Mindful
Continuing Education

Prevention, Identification, and Treatment of Domestic Violence

Introduction

Domestic violence, also referred to as intimate partner violence (IPV), is a serious problem that has lasting and harmful effects on individuals, families, and communities. It is often considered an invisible crime because it frequently encompasses shame and secrecy. The dynamics of this type of violence are often intertwined within common and cyclical patterns of behavior, and it is critical that those involved are identified and treated. Furthermore, in addition to the impact that is felt by the partners in the relationship, children who have been exposed to domestic violence are more likely than their peers to experience a wide range of difficulties. Prevention and intervention efforts are necessary to reduce the occurrence of IPV by promoting healthy, respectful, nonviolent relationships.

Domestic Violence Statistics

Domestic violence is widespread in every community and affects everyone regardless of age, sexual orientation, gender, socioeconomic status, religion, race, or nationality. Physical violence often goes hand in hand with emotional abuse and controlling behaviors as part of a larger, systematic pattern of dominance and control. Domestic violence can result in physical injury, psychological trauma, and even death. The devastating consequences of domestic violence can cross generations and last a lifetime. The prevalence of such violence is alarming, as demonstrated by the following statistics (Keilholtz & Spencer, 2022; NCADV, 2022; Gulati & Kelly, 2020).

Approximately 10 million women and men are annually subject to intimate partner violence in the United States. This breaks down to about 20 people per minute whom a partner physically abuses.

1 in 3 women and 1 in 4 men have experienced some type of physical violence by an intimate partner. These behaviors include slapping, shoving, and pushing, which some may minimize and not consider "domestic violence."

1 in 4 women and 1 in 9 men experience severe intimate partner physical violence (beating, burning, strangling), intimate partner sexual violence, and/or intimate partner stalking. The effects of this intimate partner violence include fearfulness, injury, post-traumatic stress disorder, contraction of sexually transmitted diseases, use of victim services, and more.

1 in 7 women and 1 in 25 men have been injured by an intimate partner. Only 34% of people injured by their intimate partners receive the medical care they need for their injuries. 1 in 10 women has been raped by an intimate partner (there is limited data available on male rape by an intimate partner). 1 in 5 women and 1 in 71 men in the United States have been raped in their lifetime. 46.7% of female and 44.9% of male victims were raped by an acquaintance in the United States. 45.4% of female rape victims and 29% of male rape victims were raped by an intimate partner.

19.3 million women and 5.1 million men in the United States have been stalked in their lifetime. 1 in 7 women, and 1 in 18 men have been stalked to the point they felt fearful or believed that they or someone close to them would be harmed or killed. 60.8% of female stalking victims and 43.5% of men reported being stalked by a current or former intimate partner.

19% of domestic violence involves a weapon. The presence of a gun in a domestic violence situation increases the risk of homicide by 500%.

20% of intimate partner homicide victims are not the intimate partners themselves but friends, family members, neighbors, people who intervened/bystanders, and police responders.

72% of all murder-suicides involve an intimate partner; 94% of the victims of these murder-suicides are female.

15% of all violent crimes are intimate partner violence.

1 in 15 children are exposed to domestic violence every year. 90% of the children are eyewitnesses to the violence.

IPV victimization is linked with a higher rate of depression and suicidal behavior. Physical, mental, and sexual and reproductive health effects have been correlated with intimate partner violence, including adolescent pregnancy, unintended pregnancy, miscarriage, stillbirth, intrauterine hemorrhage, abdominal pain, nutritional deficiency, and other gastrointestinal difficulties, neurological disorders, disability, chronic pain, anxiety, and post-traumatic stress disorder, as well as non-communicable diseases such as cancer, hypertension, and cardiovascular diseases. Victims of domestic violence are at a higher risk of developing addictions to tobacco, alcohol, and drugs (NCADV, 2022). IPV victimization can have physical health consequences, including injury, back, and abdominal pain, digestive issues, gynecological issues, and central nervous system issues. IPV victimization has numerous mental health consequences, including anxiety,

depression, post-traumatic stress disorder, suicidal ideations, and substance use (Keilholtz & Spencer, 2022).

It is estimated that 37% of women and 30% of men in the United States will experience intimate partner violence in their lifetime. Intimate partner violence can be physical and consists of pushing, kicking, shoving, hitting, biting, and strangling. Psychological IPV can include insults, threats, yelling at one's partner, and breaking the partner's belongings. Sexual IPV is forcing one's partner to have sexual contact without consent and can include coercion, threats, and physical harm. It can include financial abuse, stalking, or coercive control tactics (Keilholtz & Spencer, 2022). The Power and Control Wheel (Appendix A) shows a breakdown of the different types of abuse and examples.

Approximately 47% of women and men in the United States have experienced psychological IPV. Gender differences emerge when looking at other types of IPV. Approximately 32% of women and 28% of men have experienced physical IPV; when looking at severe physical IPV, 23.3% of women and 14% of men. In Intimate partner homicide, the gender gap opens even further, with 39% of female homicide victims and 3% of male homicide victims being killed by current or former intimate partners. 16% of women and 7% of men experience sexual IPV, and 10% of women and 2% of men have experienced stalking from a former or current partner (Keilholtz & Spencer, 2022).

Individuals who belong to a racial or ethnic minority group have a higher risk of experiencing IPV victimization. Approximately 54% of multiracial women and 44% of Black women report experiencing physical IPV, sexual IPV, or stalking in their lifetime, compared to 35% of White women. Among American Indian/Alaskan Native women, 56% have experienced physical IPV, 66% have experienced psychological IPV, and 49% reported experiencing stalking. While 35% of heterosexual women report experiencing some form of IPV in their lifetime, those who are sexual minorities have a higher rate of IPV victimization, with bisexual women reporting 61.1% and lesbians experiencing 43.8% (Keilholtz & Spencer, 2022).

Intimate partner violence can impact people of all backgrounds, genders, races, or sexual orientations. It is important to note that women, racial minorities, gender minorities, and sexual minorities are at an increased risk of IPV victimization (Keilholtz & Spencer, 2022).

Domestic violence affects women more often than men, with close to one in three women being victimized by physical or sexual violence in their lifetime. Rates of reporting domestic violence vary across locations and cultures. While rates tend to be

higher among those who struggle with homelessness and poverty, domestic violence is seen in all countries and all socioeconomic groups (Gulati & Kelly, 2020).

As can be seen from the above statistics, domestic violence is a gendered crime. While men may also be victims and abuse can occur in same-sex relationships, it is disproportionately women who are the victims and men who are the perpetrators.

Signs of Abuse

Anyone can be an abuser. They come from all groups, cultures, religions, economic levels, and backgrounds. They can be your neighbor, pastor, friend, child's teacher, a relative, or a coworker. Most perpetrators are only violent with their intimate partners. 90% of abusers have no criminal record and are generally law-abiding outside the home.

There is no perpetrator personality, but there are frequent traits seen among people who are abusers. These characteristics include:

- Denying or minimizing the violence's seriousness and its effects on the victim and family members.
- Objectifying the victim and seeing them as their property or sexual objects.
- Having low self-esteem and feeling powerless and ineffective in the world. While they may appear successful internally, they feel inadequate.
- Externalizing the causes of their behavior. Blaming their violence on circumstances such as stress, their partner's behavior, a bad day at work, alcohol, drugs, or other factors.
- He or she is seen as nice to others outside the relationship and is pleasant and charming between periods of violence (NCADV, 2022).

Warning signs of an abusive person include but are not limited to:

- Extreme jealousy
- Possessiveness
- Unpredictability
- A bad temper

- Cruelty to animals
- Verbal abuse
- Extremely controlling behavior
- Old fashion or traditional beliefs about women's and men's roles in relationships
- Forcing sex or disregarding their partner's reluctance to have sex
- Refusing to honor the agreed-upon methods of birth control
- Blaming the victim for all the bad things that happen
- Obstructing or sabotaging the victim's ability to attend school or work
- Controlling all the finances
- Abusing other family members, children, or pets
- Controlling what victims wear and how they act
- Accusing the victim of flirting with others or having an affair
- Embarrassing or humiliating the victim in front of others
- Demeaning the victim either privately or publicly
- Harassing the victim at work (NCADV, 2022).

Dynamics of Abuse

Anyone can be a victim of domestic violence. Victims of domestic violence do not bring violence upon themselves. There is no such person as a "typical victim." Victims of intimate partner violence come from all walks of life, all backgrounds, all age groups, all education levels, all economic levels, all ethnicities, all cultures, all religions, all communities, all abilities, and all lifestyles.

Violence in relationships happens when individuals believe they have the power and control over their partners, and they choose to use abusive tactics to gain and maintain control. In relationships with intimate partner violence, violence is not equal. Even if the victim fights back or instigates violence to diffuse a situation, there is always one person who is the primary, constant source of power, control, and abuse in the relationship.

Every relationship is different, but the commonality among all abusive relationships is the tactics used by the perpetrator to gain and maintain power and control over the victim. Threats of and acts of physical and sexual assault are the most obvious forms of domestic violence and are usually what brings the abuse to the attention of others. Regular use of other abusive behaviors makes up a larger piece of abuse reinforced by physical abuse. While physical violence may only occur occasionally, it creates fear of future attacks and allows the abuser to control all aspects of the victim's life.

The power and control wheel identifies less visible aspects of intimate partner violence that help establish and maintain a pattern of intimidation and control in the relationship. It also illustrates the cyclical nature of abuse (See Appendix A).

Domestic Violence & Mental Health: Perpetrators

While some may have an association with mental health and violence, the vast majority of people with a mental illness are not violent. Likewise, domestic violence is not caused by mental illness. Domestic violence is almost always about power and control, which are not necessarily linked to the perpetrator's mental illness, if one exists at all. With that disclaimer being said, there are associations between some mental disorders and domestic violence. One study found that men with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, attention deficit hyperactivity disorder, and personality disorders had a higher risk of domestic violence against women. Those with alcohol use disorders and drug use disorders had the highest rates of domestic violence perpetration (Gulati & Kelly, 2020).

Victims

People with severe mental illness are at higher risk of experiencing domestic violence. One study of psychiatric patients found 30% of inpatient females and 33% of outpatient females reported experiencing domestic violence. It is expected that this, and much domestic violence information, is underestimated. Some of the reasons people with mental illness have reported not disclosing abuse are fear of the consequences (potential for more abuse and violence), fear of services involvement (child protective), fear the disclosure would not be believed, and feelings of shame. Poor mental health can be a result of victimization and include post-traumatic stress disorder, depression, suicidality, and alcohol or substance misuse (Gulati & Kelly, 2020).

Post-traumatic stress disorder is anxiety caused by experiencing frightening, traumatic, or stressful events. A person with PTSD often relives frightening events through flashbacks and nightmares and has a range of other symptoms, such as feelings of isolation, irritability, guilt, insomnia, and problems concentrating (Radford et al., 2019).

Types of Intimate Partner Violence

Domestic violence and abuse is any incident of controlling, coercive or threatening behavior, violence, or abuse between people who are or have been intimate partners, regardless of their gender or sexuality. Domestic violence and abuse covers a range of types of abuse, including, but not limited to, physical, psychological, sexual, emotional, or financial abuse and a range of controlling and coercive behaviors used by one person to maintain control over another (Radford et al., 2019). Below are definitions and examples of each type of abuse that are defined by the National Domestic Violence Hotline (2022).

Physical Abuse

Physical abuse is when a person hurts or tries to hurt a partner by using physical force such as hitting or kicking. Examples include:

- Pulling hair or punching, slapping, kicking, biting, choking, or smothering
- Forbidding or preventing a partner from eating or sleeping.
- Using weapons against a partner, including firearms, knives, bats, or mace.
- Preventing a partner from contacting emergency services, including medical attention or law enforcement.
- Harming children or pets.
- Driving recklessly or dangerously with a partner in the car or abandoning a partner in unfamiliar places.
- Forcing the partner to use drugs or alcohol, even if the partner has a history of substance abuse.

- Trapping a partner in the home or preventing the partner from leaving.
- Throwing objects at a partner.
- Preventing a partner from taking prescribed medication or denying necessary medical treatment.

Emotional and Verbal Abuse

Psychological abuse is the use of verbal and non-verbal communication with the intent to harm a partner mentally or emotionally and to exert control over a partner. Examples include:

- Calling partners names, insulting them, or constantly criticizing them.
- Acting jealous or possessive or refusing to trust a partner.
- Isolating partners from family, friends, or other people in their life.
- Monitoring partners' activities with or without their knowledge, including demanding to know where they go, whom they contact, and how they spend their time.
- Attempting to control what partner wears, including clothes, makeup, or hairstyles.
- Humiliating partner in any way, especially in front of others.
- Gaslighting their partners by pretending not to understand or refusing to listen to them; questioning their recollection of facts, events, or sources; trivializing their needs or feelings, or denying previous statements or promises.
- Threatening partners, their children, their family, or their pets (with or without weapons).
- Damaging partner's belongings, including throwing objects, punching walls, kicking doors, etc.
- Blaming their partners for their abusive behaviors.
- Accusing their partners of cheating or cheating themselves and blaming their partners for their actions.

- Cheating on their partners to intentionally hurt them and threatening to cheat again to suggest that they're "better" than their partner.
- Telling their partners that they're lucky to be with them or that they'll never find someone better.

Sexual Abuse

Sexual abuse is forcing or attempting to force a partner to participate in a sex act, sexual touching, or a non-physical sexual event (sexting) when the partner does not or cannot consent. Behaviors that perpetrators exhibit include:

- Forcing their partners to dress in a sexual way they're uncomfortable with.
- Insulting their partners in sexual ways or calling them explicit names.
- Forcing or manipulating their partners into having sex or performing sexual acts, especially when they're sick, tired, or physically injured from their abuse.
- Choking their partners or restraining them during sex without their consent.
- Holding their partners down during sex without their consent.
- Hurting their partners with weapons or objects during sex.
- Involving other people in sexual activities against the partner's will.
- Ignoring their partner's feelings regarding sex.
- Forcing their partners to watch or make pornography.
- Intentionally giving a partner or attempting to give a partner a sexually transmitted infection.

Sexual Coercion

Sexual coercion is sexually aggressive behavior, and it may vary from begging and persuasion to forced sexual contact. It can be verbal and emotional through comments made to pressure, guilt, or shame, or it can be more subtle. Making one's partner feel obligated to perform sexual acts, even if there is no force, is coercion. Examples include:

- Implying partner owes something sexually in exchange for previous actions, gifts, or consent.
- Giving partner drugs or alcohol to "loosen up" inhibitions.
- Using their relationship status as leverage, including by demanding sex as a way to "prove their love" or by threatening to cheat or leave.
- Reacting with anger, sadness, or resentment if the partner says no or doesn't immediately agree to something. Trying to normalize sexual demands by saying that it is needed.
- Continuing to pressure the partner after the partner says no or intimidating the partner into fearing what will happen if the individual says no.

Reproductive Coercion

Reproductive coercion is a form of power and control where one partner removes the other partner's ability to control the individual's reproductive system. It can be harder to identify this form of coercion as it is less visible than other types of abuse. It may appear as pressure, guilt, or shame about having or wanting children (or not having or wanting them). Examples include:

- Refusing to use a condom or other types of birth control.
- Breaking or removing a condom before or during sex or refusing to pull out.
- Lying about methods of birth control (having a vasectomy or being on the pill).
- Removing birth control methods (rings, IUDs, or contraceptive patches) or sabotaging methods (poking holes in condoms or tampering with pills).
- Withholding money to purchase birth control.
- Monitoring partners' menstrual cycles to inform abuse.
- Forcing pregnancy or not supporting the partner's decisions about when or if to have children.
- Intentionally becoming pregnant against a partner's wishes.
- Forcing the partner to get an abortion or preventing the individual from accessing one.

- Threatening the partner or acting violently if the individual doesn't agree to terminate or continue a pregnancy.
- Impregnating partner shortly after having a child, to ensure that individual is continually pregnant.

Financial Abuse

Financial or economic abuse is when an abusive partner extends their power and control into financial situations. Examples include:

- Providing an allowance and closely monitoring how the partner spends it, including demanding receipts for purchases.
- Depositing a partner's paycheck into an account that the individual can't access.
- Preventing partners from viewing or accessing bank accounts.
- Preventing partners from working, limiting the hours that they can work, getting them fired, or forcing them to work certain types of jobs.
- Maxing out a partner's credit cards, using credit cards without permission, not paying credit card bills, or harming a partner’s credit score.
- Stealing money from partners, their families, or their friends.
- Withdrawing money from children's savings accounts without children's or partners' permission.
- Living in a partner's home but refusing to work or contribute to the household.
- Forcing their partners to provide them with their tax returns or confiscating joint tax returns.
- Refusing to supply money for necessary or shared expenses (food, clothing, transportation, medical care, or medicine).

Digital Abuse

Digital abuse is using technology and the internet to harass, bully, intimidate, stalk, or control a partner. This behavior is a form of verbal or emotional abuse conducted online. Examples include:

- Demanding partners share their passwords.
- Pressuring their partners to send any explicit photos, videos, or messages that they're uncomfortable sending.
- Expecting a partner to have the phone on at all times and respond to the text or phone calls immediately.
- Sending threatening messages, photos, videos, or voicemails.
- Calling partners from unknown numbers so they will answer (if they suspect their number has been blocked).
- Saving partners' posts or messages to use against them at a later date.
- Sharing tests, messages, or other digital materials that were supposed to be private.
- Following and/or revealing their partners' movements by their online presence

Stalking

Stalking is when someone watches, follows, or harasses someone repeatedly, making the victim feel afraid or unsafe. Stalking can occur from someone who is currently known, a past partner, or a stranger. Examples include:

- Showing up at a partner's home or workplace unannounced or uninvited.
- Sending partner unwanted texts, messages, letters, emails, or voicemails.
- Leaving partner unwanted items, gifts, or flowers.
- Calling a partner and repeatedly hanging up or making unwanted phone calls to the individual, to the individual's employer, a professor, or a loved one.
- Using social media or technology to track partners' activities.
- Spreading rumors about a partner online or in person.
- Manipulating other people to investigate the partner's life, using someone else's social media account to look at the individual's profile, or befriending the partner's friends in order to get information.
- Waiting around at places where the partner spends time.

- Damaging partner's home, car, or other property.
- Hiring a private investigator to follow or find the partner as a way of knowing the individual's location or movements.

Impacts on Victims

Domestic violence victims experience various emotions and feelings about the abuse they have endured. When they can safely leave and maintain freedom from their abuser, they often struggle with long-term and sometimes permanent effects on their mental and physical health, their relationships with friends and family, and impacts on their financial stability. Feelings and behaviors victims of domestic violence may experience that compel them to stay in an abusive relationship or believe they are unable to leave include:

- Wanting the abuse to end but wanting to maintain the relationship
- Feeling isolated
- Feeling depressed
- Feeling helpless
- Being unaware of what services are available to help them
- Being embarrassed by the situation they are in
- Fearing judgment or stigmatization if they disclose the abuse
- Denying or minimizing the abuse or making excuses for the abuser
- Still loving the abuser
- Withdrawing emotionally
- Distancing themselves from family or friends
- Being impulsive or aggressive
- Feeling financially dependent on the abuser
- Feeling guilt related to the relationship

- Feeling shame
- Having anxiety
- Having suicidal thoughts
- Abusing alcohol or drugs
- Being hopeful the abuser will change or stop the abuse
- Having cultural, religious, or other beliefs that encourage staying in the relationship
- Having no support from friends or family
- Fearing cultural, community, or society backlash that may hinder escape or support
- Believing they have no ability to get away or nowhere to go
- Fearing they won't be able to support themselves after they leave the abuser
- Having children in common with their abuser and fearing for their safety if the victim leaves
- Having pets or other animals they don't want to leave
- Being distrustful of local law enforcement, courts, or other systems if the abuse is revealed
- Having unsupportive experiences with friends, family, employers, law enforcement, courts, and child protective services. Believing they won't get help if they leave or fearing retribution if they do (they may fear losing custody of their children to the abuser) (NCADV, 2022).

Types of Intimate Partner Violence

There are four situational types of intimate partner violence.

1. **Intimate Terrorism** is characterized by one partner using violence as a means of control and power over a partner. This is typically chronic violence and has the most chance of leading to injury. This type of violence is the most severe and

includes (severe physical abuse, strangulation, coercive control tactics, and constant emotional abuse). There is a clear perpetrator of the abuse and victim. Couples therapy is NOT appropriate for this type of violent behavior. There is too much potential for the danger of the perpetrator becoming angry toward the victim about disclosures during therapy.

2. **Common Couple Violence/Situational Couple Violence** is typically, but not always, bidirectional, less frequent, and less severe. It usually occurs as a result of escalating conflict surrounding a specific situation. It involves a lower level of violence, such as pushing, shoving, or shouting, and is not used in a manner to control or dominate one's partner. Situational couple violence often occurs in the context of an argument or disagreement and can be related to a lack of anger management skills, a lack of conflict resolution skills, or a lack of healthy communication strategies. Couples therapy is appropriate and most successful with this type of violence.

3. **Violent Resistance** is when the primary victim uses violence against the perpetrator in an attempt to regain some power in the relationship. Couples therapy is not appropriate for those experiencing this type of violence.

4. **Mutual Violence Control** is when both partners use violence against each other in an attempt to establish power and control in the relationship. This is the least common type of IPV. Couples therapy is not appropriate in these situations (Stith et al., 2020; Keilholtz & Spencer, 2022).

Why Do Victims Stay?

Abusers will go to extremes to keep their victims from leaving. Leaving an abuser is the most dangerous time for a victim of domestic violence. Victims have numerous reasons for staying with their abusers, but one key reality is that the abusers will most likely follow through with their threats. Abusers will hurt or kill their victims and/or their children, they will win custody of the children, will hurt or kill pets, harm extended family members or friends, or financially ruin their victims, and these are just a few of the threats they use to keep their victims trapped. Victims of domestic violence know their abusers best and what they can do to maintain control. The victims may know they can not safely escape or protect their loved ones. The statistics support this fear; 20% of intimate partner homicide victims are family members, friends, neighbors, bystanders who intervened, and law enforcement responders (NCADV, 2022).

Other barriers to escaping violent domestic relationships include:

- Fearing the abuser's behaviors will become more violent and potentially lethal if the victim attempts to leave.
- Lack of support from family and friends
- Knowing the difficulties of single parenting and reduced financial means
- Knowing that the relationship is a mix of good times, love, hope, manipulation, intimidation, and fear.
- The victim's lack of knowledge or access to support and safety
- Fear of losing custody of their children if they leave or divorce their abuser and even fear the abuser will hurt or kill their children
- Lack of ability to support themselves and their children financially or lack of access to cash, bank accounts, or assets
- Lack of having somewhere to go (no friends or family to help, no money for a hotel, shelter programs are full or limited by the length of stay, or do not accept children or pets)
- Fearing homelessness may be a reality if they leave.
- Religious or cultural beliefs may not allow for divorce or may dictate traditional gender roles that keep the victim trapped in the relationship.
- The belief is that two-parent households are better for children, despite the abuse.

While the above list looks at individual barriers to leaving a violent relationship, societies also present barriers that victims must face, including (NCADV, 2022):

- Fear of being charged with abandonment and losing custody of children and joint assets.
- Worry about a decline in living standards for themselves and their children
- Pressure from clergy and counselors to save a couple's relationship at all costs rather than focusing on the goal of stopping the violence.

- Lack of support from police and law enforcement, who may treat violence as a "domestic dispute" instead of a crime. Often, abuse victims are arrested and charged by police, even if they were only defending themselves against the abuser.
- Police discourage victims from filing charges. Law enforcement, at times, dismisses or downplays the abuse, sides with the abuser, or does not take the victim's account of the abuse seriously.
- Reluctance by prosecutors to pursue cases. Court systems may allow the abuser to plead to a lesser charge, further endangering the victims. Judges rarely impose the maximum sentence on convicted abusers. Probation or a fine is most likely to occur.
- Despite issuing a restraining order, there is little to prevent a released perpetrator from returning and repeating the violence.
- While there is greater public awareness of IPV and an increase in available housing for victims fleeing violent partners, there are not enough shelters for victims when they are first leaving violent partners.
- Some religious and cultural practices forbid divorce.
- Some victims are socialized to believe they are responsible for the success of their relationship. Relationship failure equals failure as a person.
- Isolation from friends and families. This can be because the abuser is jealous and possessive or because the victim feels ashamed of the abuse and tries to hide signs of it from others. The isolation contributes to the belief that there is nowhere to turn for help.
- Rationalizing that the abuser's behavior is caused by alcohol, stress, problems at work, unemployment, or other factors.
- Societal factors impress upon women that their identities and self-worth are contingent on getting and keeping a man.
- Inconsistency of abuse. During non-violent times, the perpetrator may fulfill the victim's dream of romantic love. The victim may rationalize the abuser is good until something bad happens, and then they have to let off steam. (NCADV, 2022).

Domestic Violence & COVID-19

Pre-COVID, shelters were already struggling to keep up with demand. Leaving an abusive relationship is one of the most dangerous times for victims, and the lack of emergency shelter puts them at an even greater risk.

Newspaper reports from Australia, Canada, the United Kingdom, and the United States illustrated a theme of increased reports of domestic violence and calls to domestic violence support services. This may not mean an increase in domestic violence but an increase in seeking support and increased pressure placed on service providers. In the United States, reports of domestic violence doubled once cities went into lockdown, Australia reported a sharp increase in domestic violence after the first week of lockdown, the UK's largest domestic violence service provider reported a 700% increase in calls to its hotline in a single day, and in Vancouver, Canada one domestic violence service organization reported a 300% increase in daily calls (Slakoff et al., 2020).

Pandemic lockdown safety protocols isolated victims from their support networks, their jobs, and others who might have normally had eyes on the family. It also gave the abusers unlimited access to their victims. Many service providers attempted to offer services through technological means such as phone, video, and virtual chat sessions. While the attempt was to provide services to people throughout the pandemic, some may still not have been able to access the support if their abuser was nearby (Slakoff et al., 2020).

Prior to COVID-19, there had been a decline in women's risk of lethal and less-than-lethal intimate partner violence. The decline has been attributed to a lowered risk of exposure due to changes in the economic status and well-being of women. There has been a decrease in women's dependence on marriage (due to an increase in women's employment, a decline in marriage rates, and an increase in availability and rates of divorce), general awareness of the nature of intimate partner violence, and decreasing stigma for victims to come forward and report violence, and the expansion and availability of intimate partner violence services and interventions.

With the safety measures implemented to mitigate the spread of COVID-19 (stay-at-home orders, social distancing, family isolation), and the economic impacts, there has been an increase in intimate partner violence. Restrictions to stop the spread of COVID-19 may have made violence in the home more frequent, severe, and dangerous. It is difficult to know the full impact of IPV during the pandemic due to under-reporting to law enforcement, under-utilization (or availability) of victim and social service

agencies, and the challenge of collecting self-report data during the pandemic. However, there is data to substantiate an increase in reports of IPV during the pandemic to police, emergency rooms, domestic violence hotlines, and social service agencies. It is important to note that the increase in reporting does not necessarily mean an increase in victimization. It may be a function of the change in experience and decision-making of victims, and the pandemic may have served as a catalyst for victims to report their experiences (Kaukinen, 2020).

Challenges of providing services during the pandemic included (Slakoff et al., 2020):

- Physical distancing mandates and lockdown orders exacerbated the loss of access to services.
- Service providers fell ill and needed to quarantine. The sudden shift to providing services remotely had challenges and increased stressors for the providers.
- Some shelters and service locations closed, reduced face-to-face hours, or limited their services available due to physical distancing mandates.
- Domestic violence prevention and intervention programs were already struggling pre-pandemic to meet the demand for services and did not have the resources available to meet the increased demand.
- Domestic violence victims' psychological recovery takes longer when a disaster is involved. Similar aspects were seen with the pandemic, including housing scarcity and unemployment.
- Part of domestic violence behaviors includes coercive control, a perpetrator's abusive pattern of behavior that has negative long-term impacts on victims. These behaviors include violence, intimidation, threats, isolation, surveillance, stalking, gendered micro-regulations of everyday behaviors associated with housework and childcare, and other controlling tactics. There was an intensification of coercion and control during the pandemic, including limiting or monitoring victims' communication with family and friends, depriving victims of their basic needs, withholding information about the virus and public health measures, and controlling access to the internet, restricting medications, and personal hygiene products (masks, gloves, cleaning supplies, hand soap, and sanitizer).

There has been an increase in domestic violence concerns in many countries since governments restricted travel and implemented safety measures to reduce infection

rates. The reasons for the heightened risk have been linked to social isolation, economic and psychological stressors, an increase in negative coping techniques (alcohol misuse, increased drug use), and the inability to access support systems or escape abusive households due to quarantine (Gulati & Kelly, 2020).

At the onset and during the height of the pandemic, there was a decrease in mental health referrals despite an increase in psychological distress, victimization, and mental illness. Many people did not seek help due to fears services were overwhelmed and that attending an in-person appointment could put them at risk of infection. Especially during a crisis such as a pandemic, mental health needs to be recognized as a primary care need, and services must remain available. Many times domestic violence does not become apparent until comprehensive assessments are completed, and a trusting therapeutic relationship is developed. Also, effective treatment of mental illness and substance abuse is needed to reduce the risk of domestic violence perpetration (Gulati & Kelly, 2020).

Technology can help victims maintain their support system, but abusers also use technology to perpetrate coercive control. Many intimate partner violence survivors report having experienced technology surveillance (ex., spyware installed on their cellphones). Service providers report victims being concerned during the lockdown about their phone calls being overheard and not having a safe space to be able to talk. Victims would end phone calls, change the topic, or end the call and call back later when it was safe for them to talk (Salkoff et al., 2020).

Mandatory Reporting

36% of women have experienced stalking, physical, and/or sexual intimate partner abuse in their lifetime. The rates are higher for women and men of color when compared to their white peers. Lesbians, gays, and bisexuals have the same rate, if not higher, of IPV when compared to heterosexual peers; rates of IPV are higher among transgender people when compared to cisgender people. Due to the high rates of IPV, all survivors need to have access to necessary support (Lippy et al., 2020).

Mandatory reporting federal and state laws are set in the United States to require certain individuals to report abuse or suspected abuse to legal or government organizations. Mandated reporters typically include healthcare providers, social workers, school personnel, childcare workers, clergy, and other health and mental health professionals. The types of abuse that fall under these mandatory reporting laws include

crime-related injuries from the use of a weapon, child abuse and neglect, elder abuse or neglect, and domestic violence or sexual assault. Mandatory reporting laws aim to protect vulnerable people who may be unable to protect themselves (Lippy et al., 2020).

A mandated report (MR) can be triggered in multiple ways.

- Most states have MR laws requiring healthcare providers to report domestic violence-related injuries, and only four states allow the victim to refuse the report being made.
- In some states, domestic violence advocates are mandated reporters, which can cause some parents to feel at risk of being reported or watched while at shelters.
- Those who seek medical attention after receiving injuries from abuse with the use of a weapon may have a report made due to mandated reporting laws with crime-related injuries.
- Most states have mandated reporting laws regarding child abuse and neglect, and this includes exposure to domestic violence.
- Eighteen states & Puerto Rico have laws that all persons over the age of 18 are required to report suspected child abuse and neglect. This now turns not only formal support networks but the person's informal support network (friends, family, acquaintances, co-workers) as well into mandated reporters (Lippy et al., 2020).

While mandated reporting laws were put into place to protect people, there are negative consequences the laws have that may deter IPV victims from seeking help. They may avoid seeking medical assistance for injuries for fear of triggering a report. Others may delay seeking help for fear that disclosing IPV could lead to the removal of their children. Their fears are confirmed by studies that show domestic violence child welfare cases are more likely to result in child removal and out-of-home placement compared to cases with other issues. Victims who have called the police to have their abuser removed from their home have instead had their children taken away or had to plead guilty to child neglect in court for allowing the children to be exposed to IPV. Mothers of color are more likely to be referred to CPS for IPV concerns than white mothers, who are more likely to be referred for mental health services (Lippy et al., 2020).

Informal support networks are important for survivors and whom they often turn to first for support. This is particularly true for those from marginalized backgrounds due to the

disparate treatment they often receive from formal support, including social service agencies, law enforcement, and the court system.

Lippy et al. (2020) reviewed pre-existing data from the National LGBTQ Domestic Violence Capacity Building Learning Center in partnership with the National Domestic Violence Hotline. Their sample consisted of 2462 survivors, 57% White, 16% Latinx, 14% Black, 7% Asian, and 6% Multiracial. Participants were between 18-74 years of age and identified as non-transgendered women (88%), non-transgendered men (11%), and transgendered or gender non-conforming (2%). They reviewed the data seeking information on if mandatory reporting affects survivors. They found survivors were afraid to ask for help:

- 35% of participants said they did not ask at least one person for help because they feared the information would be reported.
- 29% said they did not ask a family member or friend because they feared that person would legally be required to report them.
- 19.4% did not ask for help from anyone for fear of being reported.
- Almost every survivor expressed the fear that if they asked for help, their partner would be arrested and go to jail, which could lead to other consequences, including fear of retaliation, loss of family income, and loss of the relationship.
- Mostly among the women respondents, they feared CPS involvement and their children being taken away.
- 3.2% of participants expressed fear of housing instability and becoming homeless.
- Another small portion of respondents expressed fear of their or their partner's deportation should they seek help.
- 15.2% of survivors reported that when they sought help, they were warned that the person they were talking to was mandated to report the abuse to authorities. 60.7% reported the warning changed what they shared with the person who gave it. The warning prevented survivors from fully disclosing their experience and receiving the help they may have needed. 22.7% reported the warning stopped them from seeking help altogether.
- 8.2% of respondents had the information they shared reported. 51.2% of survivors said the report made the situation "much worse," and only 1.8% stated

the report made their situation "much better." 83.3% stated the report made things worse or had no impact. Approximately 17% stated the report made their situation better in some way.

- Victims stated that mandated reporting often resulted in negative results such as police involvement angering their partner and worsening abuse, mandated arrests often only resulted in one night in jail with no other consequences or supports, and cases being dismissed for "lack of evidence," children being removed from home and the victim being charged with allowing the children to be exposed to domestic violence (Lippy et al., 2020).

Policy & Practice Implications

Requiring more people to be mandated reporters can isolate victims of domestic violence and limit their access to both formal and informal support. Policies need to address how victims can seek help without initiating a mandated report. When providers alert those seeking help of their mandated reporter status, they reduce victims' ability to seek the help they need and inhibit their ability to be honest about the abuse without fear of consequences. Providers and policymakers must assess the cost-benefit of mandated reporting laws. While they were initially established to protect vulnerable people, there is ample evidence that the implementation of the law did not have the intended results and often led to the worsening of the abuse situation instead of protecting the people it was intended to help (Lippy et al., 2020).

Evidence-Based Treatment for Couples

Safety Assessment

Before beginning treatment with couples for intimate partner violence, a thorough assessment should be completed with both partners separately and privately. This allows each person to speak candidly without fear of angering the perpetrator. It is essential to ensure that both partners feel safe and have complete opportunities to disclose violence and the relationship dynamics. Both partners must feel safe in order to be appropriate candidates for couples therapy. Both partners' reports of IPV in the relationship should be similar. If there are significant discrepancies in the accounts of violence, it may show the inability of the perpetrator to be accountable, and couples

therapy would not be appropriate. A joint commitment to safety is a required precondition of couples' IPV therapy; if either partner refuses to sign a no-violence contract, couple's therapy is not recommended. If the individuals involved are questioning their commitment to the relationship or considering terminating the relationship, couples therapy would not be a good option (Keilholtz & Spencer, 2022).

Substance Use Assessment

There is a well-documented link between substance use and intimate partner violence. Substance use can, along with other factors such as mood and environment, increase the severity and frequency of violence. When assessing for violence, it is necessary to address how substance use impacts violence. Substance use is usually seen as an issue that needs to be treated before a couple's IPV treatment can begin (Keilholtz & Spencer, 2022).

Mental Health Assessment

There is also an established link between mental health and IPV; therefore, assessing mental health and how it impacts violence is necessary. Consideration should be given to how certain diagnoses, such as personality disorders (particularly narcissism, antisocial, and borderline), are associated with more severe violence. When one or both partners are struggling with mental health problems, the couple's treatment may need to wait until both people have addressed their mental health issues (Keilholtz & Spencer, 2022).

Children's Safety Assessment

Because of the correlation between IPV and child abuse, it is essential to assess parent/child relationships and violence when assessing IPV. Mental health professionals must be aware of their state reporting requirements related to child abuse and children witnessing parental violence and be prepared to determine if reporting is warranted. Since there are not any explicit recommendations for situations where both child abuse and IPV are present, any treatment recommendations will need to be made on a case-by-case basis. It is well-established that IPV among parents or caregivers can negatively impact children's well-being. Children exposed to IPV are susceptible to physical and mental health problems, conduct and behavioral problems, increased delinquency, crime, and victimization. Treatment for children exposed to IPV typically falls into four

categories: counseling/therapy, crisis/outreach, parenting, and multicomponent intervention programs. When working with couples who have children, therapists should be prepared to make appropriate referrals for children needing further assessment or treatment (Keilholtz & Spencer, 2022).

Gun Safety Assessment

The strongest risk factor for intimate partner homicide was the perpetrator's direct access to a gun. Having direct access to a gun increased the chance of a homicide occurring by over 1000% when comparing cases of intimate partner violence and intimate partner homicide. While it is common practice for mental health professionals to ask about gun and weapon access to clients with suicidal ideations, it is just as important to screen for when working with those experiencing IPV. If a couple reports having a gun, it would be valuable to create a plan to securely remove and store the gun outside the home to promote safety (Keilholtz & Spencer, 2022).

Referrals

Upon completion of the assessment process, if couple's therapy is determined to be inappropriate, the mental health provider needs to have a referral process for the victim (shelters, victim services) and perpetrators (batterer intervention programs). Referrals may also include substance use treatment, mental health treatment, or other services that would be appropriate to meet the individual and couple's needs (Keilholtz & Spencer, 2022).

Research suggests that mental health providers may unknowingly work with couples experiencing IPV in their relationship. 36% and 58% of couples seeking couples therapy/ counseling have experienced IPV in their current relationship. While clients may not present with IPV as their primary issue in couples' treatment, there is a chance that IPV may still be present. Some couples may choose to stay together after a violent incident, and treatment can be beneficial to preventing future violence. However, couples therapy, or conjoint treatment, is not a suitable approach for all couples experiencing IPV, which makes assessment an integral part of determining potential treatment modalities when working with IPV. Implementing a thorough assessment to ensure couples' treatment is appropriate will aid in protecting the victim, which is the priority (Keilholtz & Spencer, 2022).

CASE EXAMPLE

The following is a case example of a completed assessment and recommendations from Keilholtz & Spencer (2022).

Daniel and Emily came to couples therapy to improve their relationship overall. They did not come to therapy to specifically address violence in their relationship. Prior to beginning the session, the therapist had each partner fill out assessments. During the first session, the therapist separated Daniel and Emily to assess for safety, violence, and commitment to the relationship. The therapist started the conversation by normalizing conflict in the relationship by stating, "There can be conflicts in all relationships, so I just want to ask a few questions about how you and Emily handle conflict in your relationship." Instead of vaguely asking if the couple experiences violence in the relationship, the therapist asked direct questions about specific acts (e.g., yelling, pushing, shoving, striking) and if they have occurred in the relationship, acknowledging any violence reported in the CTS2 assessment.

The therapist first asked about yelling, and Daniel stated that the couple would argue, and at times they would have verbal arguments where they would yell at one another. The therapist asked Daniel what the verbal arguments in the relationship looked like and began to ask specific questions to gain further details about the verbal conflicts (e.g., "do these verbal arguments ever escalate to where one of you pushes or shoves the other?"). Daniel appeared to be agitated with the questioning and asked the therapist why this was important to discuss. The therapist remained calm and told Daniel that it would help the therapist understand the relationship and the conflicts that the couple were experiencing. Throughout the discussion, Daniel reported that the couple would only yell at one another on occasion. He stated that they never physically harmed one another. Daniel told the therapist that their verbal conflicts seemed to be becoming more frequent. The therapist asked if the verbal conflicts were escalating in severity, and he reported that they were not. Daniel told the therapist that he was not afraid of his partner, felt safe in the relationship, and was committed to improving the relationship.

Next, the therapist met with Emily individually. The therapist asked what conflict looked like in the relationship and asked specific questions about specific acts, as was done with Daniel. Emily told the therapist that their arguments have been "getting worse and worse" lately. The therapist asked Emily what was happening during these arguments that made it feel like the arguments were escalating. Emily told the therapist that Daniel had become "very scary" recently. The therapist asked Emily what Daniel was doing that was scary, and Emily reported that Daniel was becoming aggressive. The therapist began to ask Emily about specific acts of physical aggression and learned that Daniel had

slapped Emily multiple times, pushed her on the floor, threatened to harm her physically, and strangled her during one of their most recent arguments. Emily asked the therapist, "you're not going to report him to the police, are you?" The therapist explained to Emily that in the state they live in, violence between two adults does not require a report, so Daniel would not be reported unless Emily wanted to file a police report. Emily did not want to file a report and stated that she was relieved because she would feel unsafe if Daniel knew she had disclosed what happened. Because of the differing reports of violence, the severity of violence, and Emily's fear, the therapist explained to Emily that couples treatment would not be a good fit. The therapist provided Emily with local victim advocacy resources and recommended individual therapy for both Daniel and Emily. When the therapist met with Daniel and Emily together after their individual meetings, the therapist did not share Emily's report of violence with Daniel. However, the therapist told both partners that they recommended individual therapy for each partner and thought that they would have better results with an individual approach.

General guidelines for determining appropriateness for couples therapy include excluding if there is a clear victim and that person appears fearful or is unable to speak freely in sessions. Also excluded are couples where the primary perpetrator minimizes or denies the violence disclosed by a partner. These situations could lead to endangering the victim should couples therapy be attempted. If during the initial assessment, substance abuse and/or other mental health issues are identified, these should be referred for specialized treatment. Some people may be able to participate in programs concurrently, while others may need to complete their individualized treatments first before beginning couples therapy. Couples therapy is a viable treatment for some types of IPV, particularly low to moderate levels of situational couple violence, to improve relationship functioning. The following are models of couples therapy that have been shown to be effective (Stith et al., 2020).

Treatment Programs

Domestic Violence-Focused Couples Therapy (DVFCT)

Domestic Violence-Focused Couples Therapy is an 18-week program developed for couples who choose to stay together after experiencing situational violence. Couples are carefully screened for violence, substance abuse, depression, and relationship satisfaction. The program is delivered by co-therapists, either in a single-couple format or a multi-couple format. The primary objective of the program is to end all forms of

violence (physical, psychological, and sexual), to build conflict resolution skills, and enhance couple relationships for couples who choose to stay together or who share custody of children. Domestic violence-focus couples therapy is based on a solutions focus treatment model, and therapists are encouraged to build on client strengths and help them develop non-violent conflict resolution strategies. An important aspect of the program is the development and continued practice of a negotiated timeout design to help couples de-escalate when they begin to become reactive. To enhance safety, each client (or gender-specific group) meets with one of the two therapists before and after each joint session. During these pre-and post-meeting sessions, the therapist assesses for safety and provides support to individual clients (or gender-specific groups). The first six sessions focus on honoring the problem and developing a vision of a healthy relationship, providing an overview of issues regarding IPV, teaching and practicing mindfulness strategies, developing a negotiated timeout, and considering the impact of substance use on the problem. For the last 12 weeks, the program focus shifts to more couples' work and it becomes more client directed than therapist directed. The goal of treatment shifts from establishing safety and developing a healthy image of relationships to monitoring risk and enhancing safety within the relationship. Sessions still begin and end with individual (or gender-specific group) safety check-ins.

Research on the effectiveness of DVFCT found that both male and female marital aggression was significantly lower at six month follow-ups than compared to pretest aggression. Couples also reported higher levels of disapproval of relationship violence and higher levels of marital satisfaction (Stith et al., 2020; Keilholtz & Spencer, 2022).

Behavioral Couples Therapy (BCT)

Behavioral Couples Therapy is an evidence-based dyadic intervention for individuals seeking treatment for alcohol and drug abuse. While it was developed to address substance abuse, it has been found to be effective in treating IPV, likely due to the frequent comorbidity of substance use and domestic violence. The main purpose of BCT is to build support for abstinence and to improve the relationship functioning of married or cohabiting people seeking treatment by helping couples change their substance-related interactions. In the BCT model, help is enlisted from the non-substance-abusing partner to act as a support for the recovery of the substance-abusing person. During the intervention, the substance-abusing person and partner are seen together for 12-20 weekly outpatient couple sessions. The person using substances may also participate in additional individual counseling. BCT has two parts, which include behaviorally focused interventions. The initial intervention focuses on substance use, and the couple

negotiates a verbal recovery contract that involves a daily sobriety trust discussion during which the substance-abusing partner agrees not to use substances that day and to comply with other activities that aid recovery, such as medications, with the partner providing support for this intention. Once abstinence has been established, the focus of the intervention shifts to relationship functioning. During the relationship-focused phase, the goal is to increase positive interactions, learn effective communication skills (such as active listening and expressing feelings), enhance relationship satisfaction, and increase positive interactions (such as engaging in shared pleasurable activities and behaviors) and learn conflict resolution and problem-solving skills.

Research on the impact of BCT found that 61.3% of couples reported IPV in the relationship prior to receiving BCT, and only 18.7% reported violence at a two year follow-up. BCT is not indicated if both partners are abusing substances or if the relationship violence is severe (Stith et al., 2020; Keilholtz & Spencer, 2022).

Couples Abuse Prevention Program

The Couples Abuse Prevention program was developed to address risk factors for partner aggression among couples dealing with low to moderate physical and psychological violence. These factors include beliefs that justify aggression, poor communication, skill deficits, and poor emotional regulation. The couples abuse prevention program and intervention sessions focus on psychoeducation about different types of intimate partner violence, risk factors for IPV, impact of IPV on the health and well-being of individuals and couples, anger, management training, cognitive restructuring, problem-solving, training, and strategies to help couples deal with trauma from previous relationships. It is a cognitive behavioral couples treatment. The treatment is delivered to individual couples over ten 90-minute sessions or 20 45-minute sessions, depending on the couple's availability. The treatment begins with an assessment of the individual's and the couple's functioning and the safety of individual partners in the relationship. Conjoint treatment is deemed appropriate only if there are no safety concerns. In the first session, the therapist provides an overview of the intervention protocol and gives information on the structure and expectations during the intervention phase. The clinician then gathers information on the clients' relationship history, and develops intervention goals. with an agreement that the primary aim is to help couples have an aggression-free relationship. Session 2 is focused on a review of client goals, teaching clients about cognitive and behavioral constructs, communication, and strategies for anger management. Sessions 3 and 4 focus on

teaching and practicing communication skills and on practicing anger management skills. Sessions 5 through 7 emphasize problem-solving techniques with a focus on learning to resolve conflict without aggression. Clients are coached into combining communication and problem-solving skills and applying them. Gender roles, cultural influences, family history, and other beliefs are discussed, and influence aggression among couples is explored. In sessions 8 through 10, clients focus on the maintenance of new knowledge and skills learned by continuing to practice their new communication and problem-solving skills. There's also an emphasis on recovery from past relationship trauma, increasing couple-based positive activities, providing each other support, and learning to be a team (Stith et al., 2020).

Strength at Home Couples

Strength at Home Couples is a military-specific and intimate partner violence prevention program. It includes 10 cognitive-behavioral sessions with a couple-based design to prevent IPV among returning military service members and their partners. The intervention is informed by the social information process model for IPV perpetration among the military population, and it incorporates components of CBT for IPV anger management, assertiveness training for veterans, and relational treatment of PTSD.

The primary focus of the intervention is to help couples develop effective conflict resolution skills, increase intimacy and closeness in their relationships and improve their communication. Sessions 1 through 3 focus on PTSD psychoeducation, and the relationship between trauma exposure, deployment, and relationship difficulties. Sessions 4 through 6 focus on conflict management by teaching couples to identify and effectively manage relationship difficulties and conflict. Sessions 7 through 9 emphasize the importance of basic communication skills, such as active listening, giving assertive messages, and identifying and expressing emotions. Couples are encouraged to practice the skills both in and out of the sessions. Couples review changes made during the intervention and develop plans for the future in the last session. The intervention is carried out in groups with 3 to 5 couples per group, and the two hour sessions occur weekly for ten weeks (Stith et al., 2020).

Creating Healthy Relationships Program (CHRP)

The Creating Healthy Relationships Program is a psycho-educational program to reduce IPV in low-income couples who are parents and experience situational violence. The program materials were developed to meet the needs of those with low literacy levels. The goal of the program is to increase skills to create and maintain strong relationships

and navigate conflict. It is based on relationship theory, focusing on seven areas of healthy relationships, including building love maps, sharing fondness and admiration, building positive perspectives, managing conflict, making dreams come true, and creating shared meaning. The intervention consists of 22 2-hour couple group sessions co-facilitated by a male and female therapist. The format of sessions includes watching a video of a couple interacting on the theme of the week, then a discussion on the relevance and reactions the couples have to the video vignette. The co-facilitators then provide educational material on the week's theme, and finally, skills are taught and practiced, and the couple is encouraged to practice the new skill throughout the week. Weekly themes include managing stress, managing conflict, establishing connections in the family (between partners and with children), creating shared meaning, and maintaining intimacy.

Research into the effectiveness of CHRP found couples reported a reduction in IPV through improved relationship skills, improved relationship satisfaction, and positive navigation of conflicts (Stith et al., 2020; Keilholtz & Spencer, 2022).

No Kids in the Middle

No Kids in the Middle is a multifamily intervention for couples with children who have experienced IPV. The program goals are to reduce destructive parental conflict and limit its damaging impacts on children in high-conflict divorced families. Additionally, the intervention strives to enhance engagement and communication between parents, children, and others who interact with the family both formally and informally. The program consists of two intake sessions, one network information session, and eight 2-hour parent sessions while children attend their own eight sessions. The children's group is not directive but encourages artistic expression and gives opportunities to interact with other children and share creations with parents. The parent sessions focus on understanding and accepting one another's differences with an increased capacity to navigate challenges. This is accomplished through increasing awareness of triggers, enhancing conflict de-escalation skills, and engaging social networks. The goal is not for reconciliation.

Research has shown that No Kids in the Middle is effective at reducing harmful conflict between parents and decreasing the frequency and intensity of conflicts, which leads to improved problem-solving and co-parenting. Children substantiated parent reports by also reporting decreased parental conflicts (Stith et al., 2020; Keilholtz & Spencer, 2022).

Themes in Evidence-Based Treatments

While each of the above treatment programs are slightly different and target different populations experiencing intimate partner violence, there are some essential recurring themes that all programs address. Common themes include establishing safety, stabilization of other risk factors as needed (mental health, substance use, other challenges), learning new skills and behaviors, and improving conflict management and relationship satisfaction. These were all tied into addressing risk factors surrounding IPV on low relationship satisfaction, verbal arguments, stress, and emotional dysregulation. IVP couple's therapy is not appropriate for all couples, and mental health providers must thoroughly assess for safety in the relationship and for any repercussions that may occur from having treatment discussions about the violence (Keilholtz & Spencer, 2022).

Evidence Based Treatment for Perpetrators

Historical responses to IPV favored sheltering victimized women and children. Due to the large number of women returning to their partners and because some perpetrators victimized multiple women, shelter workers recognized the need to develop interventions to address perpetrator behavior. Early programs were psychoeducational and cognitive-behavioral based. Many of these programs for men were in response to policy changes that mandated arrests and prosecution.

The Duluth Model was one of the earliest IPV perpetrator treatment programs. It holds that IPV is the product of patriarchy or male socialization and results because the perpetrator wants power and control over his partner. The model is a 28-week group psychoeducational intervention program. Reeducation is accomplished through video reenactments, role plays, individualized action plans, worksheets and logs, and examples of contrast between equality versus power and control.

Cognitive-Behavioral Therapy is a therapeutic modality that seeks to change unhelpful thoughts and behaviors and improve skills to enhance functioning. CBT targets thoughts and behaviors that contribute to violence and offers an alternative to incarceration, prosecution, and associated costs. CBT can be performed in individual or group settings. Facilitators may utilize a variety of techniques, including functional analysis of abusive behaviors, cognitive restructuring, identification of relapse patterns and cues, anger management, and relationship skills training. While these two approaches are very different, they do cover similar themes of increasing personal responsibility; raising the consciousness of abusive behaviors and reinforcing adaptive relationship behaviors;

recognizing relationship thinking errors and other distorted thought patterns; and teaching anger management, problem-solving, and communication skills.

Research has found these two models to have very modest success, and new programs are emerging in an attempt to intervene with IPV perpetrators in a more successful manner and to reduce recidivism. Alternative programs with higher success in treatment focus on individualized treatment have the following themes:

1. Individual characteristics of the perpetrator impact treatment outcomes, including completion and recidivism. Examples in research include:

    - Older men who were more educated had briefer criminal histories and did not display signs of problematic substance use, and had lower odds of re-arrest independent of the kind of treatment they received.
    - Mental health issues and low socioeconomic status were important determinants of recidivism and treatment dropout.
    - Higher social class (a combined measure of marital status, level of education, full-time employment, and income) was a significant predictor of program completion.
    - Low income, high levels of hostility, and no longer being in a relationship with the survivor were all predictive of treatment attrition.

    Implications for treatment:

    - Younger perpetrators with fewer resources and more emotional difficulties may benefit from a more intensive track of treatment.
    - By helping perpetrators from disadvantaged backgrounds access basic necessities like housing, employment, education, and health care, social workers may indirectly address IPV by helping perpetrators stay in treatment longer and reducing stressors that magnify the risk for IPV.

2. Develop perpetrator typologies to guide treatment. Some research has found support in three subtypes of IPV perpetrators; family-only, borderline/dysphoric, and generally violent/antisocial. Family-only perpetrators exhibit relatively low IPV and exhibit lower rates of alcohol abuse, depression, and personality disorders than the other groups. Borderline/dysphoric perpetrators have high

levels of anger and depression, moderate levels of substance use, and more personality disorders. They exhibit higher levels of IPV but low generalized violence. Finally, generally violent/antisocial perpetrators present with high levels of both marital and generalized violence and show criminal tendencies. Family-only perpetrators appear to fare best in terms of treatment completion and recidivism, while generally, violent/antisocial perpetrators appear to do the worst.

Implications for treatment: These results reinforce the importance of assessing perpetrators and assigning treatment format and intensity based on individual characteristics, histories, and needs. Family-only perpetrators may benefit most from couples counseling, insight-oriented or psychodynamic approaches. The therapist needs to be aware of general violent/antisocial perpetrators as not to support their ability to manipulate others, and avoid treatments that emphasize interpersonal skills, empathy, or self-esteem. Borderline/dysphoric perpetrators may benefit from treatments that address emotion dysregulation and resultant behavioral difficulties. Using dialectical behavior therapy with this type of IPV perpetrator may be well suited.

3. Individual perpetrators' readiness to change is a key component of successful completion and long-term recidivism. This is based on the transtheoretical model of change, which sees people moving through five stages of change, which include:

   Precontemplation - a person is unaware of problematic behaviors and has no intention to change.

   Contemplation - a person is aware a problem exists and is considering changing, but has yet to commit to taking action.

   Preparation - a person plans on taking action immediately and may have already made preliminary, minor behavioral changes.

   Action - a person is actively engaged in modifying behaviors and working to overcome problems.

   Maintenance - a person works to maintain changes and prevent falling back into former behaviors.

   Motivational interviewing is a non-confrontational, person-centered interviewing approach that emphasizes client autonomy and decision-making, and change. It has shown some success in treating certain types of IPV perpetrators, those who

were first-time perpetrators, men who were court-ordered into treatment, and men in the early stages of change. Men who were in the later stages of change had more success with a CBT approach.

Implications for Treatment: Stages and readiness for change should be considered when developing a treatment plan. Perpetrators who are court mandated to treatment may be at earlier stages of change. Interventions that are confrontational may increase defensiveness and resistance to IPV treatment.

Co-occurring individual issues such as substance use and mental health disorders are frequently associated with intimate partner violence perpetration.

Substance Use is frequently correlated with IPV, both in victimization and perpetration. Almost half of all men participating in batterer intervention programs report having issues with alcohol, and one-third have a drug-related diagnosis. Not only is substance use a risk factor for IPV. It is also a predictive factor of lower treatment engagement and attrition and more violence.

Implications for Treatment: Screening for substance use should be automatic for all perpetrator treatment programs. Referrals for substance use treatment should be made as needed. Perpetrators with co-occurring substance use are less likely to engage in acts of IPV *following* substance use treatment; furthermore, those who stay sober are two to three times less likely to perpetrate IPV than those who relapse

Mental Health issues are associated with both intimate partner violence victimization and perpetration. Mental health diagnoses that are linked to IPV perpetration include PTSD, personality disorders, depression, bipolar disorder, generalized anxiety disorder, panic disorder, and social phobia. Unaddressed mental health issues are associated with IPV severity, re-arrest, and treatment attrition.

Implications for Treatment: It is advisable to either integrate targeted mental health treatment into perpetrator treatment for individuals with co-occurring mental health issues—or refer such individuals to adjunctive, standalone mental health services. Ensuring individuals with mental health issues and past trauma receive proper care may in itself deter IPV (Butters et al., 2021).

Treatment interventions geared toward fathers focus on stopping the father's violence by increasing his awareness of the violence and its impact on the child, by increasing his accountability for the violence, and by helping to create empathy for the child. They also promote father involvement in parenting and give fathers skills to develop healthy and non-violent parenting. Programs for fathers that have shown some evidence of success in changing behaviors include "Caring Dads Safer Children" and "Fathers for Change" (Radford et al., 2019).

Perpetrator treatment needs to focus on individualized interventions that emphasize assessment, motivation enhancement, and interventions for substance use and mental health concerns.

Evidence-Based Treatment for Victims & Survivors

There are a number of programs that offer support to mothers and children who have been exposed to intimate partner violence. These programs tend to fall into three categories:

Separate Interventions are psychosocial interventions taking place simultaneously for mothers and children, but independently from one another. Often these are held at the same time and same place. These approaches run for 1 hour over 10-12 weeks. The psychoeducational group for mothers covers parenting skills and appropriate praising/reprimanding, positive expression of emotion, enhancing self-esteem and mental well-being, promoting prosocial child behavior, safety planning, setting goals for the future, and learning how to create and maintain successful interactions. The children are grouped into similar ages, and the structure of sessions are tailored accordingly. Topics included: mastery of behavior, managing feelings, dealing with conflict between peers, recognizing violent behavior in others, keeping safe, and taking responsibility for their own behavior.

Joint Interventions are those where the mother and child attend the interventions together but do not receive psychosocial support independently of each other. Interventions last 30-60 minutes over 8-12 weeks. The family intervention addresses difficulties in mother-child interactions and deficits in children's functioning, emotional support, problem-solving, and effective communication.

Combined interventions have separate intervention programs for mothers and children with joint sessions which they attend together. Examples of combined interventions are

a 10-week psychoeducational program with sessions lasting up to 2.5 hours. The first half of sessions are spent with mother and child together, working jointly on activities that aim to help share their experiences of the abuse and to acknowledge their related feelings and concerns while supporting one another. The second half of the sessions are in separate groups, where a structured program is implemented.

Interventions held separately for mothers and children were successful in targeting adjustment behaviors and parenting stress and in enhancing IPV-related coping skills. Interventions that worked with mother and child in a joint session were particularly useful in regard to child-centered, play-oriented principles as well as improving conduct problems. Interventions implementing a combination of separate and joint working were seemingly more successful in improving a wider range of outcomes, including traumatic stress, child adjustment, self-esteem, social problems, and positive attitudes. as well as increasing social support, self-efficacy, depression and confidence for mothers (Anderson & Van Ee, 2018).

An assessment of each family's experience and needs prior to referring to a program may help family members have the most success at recovering from their domestic violence experience.

Domestic Violence & Children

Often domestic violence co-occurs with other problems, and therefore children who experience family violence are frequently exposed to other adversities. These stressful situations early in life are referred to as adverse childhood experiences (ACEs). Traumatic exposures have long-lasting effects into adulthood and can impact one's physical and mental health and lead to substance misuse, interpersonal violence, and self-harm. While exposure to domestic violence can have long-term consequences, it does not mean that a person or child is permanently damaged. Everyone is capable of post-traumatic growth and recovery (Lloyd, 2018).

There are long-term effects on the 15 million children in the United States who have experienced domestic violence in their homes at least once. Children who experience domestic violence have a greater risk of continuing the cycle of abuse themselves, as adults, either becoming an abuser or entering into an abusive relationship and becoming a victim of domestic violence. Research shows that boys who see their mothers being abused are ten times more likely to abuse their partner as an adult. Girls who see their father abuse their mother are more than six times as likely to be sexually abused

compared to a girl who is raised in a non-abusive home. Children who witness abuse or are abused are at a greater risk of health problems than adults. The problems include mental health issues (including depression & anxiety), diabetes, obesity, heart disease, poor self-esteem, as well as other concerns (womenshealth.gov, 2022).

Impact of Abuse on Children

Research has shown that the duration of a child's exposure to domestic abuse has more impact on their stress level than the severity of the abuse. Domestic violence harm can be physical, emotional, behavioral, cognitive, and social, and the effects are usually intersected. Challenges arising from domestic violence vary across ages and the responses to the experiences, and each individual's needs and context are different.

Children who witness or are victims of domestic violence are at risk for long-term physical and mental health problems. Additionally, they may be fearful and anxious, constantly waiting for the next violent act to happen. Depending on their age, they can react in different ways.

Everyone, including children within the same families, respond to trauma and abuse differently; some are more resilient, while others are more sensitive. A child's success at recovering from abuse is dependent on numerous factors, including a good support system or a positive relationship with a trusted adult(s), high self-esteem, and healthy friendships. The sooner a child is able to receive help for the abuse they witnessed or experienced, the greater their chances are for dealing with their emotions and memories and recovering to become a healthy adult (womenshealth.gov, 2022).

Children who witness intimate partner violence are also more likely to experience physical abuse. Parental risk factors for child abuse include having children at a young age, lack of knowledge and experience raising children, low education levels, being exposed to violence in childhood, substance use, and mental health issues, including personality disorders. 52% of children who witness domestic violence have behavioral problems, 39% have adjustment disorders, and 60% of children believe they are responsible for domestic violence. The younger and longer children are exposed to domestic violence, the earlier they begin to show mental health difficulties (Almis et al.,2020)

Infants and very young children are especially vulnerable due to their dependence on adults for all aspects of their care. In utero, children may be exposed to violence that could cause miscarriage, premature birth, birth defects, or low birth weight. A mother living with the stress of abuse may use unhealthy stress-relieving tactics such as smoking or drinking, which can affect the fetus. The mother's partner may prevent her from attending health checks during pregnancy which could also cause harm to the fetus. Children under the age of one are at the greatest risk of homicide (Radford et al., 2021).

The first three years of a child's life are key for developing secure attachments with caregivers. Living in an environment with domestic violence or neglect can create attachment problems for a parent and child and influence the child's future ability to form secure relationships (Radford et al., 2021).

Impacts on Birth and Infancy

Infants exposed to IPV can experience low birth weight, premature birth, side effects from violence on fetal health, higher risks of homicide, delayed language development, delayed toilet training, sleep disturbance, crying and fretfulness, and fear of separation.

Impact on Young Children (age 1-4)

Research shows that psychosocial development is more problematic among toddlers exposed to IPV who also experience physical abuse. Domestic violence during early childhood can cause emotional problems. In preschool children, it can lead to separation anxiety from the non-abusing parent. Due to their young age, preschool children have limited coping skills and they may react to interparental violence through behavioral and psychological disengagement. Preschoolers who are sensitive to the noise of family violence may cope by tuning out the noise, which can pose challenges for those who want to interact with them in school. Young children are most likely to react to familial domestic violence in several ways, including being anxious, withdrawn, engaging in repetitive play, regressive behavior, inhibited independence, sleep difficulties, tantrums, or impaired understanding. The signs and symptoms of domestic violence are not always detectable, and it may be difficult for preschool staff to know whether the child's behavior is due to domestic violence exposure or regular age-appropriate behaviors. Staff can help by watching for changes in the child or their behaviors, particularly in the parent-child interactions, and notice if the child is reluctant to go home or appears fearful in the presence of a parent. Preschool staff can also provide support to the child by giving positive feedback, focusing on desirable behaviors, validating the child's feelings, and preparing them for transitions during the day. Children in preschool may

revert to younger-aged behaviors such as bed-wetting, thumb-sucking, and increased crying and whining. They may have difficulties falling and staying asleep, have severe separation anxiety, or show signs of terror, such as stuttering or hiding. They are at an increased risk for asthma, headaches, stomach aches, and nightmares. They may struggle with emotional dysregulation, behavior problems, social problems, low self-esteem, post-traumatic stress disorder, lack of empathy, tantrums, aggression, and anxiety. In these instances, preschool staff should provide space spaces and make referrals for help for the children when appropriate.

Impact on Children (age 5-10)

Young school-aged children experiencing separation anxiety can be clingy, fake sickness, or be disruptive at school in the hope of being sent home. Impacts of domestic violence may be experienced physically and include injury, eating difficulties, and stress-related conditions such as asthma and bronchitis. Effects may be experienced emotionally and include disruption to schooling, non-attendance, attention and concentration difficulties, sleep difficulties, withdrawal, insecurity, guilt, depression, and low self-esteem. Effects may also be experienced behaviorally, including changes in conduct, unpredictable behavior, aggression, anger, hyperactivity, and bullying (either as the perpetrator or victim). Some children who experience domestic violence at home display hypervigilance or hyperarousal at school, being constantly watchful and fearful of danger. It can also negatively impact their cognitive skills, language development, and educational achievements. School-aged children may feel guilty about the abuse and blame themselves for it happening. Domestic violence exposure harms a child's self-esteem. They refuse to participate in school activities, have failing grades, have few friends, and get into trouble frequently. They may also have physical health symptoms of frequent headaches and stomach aches. They may experience post-traumatic stress disorder, conduct disorder, and depression. These signs indicate that children need interventions to help them as they navigate their home and school lives (Lloyd, 2018; womenshealth.gov, 2022; Radford et al., 2021).

Impact on Older Children (age 11-16)

Potential signs of domestic violence in the home for older children include self-blame, depression, substance abuse, self-harm, suicidal ideation, risk-taking behavior, criminal behavior, lack of social networks, disaffection with education, and eating disorders. At this age, research begins to show a differentiation based on gender. Girls are more likely to internalize symptoms in the form of withdrawal, anxiety, and depression. Boys are more likely to externalize symptoms through violence against peers or antisocial

behavior as a way to mask anxiety and depression. Teenagers who witness domestic violence may act out in negative ways or risky behaviors such as fighting with family members, skipping school, using alcohol or drugs, having unprotected sex, running away from home, or becoming involved with gangs. They may also experience low self-esteem, have difficulties making friends, get into fights with peers or teachers in school, bully others, and have interactions with the law. Typically boys have more acting-out behaviors, and girls are more likely to be withdrawn or depressed. They may experience self-harm or suicidal thoughts and withdrawal from friends. Being listened to, taken seriously, and being involved in finding solutions are key to helping children in the age group cope. (Lloyd, 2018; womenshealth.gov, 2022; Radford et al., 2021).

School

Teachers can play a crucial role in identifying and responding to domestic violence, as they have more contact with children than any other service. While school staff may not be able to stop the violence at home, they are in a position to make referrals and offer support to the children in their classroom.

While some children may struggle with schoolwork, others may throw themselves into schoolwork as a form of escape. Some students experiencing domestic violence at home may find school a place of stability and security, while others may find it challenging. It is important to acknowledge that children experience a range of responses to domestic violence exposure (Lloyd, 2018).

Teachers report that students who experience domestic violence also have unstable living environments and can be exposed to homelessness, overcrowding living arrangements, living with relatives, living longer distances from school, and frequent moves. All this impacts students' ability to engage socially and academically. Other impacts reported due to the lack of stable housing because of domestic violence included a lack of home study space, limited access to a computer to complete homework, increased anxiety and stress, and living in noisy, overcrowded accommodations, which affected sleep. Teachers observed younger children being more withdrawn while older children showed more anger and aggression. Additionally, teachers reported that students living in shelters were more vulnerable to teasing and bullying.

Good practices in schools for addressing domestic violence include schools having awareness-raising assemblies, hanging posters and circulating information booklets,

hosting visits from social service agencies and the police, counselors, play therapists, and other learning professionals who work with child victims, and providing parents with support service information. Having support resources in school can be an important service for peers whose friends may confide in them.

Disclosing to an adult can be traumatic for children, with the potential for family members to become angry and the child to feel responsible for the consequences. Interventions can be perceived as punitive instead of protective.

Those experiencing domestic violence have a range of needs, and service providers must implement an intersectional approach that considers disability, race and ethnicity, age, socio-economic status, immigration status, gender and sexual orientation of children and parents (Lloyd, 2018).

Resilience & Protective Factors

There are a number of resilience and protective factors that have been identified for children exposed to domestic violence and abuse. Resilience is the ability to navigate through adversity using internal and external resources to support healthy adaptation, recovery, and successful outcomes for life. Resilience factors in children experiencing domestic violence fall under three categories, individual, interpersonal, and contextual. Mental health providers can support children by identifying and promoting existing protective factors to foster resilience, or they can help seek opportunities to develop resilience. Having a good, emotionally supportive relationship with an adult caregiver (most often the mother) significantly helps a child's ability to overcome the consequences of living with domestic violence (Radford et al., 2021).

Protective factors include:

Individual

- Self-confidence
- Greater self-worth
- Ability to regulate emotions
- Spirituality or faith
- Commitment to breaking the cycle of violence

- Being motivated or having goals
- Academic success
- Internal locus of control
- An easy temperament

Interpersonal

- One secure attachment
- Access to one safe adult
- A protective mother
- Maternal warmth
- Sensitivity and good mental health
- A social network that includes a trusted adult who comes into the home, such as a trusted relative
- Peer and social supports

Contextual

- A safe haven and accessible community resources
- Exit options, such as leaving home for college
- Having an educated mother with her own stable employment
- Connection to spirituality or faith
- Bicultural influence (Radford et al., 2021)

In the past, a child's exposure to domestic violence and abuse was defined as the child seeing or hearing physical violence between parents or adults in their home. It is now acknowledged as being broader than that. Different types of exposure to domestic violence include the following:

- Exposure prenatally where the mother experiences violence during her pregnancy
- Direct violence to the mother and violence to the child from either parent

- Seeing or hearing the violence
- The child intervening to stop the violence
- Being manipulated or forced into participating
- Observing the initial effects of the violence
- Hearing about the violence indirectly
- Experiences that result from the aftermath
- Being seemingly unaware (Radford et al., 2019)

Interventions for Children Exposed to Domestic Violence and Abuse

Building Strong Families (BSF)

BSF is a relationship skills program for new parents in low-income families who are not experiencing domestic violence at the time of intake screening. Positive results post-completion of the program included decreased paternal depression (self-reported) and partner violence (as reported by the mothers) when the child was aged 15 months. It also had a positive impact on children's internalizing and externalizing behaviors (as reported by fathers) when the child was aged 36 months (Radford et al., 2019).

Family Foundations

The Family Foundations Program is for first-time parents with the aim to promote co-parenting to improve outcomes for children. The classes are offered before and after birth. The focus is on each parent's adjustment (stress, depression, anxiety), self-regulation, co-parenting cooperation and support, and early parenting sensitivity.

Primary Prevention Programs

Primary prevention programs aim to stop domestic violence before it happens. This is accomplished by targeting families thought to be the most vulnerable. Much of the primary prevention work on domestic violence and child maltreatment addresses the

social norms and attitudes linked with violence. The emphasis on gender norms varies between programs; some address gender inequity indirectly by promoting joint decision-making and open communication between caregivers. One prevention tactic is home visits by health care professionals. This is usually done to deliver healthy parenting or healthy child services and does not necessarily directly address domestic violence incidents (Radford et al., 2019).

Best Practices Considerations

Best Practices for Service Providers

Protocol Development

Protocols surrounding IPV should be working documents that can be modified in response to community needs. For example, during the COVID-19 lockdown, protocols needed to be modified to address medical safety requirements. Protocols enable communication with clients, such as in-person vs. virtual working hours and what support services the organization provides. Protocols enable communication among service providers and collaboration and coordination between different agencies. Protocols also help mitigate financial challenges and burnout faced by agencies with fewer staff and resources. Having more information about what each shelter offers can assist a woman in planning her escape, and it can encourage others to be more knowledgeable of services so they may also make referrals (Slakoff et al., 2020).

Coercive Control and Intersectionality

Domestic violence service providers are expanding their definitions of intimate partner violence to include coercive behaviors. Service providers are also acknowledging how one's multiple identities can impact their experience with intimate partner violence. For example, impoverished victims may not have access to a phone or internet, and meeting those needs will be required for them to be able to access services. By recognizing multiple marginalized identities, service providers can better tailor their services to meet their client's needs (Slakoff et al., 2020).

Prevention and Intervention

Service providers should educate victims on COVID-19 and other crisis situations, so they can recognize if their abuser is using misinformation to maintain control over them.

Being isolated with an abuser during a pandemic or crisis limits a victim's access to informal and formal supports. While free and confidential 24-hour hotlines are available, victims may be unable to access them due to the abuser's increased power and control. Service provider roles include:

- recognizing safety concerns and supporting victims who seek services
- assessing risks
- creating a safety plan to support victims in isolation due to the pandemic or other crises

Standard aspects of a safety plan include whom to contact for help should the abuse escalate, the safest rooms in the house, and what personal items should be gathered together in case a swift exit is necessary. Safety plans should include how to safely use technology, including which organizations' websites have a quick-escape feature. In addition, service providers can encourage victims to establish a code word with friends, family, or other safe persons to signal distress.

Service providers must be aware of technology-assisted abuse, as abusers may monitor or hack a victim's phone or computer without their knowledge. This abuse was an added challenge during the pandemic when many organizations shifted to remote services. Providers must quickly and effectively build a social support network and safety plan when contacting a victim. This may be their only chance to communicate with the victim should their abuser discover the communication and prohibit further interactions. Lack of shelter space is often a concern for many organizations (Slakoff et al., 2020).

Education for Informal Supports

Since victims tend to disclose intimate partner violence to informal support first, service providers should educate everyone to recognize and respond to intimate partner violence and to know when and how to refer victims to professional support. For example, educating informal support on how to establish safety check-ins or receive alerts from individuals who need help, such as code words of "we're out of milk," flicking an outdoor light on and off, or opening and closing blinds. A victim may also signal for help during a video call by using a tucked-thumb and closed-fist hand gesture (Slakoff et al., 2020).

Best Practices For Technology

Technology Education

Advocates and victims need to be aware of the most up-to-date technologies abusers use to monitor and track their victims. In addition, organizations can help victims stay safe online through educational resources. The following are examples of safety apps and tools that service providers and victims should be aware of:

1. Incognito mode is a setting in the browser that prevents any website history, including web pages, cookies, and images, from being stored or saved to the user's computer.
2. The Circle of 6 app allows victims to use two taps to send a pre-programmed text message with their location to a select group of people asking for help. The app can also send a text asking someone to call the victim at a moment that needs to be interrupted.
3. The One Love app has a danger checklist validating that, "Yes, this is abuse," to those who may be unsure. This app is useful for victims/survivors and concerned friends and family to educate themselves.
4. Within-game chat features allow a victim to communicate with others to get help and make a safety plan with friends or family instead of through text messages. While some abusers may check text messages, they may not think to check the chat feature in a game.
5. Digital communication programs that do not require downloading an app to the victim's device ae us, such as Gruveo, an encrypted web-based video chat service used by some organizations in Australia to connect with victims who were isolated at home during COVID-19 (Slakoff et al., 2020).

Digital Aid Tools

- A shielded website has a specific icon in the footer that, when clicked, launches a modal window (similar to a pop-up, a modal window presents new information without leaving the current page). The modal window contains information about domestic violence and a live chat option for support and safety planning. It also includes a contact form to request a call or email from a professional advocate. A modal window means only the host website will appear in the browser history,

making it a safe and secure method for accessing support for victims whose abusers are monitoring their internet use.

Other examples of technologies being modified to address domestic violence safety include:

- Yolo County, California, is implementing an online court document filing system instead of requiring paperwork to be submitted in person or completed over the phone.
- An app to assess users' safety and provide a list of resources to match their indicated needs.
- Snapchat began to offer support and resources for domestic violence victims and survivors. Resources are offered with subtitles so people can view them silently and safely.
- Websites that may offer information that could put a victim at risk should have quick escape buttons on their pages. It allows the user to quickly close the site, and the button is usually large and easy to see on each page and easier and quicker than closing with the small tab x button. It is more discreet than closing a laptop or shutting down one's computer. Another design consideration with a quick escape button is that it could close the current page and open a new website that is less suspicious to the abuser. When the back button is hit, there is either no previous history for that window or tab, or it goes to the second previous webpage, completely skipping or erasing the domestic violence website history.
- Technology developers should be educated on how their technology could be subverted for domestic violence misuse and the steps they could take to make their websites and apps safer to use (Slakoff et al., 2020).

Best Practices for Media

Media representatives have an important role in how they depict intimate partner violence and in influencing how viewers perceive victims and perpetrators. Media sources can quickly educate a large group of people at one time about IPV. One aspect that the media should be aware of, especially during the pandemic or other disasters/ crises, is that while the pandemic/crises exacerbate domestic violence, they do not cause domestic violence. Mithani is quoted as saying, "domestic violence is about power

and control, and when your job, finances, and livelihood are all up in the air, abuse becomes a place where people seek to regain that sense of control." Media sources could focus on education surrounding domestic violence and abusive strategies, coercive control, technology-facilitated domestic violence, prevention and intervention programs for domestic violence, and how informal supports can help victims feel safe while at home. Domestic violence is a broad social issue, not an individual issue or a pandemic crisis.

The media can also place political pressure on institutions and governments in an attempt for more public accountability. Political figures and groups often look to the media to see what issues are areas their constituents are looking for them to support. The media can help encourage governments to fund programs and their infrastructure and services provided. Even during the best of times, domestic violence shelters and service providers are overworked and underfunded, and the pandemic exacerbated many of the issues that were already there (Slakoff et al., 2020).

Conclusion

Intimate partner violence causes distress for perpetrators, victims, and others in their families and social networks. While certain populations are more vulnerable to victimization and perpetration of IPV, there is no community or group of people who are immune. IPV impacts the victims' physical and mental health, both in the short and long-term. Children's experience of IPV may be different depending on their developmental stage, how long they are exposed, and how intense or severe the violence is. Prevention and intervention programs should be tailored to the individual, couple, or family. Assessment is key in addressing safety, the best treatment intervention, and any necessary referrals for substance or mental health needs. Using evidence-based practices and ongoing research, mental health professionals are improving interventions and their effectiveness in reducing intimate partner violence.

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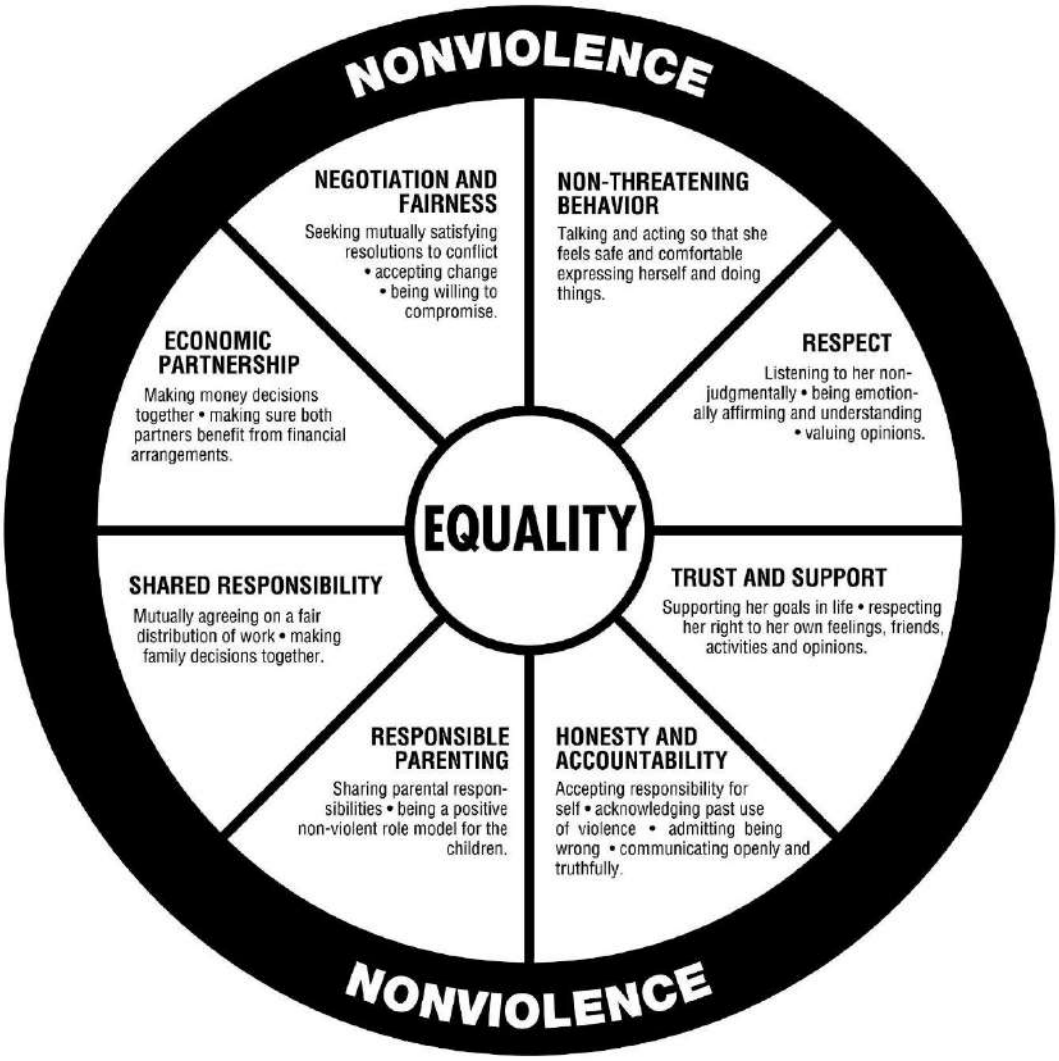
Appendix A: Power & Control Wheel

DOMESTIC ABUSE INTERVENTION PROGRAMS
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.theduluthmodel.org

Appendix B: Equality Wheel



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Appendix C: CTS2S: Revised Conflict Tactics Scale, Short

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University of New Hampshire

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, mark a "7" on your answer sheet for that question. If it never happened, mark an "8" on your answer sheet.

How often did this happen?

1 = Once in the past year

2 = Twice in the past year

3 = 3-5 times in the past year

4 = 6-10 times in the past year

5 = 11-20 times in the past year

6 = More than 20 times in the past year

7 = Not in the past year, but it did happen before

8 = This has never happened

1. I explained my side or suggested a compromise for a disagreement with my partner.	1 2 3 4 5 6 7 8

2. My partner explained his or her side or suggested a compromise for a disagreement with me.	1 2 3 4 5 6 7 8
3. I insulted or swore or shouted or yelled at my partner.	1 2 3 4 5 6 7 8
4. My partner insulted or swore or shouted or yelled at me.	1 2 3 4 5 6 7 8
5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.	1 2 3 4 5 6 7 8
6. My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.	1 2 3 4 5 6 7 8
7. I showed respect for, or showed that I cared about my partner's feelings about an issue we disagreed on.	1 2 3 4 5 6 7 8
8. My partner showed respect for, or showed that he or she cared about my feeling about an issue we disagreed on.	1 2 3 4 5 6 7 8
9. I pushed, shoved, or slapped my partner.	1 2 3 4 5 6 7 8
10. My partner pushed, shoved, or slapped me.	1 2 3 4 5 6 7 8
11. I punched or kicked or beat-up my partner.	1 2 3 4 5 6 7 8
12. My partner punched or kicked or beat-me-up.	1 2 3 4 5 6 7 8
13. I destroyed something belonging to my partner or threatened to hitmy partner.	1 2 3 4 5 6 7 8
14. My partner destroyed something belonging to me or threatened to hit me.	1 2 3 4 5 6 7 8
15. I went to see my doctor (M.D.) or needed to see a doctor because of a fight with my partner.	1 2 3 4 5 6 7 8
16. My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.	1 2 3 4 5 6 7 8
17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	1 2 3 4 5 6 7 8

18. My partner used force (like hitting, holding down, or using a weapon) to make me have sex.	1 2 3 4 5 6 7 8
19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).	1 2 3 4 5 6 7 8
20. My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).	1 2 3 4 5 6 7 8

Scoring

The recommended method of scoring for physical assault, injury and sexual coercion scale is to create a variable for "prevalence" by assigning a score of 1 if one or more instances of the items were reported to have occurred and 0 if no instances were reported. For the Negotiation scale the recommended scoring method is to sum the number of times each behavior was reported. To do this, the answer categories must be converted from 0-7 to the midpoint of the range of scores in each category.

Scale	Questions in each Subscale
Negotiation	1, 2 (cognitive) and 3,4 (emotional)
Psychological Aggression	5,6 (less severe) and 7,8 (more severe)
Physical Assault	9,10 (less severe) and 11,12 (more severe)
Sexual Coercion	13,14 (less severe) and 15,16 (more severe)
Injury	17,18 (less severe) and 19,20 (more severe)

Appendix D: Safety Plan

DOMESTIC VIOLENCE PERSONALIZED SAFETY

Name: _____

Date: _____

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

STEP 1: Safety during a violent incident. *Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.*

I can use some of the following strategies:

A. If I decide to leave, I will _____ . *(Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)*

B. I can keep my purse and car keys ready and put them *(location)* _____ _____ in order to leave quickly.

C. I can tell _____ about the violence and request that she or he call the police if she or he hears suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police, the fire department, and 911.

E. I will use _____ as my code with my children or my friends so they can call for help.

F. If I have to leave my home, I will go to _____ .

(Decide this even if you don't think there will be a next time.)

G. I can also teach some of these strategies to some or all of my children.

H. When I expect we're going to have an argument, I'll try to move to a place that is low risk, such as _____. *(Try to avoid*

arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.)

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we

STEP 2: Safety when preparing to leave. *Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safe- ty. Batterers often strike back when they believe that a battered woman is leaving a relationship.*

I can use some or all of the following strategies:

A. I will leave money and an extra set of keys with _____ so I can leave quickly.

B. I will keep copies of important documents or keys at _____ .

C. I will open a savings account by _____, to increase my independence.

D. Other things I can do to increase my independence include: _____

_____ .

E. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month's phone bill will show my batterer those numbers I called after I left. To keep my phone communications confidential, I must either use coins, or I might ask to use a friend's phone card for a limited time when I first leave.

F. I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

G. I can leave extra clothes or money with _____.

H. I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____ (domestic violence advocate or friend's name) has agreed to help me review this plan.

I. I will rehearse my escape plan and, as appropriate, practice it with my children.

STEP 3: Safety in my own residence. *There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.*

Safety measures I can use:

I can change the locks on my doors and windows as soon as possible.

I can replace wooden doors with steel/metal doors.

I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

I can purchase rope ladders to be used for escape from second floor windows.

I can install smoke detectors and fire extinguishers for each floor of my house/ apartment.

I can install an outside lighting system that activates when a person is close to the

house.

G. I will teach my children how to make a collect call to me and to _____ (name of friend, etc.) in the event that my partner takes the children.

H. I will tell the people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include:

_____ (name of school)

_____ (name of babysitter)

_____ (name of teacher)

_____ (name of Sunday-school teacher)

_____ (name[s] of others)

I. I can inform _____ (neighbor) and _____ (friend) that my partner no longer resides with me and that they should call the police if he is observed near my residence.

STEP 4: Safety with an Order of Protection. *Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protective orders.* I recognize that I may need to ask the police and the courts to enforce my protective order.

The following are some steps I can take to help the enforcement of my protection order:

A. I will keep my protection order _____ (location). *Always keep it on or near your person. If you change purses, that's the first thing that should go in the new purse.*

B. I will give my protection order to police departments in the community where I work, in those communities where I visit friends or family, and in the community where I live.

C. *There should be county and state registries of protection orders that all police departments can call to confirm a protection order.* I can check to make sure that my order is on the registry. The telephone numbers for the county and state registries of protection orders are:

_____ (county) and _____ (state).

D. I will inform my employer; my minister, rabbi, etc.; my closest friend; and _____ that I have a protection order in effect.

E. If my partner destroys my protection order, I can get another copy from the clerk's office.

F. If the police do not help, I can contact an advocate or an attorney and file a complaint with the chief of the police department or the sheriff.

G. If my partner violates the protection order, I can call the police and report the violation, contact

STEP 5: Safety on the job and in public. *Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family, and co-workers can help to protect women. Each woman should carefully consider which people to invite to help secure her safety.*

I might do any or all of the following:

A. I can inform my boss, the security supervisor, and _____ at work.

B. I can ask _____ to help me screen my telephone calls at work.

C. When leaving work, I can _____ .

D. If I have a problem while driving home, I can _____ .

E. If I use public transit, I can _____ .

F. I will go to different grocery stores and shopping malls to conduct my business and shop at hours that are different from those I kept when residing with my battering partner.

G. I can use a different bank and go at hours that are different from those kept when residing with my battering partner.

STEP 6: Safety and drug or alcohol use. *Most people in this culture use alcohol. Many use mood-altering drugs. Much of this is legal, although some is not. The legal outcomes of using il- legal drugs can be very hard on battered women, may hurt her relationship with her children, and can put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. Beyond this, the use of al- cohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him an excuse to use violence. Specific safety plans must be made concerning drugs or alcohol use.*

If drug or alcohol use has occurred in my relationship with my battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. If my partner is using, I can _____

and/or _____

.

C. To safeguard my children I might _____

.

STEP 7: Safety and my emotional health. *The experience of being battered and verbally de- graded by partners is usually exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy.*

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and am returning to a potentially abusive situation, I can _____

_____

.

B. When I have to communicate with my partner in person or by telephone, I can _____

_____

C. I will try to use "I can … " statements with myself and be assertive with others.

D. I can tell myself, "_____ " whenever I feel others are trying to control or abuse me.

E. I can read _____ to help me feel stronger.

F. I can call _____ and _____ for support.

G. I can attend workshops and support groups at the domestic violence program or _____ _____ to gain support and strengthen relationships.

STEP 8: Items to take when leaving. *When women leave partners, it is important to take certain items. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.*

Money: Even if I never worked, I can take money from jointly held savings and checking accounts. If I do not take this money, he can legally take the money and close the accounts.

Items on the following lists with asterisks by them are the most important to take with you. If there is time, the other items might be taken, or stored outside the home. These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly. When I leave, I should take:

*Identification for myself

*My birth certificate

*School and vaccination records

*Checkbook, ATM card

*Key - house, car, office

*Children's birth certificate

*Social Security cards

*Money

*Credit cards

*Driver's license and registration

*Medications

*Copy of protection order

*Welfare identification, work permits, green cards

Passport(s), divorce papers

Medical records - for all family members

Lease/rental agreement, house deed, mortgage payment book Bank books, insurance papers

Address book Pictures, jewelry

Children's favorite toys and/or blankets Items of special sentimental value

Telephone numbers I need to know:

Police/sheriff's department (local) - 911 or _____

Police/sheriff's department (work) _____

_____

Police/sheriff's department (school) _____

_____

Prosecutor's office _____

_____

Battered women's program (local) _____

_____

National Domestic Violence Hotline: 800-799-SAFE (7233)

800-787-3224 (TTY)

www.ndvh.org

County registry of protection orders _____

_____

State registry of protection orders _____

Work number _____

_____

Supervisor's home number _____

_____

I will keep this document in a safe place and out of the reach of my potential attacker.

Review date: _____