. Some authors (e.g., Winstok, 2017) argue that the gender symmetry evidenced in IPV victimization reports in community-based representative samples provides support to the idea that IPV is currently not associated with gender. However, gender theorists argue that gender structure and gender relations explain why women are more frequently victims of severe forms of violence; are stigmatized, blamed and mistrusted when they report violence; and, are more likely than men to stay in violent relationships (Anderson, 2005). We hold a view closer to Johnson's (2017, feminist response), where power relations by gender are the primary explanatory factor for some types of IPV (for intimate terrorism and violent resistance), but not for all IPV types (e.g., for situational partner violence).

7.4 Statistics of IPV in Colombia

IPV is a prevalent social and mental health issue in Colombia. According to the annual report from the National Institute of Legal Medicine and Forensic Sciences (2019), there were approximately 43 thousand reports of physical IPV victimization in Colombia. Men's reports represented 14.1% and women's 85.9%. Most men and women who reported were in a relationship with a partner of the opposite sex. Only 1.3% of women and 7.5% of men reported physical IPV in a same-sex relationship. Perpetrators were mainly current intimate partners (44.3% and 43.2% for women and men, respectively) or ex-partners (32.4% and 33.1% for women and men, respectively). Regarding other types of IPV, a nationally representative survey showed that 64.1% of women and 74.4% of men between the ages of 13 and 49 have been victims of psychological violence; 31.1% of women and 25.2% of men of economic violence, 31.9% of women and 22.4% of men of physical violence, and 7.6% of sexual violence by their partners or ex-partners (Demography and Health Survey; Profamilia-Ministry of Health and Social Protection, 2017).

7.5 Laws and Policies

Since 1991, with the new Constitution, Colombia has developed two separate normative frameworks to protect victims of IPV. On the one hand, some laws have focused on the prevention and elimination of violence within the family. These laws

establish protective measures (e.g., taking the aggressor out of the home and prohibiting contact with victims) and consequences for perpetrators (e.g., fines, incarceration, and treatment). On the other hand, a separate set of laws has focused on eliminating gender-based inequalities in a broader sense and, more specifically, different forms of gender-based violence that occur in different contexts (e.g., sexual harassment, exploitation, and family violence). For instance, law 1257 (Colombian Congress, 2008) focuses on GBV both within and outside of the family. This law not only includes protective and punitive measures but also establishes measures to raise awareness and prevent GBV. A study by Jaramillo-Sierra et al. (2016) suggests that these legislative efforts, and their corresponding developments, have resulted in two distinct approaches to social policy and psychosocial interventions regarding IPV within public agencies in Colombia, namely, a family-centered approach and a gender-informed approach.

Firstly, laws, policies, and agencies that hold a family-centered approach focus on violent acts between adults within the family (e.g., IPV) as well as intergenerational violence (e.g., violence against children and elderly family members). In addition, family-centered laws, policies, and agencies focus on restoring the rights of victimized family members (more often children) and preventing future occurrence of violent acts. Interventions are directed toward different family members, with a special interest in keeping the family unit together. Lastly, this set of laws does not conceptualize family violence and IPV as being nested in gender-based social inequalities.

Secondly, laws, policies, and agencies based on a gender-informed approach to IPV originated from the government's alliance to international agreements to protect the rights of women and children both inside the family and in other social contexts (e.g., workplace, armed conflict). Their primary focus is the restoration of women's rights within the family system, and, therefore, the interventions and services that derive from these policies are centered exclusively on women. They are based on a conceptualization of different forms of gender-based violence (including couple violence) as products of social inequalities and the abuse of power by men over women.

7.5.1 Legislation on Same-Sex Couples

Colombian legislation has also advanced in the recognition of same-sex couples and the protection of the rights of individuals with diverse gender identities and sexual orientation. In 2011, the Constitutional Court passed laws to include same-sex couples in the constitution's definition of a family and to protect the rights of families formed by sexually diverse individuals, including the right to receive assistance and protection in cases of family violence (Noguera & Guzmán, 2012). As is in the case for different-sex couples, IPV legislation considers violent acts a criminal offense and laws focus primarily on punishing the offending partner and protecting the victim. Revisions to current legislation on IPV should include a systemic

conceptualization of IPV and the factors involved in generating and maintaining this issue that would lead to a) developing actions to intervene on risk factors both within and outside the family and b) implementing strategies to transform interaction patterns within the family and use family resources (Santander et al., 2020).

7.5.2 Services Available for IPV Victims

As mentioned above, there are different types of legislation and policies that deal with IPV and other forms of family violence. Depending on the emphasis and focus of laws, policies, and agencies, there are different government institutions that are responsible for receiving IPV reports and taking actions to restore the rights of victims and prevent future violent episodes. For instance, family commissaries are government institutions – created and regulated by family-centered laws and policies – that are responsible for receiving IPV reports, conducting assessments, and referring partners to services (e.g., mental health, legal services). Most of the interventions suggested by family commissaries involve both members of the couple and other subsystems in the family. However, institutions such as houses for equal opportunities and shelters – which operate under laws and policies based on a gender perspective of IPV – focus their services specifically on women victims of IPV.

Depending on the type of institution receiving the IPV report, there may or may not be services available for perpetrators of IPV. For instance, family commissaries usually work with both members of the couple and refer them to individual or couple therapy. Legal professionals attempt to reach a conciliation as a measure to prevent future violent episodes and to deal with conflicts around child support. In contrast, houses for equal opportunities do not offer any services for perpetrators, and their services seek to empower women to become emotionally and financially independent.

Services available to women victims of IPV include counseling, shelters, and a 24-hour phone assistance to provide information and refer women to services. However, these services are primarily available in the country's main cities, and, unfortunately, women living in rural areas still do not have access to them. There are also shelters available to members of the LGBT+ community who are victims of IPV and other forms of familial or societal violence (District Secretary of Government, 2019).

7.6 Research on IPV

Research on IPV in Colombia has predominantly focused on two different issues: (a) systemic and contextual risk factors and (b) psychological characteristics of offenders and victims. Research on risk factors has examined educational and

economic factors (Friedemann-Sanchez & Lovaton Davila, 2012), alcohol and drug use (Klevens, 2001; Tuesca & Borda, 2003), and the intergenerational transmission of violence (Barón, 2012). Research studies have also focused on characteristics of female victims (Muñoz & Torres, 2014) and the psychological needs of male perpetrators (Medina et al., 2014).

Also, a few studies have explored IPV against men, although characteristics of the samples in such studies do not allow definite conclusions to be drawn because of sample selection methods, sample size, and types of IPV that have been studied. One study – based on a sample of 78 men who reported physical violence in a different-sex couple relationship to legal authorities – found that most (88%) were young adults (25 through 40 years), in cohabitating relationships (40%), and from lower-middle class. Approximately 74% reported previous IPV from their aggressor (mainly physical). In addition, partner's intolerance, jealousy, and alcohol abuse were seen as the main factors that triggered IPV (Floyd-Aristizabal et al., 2016). Another study explored IPV in same-sex relationships based on 90 individuals (64% gay men, 12% lesbian women, 18% bisexual, and 6% transgender and intersex individuals) who reported on frequency of violent behaviors and attitudes toward IPV (Muñoz, 2018). No significant sex differences were found in reports of minor and severe physical, psychological, and sexual violence (both received and perpetrated). Thus, men, women, and intersex individuals reported on average the same frequencies of these forms of IPV. Future studies about IPV against men should focus on (a) the relationship dynamics (e.g., power, control) that maintain these interactions in different-sex and same-sex couples; (b) characteristics of female perpetrators in different-sex partnerships; and (c) men's coping strategies when services available for men victims are scarce.

More research is needed on IPV in couple relationships formed by individuals with diverse sexual orientations and gender identities in Colombia. Muñoz (2018) found no significant differences according to sexual orientation in frequency of psychological aggression or physical aggression (perpetrated or received), between gay, lesbian, and bisexual individuals. However, intersex and transgender individuals who identified as heterosexual showed more acceptance of minor acts of physical violence (both received and perpetrated) and minor sexual coercion. Some limitations of this study are its sample size (90 individuals, with only 6% who identified as transgender and intersex) and the non-random sample selection method, which does not allow for generalizations to a specific population.

Some studies have examined the effectiveness of interventions for IPV in the Colombian context. A quasi-experimental research study that evaluated the effectiveness of an intervention for court-mandated couples found a decrease in violent interactions (i.e., physical and psychological violence), as reported by women, as well as an increase in positive communication patterns (González, 2016). The intervention focused on developing emotion regulation and coping skills.

A cultural adaptation of the DVFCT intervention for couples dealing with situational violence in Bogotá, Colombia, provided evidence for its feasibility and potential for therapeutic changes (Jaramillo-Sierra & Ripoll-Nuñez, 2018). The resulting program includes seven structured sessions based on solution-focused

therapy principles, as well as IPV education and safety planning, and training in emotion regulation and communications skills. Through pre-session surveys and post-intervention interviews, couples participating in a pilot study reported elimination of physical violence, decreased psychological violence, and increased shared couple time, communication, and intimacy.

Another study piloted a group-based compassion-focused intervention for women who reported IPV in a current or previous relationship (Naismith et al., 2020). This 6-week program targeted psychological symptoms as well as cognitions that derive from the trauma associated with IPV. Results indicated a clinically significant change in PTSD (i.e., intrusions/hyperarousal), depression, and anxiety symptoms, as well as in guilt and self-inadequacy cognitions that continued at a 6-week follow-up. Lastly, a qualitative research study explored clients' and therapists' ideas about therapeutic change in mandated IPV cases (Ripoll-Núñez et al., 2012). Both clients and therapists reported individual (e.g., increased self-worth, improved reaction to conflict) and relationship (e.g., positive communication, less criticism) changes as outcomes of the therapy process.

In conclusion, research on interventions for IPV have mostly focused on treatments for women and couples. Future research should focus on evaluating the effectiveness of existing interventions in randomized controlled studies. In addition, research studies on the effectiveness of multi-component interventions that target adult victims and perpetrators and also deal with the consequences of IPV on parent-child relationships are needed. Such multi-component interventions could attend to the diverse needs of spouses/partners and other family members, victims, and perpetrators of different types of violence. They could both protect children, the focus of the family-based approaches, and women, the interest of the gender-informed approach. In addition, such interventions could also respond to the needs of groups currently underserved, such as perpetrators. Government policies for IPV must include a funding program to support research on the effectiveness of clinical interventions, which would later be implemented by public agencies dealing with this critical issue.

7.7 Challenges to Laws and Policies

Policy analysts have argued that having two different sets of laws that refer to IPV – either directly or indirectly – often makes it difficult for those making decisions and implementing interventions to consider both the protection of individuals' rights and the needs of the family as a system (Santander et al., 2020). Another criticism to most existing policies on IPV is that they focus on protecting and restoring the rights of those who are targets of violent acts – most often women and children – but they are not based on a clear conceptualization of violence as a phenomenon associated with multiple factors in the ecology of family relationships (Santander et al., 2020).

Another issue that is connected to the conceptualization of IPV in existing social policies has to do with the need for a differential approach in the evaluation and intervention of couple violence that be clearly defined and based on existing evidence on the typology of violent couple relationships (Johnson, 2017). In our view of current policies on IPV, there is a need for more specific guidelines on how to intervene when coercion and control are present (or absent) and when violence is primarily unidirectional vs. bidirectional (Jaramillo-Sierra & Ripoll-Núñez, 2018). This is especially critical for social agencies that implement IPV policies and requires that professionals receive training to evaluate and make decisions on the most appropriate intervention in each case.

Lastly, international experts recommend that family policies should be based on existing empirical evidence on the most effective interventions to deal with serious social issues such as IPV. This approach to family policies, known as evidence-based public policy (Bogenschneider & Corbett, 2010), requires permanent communication mechanisms between academics-researchers and officials in charge of designing policies. In addition, the creation of alliances between academic and government institutions that design and implement policies would result in essential actions for the development of social policies such as (a) joint funding of research on interventions and their effectiveness and (b) support in the evaluation of programs and strategies contemplated in the policy, among others.

7.8 Challenges to IPV Services in Colombia

Recommendations for future public policy development in Colombia include increasing awareness of IPV and services provided. Currently, even when services are available, they may be used only on a limited basis. In a recent research study (Ripoll-Nuñez & Jaramillo-Sierra, 2020), we found that psychologists working at NGOs and government agencies identified four types of limitations regarding IPV services. First, individual and family factors, including limited financial and time resources to access services outside the home; previous violence or criminal history that prevented family members from accessing services; and cultural beliefs normalizing couple violence. Second, professionals identified institutional obstacles such as limited budget and personnel in agencies attending IPV and/or GBV as well as increased bureaucratic tasks involved in attending this problem. Third, professionals expressed concern about the difficulties for collaboration between different government and non-government agencies. In their experience, it is exceptional that agencies collaborate to provide legal, psychological, and social services to a couple or family.

7.9 Conclusion

Similar to other countries in Latin America and the Caribbean, Colombia has high rates of couple violence that have periodically been measured in demographic and health studies. Recent evidence shows that both women and men in the country are frequently victims of violence by partners and ex-partners (Profamilia-Ministry of Health and Social Protection, 2017). Couple violence has been recognized by law in Colombia through two different sets of laws, policies, and agencies, one holding a family-approach perspective and another one promoting a gender-informed perspective. Such opposing perspectives frequently become an obstacle to families seeking services. Research on IPV interventions in Colombia in the last decade provides promising evidence for systemic, behavioral, solution-focused, and compassion-focused treatments to eliminate and/or reduce violence and psychological symptoms resulting from long-term couple violence. Alliances between policy makers, government agencies, and researchers are necessary to improve treatment efforts for couple violence. Such alliances could better integrate evidence-based treatments with the different needs identified nationally and internationally to protect children, women, and families.

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Chapter 8
Intimate Partner Violence in Finland

Juha Holma, Helena Päivinen, Heli Siltala, and Salla Kaikkonen

8.1 Introducing Ourselves to You

I, Juha, am a clinical psychologist, family psychotherapist, trainer, and supervisor. When working as doctoral student, the local crisis center, Mobile, developed an initiative, forming a group for perpetrators at the new founded Psychotherapy Training and Research Centre at the University of Jyväskylä. My colleague, Aarno Laitila, and I were interested on this initiative. This was a start of the development of a multi-professional network against violence against women and research projects concerning IPV described later in this chapter. Since then, many students and researchers have participated in these projects, and interdisciplinary cooperation at the University of Jyväskylä has developed, including international conferences and the Violence Studies program. We, Helena, Heli, and Salla, started our research careers in the IPV research projects at the University of Jyväskylä. I, Helena, started work in the IPV projects in 2008, first by doing my master's thesis on the data, and later, after few years of working as a clinical psychologist in the prison and in mental healthcare, I began my PhD program. My research interest from the start has been in gendered identity work, which, in the context of IPV treatment, offers an important perspective to change processes. During my doctoral studies, I also worked as a facilitator in the group for perpetrators and started training to become an integrative psychotherapist. Currently, besides doing clinical work, I work as a post-doctoral research fellow in an EU-funded research project at the University of

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Tampere in which training for school professionals on GBV is developed. My (Heli) first touch with domestic violence as a research topic was when I was planning a topic for my bachelor thesis as a second-year psychology student around 2012. I was interested in feminism and other socio-political issues and felt that domestic violence research offered the best way to include these interests in my psychology studies. I have been on that path ever since, writing my bachelor and master theses on the subject and then continuing to work on my dissertation which deals with prevalence and effects of domestic violence within healthcare settings. Since 2016, I have also worked as a facilitator in the group intervention for perpetrators of domestic violence, which I have found to be a crucial and very rewarding addition to my research work. I, Salla, too became interested in violent behavior and especially domestic violence during my psychology bachelor and master studies in the University of Jyväskylä. During my studies, I was focused on forensic psychology and have had courses in Canada and the Czech Republic as well as in Finland. My bachelor and master theses were focused on post-separation stalking and professionals' attitudes toward stalking. Since graduating as a clinical psychologist, I have been working in organizations offering help and guidance to people whose lives are affected by domestic violence. Currently, in 2020, I work in Tukikeskus Varjo, a national support center for post-separation stalking, and pursue doctoral studies on post-separation stalking, focused on the perpetrators. I also work as a facilitator in University of Jyväskylä's group intervention for perpetrators.

8.2 Country Overview

Finland is a relatively small country population with only 5.5 million inhabitants. However, Finland is the fifth-largest country in Western Europe (338,440 km^2), and the population is mostly living in cities of southern Finland, making many parts of the country very thinly inhabited. According to Statistics Finland (2019), 7.3% of the entire population has foreign backgrounds. Most of them were first-generation immigrants. The largest group of persons with foreign backgrounds were from Russia or the former Soviet Union and Estonia.

Finland's GDP grew by 1.7% in 2018 and amounted to EUR 232 billion. GDP per capita was 40,612 euros in 2017. Most Finns are Christians. The largest religious community in Finland is the Evangelical Lutheran Church of Finland to which about 70% of the population belongs.

A high standard of education, social security, and healthcare exists in Finland, all financed by the state. By the end of 2017, 72% of the population aged 15 or over had completed a post-comprehensive level qualification (i.e., high school or vocational education; Statistics Finland, 2019). Thirty-one percent of the population had completed a tertiary level qualification (i.e., bachelor, master's, or doctoral education). The educational level of the population has risen in the past few decades mainly as a result of women seeking higher educations. Today, there are slightly more women with tertiary level education than men. Despite the rise in the education level of

women, the focus of education and career paths has remained strongly segregated by gender.

Finland was the first country in the world to have universal and equal voting rights for men and women in the parliamentary elections in 1907. Women's representation in Parliament has increased over the decades but has not thus far exceeded 50%. Finland had the fourth highest gender equality index in EU 2017 after Sweden, Denmark, and France (European Institute for Gender Equality, 2019). This has led to the development of a strong notion of Finnish gender neutrality and the more recent notion of gender equality in extra-parliamentary politics in the 1970s and in law in the 1980s (Hearn & McKie, 2010). The Strategic Program of Government in 2015 reflects the main discourse that "Finland is also a land of gender equality" (Program of Prime Minister Juha Sipilä's Government, 2015).

8.3 Intimate Partner Violence in Finland

Violence experienced by Finnish women has been assessed in two interview surveys conducted in 1998 and 2006. According to the latest survey (Piispa et al., 2006), 43.5% of women had experienced physical or sexual violence or threat of it by a man at least once after turning 15. Around one in five women had experienced violence or threats of violence by their current partner. Men's experiences of victimhood were analyzed in a questionnaire survey in 2010 (Heiskanen & Ruuskanen, 2010). Men were most often victims of violence committed by strangers (42%) or acquaintances (24%) since the age of 15. In both violence groups, the perpetrators were most often men. Regarding violence committed by partners, 16% of men living in a relationship had experienced violence or threats committed by their partner at least once. A 2014 survey conducted by the European Union Agency for Fundamental Rights among the 28 EU Member States showed that the lifetime prevalence of physical and/or sexual violence against women by intimate partners was 30% in Finland, being clearly above average in the EU (FRA, 2014). Intimate partner violence (IPV) among LBGTQ partners has not been currently addressed or studied in Finland.

The homicide rate is higher than that of other Nordic countries, which is mainly due to alcohol-related offences committed by socially excluded, male alcoholics (Lehti & Suonpää, 2020). Twenty percent of all homicides in Finland are attributed to a woman's death at the hands of a current or former partner, according to the National Research Institute of Legal Policy (Kivivuori & Lehti 2006; Lehti, 2016). Female intimate partner homicides (IPHs) constitute approximately 60% of all female homicides, but male IPHs make up only approximately 5% of all male homicides. The overall homicide rate has been in decline during the past 20 years, but there is no decreasing tendency in intimate partner femicides.

High prevalence of IPV against women and high levels of gender equality appear to exist together in Finland as well as in other Nordic countries, producing what has been called the "Nordic paradox" by Gracia and Merlo (2016). One theory the

authors suggest was that Nordic countries may be suffering from a backlash effect as traditional definitions of both manhood and womanhood begin to be challenged in a meaningful way. Another possible explanation is information bias, i.e., women in Nordic countries may feel freer to talk about IPV because of their equal status. However, the survey of European Union Agency for Fundamental Rights (FRA, 2014) showed lower levels of disclosure of IPV to the police in Nordic countries as compared to other EU countries. Country level of gender equality did not have an effect on the individual victim-blaming attitudes (Ivert et al., 2018). Violence against women by non-partners and levels of acceptability and victim-blaming attitudes in cases of violence against women also support the high prevalence of IPV against women in Nordic countries (Gracia & Lila, 2015; Gracia & Merlo, 2016).

Due to the widely accepted notion of Finland as a gender equal (or neutral) country, a gender perspective is often presented as self-evident. However, it tends to disappear in concrete practice, where dimensions of gender and power are not addressed sufficiently (Wemrell et al., 2019). The relative absence of a gender perspective, related to an associated assumption of gender equality, has been found to have potentially problematic consequences. For example, substantial responsibility for violence is often placed on female victims. Within healthcare, professionals have been observed to adopt such understandings of IPV that enable them to focus on fixing the injuries caused by IPV without intervening with the violence itself (Husso et al., 2012). This happens despite (or because) violent experiences are common among healthcare professionals themselves (Siltala et al., 2019).

8.4 Challenges and Issues in IPV Services in Finland

It can be argued that the main problem in Finland is the lack of intervention, which allows violence to continue (Husso et al., 2012; Niemi-Kiesiläinen, 2004). Finland criminalized rape in marriage in 1994, being one of the last European countries to do so. The legislation has been modernized over the years in order to improve the position of victims of intimate partner violence and sexual violence, in particular. For instance, even petty assaults occurring in an intimate relationship were made subject to official prosecution in 2011; sexual intercourse with a defenseless party was specified as rape in 2011, and stalking was criminalized in 2014.

The Finnish government published its first Program for the Prevention of Prostitution and Violence against Women in 1997 (Ministry of Social Affairs and Health, 1997), and enhanced it in 2002, to raise awareness of violence and its impact on individuals. In 2008, the UN Convention on the Elimination of Discrimination Against Women (CEDAW) criticized Finland for its lack of effective policy development on IPV (Hearn & McKie, 2010). In 2014, CEDAW recognized the National Action Plan to Reduce Violence against Women 2010–2015, but was critical that insufficient resources have been allocated to the implementation of the plan and that the incidence of violence against women remains high (CEDAW, 2014). The lack in services for victims of gender-based violence (GBV), which was also criticized in

the CEDAW report, has lately been improved. Women's shelters, which were formerly operating on the initiative of non-governmental organizations (NGOs), are now funded and organized by the state. A 24-h free helpline service called Nollalinja has also been established for victims. However, there is still an absence of an effective institutional mechanism to coordinate, monitor, and assess measures at the governmental level to prevent and address violence against women. Municipalities are legally responsible for securing adequate services for victims, but many do not allocate enough resources for these services. Also, work with perpetrators of IPV to end violence is not coordinated or funded nationally, and the programs vary in their approaches (Holma & Nyqvist, 2017). These programs are carried out mostly by NGOs and are based on voluntary participation.

8.5 Recent Developments and Projects

A few research and development projects concerning couple therapy in cases of IPV have been carried out by the Psychotherapy Training and Research Centre at the University of Jyväskylä in cooperation with several social and healthcare service. There is considerable controversy in the field over the indications for couple therapy in cases of IPV. However, a growing body of research has emphasized its benefits. The Jyväskylä research project on couple therapy for IPV was conducted within a cooperative multicenter research network (Vall et al., 2018). The project data were gathered between 2009 and 2013. Findings show how important it is that therapists are aware that male perpetrators exert pressure to justify their behavior and that female clients try to change the topic from the male partner's justification to address what has actually happened, which has been the act of violence. Therapists have to try to give power to the marginalized voices and give voice to the female client while acknowledging the male client at the same time. Detecting abuse of power and dominance seems to be crucial for the therapeutic outcome. When abuse of power is addressed, it should also be accompanied by strategies to increase the therapeutic alliance. Moreover, violent behavior, responsibility, parenthood, and client satisfaction emerged as crucial topics. It is important that the presence and forms of violent behavior are assessed throughout the therapy process and addressed continually to detect possible changes. It was found that in cases of psychological abuse, clients may have more difficulty positioning themselves as responsible for the violence and might ask their partner to be held responsible for it as well. Therefore, accepting responsibility would seem to be especially crucial when starting couple therapy for psychological IPV. The findings also highlight parenthood as an important theme in IPV couple therapy conversations. It is essential that therapists take into account the views of children affected by the violence between their parents. Parenthood may strongly motivate IPV perpetrators to take responsibility and work to change their behavior. It seems important that therapists are active in their approach, try to make everyone feel heard, and are able to focus on the abusive behavior. Focusing on the abuse should be done by pointing out the harmful way of

behaving, not blaming the person's identity by, for example, naming them as the perpetrator. Identity blaming has been noticed to be very affect provoking (Päivinen et al., 2016a, b).

A more recent and ongoing project is multi-couple treatment in cases of IPV. The Safe Family project is targeted at families and couples who have experienced domestic violence but now want to stop the use of violence in their relationship and prevent the models of violent behavior passing to the next generation. After the assessment period, it is possible for the couples to take part in multi-couple group sessions. This possibility applies to couples that have shown motivation and commitment toward non-violent behavior, and it is considered safe enough to continue in the program. The aim of the multi-couple group is to further support the non-violent behavior, strengthen the abilities for interaction, and build up the capacity to calm down. The model originates from the model by Sandra Stith et al. (2011). The adapted model is a 12-session program with different themes and the use of the group as a reflective team. The Safe Family project takes place in the North Savo region of Finland and is managed by the Kuopio mental health association. The project works in close cooperation with the public sector and other associations (NGOs) that work in the field of domestic violence in the region. The project also cooperates with a few international experts on violence and collaborates with the Department of Psychology at the University of Jyväskylä, Finland.

Post-separation stalking and intimate partner stalking are defined as a form of IPV. Post-separation stalking is defined here as repeated unwanted acts toward a former intimate partner, in order that the acts cause fear and anxiety to a reasonable person. Knowledge and training for authorities on stalking has been very rare, if any, in Finland. The aims of a Finnish VARJO project, carried out during 2012–2017, were to strengthen the safety of families suffering from violent post-separation partner stalking, improve precautionary work, and create possibilities for supporting victims' functioning through peer support and help in their recovery from the stalking experience. The project's target group included the immediate victims of stalking, children of the families, other family members affected by stalking, and stalkers. The project arranged several seminars for authorities, developed services for victims of stalking and other family members, and published guidebooks on intimate partner stalking and digital stalking. Throughout the years, experts by experience have had a great role in the work of the project, in example giving their expertise and views of how they have been acknowledged in various institutions and services of the Finnish society, and contributing to the educational material produced on post-separation stalking. After 2017, VARJO project has continued as a VARJO National Support Centre for post-separation violent stalking, funded by the Funding Centre for Social Welfare and Health Organizations (STEA), and continues to help families encountering post-separation stalking as well as aims to develop services and increase knowledge about the stalking phenomenon.

The programs for perpetrators of IPV started in the 1990s and are carried out by NGOs. The Jyvaskyla model of working with IPV started 20 years ago as a multi-professional collaborative project in Jyvaskyla, Finland, by two main collaborating agencies, the local Crisis Center Mobile and Jyvaskyla University Psychotherapy

Training and Research Centre. The Jyvaskyla program for perpetrators is part of multi-agency networking of public social and health services as well as police. The aim of the network is to raise awareness on IPV among professional and develop services for victims, eyewitnesses, and perpetrators. The program itself is voluntary based and non-manualized. The partners are met regularly, and cooperation with victim services is constant. The main principles of the group treatment include a focus on security, violence, choices, feelings of guilt, and masculine identity (Holma et al., 2006; Päivinen et al., 2016b). When attending the group treatment, a perpetrator commits for at least 15 sessions. There is no limit to the number of sessions, but the average length is about 30 sessions, which is 1 year. The program is voluntary, and most of the participants are referred by the social and health agencies. The group treatment is possible only after individual sessions at the Crises Centre Mobile. The groups are semi-open, meaning that each group consists of people in different phases of their treatment. New participants are taken in a couple of times a year, and the new participants agree to minimum of 15 sessions. However, the perpetrators are free to stay longer if they wish.

During the two decades the program has been in existence, the process and utility of group treatment have been studied by applying discursive and narrative approaches (Päivinen et al. 2016b). These research topics can be grouped under two headings: gendered perspective and strategies of therapists. Gendered perspective entails analysis of gendered views of violence and the couple relationship and masculine identity in relation to violence (fatherhood, sexuality). One aspect of masculine identity that is often raised is fatherhood, since most of the participants have children, and the therapists therefore repeatedly refer to the viewpoint of women and children in the group conversations. Combining fatherhood and violent behavior in one's identity produces a serious contradiction, and the therapists actively addressed this issue to promote the motivation to change. Trauma history of the participants needs to be faced in group treatment, as over half of the men in the group therapy had experienced violence in their childhood and youth. Group members were able to position themselves in the place of the victim of their own violence through their own traumatic childhood experiences. This enabled them to take up the position of a responsible father, which further motivated the cessation of violence.

Several studies on the group program have compared men with good and poor outcomes. The good outcome clients were characterized by better ability to describe their thoughts, feelings, and interpretations. As opposed to the good outcome clients, the poor outcome clients were characterized by greater use of concrete and indicative language in a monological mode, that is, not allowing alternative viewpoints to be discussed and formulating closed utterances (Räsänen et al., 2012a). The men varied in their degree of motivation to participate in the group and in their stage of change, which presents the therapists with the challenge of flexibly adapting their interventions (Räsänen et al., 2014). The therapists used more indicative language, i.e., asking questions that did not need any elaboration such as "Who called the police?" and "Were the children at home when this happened?" at the beginning of the group treatment. It was possible to answer these questions with one

or two words referring to concrete things or people, and therefore, engagement in further discussion or more complicated meaning-making becomes unnecessary. The therapists used more conversational dominance and a more structured approach when focusing on the consequences of violence and the clients' responsibility. Later, the therapists took a more non-dominant position and made greater use of dialogical responses and on the symbolic level (Räsänen et al., 2012b). In the symbolic level of expression, there are more varying meanings for the concepts used, and thus, more effort is required for understanding. For example, by answering "I don't know the answer to your question but what I wonder is what it would mean to you if it was inherited or what if it wasn't," the facilitators used an open, reflective style of responding, inviting clients to engage in more profound consideration of their feelings and thoughts.

A study showed that those men lacking mentalizing speech, i.e., they were unable to recognize and verbalize their emotions at the beginning of the group treatment, did not recognize the effects on their victims of their psychological and emotional violence and had problems in recognizing their spouses' mental states (Kuurtokoski, 2009). The problems of mentalizing were associated with continuing psychological IPV. Thus, it seems that, for perpetrators, improved recognition of their spouse's mental states is essential in reducing psychological violence.

The therapist has to be able to adapt their intervention approach to suit the needs of different men at different stages of change, reflexivity, and motivation. The main aim of the perpetrator program is to construct a new identity with a new understanding of parenthood and a more flexible attitude to masculinity (Päivinen & Holma, 2017).

Efforts in tackling IPV and GBV also include training professionals in identifying and intervening with the problem. However, this knowledge and skills training has not generally been part of basic education of the social, health, and educational professionals. Also, lack of coordination of such training has existed. In the past few years, there have been several development projects in Finland, co-funded by the European Commission, in which such training has been developed. The project, Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS), focused on the needs of social and healthcare professionals as well as the police in addressing IPV (Nikander et al., 2019). The project analyzed the training needs of these professionals and developed an online training program for multi-sectorial use.

Another project has followed, in which a training program for teachers and other professionals at school is being developed (see https://projects.tuni.fi/erasegbv/). This project, Education and Raising Awareness in Schools to Prevent and Encounter Gender-Based Violence (ERASE GBV), answers the urgent need of preventing and intervening GBV in the school context, among children and youth. The project also gathers information on the experience, knowledge, and skills of the professionals, and the developed online training will be based on this information.

The online format of these training programs makes them easy to access. However, for a more effective knowledge building and skills training, training among peer groups or work communities would be more likely to foster shared

understanding of the problem and unified procedures of intervention. The Finnish Institute for Health and Welfare has taken up coordination of the different online trainings for social and healthcare professionals including trainings on intervening IPV and GBV in Finland.

8.6 Conclusion

Finland is a country with paradoxical amounts of IPV in the context of high gender equality. Victim-blaming attitudes appear to be quite resistant to change over the years, and the constant disappearance of the structural gender perspective in the discussions of violence supports this resistance. The work with both victims and perpetrators of violence lacks coordination, and more intervention programs are needed. More adequate training and intervention procedures should be provided for professionals working in social and healthcare services in order to increase the identification of IPV. The number of migrants is increasing, and special services are needed as well as efforts to eliminate issues, such as genital female genital mutilation and so-called honor killings. Furthermore, next steps in preventing gender-based violence in Finland need to include early preventative, educational programs that reach the general population and children in particular. Educating the educators of schoolchildren is a promising action in increasing early detection, support, and guidance to services for the most vulnerable group that are affected by violence, the children.

The current government has drawn up an action plan for combating violence against women on 2020 (Ministry of Justice, 2020). The cross-cutting theme of the action plan is the prevention of violence. Of specific forms of violence, the action plan covers honor-related violence and digital violence. In addition, emphasis is placed on the work to be carried out with perpetrators of violence and on the competence development of authorities responsible for criminal investigation, criminal procedure, and criminal sanctions.

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Chapter 9
Intimate Partner Violence in Turkey

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9.1 Introducing Ourselves to You

I, Nesteren, am a psychologist, a family psychotherapist, and an Assistant Professor at Maltepe University, Department of Psychology. I am a certified Satir Systemic Couple and Family therapist and eye movement desensitization and reprocessing (EMDR) therapist, and I have been applying a systemic transformational model to my counseling and other projects. Since 2009, I have been working as a facilitator in TOÇEV's (an educational NGO) domestic violence, adolescence, and family projects. I am also a board member and general secretary of the Turkish Couple and Family Therapy Association. I am a member of Satir Global, the International Family Therapy Association (IFTA), and the American Psychological Association (APA). I work as a family therapist at a private practice and have established an organization called PSIEO, where keynote speakers around the world are invited to give seminars and workshops in Turkey on intimate partner violence (IPV) and well-being. I am also a professional speaker, where I speak at schools, municipalities, and public events. In my public speeches, I generally prefer creating awareness about IPV and domestic violence. I also provide supervision classes at Bilgi University's Couple and Family Therapy Clinical Psychology Graduate Program. My research interests are domestic violence, Internet addiction, middle adulthood, and positive psychology. My doctoral thesis was on Internet usage and well-being in middle adulthood. I am particularly interested in integrating the Satir Model perspective in couple therapy and IPV treatment. I have written several book chapters and translated two books into Turkish on family therapies.

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9.2 Country Overview

Turkey is the 37th largest country in the world (783.562 square meters in land area) and has the 17th largest population (approximately 83.5 million inhabitants). According to Turkey Statistical Institute (2021), 50.1% of the population is male, and 49.9% is female. The mean age of the population in Turkey 32.7, and 67.7% of the population is working. The annual population increase was 12.4‰ in 2017, 14.7‰ in 2018, 13.9‰ in 2019 and 5.5‰ in 2020. The capital of Turkey is Ankara. Istanbul is the most crowded city with 18.4% of the population (15.5 million) living in Istanbul. The country serves as a bridge between two continents, Europe and Asia, and the country has a rich blend of historical heritage.

The Turkish Republic is a secular country, and individuals' freedom of religious belief is secured by the constitution. Approximately 99% of the population is Muslim (Department of Religious Affairs, 2014). Additionally, there are some communities in Turkey that practice Christianity and Judaism, as well as several other religious beliefs. According to a longitudinal research on lifestyles in Turkey (Konda, 2021), over the past 10 years, the number of religious people has decreased and non-believer/atheist has slightly increased, the number of religious conservatives has decreased, and the traditional conservatives have increased. In 2016, there was a change of political regime from a parliamentary system to a presidential system. The current government has a right-wing political position, and the party

has been elected for the past 19 years. According to World Bank national accounts, Turkey's gross domestic product (GDP) is $754.412 billion and GDP per capita is $9.043 (The World Bank, 2020). The Global Gender Gap Report 2020 examined countries concerning women's economic participation and opportunity, educational attainment, health survival, and political empowerment criteria. In the report, Turkey is indexed as the 130th country out of 153 countries (World Economic Forum, 2020), meaning that the gender gap is high in Turkey. When the report is examined in depth, the major fields of the gender gap are shown as economic participation, opportunity, and political empowerment, whereas educational attainment, health, and survival seem very close to full gender parity.

Over decades, the family has carried a central role in Turkish culture. Historical phases of Turkish families can be examined in three periods: Family in Old Turks, Family in Islamic Period, and Family in Modern Turkey (Koçak & Evran, 2019). Family in Modern Turkey is constituted by civil law, and couples in marriage have equal lawful rights. According to research, lifestyles in rural and urban Turkey differ from each other regarding marriage age and marital adjustment (Kaya & Cin, 2019), gender roles, and attitudes toward out-of-wedlock sexual intimacy (Yıldıray & Çelik, 2020). However, written laws and unwritten cultural rules have transferred through generations, and these unwritten and unspoken taboos lead to some problematic issues, such as insufficient sex education, forced marriages, or child brides. It is forbidden by the law to get married before the age of 18, but with the regional cultural differences, combined with the effect of poverty and lack of education, almost 7.2% of marriages are conducted with a female partner below the permitted age (Boran et al., 2013). In 2019, the number of marriages in Turkey was 541.424, and 4% of these marriages were between first cousins. This ratio was 5.9% in 2010 (Turkey Statistical Institute, 2020a, b), suggesting that people may be changing their mindset toward marriages within families. LGBT marriage is not legally permitted in Turkey.

According to the Marriage and Divorce Statistics Report (Turkey Statistical Institute, 2020c) in 2019, 142.448 people got divorced. Over the years, an increase in divorce rate and a decrease in marriage rate has been observed. The divorce rate in 2001 was 1.41% and in 2019 it was 1.88%, while the marriage rate in 2001 was 8.35% and in 2019 it was 6.56%. This change can be explained by social awareness campaigns are increasing educational access and economic constraints (e.g., programs about child brides). Additionally, the mean age at first marriage has also increased. In 2015, the mean age at first marriage was 27.5 for males and 24.4 for females, while in 2019 it is reported as 27.9 for males and 25.0 for females. These ages are younger in rural areas, so cultural constraints or forced marriages should also be considered while comparing rural and urban areas. Another cultural constraint is sex education. Although, in the last 20 years, sex education has been provided in high schools under the titles of "Reproduction Health" or "Adolescence Awareness," Kısa, Zeyneloglu, Yılmaz, and Verim (2013) reported that couples on the eve of marriage do not have enough knowledge about sexuality.

9.3 Intimate Partner Violence in Turkey

Most of the research examining the prevalence of IPV in Turkey has only examined violence against women. Gencer et al. (Genç et al., 2019) found that 67.71% of their female sample (living in Istanbul) reported IPV victimization, with 36.28% having experienced physical violence, 58.28% psychological violence, 40.28% economic violence, and 24.28% sexual violence. Domestic violence toward women research conducted by the Ministry of Family, Labour and Social Services and Hacettepe University (2014) indicated that 33.5% of married women reported experiencing physical violence and 5% reported they had experienced sexual abuse within their marriage. A remarkable point in this research was that 19.5% of women who were divorced or living separately from their spouse reported that they had experienced physical violence and 11.8% had experienced sexual violence in the last 12 months. This leads us to intergenerational transferred cultural beliefs. These beliefs are changing in urban areas with the increase of education, but in rural areas, it is still a problem. For example, especially in Anatolian regions, there is a saying like, "women are my honor." The word "honor" reflects innocence, purity, woman's virtue, virginity, chastity, etc. Therefore, the concept reflects male supremacy in terms of "honor." This, in a way, leads to men being raised as guardians of women and women seeking the protection of men. These kinds of thoughts and intergenerationally transferred family customs can be seen to encourage violence toward women, as they highlight that in order to receive social acceptance, boys are forced to be a "strong man" to protect women and girls are forced to be a "weak woman" to be protected. Unfortunately, some of these obsessed honor beliefs end up in murder, and 42% of the murderers mentioned that their acts were approved by their families (Baglı & Özensel, 2011, as cited in Sakallı Uğurlu & Akbas Uslu, 2013). When considering the individual's emotions and behaviors, family and societal values play a major role (Kağıtçıbaşı, 2005). Therefore, a systemic stance should be held while examining IPV. Kağıtçıbaşı (2005) focused on human development in a sociocultural context and developed two main theories, Family Change Theory and the Theory of Autonomous-Related Self, indicating that families change as contexts change via urbanization and socioeconomic development (Aycan & Cemalcilar, 2018). As the years spent in education increase, percentages of exposure to physical or sexual violence decrease (Ministry of Family Labor & Social Services and Hacettepe University, 2014). Most of the research has focused on women and how their education level can impact the avoidance of IPV, yet on the other side of the medallion lies the hidden intergenerational violence victimization of males. Beşpınar et al. (2020) discussed that a man does not have a chance to change his past or his victimization in his family of origin, but with the help of supportive policies on education, employment, and social security, he can avoid becoming a perpetrator. Besides the level of education, research also indicates that economic difficulties have a significant relationship with IPV. A study conducted by Genç et al. (2019) focused on men's understanding of violence against women or why they believed IPV against women occurred. Participants in their study generally

reported that violence was related to economic problems, betrayal, psychological problems, community pressure, and substance abuse. Additionally, other research in Turkey suggests that factors such as unemployment, poverty, cultural changes, and alcohol do not cause IPV, but might indirectly contribute to the emergence of an existing IPV tendency (Şener Bozkurt, 2010).

In Turkey, different characteristics are attributed to women and men by society, facilitating a sexist division of labor and traditional patterns of femininity and masculinity with the belief that these patterns are natural (Şener Bozkurt, 2010). These patterns allow men to establish superiority over women, in both the private and social areas, while imposing the submission of women to men in all circumstances. This plays a role in the normalization of domestic violence; in other words, the learned helplessness of women, as a result of gender role socialization, fosters violence (Şener Bozkurt, 2010). In addition to gender role socialization, Akadlı Ergöçmen et al. (2015) point to the intergenerational transmission of violence in Turkey, indicating that if individuals grow up in non-violent homes, they are less likely to engage in violence in their own families. Similarly, those who have grown in families where their mothers were subjected to IPV are more likely to physically abuse their children.

9.4 Challenges and Issues in IPV Services in Turkey

The Ministry of Family, Labour and Social Services (2014, 2019) has shelters for women who have been victims of physical, emotional, sexual, economic, or verbal abuse. Women can stay at these guest houses with their children for up to 6 months and may request an extension after 6 months. There are 143 shelters in Turkey operated by the Ministry of Family, Labour and Social Services, by municipalities, and by NGOs with a total capacity of 3444 habitants (Ministry of Labor, Social Services and Family, 2019). Çiltaş and Çalık Var (2019) investigated sociodemographic and satisfaction levels of women at these shelters and found that the majority of women staying at shelters were married at young ages and most of them had low education levels. Nearly 50% of their sample mentioned that it was not their first time staying at the shelter, indicating a repeated cycle of violence. Additionally, most of the participants were satisfied with the shelter services.

It may be difficult for women to leave an abusive relationship. Getting divorced, especially in the case of IPV, is not a difficult process legally. However, the cultural norms, societal beliefs, and familial pressure are where the difficulty resides. As mentioned in the "Country Overview" section, some of the marriages are in-family marriages, which means that people get married to their relatives. Therefore, during the process of divorce, familial pressure and misbeliefs about honor occur. The Research on Domestic Violence against Women in Turkey (2015) found that women who experience violence are victimized by men closest to them, such as husbands, fiancées, or boyfriends. Yıldırım (2018) investigated 1260 out of the total of 2380 homicides committed against Turkish women in the past 10 years and found that out

of the 1260 homicides, 176 were related to divorce, 348 were related to an argument, and 114 were related to jealousy or envy.

In 1980, United Nations member countries were able to vote on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In 1986, CEDAW entered into force (was approved) in Turkey (Acar & Ege, 2001). The CEDAW report for Turkey (2016) suggests several items about empowering women, especially in rural areas. In 1998, an important legal step was taken to combat domestic violence against women with the Law on the Protection of the Family No. 4320. In 2011, the Council of Europe Convention on preventing and combatting violence against women met in Istanbul (Council of Europe, 2020). Turkey signed on and confirmed the obligation of the state to fully address IPV, including prosecuting perpetrators. In March 2021, a presidential degree was issued about the withdrawal of Turkey from the Istanbul Convention. A revised version of the 1998 law came into force on March 8, 2012, which provided fair, effective support and services to victims of violence, and established violence prevention programming and monitoring centers that operate on a 24-h basis. In order to support the participation of the protected person in the working life, the provision of childcare payment for families from the Ministry's budget was also supported. The Ministry agreed to pay either a 2-month or a 4-month fee for childcare based on the working status of the protected person. In addition, the Domestic Violence Emergency Helpline was established, because women rarely ask for help from health institutions, the police, or other support services. For example, 49% of women who have experienced physical or sexual violence from their partner do not tell anyone about the violence, and 92% of women who have experienced physical or sexual violence from their partner do not consult any governmental or non-governmental organization (Şener Bozkurt, 2010). Despite these changes, the law has been criticized due to several issues: It does not focus on raising awareness about domestic violence on a societal level, promoting gender equality, establishing prevention services, training law enforcement officers to properly implement the law, providing victim support programs, and restricting media channels' content that promote gender inequality and violence. Even though CEDAW was signed, there are still ongoing debates about a few of its clauses including its recognition of LGBTQ relationships and its defense for granting orders of protection based on the women's word. These clauses have been criticized by some political groups for endangering the unity of the family and jeopardizing the family values (Doğruluk Payı, 2020).

Although there are many efficient campaigns held by the Ministry of Family, Labour and Social Services and a variety of social agencies, there is still a way to go. For example, looking at the problem from a broader perspective by integrating male and female power is needed. In 2019, Yanındayız Association was established by 40 men to ensure gender equality and combat all kinds of discrimination. Founder President of the association, Mr. Ger, mentioned that in order to achieve full equality, men must be involved in responding to the issue. In Turkey, IPV is mainly seen as a problem of male perpetrators and female victims, and research on IPV toward men is limited. Comprehensive studies to learn whether violence against men is hidden, or if no such form of violence exists, are needed (Adak, 2013).

As in many countries, IPV is a major problem in Turkey. Current punishments granted to perpetrators of violence do not seem to be a deterrent, as 300 women were killed in Turkey in 2020 and 297 of those were committed by men that the victim knew (Kadın Cinayetlerini Durduracağız Platformu, 2021). Many campaigns have been held, and volunteers and policy makers are working on the issue, but it takes time to change cultural beliefs and intergenerational family rules. In order to deal with IPV, all the parts of the society should take a stance. This includes government, policy makers, and the public and private sector. As declared by the World Health Organization, the COVID-19 (coronavirus) pandemic started in Wuhan City of the People's Republic of China in December 2019 and spread rapidly around the world (World Health Organization, 2020). This unexpected pandemic made it compulsory for many individuals to live according to social isolation and quarantine rules. Therefore, families, couples, and partners started to spend 24 h a day locked down in a home with all their problems and issues. It becomes even more critical to combat IPV by increasing social awareness on culture, misleading rules and customs, obtaining equal gender rights, and eliminating violence.

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Chapter 10
Intimate Partner Violence in Nigeria

Kolawole A. Oyediran

10.1 Overview of the Author

I am a Nigerian with more than 20 years' experience in my native country before relocating to the United States in 2012. I am a demographer and social statistician by training with a research focus on population dynamics and health, with a particular interest in sexual and reproductive health, women's position and roles in the society, and men's engagement in reproductive health. My previous research examined the processes through which women and men engage in different aspects of sexual and reproductive health in response to the demands of a changing social environment.

More recently, my work has focused on women's status within the family and society and emphasized the importance of the larger social context on issues of gender-based violence (GBV) and intimate partner violence (IPV), women's reproductive health autonomy, and male responsibility as partners in the development programs. My interest in research on a woman's status was strongly influenced by my experience growing up as a boy with four sisters and witnessing my uncles abusing their spouses, particularly when they disagreed over sexual relations within their marriage. My interest in understanding ways Nigeria can reduce levels of IPV was strongly influenced by the principles and philosophy of the 1994 International Conference on Population and Development held in Cairo, Egypt, and the 1995 Fourth World Conference on Women, held in Beijing, China, which endorsed changes in gender norms and gender equity.

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10.2 Overview of Nigeria

Nigeria is multiethnic and culturally diverse, with more than 386 ethnic groups (Ugbem, 2019). It has 36 autonomous states and the Federal Capital Territory with 774 local governments. Family structures in the country are both nuclear and extended, with elites inclining more toward the nuclear structure with minimal linkages to the extended family and the family structure being extended in the general population. Christianity and Islam are the two predominant religions in Nigeria, though traditional beliefs also persist.

Largely because of its oil revenue, Nigeria is seen as a powerhouse of economic strength and development in sub-Saharan Africa. However, the erratic nature of global oil prices has led to unstable economic growth, despite recent diversification to non-oil sectors such as tourism and agriculture (Riti et al., 2016). Despite some progress in the socioeconomic spheres, Nigeria's human capital development remains poor. The country ranked 152 of 157 countries in the World Bank's 2018 Human Capital Index and 125 out of 145 countries on the Gender Equality Index. In addition, employment creation remains weak because of various developmental challenges facing the country with negative impacts on social and economic well-being.

The patriarchal nature of Nigerian society exposes Nigerian women and girls to disproportionate inequality in income and opportunities which, in turn, renders them more prone to poverty and more vulnerable to domestic violence (Oyediran et al., 2011; Feyisetan & Oyediran, 2019). After marriage, a woman surrenders to her husband's exclusive rights of household decision-making, including those related to employment and career progression. This traditional view gives male spouses permission to violate or batter their wives as a disciplinary measure to ensure their compliance to marital obligations (Oyediran & Feyisetan, 2017). Nigeria's rigid gender norms also result in acceptance of wife battering, increase the power of the extended family over married couples, and restrict women's ability to seek redress against violence within the marriage (Oyediran & Isiugo-Abanihe, 2005; Rettig et al., 2020).

This feminization of poverty often forces poor women to rely on their partners for personal needs and household maintenance; and men use this economic vulnerability to abuse and violate their wives. The experience of an IPV survivor, shared with the Coordinator of the Lagos State Domestic and Sexual Violence Response Team (DSVRT), captures the implication of feminization of poverty on IPV in Nigerian context: "At least I work and I earn a salary. What would have happened if I were a housewife without money, no family support? It would have been terrible. Not that it is not terrible … but it could have been worse" [Wana Udobang, quoted from *The Guardian*, January 5, 2018].

10.3 Intimate Partner Violence in Nigeria

IPV generally includes physical, sexual, and emotional abuse, which often do not occur in isolation of each other. The Nigeria Demographic and Health Survey (NDHS) showed that the combined prevalence of IPV (physical, sexual, or emotional) increased from 31% in 2008 to 36% in 2018 (NPC Nigeria & ICF, 2019). IPV prevalence (including physical, sexual, and/or emotional violence at spouse's hands) varies by geographical setting in Nigeria: from a high of 50% in the North Central region to a low of 20% in the South West region of the country, according to the Nigeria Demographic and Health Survey (2018). Results differ widely by state; the proportion of women experiencing IPV by a husband in the last 12 months is highest in Gombe (69%) and lowest in Jigawa (10%) (NPC Nigeria & ICF, 2019).

These geographic variations in IPV prevalence can be attributed to differences in human capital development and cultural conservatism, especially education and social norms that encourage women's roles and responsibilities in the family and society. Women in the South West are more educated than their counterparts in the North Central. When women have a higher level of education, men are more likely to feel threatened and to fear that women might break patriarchal norms and values that promote women's subjugation and subservience, which can increase male-to-female violence. Conversely, though, education may help in conflict resolution and communication among couples. The education configuration may also explain the difference in the prevalence and incidence of IPV at the state level.

Nigeria's patriarchal culture shapes the context of IPV prevalence. Husbands are seen as always right and usually win in any marital disputes against their wives. Family members who step in to mediate are likely to pronounce women guilty—despite obvious signs of violence—because they are mostly concerned about the family name. Mrs. Titilola Vivour-Adeniyi, the Coordinator of the DSVRT in Lagos State, described a situation in which Mrs. XYZW (masked) went to her parents for help after years of abuse. Her father urged her to drop all the charges filed against her husband, while her mother was worried about the family's reputation. "My mother said they want to return me back so I don't disgrace her. Even after the beating she said you have to save the face of the family. You have to go back. So I went back" [Wana Udobang, quoted from *The Guardian,* January 5, 2018].

Despite the high incidence of IPV, marriage is still regarded as a prized attainment in Nigeria. Nigerian women have adopted a sort of "don't ask, don't tell" rule when it comes to reporting violence or leaving the marriage, because wedding vows are regarded as sacred. Because of this view, women are quietly encouraged to remain in abusive relationships. Nevertheless, the negative impacts of IPV are clear and serious. Exposure to IPV may result in poor health outcomes, physical injuries, gynecological problems, unintended pregnancy, sexually transmitted infections, depression, and, in extreme cases, death (Gordon, 2016; Anzaku et al., 2017).

Given the growing rates of IPV and its consequences, scholars have identified key predictors of IPV in Nigeria. Many studies have drawn attention to the scope of violence against women in Nigeria and the factors that place women at risk of IPV

in general (Anzaku et al., 2017; Oladepo et al., 2011; Oyediran & Cunningham, 2014; Oyediran & Feyisetan, 2017; Fagbamigbe et al., 2020). This research has created platforms for open debate and opportunities for design of evidence-based interventions and policies to prevent this type of violence.

Research shows that IPV is more likely among women with primary education, those living in cities or in the south-south region, Christian women, women whose husbands consume alcohol, and women who witnessed domestic violence as a child (Oyediran & Feyisetan, 2017). As an example, having lower levels of education limits opportunities and increases economic vulnerability, so that less educated women are more vulnerable and more likely to be abused by their husbands, who are often more economically stable. Due to the norms of intergenerational marriage, in which wives often marry much older partners and defer them, women are likely to submit to male power and abuse (Oyediran et al., 2011). Infertility and lack of children are well entrenched as a major cause of IPV. Infertility also drives illegal recruitment of young girls to be surrogates in so-called baby factories, where they are forced into surrogate pregnancy, and the babies they bear are sold (Makinde et al., 2017a; Solanke et al., 2018).

10.4 IPV Interventions

The numerous negative health and social consequences on individuals, families, and the wider society have led policy makers, implementers, and civil society to seek ways to tackle the problem. These stakeholders recognize IPV as a serious concern, not just from a human rights perspective but also from social, economic, and health standpoints. This acknowledgment is evident in the number of programs implemented and the increasing level of resources earmarked for such program. For instance, the 2015 Violence Against Persons Prohibition (VAPP) Act is passed with the objective of eliminating all forms of violence in both the private and public spheres and includes the right of victims of violence to seek assistance (Federal Ministry of Women Affairs and Social Development [FMWASD], 2015).

Because of the governance structure that authorizes the autonomous state to legislate on concurrent issues as prescribed by the constitution, Nigerian states, including the Federal Capital Territory, are expected to integrate the VAPP within their statutes, and states have begun this integration. A number of states have also passed similar laws to address IPV, including the Gender-Based Violence (prohibition) Law in Ekiti State (2011) and the Prohibition Against Domestic Violence Law of Lagos, State Law No 15 (2007).

A number of civil society organizations (CSOs) and nongovernmental organizations (NGOs) address IPV by providing legal clinics, psychosocial services, shelters, and mental health therapy to IPV survivors. An important CSO in this field is the International Federation of Women Lawyers (FIDA), with affiliates in all 36 states and the Federal Capital Territory. This non-state actor operates through the state umbrella to provide prompt, effective representation for IPV survivors. The

FIDA state chapters collaborate with the federal and state ministries of justice, serving as an important resource for IPV survivors who lack the financial capacity to pay for representation.

Research has also identified the need to provide IPV survivors with medical service. Providers have begun receiving training on how to screen and identify survivors or women who are at risk of IPV during medical visits and antenatal visits (Fawole et al., 2019). Some IPV survivors also use social media, such as WhatsApp groups, to obtain information and mobilize support. There is a need to expand such initiatives and to make support and surveillance widely available.

Research on IPV interventions in Nigeria is sparse. Only one study has examined the effectiveness of these interventions. This study evaluated the effectiveness of counselling sessions for pregnant women identified as being in a dysfunctional family. During 3 biweekly interventions that coincided with their routine antenatal care, providers used the SOS-DoC counselling framework: offer *s*upport and assess safety; discuss *o*ptions; validate patient's *s*trengths; *do*cument observations, assessment, and plans; and offer *c*ontinuity (Stratton et al., 2010). The counselling emphasized encouraging women to take actions to reduce their own vulnerability. The results showed an improved family function score among the experimental group from 2.92 ± 0.92 to 2.16 ± 0.63 ($p < 0.0001$), and the control group score changed from 2.48 ± 0.73 to 2.29 ± 0.82 ($p = 0.116$) (Akor et al., 2019). This result implies that improving women's skills in communicating and handling conflicts could contribute to reducing the incidence of IPV. However, there is clearly a need for more research to show other interventions that can reduce IPV in the Nigerian context.

Though many of the studies on IPV have focused on women as victims, men also experience IPV. The root cause for women's violence in Nigeria is unclear. However, in a patriarchal context, women are more likely to become aggressors or perpetrators of IPV when their male partners cannot fulfill their responsibility as the provider of household needs. A number of men have died, were brutalized, or were maimed for life by their violent female partners. However, evidence on this phenomenon is limited in Nigeria. The small number of studies on the topic has had mixed results; some studies say such cases are rare, while others describe an epidemic of IPV against men (Dienye & Gbeneol, 2009; Oladepo et al., 2011, Ayodele, 2017). Dienye and Gbeneol (2009) conducted a retrospective medical record review of all the patients who were seen at the General Outpatient Department of the University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria, over a period of 5 years (2000–2005). They found an incidence of 22 male IPV victims per 100,000 cases examined. Another study in Oyo, Kaduna, and Enugu states found that 12% of male patients were physically abused by their partners and 7% were sexually abused (Oladepo et al., 2011). The underreporting of IPV among male victims is likely due to patriarchal norms (making men unwilling to acknowledge their abuse), stigmatization, and women's use of traditional norms to control their male victims (Ayodele, 2017).

There are no existing studies or known interventions on IPV among lesbian, gay, bisexual, transgender, and queer (LGBTQ) in Nigeria or in the overall West Africa

subregion of sub-Saharan Africa. This is likely due to social attitudes toward LGBTQ throughout the region.

The outbreak of Covid-19 early in 2020 has forced government to employ restrictive measures and lockdown to slow the transmission of the virus. The restrictive measures and lockdown, along with the accompanying disruption in social networks' financial and job insecurity, may contribute to relationship distress and the potential for IPV. The spike in domestic violence due to the spread of Covid-19 remains a concern to Nigerian policy makers and development partners. Emergency calls by women subjected to violence by their intimate partners tripled in a single month, according to the Lagos State Domestic and Sexual Violence Response Team (UN Women, 2020). United Nations data from 24 Nigerian states showed a spike in GBV incidents, from 346 in March to 794 in the first part of April 2020, an increase of over 100% in just 2 weeks of lockdown (UN Women, 2020). The situation in Nigeria reflects a trend faced by women in stable relationships across sub-Saharan Africa.

10.5 Challenges to Controlling IPV in Nigeria

The patriarchal norms and values that shape thinking and behavior in Nigeria remain an obstacle. However, global changes in norms and attitudes have implications for reducing the trends of IPV in most countries, including Nigeria—as seen as the national laws and policies prohibiting GBV at both national and state levels, which support the concept that IPV and other domestic iniquities are unacceptable. However, a recent setback to these achievements was the rejection of the Gender and Equal Opportunities Bill by the Nigerian Senate. The bill was rejected because cultural and religious arguments were used to oppose the content and context (Makinde et al., 2017b).

A major barrier to eliminating IPV is the fact that survivors of domestic violence often choose to maintain their marriages, rather than seek help. Such actions are driven by societal and cultural views of divorce, especially the negative views toward divorced women, as even justified divorces are seen as failures. As a result, Nigerian women are often willing to trade their physical, emotional, and mental well-being for the title and status associated with being a married woman.

10.6 Current Opportunities to Curtail IPV in Nigeria

Despite the continuing incidence of IPV in Nigeria, and of the culture that enables IPV, current legal and cultural trends—including the enactment of laws at the national and state levels and the increasing number of IPV activists and resources—represent growing opportunities to implement broad-based, culturally specific interventions to reduce IPV. Reporting of IPV has increased relative to past years, due to

increased awareness of the issue and the availability of champions working toward elimination of the epidemic. The evolution of enhanced legal frameworks suggests further possibilities, for example, the VAPP Act of 2015, which specifies essential financial, legal, medical, and psychosocial support services for IPV survivors. In addition, the Lagos State-funded Domestic and Sexual Violence Response Team provides legal, medical, emergency, and psychological assistance to victims of domestic violence. The Federal Ministry of Women Affairs and Social Development and a number of states provide hotlines for women experiencing IPV; and the Lagos State emergency unit indicates that they have "an immediate response team (ready to be) deployed to the scene."

International Federation of Women Lawyers' (FIDA) legal clinics and mediation centers offer psychological treatment and counselling support for both IPV survivors and perpetrators. The counselling procedure is designed to strengthen spousal communication to reduce tension and de-escalate stress. Since the culture of male dominance still exists, the counselling focuses on arbitration, mediation, and helping couples learn how to walk away from a disagreement, rather than resorting to violence.

Furthermore, the current integration of gender-based activities into training programs for physicians, nurses, and other health-care cadres by some NGOs in Nigeria offers opportunity to provide and/or expand the needed physical, emotional, psychological, and health-care services to victims (Fawole et al., 2019). This expanded focus on IPV also improves providers' readiness to screen clients for risk or experience of IPV. There is a consensus among policy makers and programmers that training for health-care providers on counselling and screening is an opportunity that should be expanded. Government actors at both national and state levels should explore options for expanding IPV service provision at all level of health-care delivery in Nigeria building on the progress made by the professional bodies and civil society organizations in improving the legal environment and policy framework.

Religious leaders could also serve as champions in eliminating IPV. Traditionally, conservative religious norms and values have fueled IPV among Nigerian couples. However, since nearly the whole population (98.6%) identifies with some form of organized religion (NPC Nigeria & ICF International, 2019), there is a large potential for religious groups to play a positive role in combatting IPV. Religion and religious leaders have substantial influence on the behavior and attitudes of adherents (Oyediran et al., 2020). Also religious leaders are commonly the first responders in cases where married couples disagree (Wahab & Odetokun, 2014). Creating a counselling unit within religious institutions like mosques and churches, with a trained cleric as a mediator, could support positive changes in communities' views about IPV.

10.7 Conclusion and Way Forward

In Nigeria, IPV is prevalent but grossly underreported and under-documented due to a culture of silence. IPV cases are often resolved locally through indigenous mediation processes at home, at the community level, through religious institutions, or by a third party, mostly clan heads or religious clerics, who are considered to be neutral. IPV is a major contributor to morbidity and mortality among women and girls due to injury, chronic pain, gastrointestinal and gynecological problems, depression, and post-traumatic stress disorder.

At present, the prevailing laxness about addressing IPV, both in government and society in general, represents a major barrier to the reduction of IPV. There is no doubt that IPV survivors, and interventions to reduce the IPV epidemic, face enormous challenges in Nigeria and will continue to do so. First, the culture of silence will continue to influence the perception of women affected by IPV, impeding the collection of data on the extent of the problem. Second, pervasive cultural norms of male dominance hinder implementation of existing policy and programmatic action plans including legal frameworks. For example, though laws and policies have been enacted at the national and subnational levels, they require an implementation framework. Further, ensuring enforcement of laws against domestic violence will require changes in perceptions of women among government officials, law enforcement officers, and the population at large. Law enforcement officers and responders should regard IPV cases as health and human rights issues, rather than as "family affairs" that should be settled out of court. Third, responders and service providers, especially medical providers, need better training on IPV to be able to provide necessary clinical and therapeutic treatment. Lastly, there is a need for action research using a participatory approach, with high community involvement, to address IPV in Nigeria.

Despite these enormous challenges, there are opportunities to address the menace of IPV and its associated gynecological, physical, and psychological consequences in Nigeria. Policies and laws at the national and state levels should serve as enabling environments for survivors and advocates to report cases of domestic violence to the appropriate constituted authorities. In addition, the VAPP and other state-level policies and legal frameworks have increased activities by CSOs and champions to create awareness and raise resources to prosecute cases of IPV.

As importantly, the commitment of policy makers through activities of state institutions and agencies can help ensure that existing policies and legal frameworks are enforced and that resources are available to support those who have experienced IPV. As an example, the wives of political officeholders, including the spouses of the president and state governors, have launched projects to address GBV and support gender equality in Nigeria. These interventions seek to create and advocate for female empowerment at several levels—by helping women to play more significant roles in management and the professions; gain political influence within elected and appointed positions; and participate equally in household decision-making. Leaders' wives themselves can be powerful champions, for instance, Mrs. Bisi

Adeleye-Fayemi, the wife of the Ekiti state governor is a national advocate and champion of women's empowerment.

10.7.1 Recommendations

Overall, reducing the menace of all forms of IPV in Nigeria will be a massive undertaking. A society such as Nigeria, characterized by patriarchal norms and values, will need enforcement of national and state laws as well as community-based interventions that address the intergenerational transfer of cultural norms that support the traditions of male dominance and gender inequality. Liberating communities from shackles of entrenched cultural norms and values (and reducing the incidence of IPV) will require a multi-pronged, couple-centered approach. The five actions listed below would help to address and reduce the IPV epidemic in Nigeria:

1. Improving the skills and capacity of health-care providers to identify women at risk and providing clinical services to survivors.
2. Improving the organization and coordination of civil society groups to strengthen linkages and referral of IPV survivors to services, including clinical and psychosocial treatment.
3. Capacity strengthening to increase awareness of and "legal literacy" on IPV for community groups including women, men, boys, and girls.
4. Using mainstream and social media to raise awareness about IPV and build the capacity of individuals and groups to act as advocates against violence.
5. Mainstreaming IPV into all social development interventions and using opportunities such as the GBV/HIV intersections Plan of Action by the National Agency for the Control of AIDS to advance awareness and prevention of IPV.

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Chapter 11
Intimate Partner Violence in Australia and Aotearoa New Zealand

Andrew Day, Stuart Ross, and Devon L. L. Polaschek

11.1 Introducing Ourselves

We were drawn to work together on this chapter primarily because of the opportunity that it provided for us to reflect on how intimate partner violence (IPV) prevention efforts have developed in our respective countries. What emerged, however, was a better understanding of our common interests and concerns around how violence can be best prevented and how much we still have to achieve in the countries in which we live and work.

I, Andrew, am a forensic psychologist by training who now works as an academic in the discipline of criminology in the University of Melbourne, Australia. My work has focused on the development and evaluation of interventions offered to those known to have perpetrated IPV. Over time, I have come to appreciate not only the importance of understanding the personal factors and drivers of violence that are so often the focus of prevention efforts but also the broader social and cultural context in which violence occurs – and is maintained over time. I have learned much from those who receive services – and from those who deliver them – about how the choices that are made on a daily basis are so often constrained by the circumstances in which IPV occurs as well, of course, as the persistence that is required to effect meaningful change in this area.

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I, Stuart, am a criminologist with a background in psychology and also works at the University of Melbourne, Australia. A central theme in my involvement in interpersonal violence has been the idea that reforms intended to address this problem need to be based on a foundation of accurate knowledge about its prevalence and distribution. My introduction to this subject came when I worked at the Australian Bureau of Statistics and was involved in the development of the first national survey to measure the extent of violence against women (the Women's Safety Survey, now run every 5 years in Australia as the Personal Safety Survey). In my subsequent academic career, I have maintained a strong interest in the way that policy reform, policing, and court interventions can help to reduce the level of IPV in the community and can improve responses to the needs of victim/survivors.

I, Devon, am a clinical psychologist and, from the beginning of my career, have specialized in working with people with persistent problems with criminal behavior. I started as a correctional psychologist, working with men in prison who were at high risk of future violence and very high risk of ongoing crime. Effective rehabilitation for these men has been a primary focus of my research and teaching since I became a full-time academic at Waikato University, Aotearoa New Zealand (NZ), in 1994. I began to recognize about 5 years ago that there was a need for more academic research in NZ on intimate partner, family, and whānau (the NZ Māori language term for family, referring to a more extended family structure) violence. Since that time, my graduate students and I have been studying people who perpetrate and experience these forms of violence.

11.2 Introduction

Recently, a range of IPV prevention policy and practice initiatives have been developed across both Australia and NZ. These include public education campaigns, legislative reform, and increased funding for a range of new services and programs in both countries which have contributed to much greater public awareness about both the prevalence and harms associated with IPV as well as other forms of domestic and family violence (Webster et al., 2018). In many ways, such developments have paralleled those that have occurred in other parts of world, with similar challenges facing those in both countries who work to prevent and respond to IPV. These challenges are discussed throughout this chapter, although our main aim in writing this chapter is to offer some wider context to how service delivery systems have developed in both Australia and NZ, to allow comparison with other countries, and to draw attention to the ways in which specific social and cultural factors shape IPV prevention responses. Accordingly, we start by providing an overview of both countries and summarizing current knowledge about prevalence, guiding legislation, and the main programs that are currently available.

11.3 Countries in Context

Even though Australia and NZ have much in common with one another, it is important to note from the outset that there are also distinctive jurisdictional and demographic differences that shape service delivery. Perhaps most significantly, Australia – with a population of 25 million people – is a much larger country, with a federal system whereby parliamentary authority for enacting legislation and the delivery of services can differ markedly across each of the seven states and territories. This means that while the federal government's *National Plan to Reduce Violence Against Women and Their Children 2010–2022* remains the principal policy document that coordinates the national response to prevention, most legal, law enforcement, and support service responses to IPV operate at the level of state and territory government. In contrast, NZ has a total population of around five million people, national legislation, a single criminal justice system, and no single document that currently guides government policy and practice. NZ does, however, have a longer history of addressing IPV as a major policy issue at a national level, with the first public education campaigns dating back to 1993 (Donovan & Vlais, 2005) and the government noticeably strengthening its commitment to reducing family violence in 2014: a commitment that has continued with successive governments.

An important point of difference between the two countries is that the indigenous people of NZ (Māori) represent a much larger proportion (16.5%) of the population than those (Aboriginal and Torres Strait Islander peoples) in Australia (3.3%). This is significant in relation to the NZ Treaty of Waitangi – an agreement made between a number of Māori chiefs and the British Crown in 1840 – which contains important principles concerning Crown obligations to Māori that are used to guide government policy and practice. For example, responses to IPV in NZ are typically embedded in a wider approach to reducing harm to family members and whānau (an extended family or community of related families who live together in the same area) than in Australia where the focus has largely been on preventing IPV.

11.4 Prevalence

The Australian component of the International Violence Against Women Survey (Mouzos & Makkai, 2004) and three national Personal Safety Surveys (Australian Bureau of Statistics; ABS, 2005, 2012, 2016) provide the most commonly cited Australian incidence and prevalence data. The results of the most recent Personal Safety Survey (ABS, 2016) reveal that approximately 1 in 4 women (23% or 2.2 million people) and 1 in 13 men (8% or 703,700) self-report experiencing violence from an intimate partner at some point in their life. One in 6 women (16% or 1.5 million) and 1 in 17 men (6% or 528,800) reported that they had experienced *physical violence*, with women eight times more likely to have reported sexual violence

by a partner than men. In the previous 12-month period, 1.7% of women and 0.4% of men self-reported an incident. These rates are comparable with those in NZ where the primary measure of IPV is derived from the New Zealand Crime and Victims Survey (NZCVS, Ministry of Justice [New Zealand]). The 2018–2019 survey reported similar lifetime prevalence rates to Australia (22% for women, 9% for men), with higher rates for bisexual (37%) and gay/lesbian (33%) people. The 2017–2018 NZCVS also reported 12-month IPV prevalence estimates of 1.7% for women and 0.5% for men. Although survey data is thought to underestimate the true extent of IPV (Heward-Belle, 2018), these figures nonetheless provide some indication of the size of the issue in Australia and NZ and draw particular attention to the level of harm that is likely to result. The New Zealand Violence Against Women Study, for example, has reported that half of IPV victims have been injured at least once in their lifetime (Fanslow & Robinson, 2011).

11.5 Impact of IPV

The negative impact of IPV on a range of health outcomes is well established, with IPV known to contribute to poor quality of life, chronic mental health issues, and increased use of health services and medication (e.g., Hegarty et al., 2013). In addition, there is evidence that IPV has direct and indirect impacts on employment and productivity, housing, and homelessness, as well as contributes to the systemic costs associated with justice and law enforcement responses (KPMG Management Consulting, 2009). NZ data suggest that of those victimized by IPV in the previous 12 months, around half (51%) will report anxiety, panic attacks, or depression as a consequence (NZCVS Y2 core report). In addition, one in four occurrences of family violence (i.e., aggregated across all relationship types) led to injury, with medical attention sought in 12% of incidents. The estimated economic costs in 2014 of IPV victimization in NZ, depending on the prevalence rates used in the model, were between NZ$2.7 and NZ$5.4 billion (Kahui & Snively, 2014), with estimated costs to employers in lost productivity in the year to June 2014 in the range of NZ$368 million (Kahui et al., 2014). Webster (2016) has estimated that IPV contributes around 5% to the disease burden of all Australian women aged 18–44 years and just over 2% of the burden in women of all ages. It is also the third leading risk factor for death for Australian women aged 25–44 years (AIHW, 2019).

11.6 Guiding Legislation

Since the 1980s, the primary statutory and legal mechanism that provides for the immediate and future safety for victims of IPV in Australia has been *civil domestic violence protection orders*. Referred to variously as “restraining,” “family violence,”

"intervention," "protection," or "apprehended violence" orders, these can be applied for by the victim (or by police on behalf of the victim) to protect against future violence by an intimate partner (Women's Legal Service Tasmania, 2020). Such orders also consider the safety of children and, in most jurisdictions, include a mandatory condition that prohibits (or allows only conditional access to) firearms. There is also the provision for magistrates to make perpetrator exclusion orders to enable women and children to remain safely in their homes – although Breckenridge et al. (2015) have reported that these are rarely used.

With regard to those behaviors that constitute criminal offenses, it is important to note that legal definitions vary between the federal jurisdiction and the states and territories. An example of this is the legal response to incidents of coercive control. At the federal level, for example, the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) contains a broad definition of family violence which includes coercive and controlling behavior, whereas at the state and territory level, criminal offences such as assault, damage to property, and stalking are not included in the scope of behaviors that are captured by coercion and control orders. In addition, these latter offenses are defined by single incidents and thus fail to capture patterns of coercion and control that can be associated with IPV.

NZ introduced similar legislation in 1982. The most recent legislation is the *Family Violence Act 2018*, which, along with other law changes made at the same time, broadened the types of violence that are grounds for making a protection order, included new offences (e.g., strangulation), changed bail decision-making, enhanced provisions for victims to have their statements recorded on video at the scene of the event, led to the labeling of convictions as family violence, improved information sharing between agencies, and required responses for Māori to reflect traditional values and practices. The *Domestic Violence-Victims' Protection Act 2018* also introduced the right for victims of IPV and other family violence to take up to 10 days' leave a year and made provision for short-term flexible working arrangements for victims of IPV.

11.7 Services and Programs

Specialized services for women and children experiencing IPV first became available in Australia in the mid-1970s when women's refuges were established to provide crisis accommodation and counseling. They were founded on a feminist understanding of violence against women and relied on voluntary funding and support and collective organizational arrangements. The period since can be characterized by a steadily increasing role of state and federal government in policy, funding, and service delivery and a continued focus on tertiary (crisis) responses to IPV. Some of the key national initiatives have been the establishment of the Office for the Status of Women (in 1983), the Partnerships Against Domestic Violence (PADV) initiative (in 1997), the Women's Safety Agenda in July 2005, and the National Plan

to Reduce Violence Against Women and Their Children – endorsed by the Council of Australian Governments in February 2011 (Phillips et al., 2015). State government responses have tended to focus on reforms to child protection and homelessness services (Phillips et al., 2015), as well as law enforcement and judicial system reforms, including mandatory arrest policies, specialist policing and codes of practice (Diemer et al., 2017), and access to protection orders and specialized domestic violence courts (Murray & Powell, 2009). The mid-late 1980s and early 1990s also saw a dramatic growth in the availability of men's behavior change programs. These were originally provided by nongovernment agencies but increasingly through service contracts with state government departments. These programs typically involve between 12 and 24 rolling group work sessions which follow an individual assessment, with partner engagement and support also offered. For example, the Queensland Professional Practice Standards stipulate a minimum program length of 32 h, with most programs around 32–40 h duration spread over 13–16 weeks (see Day et al., 2018).

In contrast to the explicitly gendered approach to IPV service delivery in Australia (e.g., perpetrator programs are often called "*men's* programs" in Australia), the NZ government approach is less explicit about the assumed gender of aggressors and focuses on family/whānau violence, with no exclusive approach to IPV. Most service and program provision comes from community-based nongovernmental organizations (NGOs) with very similar historical roots to those described in Australia (i.e., 1980s women's refuges, pro-feminist men's movements), reflected in the national network of family violence services *Te Kupenga Whakaoti Mahi Patunga* which originates from men's stopping violence services. Specialist NGOs are contracted by the Ministry of Justice to provide most of the programs and services for IPV, particularly in association with the granting of protection orders. The New Zealand Ministry of Justice (NZMOJ) closely monitors program standards for their contracted providers. They have adopted a code of practice rather than a highly prescriptive approach, which has allowed diversity of service development, including a number of Kaupapa Māori (indigenous) providers. Agencies may contract to provide programs for men, women, or children and for perpetrators or victims, but attendance is only mandated for perpetrators on correctional sentences or respondents of protection orders. Programs may be individually based or provided to groups. The Ministry of Social Development also provides a small amount of funding for providers to work with perpetrators (sometimes women) referred through other pathways, such as self-referrals or child protection, but is more involved in community prevention frameworks including partnerships with Māori and Pasifika.

Two distinct coordinated crisis response models for family violence have been running in pilot forms in NZ since 2016, based mainly around police calls for service. The Integrated Safety Response (ISR) brings together representatives from all relevant government departments and NGO providers to triage recent police calls for service and refer them onto suitable Kaupapa Māori or family violence services, based on assessed risk and need. An alternative initiative, Whāngaia Ngā Pā

Harakeke, is a partnership between police and iwi (a Māori language word meaning "people" or "nation," which is often translated as "tribe" or "a confederation of tribes") who work alongside NGOs and other relevant government departments. In both pilots, aggressors and victims can be referred for help even though in perhaps two-thirds of calls, no criminal offence is detected. Help provided through this referral pathway is quite diverse but is mainly individually based. There are early indications that both approaches are having positive effects (Mossman et al., 2019; Walton & Brookes, 2019).

11.8 Challenges and Opportunities

In both Australia and NZ, the prevention of IPV is an area that has evolved over time, with legislative reform, policy and regulation measures, and funding initiatives subject to continual amendment and review. Momentum for change does, however, vary – with bursts of activity often followed by some hiatus and loss of progress. In this section, we identify three challenges facing the sectors in both countries: workforce development; responding to diversity; and program evaluation and standard setting. This list is by no means exhaustive, as many other challenges – and associated opportunities – are faced by providers. For example, a particular issue arises in Australia where the federal system leads to problems in relation to the cross-boundary enforcement of protection orders because women cannot be automatically assured that their order will be enforceable across state and territory boundaries without going through a formal application or court process (Heward-Belle, 2018).

11.8.1 Workforce Development

A lack of a sufficiently sized and skilled workforce of practitioners qualified to provide programs that respond to IPV is a major constraint on service delivery. As such, an important issue going forward is practitioner training. There is very little foundational training for practitioners available in either Australia or NZ, although specialist graduate certificates are now slowly being introduced that aim to equip practitioners with the skills to work competently and safely with those who perpetrate IPV. Such qualifications are limited in their capacity to offer training to the wide range of practitioners who have a role to play in prevention, and recruiting sufficient skilled staff is an ongoing challenge (e.g., Paulin et al., 2018). Significant national support for knowledge transfer and exchange in policy and practice is, however, provided by Australia's National Research Organisation for Women's Safety Limited (ANROWS) in Australia and by the New Zealand Family Violence Clearinghouse, based at the University of Auckland.

11.8.2 Responding to Diversity

The impact of IPV is especially severe in indigenous communities, with indigenous Australian women as many as 35 times more likely to sustain serious injury and require hospitalization than non-indigenous women as a result of IPV and more likely to require emergency or refuge accommodation (Morgan & Chadwick, 2009). There is a clear need to develop culturally based services. In addition, refugees and migrant groups have been identified as particularly unlikely to seek help or report IPV and to require specialist support when they do report (Simon-Kumar, 2019). These programs are slowly becoming more available in Australia, although some are still in the concept or development phase (Fisher et al., 2020; Putt et al., 2017). In NZ, Māori are also at increased risk of IPV victimization (NZCVS, 2018). Māori- and Pasifika-led approaches focus more explicitly on building well-being and share the goals of restoring traditional cultural beliefs, values, and practices regarding family and community life that should protect against violence, using processes that are themselves part of the culture (e.g., Fa'alau & Wilson, 2020). Indigenous programs often share a recognition that the experience of IPV is in no small part due to a combination of as follows: (a) multigenerational trauma resulting from the active suppression and destruction of culture that is the process of colonization – resulting in "loss of cultural identity, isolated and fragmented family systems, weakened traditional mechanisms for support, loss of land, language and self-determination" (Dobbs & Eruera, 2014; p. 23) – and (b) the imposition or adoption by peoples that formerly revered and respected women of colonizing western belief systems that denigrate them (see also Stubbs & Wangmann, 2017).

The challenges in delivering services to diverse rural and geographically remote areas in Australia are also obvious. To illustrate, the largest Australian state, Western Australia, while having a population of only 2.3 million people, covers a geographical area of nearly one million square miles (roughly twice the size of Western Europe). While the majority (75%) of the Western Australian population reside within one metropolitan area (the city of Perth), IPV services have to be provided across the entire state, including to remote areas.

With regard to sexual and gender diversity, there are still few specialist providers of IPV services. The emphasis from support organizations to date has largely been on advising "mainstream" providers on how to meet the needs of members of the Rainbow Community (e.g., Dickson, 2016; see kahukura.co.nz), although this area is now receiving some attention (Gray et al., 2020). Similarly, the service needs of women with disability are also being increasingly explored (Maher et al., 2018).

11.8.3 Evaluation and Standards of Practice

There is clearly much work to be done in the area of evaluation and quality assurance in service delivery in IPV services and programs. Despite widespread recognition of the need for more robust evaluation, very little data on outcomes are available

in both countries – a number of qualitative, service user, and provider evaluations have been undertaken, but methodologically strong evaluations of intervention effects are largely absent. This is, in part, because of difficulties with accessing necessary data and in part due to the substantive ethical and practical challenges involved with this type of work (see Paulin et al., 2018; Walton & Brookes, 2019).

The lack of robust evidence base for practice creates particular challenges in setting standards of practice for the sector. A lack of compelling empirical evidence to suggest that any one type of intervention is more effective than any other has, for example, led to a lack of consistency in service delivery in Australia (Mackay et al., 2015), although work in this area is underway (Day et al., 2018).

11.9 Next Steps

Even though IPV (and family violence more generally) can be viewed as a significant public health and criminal justice problem, government responses have typically not provided the level of resourcing that is commensurate with the level of need, and it is often the community or nongovernment sector that provides the most impetus for service reform. Both Australia and New Zealand are at a point where their respective governments are, however, more committed to preventing IPV than ever before, and the next step is to move current interventions beyond crisis responses to target primary, secondary, and tertiary levels of prevention. Addressing the challenges associated with workforce development, diversity, and the evidence base for service delivery will be essential if integrated prevention programs are to be developed that adequately respond to the complexity of the issue.

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Chapter 12
Intimate Partner Violence in the United States

Chelsea M. Spencer

12.1 Introduction to the Author

I am a research assistant professor in the couple and family therapy program at Kansas State University. I have lived my life in the state of Kansas in the United States (US). While working on my Ph.D., I was advised and mentored by Dr. Sandra Stith. I worked with Dr. Stith on many different projects related to prevention and intervention of intimate partner violence (IPV). Since receiving my Ph.D., I have continued this work. My research has primarily focused on risk assessment for physical IPV and intimate partner homicide, as well as sexual violence. I believe that my work on risk assessment can aid helping professionals, such as therapists, in assessing for potential violence or highlighting areas of intervention when violence or IPV is present. My goal is to help survivors of violence heal, as well as to prevent IPV and sexual violence. Additionally, I am a licensed marriage and family therapist. I primarily work with individuals who have experienced trauma, with a portion of my work focusing on helping victims of IPV and sexual violence heal. When I was working on my Ph.D., I led a support groups at the local women's shelter, which was an experience that helped increase my passion for the work that I do aimed to prevent or intervene in cases of IPV.

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12.2 United States (US) Overview

Approximately 325 million people live in the United States. The majority of people living in the United States identify as non-Hispanic White (60.1% in 2019), followed by Hispanic or Latino (18.5%), Black or African American (13.4%), Asian (5.9%), two or more races (2.8%), Native American/Alaska Natives (1.3%), and Native Hawaiians/Pacific Islanders (0.2%). As of 2019, approximately 65% of the population identified as Christian (43% Protestant, 20% Catholic, 2% Mormon), and 26% identified as nonreligious, with others identified with other faiths, such as Judaism, Buddhism, or Islam (Pew Research Center, 2019). Approximately 57 million individuals reside in rural areas, and approximately 270 million individuals reside in urban areas.

The United States has a rich and diverse economy with a GDP of 20 trillion dollars; however, income inequality has increased significantly since the 1970s. Despite the wealth of the United States, in 2019, approximately 34 million people lived in poverty, which is approximately 10.5% of the population (Semega et al., 2020). It is important to note that the threshold to be considered living in poverty in 2020 is $12,760 for a single individual or $26,200 for a family of four (Federal Register, 2020).

The United States is a representative democracy. Currently, the United States faces many difficulties and challenges regarding the political climate of the country. The United States is divided on many political issues and remains divided into two primary political parties: Republicans (conservative) and Democrats (liberal). There are widely differing worldviews among citizens of the United States, making it difficult to summarize values and ideologies for the entire population. However, the dominant culture in the United States is highly individualistic, upholds patriarchal values, and places importance on individual success, competition, and achievement.

12.3 Intimate Partner Violence in the United States

Approximately one in four women and one in seven men in the US report experiencing physical IPV in their lifetimes (Breiding et al., 2014). IPV victimization has been linked to negative mental and physical health outcomes (Campbell et al., 2002; Spencer et al., 2017). In the early 1970s, the battered women's movement in the United States began advocating for resources for abused women, and since this time, access to domestic violence hotlines and shelters has increased throughout the United States (Dugan et al., 2003). The battered women's movement sought to change aspects of the US culture that contributed to the abuse of women, including traditional gender roles/beliefs, economic inequalities between men and women, and the criminal justice system that did not hold perpetrators of IPV accountable. This movement paved the way for the progress made on the quest to end IPV and provide resources and supports for victims of IPV.

Due to the hard work that took place in the 1970s and 1980s, legislative gains were made for women and victims of IPV in the 1990s. In 1990, stalking was first identified as a crime in California, and other states followed, with 49 states having anti-stalking laws as of 1996 (National Institute of Justice, 1996). Additionally, in 1990, Concurrent Resolution 172 was passed by Congress, where judges were required to determine if there has been IPV in the relationship when determining child custody. In 1994, IPV was deemed a national crime due to the passing of the Violence Against Women Act. The 1994 Violence Against Women Act also provided funding for victim services and led to the creation of the Office on Violence Against Women, which is located in the Department of Justice. The Violence Against Women Act was reauthorized by the government in 2000, 2005, and 2013. However, the Violence Against Women Act expired in September of 2018, although it was given an extension until February of 2019. However, as of 2020, the Violence Against Women Act remains expired and has not been reauthorized. However, funding to shelters from the Act has been authorized since the act expired.

12.4 Challenges and Issues in IPV Services in the United States

A growing body of research has focused on understanding risk markers for IPV perpetration and victimization (Spencer et al., 2019, 2020). Although research has sought to further understand factors associated with IPV, there has been limited funding for randomized control trials for interventions to reduce rates of IPV in the United States. In the United States, the most common interventions for IPV include shelter or victim services for women and batterer intervention programs (BIPs) for men (Holmgren et al., 2015). Typically, BIPs are group interventions for male perpetrators of IPV that focus on cognitive awareness of power and control tactics (Johnson & Kanzler, 1993). Although BIPs are mandated in most US states, research on the effectiveness of these programs continues to be discouraging. The current mandated treatment of IPV in the United States may be ineffective in truly reducing rates of recidivism, leading this to be one of the current issues in the United States with regard to IPV (Babcock et al., 2004; Arias et al., 2013). There has been a lack of funding to examine possible treatment modalities other than BIPs. Evidence suggests that a "one size fits all" approach of mandated BIPs does not show promising results. It may be useful to research different types of interventions or combinations of other interventions along with attending a BIP, such as individual therapy, couples' treatment (if the couple has decided to stay together and the violence is not severe or used to dominate and control the partner), or addictions counseling.

Another issue, which is especially important in the United States, is the constitutional right of US citizens to have access to firearms. A recent meta-analytic study found that if an abuser has direct access to a firearm (e.g., having a gun in the home), it increases the likelihood of an intimate partner homicide by over 1000% (Spencer

& Stith, 2020). According to 18 U.S.C. § 922(g) (9), an individual who has been convicted of a misdemeanor level crime of domestic violence is prohibited from possessing, shipping, transporting, or receiving ammunition or firearms. However, since many cases of IPV are not being prosecuted and many firearms in the United States are not registered, access to firearms leads to an increased likelihood of an intimate partner homicide. In addition to a lack of prosecution in IPV cases, there is a "boyfriend loophole" in the current legislation where a perpetrator who is not married to, does not live with, or does not have children with the victim can forego surrendering their firearms. There is a provision in the 2019 Violence Against Women Act to combat/close the "boyfriend loophole." However, this act has not been reauthorized as of 2020.

Currently, gun violence research in the United States is substantially underfunded and understudied, even though the United States has the highest rate of gun-related deaths among industrialized countries, with more than 30,000 gun-related deaths annually (Stark & Shah 2017). Increased funding for ways to reduce gun violence, especially intimate partner homicide, and also increased funding for randomized control trials for interventions designed to decrease IPV recidivism rates are of special importance in the United States. Gun control is a current political issue in the United States, and it is important to reduce abusers' access to firearms.

Another challenge noted in the United States, which may also be relevant to other countries as well, is reducing barriers for victims of IPV to receive formal services to help end the violence and aid in their healing process. A systematic review focusing on barriers to formal help seeking for adult victims of IPV in the United States found that the most frequently cited barriers included a lack of awareness of resources, lack of accessibility to resources (e.g., living in a rural location, not speaking English), fear of negative consequences, immigration status, lack of personal resources, and personal barriers (e.g., embarrassment or self-blame for the abuse; Robinson et al., 2020). Several of these barriers could be addressed in the United States to help victims of IPV receive needed resources.

12.5 Cultural Considerations

When examining barriers and challenges related to IPV services, it is imperative to take culture and aspects of one's identity into consideration. When looking at the intersection between race and gender, in the United States, Black and Native American/Alaskan Native women are disproportionately impacted by IPV compared to White women. For example, 56% of Native American/Alaskan Native women and 40.9% of Black women have experienced physical IPV victimization in their lifetime, compared to 31.7% of White women (Black et al., 2011; Rosay, 2016). Additionally, Black and Native American/Alaskan Native women face additional barriers in regard to reporting IPV or seeking services/resources. Native American/Alaskan Native women may experience a lack of response from law enforcement and a lack of services and interventions specifically targeted to Native

American/Alaskan Native populations, and there may be cultural considerations that reduce the likelihood of reporting IPV (Crossland et al., 2013; Hamby, 2008; Ned-Sunnyboy, 2008). For Black women, there may be a distrust of law enforcement, a need to preserve/protect the family unity, as well as systemic barriers that include a lack of viable resources or knowledge of potential resources (Kelly et al., 2020). Culturally informed services and resources are necessary. Although it may not be possible, building trust between law enforcement and victims of IPV who are racial minorities is a key challenge to overcome in order to protect victims of IPV.

Another key consideration when looking at ways to combat IPV in the United States is sexual orientation. It has been noted that "domestic violence programs and shelters are often unprepared to deal with victims of same-sex IPV" (Carvalho et al., 2011, p. 502). There is a lack of shelters and resources for male victims of IPV, whether or not they are in same-sex relationships. Additionally, women in same-sex relationships also experience a lack of safe survivor spaces (e.g., support groups, shelters) because there may be a fear that their perpetrator could infiltrate the seemingly safe survivor spaces (Harden et al., 2020). Additionally, individuals in same-sex relationships face additional barriers to access resources or report IPV. Some examples of unique barriers include fear being "outed" by their abuser or through the process of reporting, fear of how law enforcement will react/if they will take it seriously, and fear of contributing to heterosexism (Harden et al., 2020; Robinson et al., 2020). Increasing safety for individuals in same-sex relationships when reporting IPV or seeking resources is a challenge that needs to be addressed in the United States.

Although this section highlights cultural challenges related to racial/ethnic minorities and individuals in same-sex relationships, there are additional cultural and demographic factors that need to be considered in regard to preventing and intervening in cases of IPV. These include, but are not limited to, citizenship status, religious background, gender identity, socioeconomic status, ability status, and language. These aspects of identity may create additional barriers for victims to come forward to report IPV or to seek resources/services after experiencing IPV. Creating resources that take into account multifaceted identities, and how there may be systemic barriers present, is needed.

12.6 Conclusion

Just as in the rest of the world, IPV is a serious issue in the United States. The battered women's movement of the 1970s paved the way for anti-domestic violence legislation, but there is still considerable work to be done in the United States to prevent and intervene in cases of IPV. In the United States, future consideration should be paid to testing intervention strategies beyond BIPs or in conjunction to BIPs. Additionally, ensuring that 18 U.S.C. § 922(g) (9) is followed in order to remove access to guns from perpetrators of IPV (whether they are married to or dating the victim) to aid in decreasing the likelihood of an intimate partner homicide is

needed. Currently there are barriers for victims of IPV to receive services, and working to eliminate those barriers is a necessary move forward. Due to the diversity of the United States, cultural considerations such as race/ethnicity, immigration status, and sexual orientation, among other aspects of identity, need to be considered when providing services and resources to victims of IPV. Finally, at the time this book chapter was written in 2020, the Violence Against Women Act remains expired and has not been reauthorized. Future reauthorization of this act could also aid in helping victims of IPV in the United States.

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Chapter 13
A Review of International Perspectives on Intimate Partner Violence

Sandra M. Stith and Chelsea M. Spencer

Throughout this brief, we found that the authors from most countries reported similar challenges and opportunities. The challenge between focusing on gender and focusing on family highlighted by the authors from Colombia seems to be a thread across volumes. In addition, a challenge highlighted by almost every author is the discrepancy between services available in urban and rural areas. Whereas excellent services may exist in metropolitan areas, in many cases, there are no services for rural communities or for victims or offenders who do not speak the primary language of the country. Another challenge mentioned by most authors is a challenge of underreporting by women victims. This challenge is exaggerated in countries with male-dominated cultures, such as Nigeria and other sub-Saharan African countries. Related to this challenge is the challenge of developing ways to make information about services available to everyone to encourage victims to seek help. We also found a few unique challenges, resources, and policy implementations among various countries. We highlight some of these unique situations here.

13.1 Unique Challenges

13.1.1 Colombia

The authors of Chap. 7 explained that in Colombia, laws and social policies divide violence that most scholars identify as intimate partner violence (IPV) into two groups. One group focuses on gender-based violence (GBV), or violence based on

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gender inequality perpetrated by a male to a female. Agencies working from a GBV perspective do not offer services for perpetrators or for couples who want to stay together. Instead, they focus their efforts on empowering women by offering services such as empowerment workshops and legal advice, as well as by referring women to mental health services. They also have shelters available for women and their children. Family commissaries work from an IPV perspective and offer legal mediation and refer couples to therapy. They encourage families to stay together and work on their issues. Family commissaries also offer shelters, depending on the evaluation of the case. They encourage mediation, reconciliation, and family therapy first. Each of the services is important in reducing or eliminating IPV. People are not necessarily referred to agencies working from a GBV perspective or to family commissaries; they access these organizations themselves through 24-hr phone lines or by making appointments. In most cases, people contact family commissaries when, in addition to IPV, there is violence against children or other family members, as well as issues related to fathers not providing economic support for their children.

We believe that if services are tailored to the needs and desires of individuals experiencing different types of violence, staff working at these differing agencies need to collaborate and clearly assess the specific issue being presented. The authors of Chap. 7 have published their thoughts on this issue, "In our view of current policies on IPV, there is a need for more specific guidelines on how to intervene when coercion and control are present (or absent), and when violence is primarily unidirectional or bidirectional" (Jaramillo-Sierra & Ripoll-Núñez, 2018). The divided services provide unique challenges in Colombia.

13.1.2 Finland

A second unique issue was described by the authors of Chap. 8, discussing IPV in Finland. Gracia and Merlo (2016) identified the "Nordic Paradox" as being unique in Nordic countries. Finland has one of the highest rates of gender equality in Europe. In fact, Finland was the first country in the world to have universal and equal voting rights for men and women in the parliamentary elections in 1907. Finland also has one of the highest rates of IPV in Europe. This paradox is perplexing to us. One theory identified by Gracia and Merlo (2016) is that there is a backlash effect as traditional definitions of manhood and womanhood are challenged. Another theory is that people are more comfortable reporting IPV because of the high levels of gender equity. However, the survey of the European Union Agency for Fundamental Rights (FRA, 2014) showed lower levels of disclosure of IPV to the police in Nordic countries as compared to other EU countries. One possible explanation for the Nordic paradox is that the higher levels of economic development and gender equality are associated with stronger gender differentiation in

preferences. Thus, the gender equality index is not measuring gender equality accurately (Falk & Hermle, 2018). Of course, more research is needed to understand this paradox.

13.1.3 United States

An important challenge in the United States (US) is the availability of firearms. The United States has the highest rate of gun-related deaths among industrialized countries, with more than 30,000 gun-related deaths annually (Stark & Shah, 2017). A recent meta-analytic study found that if an abuser has direct access to a firearm (e.g., having a gun in the home), it increases the likelihood of an intimate partner homicide by over 1000% (Spencer & Stith, 2020). While the United States has enacted laws requiring offenders to remove firearms from their homes, many firearms are not registered and, therefore, not removed from the home.

13.1.4 China

Two primary challenges were highlighted in Chap. 5. The authors highlight the unprecedented growth of women's domestic violence activism and women's NGOs in China, especially after the fourth UN World Conference on Women in 1995. These NGOs have been active in empowering women by informing, educating, and training women about their rights. In 2015, the Chinese parliament passed its first domestic violence law. However, the authors point out the two potentially conflicting objectives of the law: (1) to stop and prevent domestic violence and (2) to promote family harmony and social stability. There is no mandatory treatment for batterers, but couples are encouraged to meet with an informal mediator to help them resolve their issues. A conflicting issue appears to be present in China. Is the focus on family harmony and maintaining marriages or is it on ending violence and supporting women's ability to safely leave violent marriages?

The second challenge the authors highlighted was that despite China having the largest population in the world, in 2009 less than 20 women's shelters were available for victims, and they are mostly underutilized due to a limitation of allowable length of the stay and traditional beliefs of keeping "family face" (Tam et al., 2012). Based on Tam and their colleagues' research, they reported that the length of allowable stay ranges from 3 days to a week. Survivors also worry where they can go after the stay in the emergency shelter since a longer-term shelter is not provided (Tam et al., 2012).

13.1.5 New Zealand

The editors of this brief (Stith and Spencer) are both from the United States. We were surprised at the unique issue present in New Zealand (NZ). The indigenous people of NZ (Māori) represent 16.5% of the population. This is significant in relation to the NZ Treaty of Waitangi—an agreement made between a number of Māori chiefs and the British Crown in 1840—which contains important principles concerning Crown obligations to Māori that are used to guide government policy and practice. While both Australia and NZ have clear laws and regulations designed to prevent IPV, the laws in NZ require any responses for Māori to reflect traditional values and practices. We recognize that the respect and honor given to a treaty from 1840 present a unique situation in NZ and possibly in other countries. The authors of this chapter also emphasized the importance of programs for indigenous peoples. They highlight that the experience of IPV is partially due to multigenerational trauma resulting from the active destruction of culture—resulting in "loss of cultural identity, isolated and fragmented family systems, weakened traditional mechanisms for support, loss of land, language and self-determination" (Dobbs & Eruera, 2014; p. 23)—as well as the imposition or adoption by peoples that formerly revered and respected women of colonizing western belief systems that denigrate them (see also Stubbs & Wangmann, 2017). The authors have clearly highlighted the importance of respecting Māori culture and made us think about how other countries, like the United States, are addressing indigenous people's needs.

13.2 Unique Resources

India stands out for having many creative and original resources at the state or local level to prevent IPV. Two of the resources, which stood out to us, were Nari Adalats (women's courts) and Bell Bajao. Women's courts are designed to involve local women from the community to staff courts. The women receive basic legal information about women's rights, divorce, marriage customs, dowry, child marriage, and property issues (Kethineni et al., 2016).The idea is that victims of IPV will feel more safe seeking legal help from women. Bell Bajao (Ring a Bell), a nationwide community and media campaign against IPV, was launched in 2008. It targets men and boys as proactive bystanders to intervene and halt domestic violence incidents in their vicinity by ringing the household's bell when they witness a couple fighting. An evaluation study conducted in three states demonstrated that the campaign effectively transformed bystanders' response to abuse, both at home and in the community (Breakthrough, 2013). Other programs are designed for specific ethnic groups or rural communities.

In the UK**,** the Women's Aid Federation is one of a group of charities that provides safety, assistance, and support to women and children. There are four main federations for each nation in the UK (Women's Aid Charity, England, 2020).

Shelters are available in all UK counties, and many in metropolitan reflect the needs of women and children from different cultural and ethnic groups.

In Turkey, families are highly valued, and it is a difficult decision to leave a marriage, which explains why 92% of women who have experienced physical or sexual violence from their partner do not consult any governmental or nongovernmental organization (Şener Bozkurt, 2010). There are 143 shelters in Turkey with a total capacity of 3444 habitants. Women can stay at the shelter with their children for up to 6 months and may request an extension (Ministry of Labor, Social Services and Family, 2019). Additionally, when a victim of IPV seeks help, the ministry agreed to pay a 4-month or a 2-month fee for childcare based on the working status of the victim.

In **Finland**, the Psychotherapy Training and Research Centre at the University of Jyväskylä in cooperation with several social and health-care service has been conducting and researching treatment for offenders and for couples who want to stay together for many years. It is clear that in Finland, the response to IPV goes beyond shelters and criminal charges, to making a difference in providing treatment. The male offender group treatment, which has been conducted and studied for more than 20 years, focuses on security, violence, choices, feelings of guilt, and masculine identity (Holma et al., 2006). The Jyväskylä research project on couple therapy for IPV was conducted within a cooperative multicenter research network (Vall et al., 2018). Therapists try to empower marginalized voices and give voice to the female client while acknowledging the male client at the same time. Moreover, violent behavior, responsibility, parenthood, and client satisfaction emerged as crucial topics.

In **Nigeria**, which also highly values family, the International Federation of Women Lawyers (FIDA), with affiliates in all 36 states and the Federal Capital Territory, provides prompt, effective representation for IPV survivors. The FIDA state chapters collaborate with the federal and state ministries of justice, serving as an important resource for IPV survivors who lack the financial capacity to pay for representation. The concept of having female lawyers supporting female IPV victims makes a lot of sense.

In **Australia**, the mid-late 1980s and early 1990s also saw a dramatic growth in the availability of men's behavior change programs. These programs typically involve between 12 and 24 rolling group work sessions, which follow an individual assessment, with partner engagement and support.

In **New Zealand**, treatment of offenders is less explicit about the assumed gender of aggressors and focuses on family/whānau violence. The New Zealand Ministry of Justice (NZMOJ) closely monitors program standards for their contracted providers. They have adopted a code of practice rather than a highly prescriptive approach, which has allowed diversity of service development, including a number of Kaupapa Māori (indigenous) providers. Agencies may contract to provide programs for men, women, or children and for perpetrators or victims, but attendance is only mandated for perpetrators on correctional sentences or respondents of protection orders.

While in many ways**,** Russia has a long way to go in order to eliminate IPV, we were impressed that progressive representatives of the Russian Orthodox Church are taking an active stand on the movement against domestic violence and developing an approach aimed at encouraging zero tolerance attitudes toward violence in Christian families. In many of the countries represented in this brief, the faith community can be an important resource. When leaders of a religious community take an active stand on eliminating IPV, a big difference can be made.

13.3 Laws and Policies

Throughout the book, it is clear that there is great variation regarding laws and policies criminalizing IPV, as well as providing protection to victims. For example, **Russia** currently does not have any law officially criminalizing IPV. Although physical IPV resulting in bodily harm could be prosecuted, it would not be prosecuted as IPV (it would be charged as a crime regardless of relationship status). Additionally, emotional abuse, economic abuse, stalking, and harassment are not punishable under Russia's current criminal code. For many other countries examined in this brief, legislation protecting women from violence and holding perpetrators accountable began in the 1990s. Colombia passed the new constitution in 1991, which initiated a series of regulations targeting a greater emphasis on protection of human rights, including women's rights. The Violence Against Women Act was passed in 1994 in the United States , which made IPV a national crime, provided funding for victim services, and created the Office on Violence Against Women located in the Department of Justice. In the **UK**, the Family Law Act 1996 Part IV was passed that criminalized sexual assault, physical assault, homicide, and harassment. IPV was considered a prosecutable crime since 1995 in Finland.

Other countries started passing legislation to support victims and prosecute perpetrators in the early 2000s. In **India**, the Protection of Women from Domestic Violence Act came into effect in 2006. In Nigeria, the Gender-Based Violence (prohibition) Law in Ekiti State (2011) and the Prohibition Against Domestic Violence Law of Lagos, State Law No 15 (2007), were passed. In 2012, legislation was passed in Turkey providing support services for victims of violence, providing prevention programming, and providing 24-hr monitoring services for IPV. Additionally, in 2011, Turkey participated in the Council of Europe Convention on Preventing and Combating Violence Against Women and signed the treaty promising to protect victims and prosecute perpetrators. In **China**, the first domestic violence law was passed in 2015, making both physical and emotional abuse illegal, as well as introduced the ability for victims to file a restraining order.

Other countries have introduced new legislation and continue to update laws and policies to criminalize IPV and support victims. For example, **New Zealand** recently passed the *Family Violence Act 2018*, which broadened the definition of what constitutes as IPV (e.g., strangulation), increased access to protection orders, and improved communication between agencies. In the same year, the *Domestic*

Violence-Victims' *Protection Act 2018* introduced the further protections and support for victims of IPV and family violence, such as providing victims 10 paid days' leave a year. In **Australia**, the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) expands definitions of IPV to include coercive and controlling behaviors.

Individuals in some countries are still working toward enacting legislation to provide further protections to victims of IPV. For example, in Iran, a group of advocates and lawyers have drafted a bill that would criminalize all forms of IPV (e.g., emotional, sexual, and physical), as well as provide more shelters for women in violent relationships. This bill has not yet been passed. In the **United States**, the Violence Against Women Act, an act providing support services and resources to victims of IPV, dating violence, sexual violence, and stalking, expired in September of 2018. It was provided an extension until February of 2019. As of 2020, the Violence Against Women Act has not been reauthorized by the US Senate. Other challenges faced by many countries are related to the implementation of the current legislation and policies in place.

13.4 Conclusion

Overall, we have thoroughly enjoyed being able to learn more from our colleagues all over the world about the state of IPV in their home countries. This brief began by examining risk factors for IPV. The more we learn about the unique challenges various countries face, we continue to wonder how risk factors vary between countries. We wonder if family therapists working in Nigeria need to focus on different factors than if they were providing therapy in the UK. As Dr. Knudsen-Martin emphasized in the foreword, this brief continues to leave us with many questions. We have identified many unique challenges, resources, and services from various parts of the world. We have also noted many similarities. Overall, we hope this brief highlights that IPV is a serious international concern and occurs in all societies and cultures. Although countries vary in legal commitment to eradicate IPV, there are advocates to combat IPV and to protect victims in every country. This brief also highlights the ways we can (and should) work together to address domestic violence internationally. Continued legislative efforts to protect victims and support services remain important moving forward to reduce IPV and help victims.

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