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

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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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S. M. Stith, C. M. Spencer (eds.), *International Perspectives on Intimate Partner Violence*, AFTA SpringerBriefs in Family Therapy,
https://doi.org/10.1007/978-3-030-74808-1_1

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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