Mindful
Continuing Education

Treatment of Men and Women Who Have Experienced Intimate Partner Violence

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Introduction

Intimate Partner Violence (IPV) is defined as any behavior by a current or past intimate partner that results in physical, sexual, or psychological harm (Gedefa et al., 2024). This encompasses acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors. “IPV can vary in frequency and severity, ranging from one episode to chronic and severe episodes over multiple years (*About Intimate Partner Violence*, 2024).” Mazza et al. (2021) explain that IPV is a significant public health issue affecting both men and women, across all demographics and can have enormous and life-altering impacts on physical and mental health.

Dynamics of Abusive Relationships

Intimate Partner Violence (IPV) often involves a cycle of abuse that includes patterns of tension-building, abusive incidents, and reconciliation. This cycle creates a dynamic of control and dependence that can trap victims in abusive relationships. Recent research underscores the role of psychological manipulation within this cycle, where abusers employ tactics such as gaslighting, isolation, and guilt to undermine their partner's sense of reality and self-esteem. This manipulation not only perpetuates the abuse but also complicates a survivor's ability to seek help or leave the relationship (Gedefa et al., 2024b).

Economic control is another critical dynamic in IPV relationships. Abusers may restrict access to financial resources, sabotage employment opportunities, or accrue debt in the survivor's name. This form of economic abuse creates a dependency that makes it difficult for survivors to achieve financial independence, which is often necessary to exit an abusive situation. Adams et al. (2024) published a study in the *Quarterly Journal of Economics* highlighting how

economic constraints can exacerbate the cycle of abuse, making it crucial for interventions to include prolonged financial empowerment strategies.

Cultural and societal norms further shape the dynamics of IPV. Gender roles, stigma, and community attitudes towards violence can influence both the prevalence and reporting of IPV. In some contexts, survivors may face pressure to remain silent or stay in abusive relationships due to cultural expectations or fear of judgment. Research from the *International Journal of Social Work and Human Services Practice* emphasizes the need for culturally sensitive approaches to IPV intervention, which consider the diverse experiences and barriers faced by survivors (Adams et al., 2024).

Understanding these multi-faceted dynamics—psychological manipulation, economic abuse, and cultural influences—offers a comprehensive framework for addressing IPV. By tailoring interventions to address these factors, practitioners can support survivors in overcoming the barriers that prolong patterns and instances of IPV and foster pathways toward recovery, resilience, and empowerment.

Isolation is a prevalent tactic in Intimate Partner Violence (IPV), where abusers deliberately sever connections to family, friends, and support networks. This enforced isolation heightens the need for the victim to depend on the abuser, limiting their access to external assistance and instilling fear if they seek help and resources. The resulting social isolation can lead to profound feelings of loneliness and entrapment, exacerbating the psychological impact of the abuse (Gillis, 2024).

Grief is another significant factor in IPV dynamics. Survivors often experience grief not only from the loss of their autonomy and well-being but also from the erosion of the relationship they once valued. This complex grief can be intensified by the abuser's manipulation, leading to confusion and emotional turmoil, among other mental health symptoms. Addressing this grief is essential in the healing process,

as unprocessed grief and trauma can hinder recovery and perpetuate psychological distress (Hamilton et. al., 2023).

Childhood trauma plays a critical role in the dynamics of IPV. Individuals who have experienced or witnessed violence during childhood are at an increased risk of becoming involved in abusive relationships as adults, either as perpetrators or survivors. This intergenerational transmission of violence underscores the importance of early intervention and trauma-informed care to break the cycle of abuse. Understanding the impact of childhood trauma is vital for practitioners working with IPV survivors, as it influences attachment patterns, coping mechanisms, and the overall therapeutic process. “Mental health challenges, such as the development of posttraumatic stress disorder (PTSD) resulting from childhood maltreatment may also increase the likelihood of experiencing or perpetrating IPV (Kisely et al., 2024).”

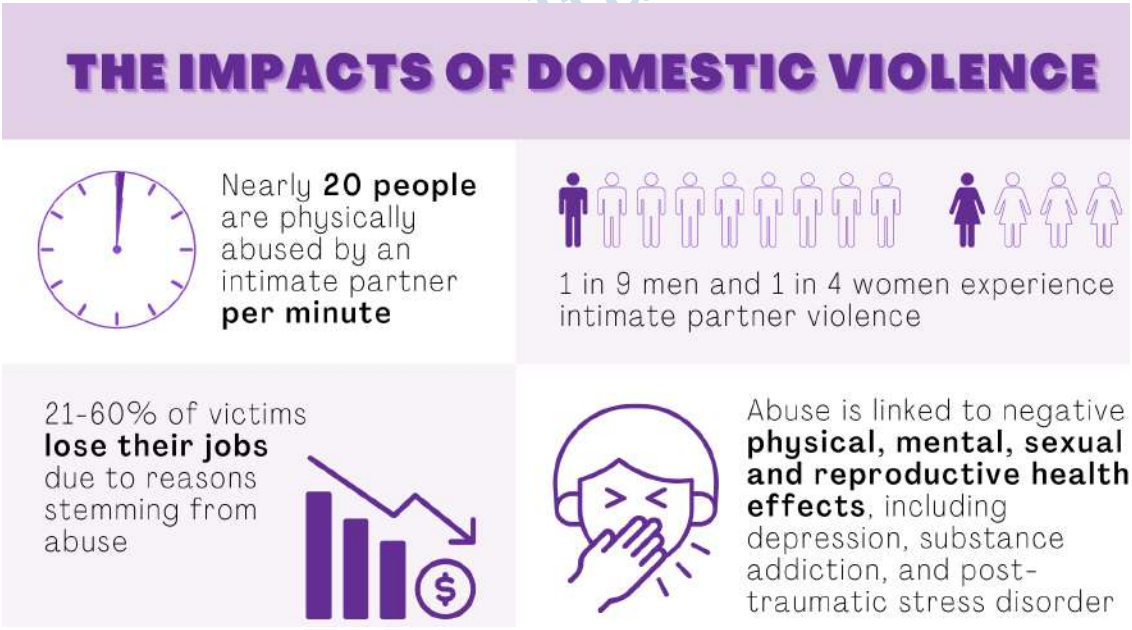

Fig 1: Los Angeles Center for Law and Justice, 2022

Exploring Attachment Theory and Intimate Partner Violence

Attachment theory provides a valuable framework for understanding the dynamics of intimate partner violence (IPV). Recent studies have highlighted the significant role of attachment patterns in both the perpetration and experience of IPV. Individuals with insecure attachment styles, particularly anxious and avoidant attachments, are more vulnerable to engaging in or becoming victims of IPV. A 2023 study found a positive correlation between anxious and avoidant attachment and IPV perpetration, suggesting that individuals with anxious or avoidant attachment styles may combat relationship dynamics, leading to increased conflict and hostile or impulsive actions in future relationships (Arseneault et al., 2023). Spencer et al. (2020) found in a meta-analysis that anxious, avoidant, and disorganized attachment styles are significant correlates of physical IPV perpetration. This emphasizes the importance of addressing attachment-related issues in interventions aimed at reducing IPV.

The interplay between complex trauma and attachment patterns also plays a crucial role in IPV. Individuals with histories of childhood trauma may develop insecure attachment styles, which can influence their adult relationships and increase the risk of experiencing or perpetrating IPV. Speranza et al. (2022) stressed the need to consider both complex trauma and attachment representations when addressing IPV, highlighting the importance of trauma-informed approaches in therapeutic settings. By understanding and addressing underlying attachment insecurities and past traumas, mental health professionals can better support individuals in forming healthier relationships and reducing the incidence of IPV.

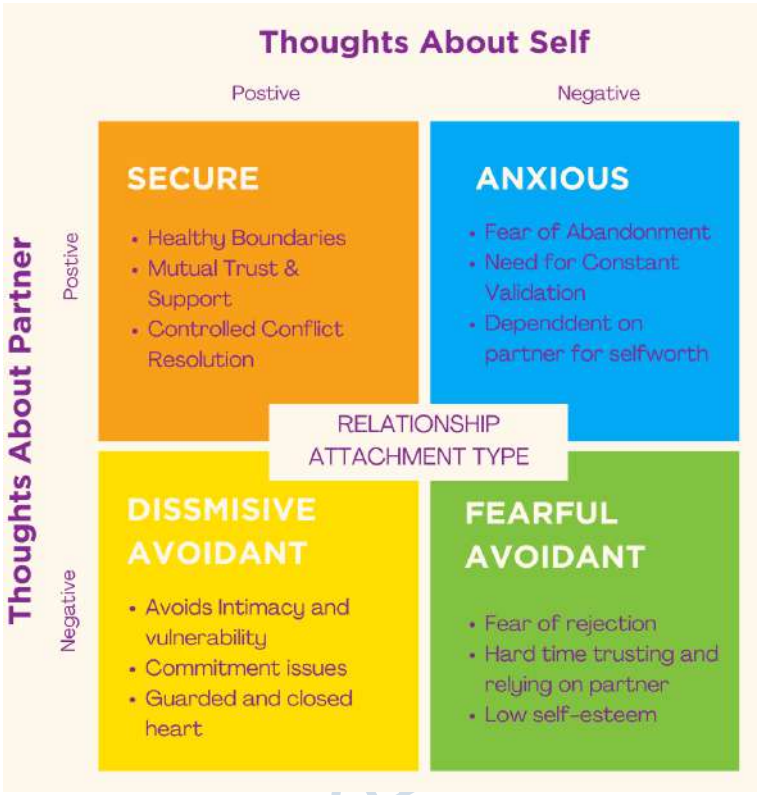

Figure 2: *Relationship attachment type*, (n.d.)

Neurobiology of Trauma and Intimate Partner Violence

Post-Traumatic Stress Disorder (PTSD) significantly alters brain function, particularly affecting regions involved in fear processing and emotional regulation. The amygdala, a central component of the brain's fear circuitry, becomes hyperactive in individuals with PTSD, leading to heightened fear responses and hypervigilance. This hyperactivity contributes to the typical symptoms of PTSD, including persistent anxiety and an exaggerated startle response. Hypervigilance, a state of increased alertness and sensitivity to potential threats, is a common symptom of PTSD. This heightened state of arousal is linked to the overactivity of the amygdala and its interactions with other brain regions, such as the prefrontal

cortex, which is responsible for executive functions and decision-making. The imbalance between the hyperactive amygdala and the underactive prefrontal cortex impairs the individual's ability to distinguish between real and perceived threats, perpetuating anxiety and stress. The phenomenon known as "amygdala hijack" occurs when the amygdala overrides the prefrontal cortex, leading to impulsive reactions without rational thought. In PTSD, this can result in sudden emotional outbursts or panic attacks triggered by reminders of the traumatic event. Understanding the neurobiological underpinnings of this response is crucial for developing effective therapeutic interventions aimed at restoring balance between these brain regions (Davis & Hamner, 2024).

Recent research has further deciphered the neurobiology of trauma, highlighting the complex interplay between various neural circuits and molecular processes, by disrupting these neurochemical pathways. Iqbal et al. (2023) explained that dysfunction in these systems contributes to the persistence of fear memories and a highly decreased chance of extinguishing them, which are tell-tale features of PTSD. Research in this field is paving the way for evidence-based treatment approaches targeting these specific neural pathways. Understanding the neurobiological alterations in PTSD, including hypervigilance, anxiety, and the amygdala hijack, is essential for developing targeted treatments. By focusing on the specific brain regions and circuits involved, therapeutic strategies can be tailored to address the underlying neurobiological dysfunctions, offering hope for more effective interventions for those affected by trauma. Thus, a trauma-inflicted brain is often referred to as “top heavy” and has neuroplastic alterations in its anatomy that can only be changed through addressing the trauma itself. Doing so, however, requires the self-determination of the abused victim to escape their circumstances. As mentioned earlier, this is a formidable task. The figure below shows the trauma brain and how the anatomy is changed.

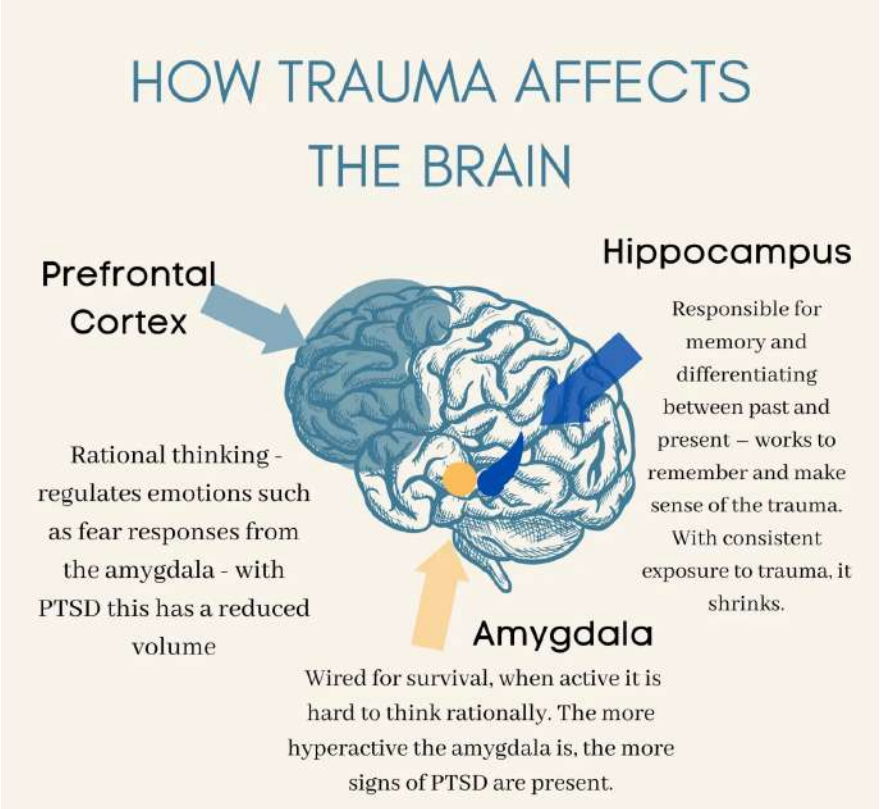

Figure 3. How Trauma Affects the Brain

IPV and the Development of Post-Traumatic Stress Disorder (PTSD)

Intimate Partner Violence (IPV) is a significant contributor to the development of Post-Traumatic Stress Disorder (PTSD) among survivors. Studies indicate that the prevalence of PTSD among IPV victims varies widely, ranging from 33% to 80%. Experiences of IPV, including physical, sexual, and psychological abuse, can lead to the development of PTSD, with variations observed across different racial and ethnic groups (Shorey et al., 2021). The impact of IPV on mental health underscores the necessity for comprehensive support systems to address the psychological consequences faced by survivors. Further, (Roland et al., 2024) found similar results in a French study aimed to examine the prevalence of PTSD

among victims and survivors of IPV consulting at specialized facilities. The research utilized a mixed-methods approach and found that IPV is associated with an increased risk of developing PTSD, highlighting the critical need for targeted interventions to support survivors in managing and mitigating these psychological effects.

Additionally, if the victims experience head trauma from IPV, this has been linked to higher development rates of PTSD, Traumatic brain injury (TBI), and depressive symptoms. Individuals who experience IPV-related head trauma often report these mental health challenges, emphasizing the importance of addressing both physical and psychological injuries in the treatment of IPV survivors (Jain et al., 2024). These findings highlight the urgent need for comprehensive mental health support and trauma-informed care for IPV survivors to address the multifaceted impact of abuse on their psychological well-being.

Assessment Methods for Intimate Partner Violence

Assessment for Intimate Partner violence (IPV) is a critical responsibility for mental health professionals requiring a specialized understanding of risk factors, effective screening tools, and collaborative approaches. Current research underlines the importance of comprehensive risk assessment frameworks in identifying and managing IPV cases. Olsson et al. (2023) highlight the necessity for mental health professionals to be skilled in utilizing structured risk assessment tools to evaluate the potential for harm accurately. These tools aid in systematically identifying risk factors associated with IPV, thereby informing intervention strategies.

The integration of standardized clients in training programs has been shown to enhance social workers' competencies in IPV assessment. This experiential learning approach allows practitioners to develop and refine their skills in a

controlled environment, improving their ability to conduct culturally sensitive and effective assessments in real-world scenarios.

Collaboration between social workers and law enforcement is also essential in addressing IPV. A 2024 study from Sweden affirmed the need for effective communication and joint risk assessments between these professionals to ensure comprehensive support for IPV survivors. Such interdisciplinary collaboration enhances the accuracy of risk assessments and the effectiveness of subsequent interventions (Larsson et al., 2024). Incorporating these insights into practice, social workers should engage in continuous professional development, including evidence-based research to stay abreast of advancements in IPV assessment methodologies. By employing structured risk assessment tools, participating in practical training, and nurturing collaborative relationships with law enforcement, social workers and other mental health professionals can enhance their capacity to identify and support individuals affected by intimate partner violence.

Intimate partner violence (IPV) screening remains controversial. Major medical organizations mandate screening, whereas the U.S. Preventive Services Task Force (USPSTF) cautions that there is insufficient evidence to recommend for or against screening. An effective IPV screening program must include a screening tool with sound psychometric properties. The HITS (Hurt, Insult, Threaten, Scream) assessment tool is a widely used screening instrument designed to identify individuals experiencing Intimate Partner Violence (IPV). Developed for quick implementation in healthcare and social service settings, HITS is a self-reported questionnaire that includes four items addressing the frequency of specific abusive behaviors: being physically hurt, insulted or talked down to, threatened with harm, or screamed at by a partner. Respondents rate each behavior on a five-point Likert scale ranging from 1 (never) to 5 (frequently). A total score of 10 or higher suggests the presence of IPV and indicates the need for further assessment or intervention (Collins et al., 2023).

HITS is valued for its brevity, simplicity, and applicability across various populations. Studies have shown its effectiveness in primary care and mental health settings, particularly due to its ability to facilitate conversations about IPV without requiring extensive time or resources. Recent research emphasizes the importance of cultural sensitivity when using tools like HITS, as cultural norms can influence how individuals perceive and report abusive behaviors (Collins et al., 2023). Social workers and clinicians are encouraged to use the HITS tool as part of a broader, trauma-informed approach to ensure that individuals feel safe and supported during the screening process.

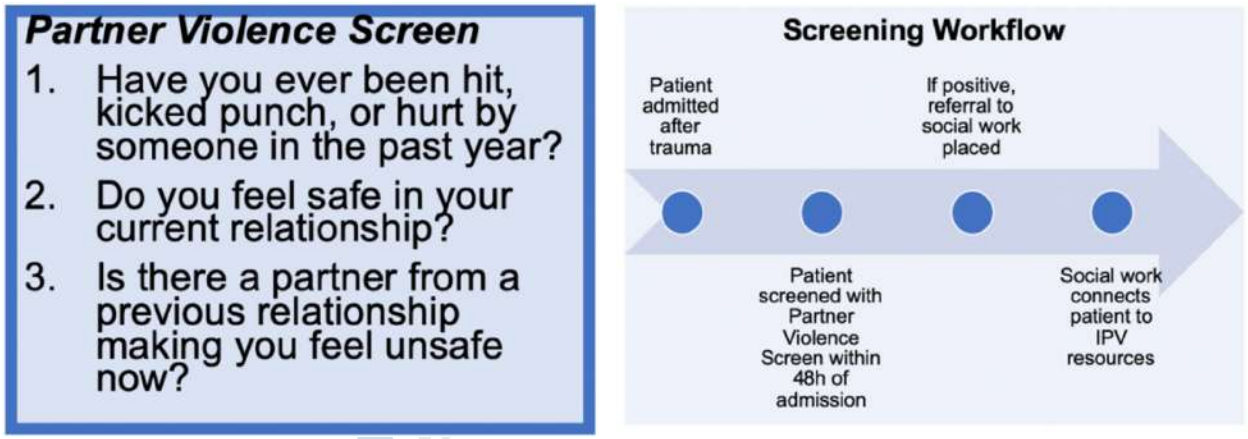

Figure 4. HITS IPV Screening

Other methods for assessing Intimate Partner Violence (IPV) include standardized screening tools, clinical interviews, and observational assessments. Each method has its strengths and is typically chosen based on the context of the assessment and the resources available. The Danger Assessment (DA) evaluates the risk of fatality in IPV situations, especially centering on the potential for severe violence or homicide and it aids in safety planning and interventions.

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following.
("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

Yes	No		
_____	_____	1.	Has the physical violence increased in severity or frequency over the past year?
_____	_____	2.	Does he own a gun?
		3.	Have you left him after living together during the past year?
_____	_____		3a. (If have *never* lived with him, check here___)
_____	_____	4.	Is he unemployed?
_____	_____	5.	Has he ever used a weapon against you or threatened you with a lethal weapon?
_____	_____		5a. (If yes, was the weapon a gun?____)
_____	_____	6.	Does he threaten to kill you?
_____	_____	7.	Has he avoided being arrested for domestic violence?
_____	_____	8.	Do you have a child that is not his?
_____	_____	9.	Has he ever forced you to have sex when you did not wish to do so?
_____	_____	10.	Does he ever try to choke you?
		11.	Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
_____	_____		
_____	_____	12.	Is he an alcoholic or problem drinker?
		13.	Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car?
_____	_____		(If he tries, but you do not let him, check here: ____)
		14.	Is he violently and constantly jealous of you?
_____	_____		(For instance, does he say "If I can't have you, no one can.")
		15.	Have you ever been beaten by him while you were pregnant?
_____	_____		(If you have never been pregnant by him, check here: ____)
_____	_____	16.	Has he ever threatened or tried to commit suicide?
_____	_____	17.	Does he threaten to harm your children?
_____	_____	18.	Do you believe he is capable of killing you?
		19.	Does he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him to?
_____	_____		
_____	_____	20.	Have you ever threatened or tried to commit suicide?
_____	_____	Total "Yes" Answers	

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Fig 5. Danger Assessment Wood et al. (2024)

The Women Abuse Screening Tool (WAST) evaluates both emotional and physical abuse in intimate relationships, providing a comprehensive overview of the abuse spectrum (Guiguet-Auclair et al., 2021). In-depth interviews allow practitioners to

explore the nuances of a survivor's experience, including the context and impact of the abuse. This method facilitates a deeper understanding of the survivor's needs and the development of tailored intervention strategies (Lock et al., 2024). Further evaluation can utilize observational methods, which require the clinician to recognize non-verbal cues, behavioral indicators, and physical signs that may suggest IPV, especially when survivors are reluctant to disclose abuse. This approach requires practitioners to be vigilant and sensitive to subtle signs of distress or fear.

Implementing trauma-informed care principles ensures that assessments are conducted in a manner that puts the potential victim's safety, autonomy, and empowerment first, thereby minimizing the risk of re-traumatization. This method recognizes the widespread impact of trauma and integrates this understanding into practice (Miller et al., 2021). Employing a combination of the above methods can ensure the validity and comprehensiveness of IPV assessments. For instance, integrating standardized tools with clinical interviews allows for both the efficient identification of IPV and a detailed understanding of the survivor's unique experience.

Recent studies emphasize the importance of cultural sensitivity and the adaptation of assessment tools to effectively serve diverse populations. Tailoring assessments to consider cultural, linguistic, gender, sexual orientation, and individual differences is crucial for accurately identifying and addressing IPV (Lock et al., 2024b). A versatile approach that combines evidence-based tools, clinical interviews, observational assessments, and trauma-informed care, all conducted with cultural sensitivity, is essential for the effective assessment of IPV in clinical practice. By incorporating these methods, clinicians can create a more comprehensive understanding of each survivor’s unique experiences and needs, ensuring that interventions are both relevant and effective. Additionally, fostering an environment of respect and inclusivity helps survivors feel understood and

supported, ultimately enhancing their willingness to engage in the therapeutic process.

Case Study #1: Assessing Potential Intimate Partner Violence

Maya Lopez, a 34-year-old woman, presents to the emergency department with complaints of abdominal pain and unexplained bruising on her upper arms and back. During the examination, Maya appears hypervigilant, frequently scanning the room and flinching at sudden movements. She is visibly anxious, avoiding direct eye contact with the medical staff. Her partner, Alex, is present and insists on staying in the room, answering questions on Maya's behalf and deflecting inquiries about her injuries.

There are clinical indicators of IPV on exam which include multiple bruises in varying stages of healing, inconsistent with the reported cause of "accidentally falling down the stairs." She presents with signs of psychological distress, including hypervigilance and anxiety, and shows hesitation to answer questions and deferral to the partner. The partner is reluctance to allow Maya to be alone with the medical team. Despite Alex's protests, the staff manage to get Maya alone under the pretext of needing Alex to complete paperwork at the front desk.

Using the **Danger Assessment (DA)** as a guideline, the following questions are posed to Maya:

1. **Frequency and Severity of Abuse:**
    - Has your partner ever physically hurt you? If so, how often and in what ways?

- Have the injuries you've sustained required medical attention in the past?

2. **Threats and Escalation:**
    - Has your partner ever threatened to harm you, your children, or others close to you?
    - Have the threats or abuse escalated recently?
3. **Control and Isolation:**
    - Does your partner control your finances, restrict your movements, or limit your access to friends and family?
4. **Access to Weapons:**
    - Does your partner own or have access to weapons, and have they ever used or threatened to use them against you?
5. **Immediate Safety Concerns:**
    - Do you feel safe going home today? Would you like assistance finding a safe place to stay?

When confronted with the possibility of Maya needing a safe environment or further intervention, Alex may offer excuses such as:

- "She’s clumsy; she always bumps into things."
- "This is all a misunderstanding—she exaggerates."
- "She’s going through a tough time mentally, and I’m just trying to help her."
- "We don’t need help; we can handle this ourselves."
- "She’ll be fine. She’s just stressed out."

Considerations for the Medical and Social Work Team

Immediate Safety:

- Can Maya be referred to a safe house or shelter if she expresses a desire to leave the situation?
- Is law enforcement intervention necessary based on the Danger Assessment findings?

Building Rapport:

- How can the team create a safe, supportive environment to encourage Maya to disclose information?

Resources and Follow-Up:

- What resources (e.g., counseling, legal aid, support groups) can be provided to Maya?
- What steps can be taken to ensure Maya has access to follow-up care and advocacy services?

Mandatory Reporting Considerations:

- While intimate partner violence (IPV) and domestic violence (DV) are not universally mandated for reporting, healthcare and social work professionals should be aware of their state's specific laws. In California, mandatory reporting is required for IPV and DV cases. Professionals should familiarize themselves with state-specific guidelines to ensure compliance while prioritizing client safety and autonomy.

This case underscores the importance of a trauma-informed, multidisciplinary approach to assessing IPV and ensuring the safety of those who may be at risk.

Examining the Cycle of Abuse

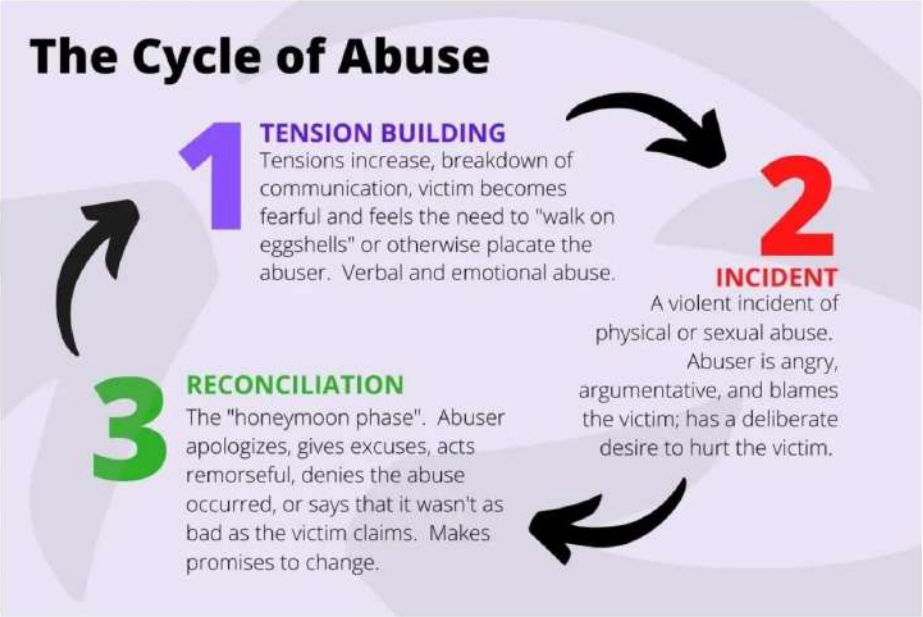

Fig 6. *Family Justice Center*, 2024

The cycle of abuse, often associated with intimate partner violence (IPV), describes a recurring pattern in abusive relationships that perpetuates harm and dependency. This cycle typically includes four stages: tension building, the incident of abuse, reconciliation, and a period of calm. These stages are not only emotionally devastating but also create an environment where victims feel trapped and unable to escape. This cyclical nature is especially relevant in IPV contexts, where perpetrators often use emotional, physical, or psychological abuse to maintain control and power over their victims (Gillette, 2022).

Recent research from 2021 to 2024 highlights the intergenerational nature versus nurture factor in IPV, showing that individuals who witness or endure IPV during childhood are more likely to engage in or become victims of abuse as adults (Kisely et al., 2024). The COVID-19 pandemic exacerbated IPV dynamics, with lockdowns and isolation intensifying emotional and psychological abuse while limiting victims' options for help or escape (Campbell et al., 2023). Understanding

the nuances of IPV is crucial for creating effective interventions, including addressing control dynamics, trauma bonds, and psychological impacts. Providing IPV-specific resources, such as emergency housing, legal assistance, and trauma-informed counseling, is essential for disrupting the cycle and promoting recovery.

Case Study #2: Escaping the Cycle of IPV

Mark Johnson sought therapy after years of emotional abuse from his wife, Susan. Susan's behaviors included verbal assaults, manipulation, and isolating Mark from his family and friends. Mark expressed feeling trapped, blaming himself for her actions, and hoping she would change. His attachment to Susan was rooted in his insecure attachment style formed during childhood, stemming from an emotionally distant mother and an overly critical father. Mark felt unworthy of love and often sought validation in unhealthy relationships. Mark was deeply concerned about his children, who were beginning to witness Susan's behavior, but he feared leaving might disrupt their lives or worsen Susan's aggression. He wanted guidance on how to protect himself and his children while breaking free from the cycle of abuse.

Case Study #2 Application Questions

Attachment Style:

1. What role does Mark's insecure attachment play in his difficulty leaving the relationship?
2. How can interventions address his fear of abandonment and promote self-reliance?

Safety Planning:

3. What immediate risks do Mark and his children face, and how can these be mitigated?
4. How can Mark prepare for legal and logistical challenges, such as custody disputes, while protecting his children?

Trauma-Informed Care:

5. How does the abuse affect Mark's sense of identity and self-worth as a man?
6. What strategies can be implemented to help Mark rebuild trust in himself and others?

Case Study #2 Answers

1. Attachment Style Considerations

   Mark's insecure attachment influenced his tolerance of emotional abuse and reluctance to leave. Key therapy interventions include helping Mark identify attachment patterns and recognize how his childhood experiences shaped his attachment style and relationship dynamics with Susan. Encourage self-reflection to foster the creation of healthier attachments.

2. Building self-worth is a key aspect of counteracting fear.

   Cognitive-behavioral therapy (CBT) can challenge Mark's belief that he is unworthy of love or responsible for Susan's behavior. Using strengths-based counseling methods like cognitive reframing to empower Mark to identify his strengths, including his dedication to his children and courage in seeking therapy. It is also necessary to validate his lived experiences (examples

below). As a therapist, this table is used often in practice in our organization.

Trauma Validation Table for IPV

Your experience is VALID, even if you do not remember all of the details.	The brain may respond by blocking out traumatic events as a protective measure.
Your experience is VALID, even if you do not have evidence.	Especially in emotional abuse, it is difficult for survivors to have evidence.
Your experience is VALID, even if you did not report it to the police.	Systemic racism, sexism, and misogyny persists in the criminal justice system.
Your experience is VALID, even if you did not get a guilty verdict.	The criminal justice system is not always a good indicator of determining guilt.

Table 1: *Developed by April Chen, LMSW*

Additionally, it is necessary to guide Mark in building supportive relationships outside of his marriage to provide a secure base during his transition. Explore ways to strengthen his bond with his children to provide emotional stability for them and support his role as a parent.

3. A safety plan is crucial to ensure Mark and his children's well-being during and after leaving the abusive environment.

   Discuss emergency steps if Susan's behavior escalates, such as identifying a safe place to go or contacting law enforcement. Provide resources for local shelters or legal aid specific to men experiencing IPV. It may pose a challenge for locating shelters for IPV for men, given that many are geared towards women experiencing IPV. Help Mark gather important documents,

such as birth certificates, financial records, and legal papers, and financial resources such as credit cards or bank accounts, and place them in a safe place or with a trusted friend or neighbor where they can be easily accessed without alerting Susan. Encourage creating a code word or signal to inform trusted friends or family of potential danger.

4. Plan for safety for the children.

   Develop a plan to ensure the children are not left alone with Susan if she becomes volatile. Explore temporary custody options to safeguard their well-being during the transition. Provide resources to Mark that include free legal services available in the community and how to access them. One website that is extremely useful in developing resources is https://www.findhelp.org/ (Find Help, 2024). As a prior hospital case manager/ social worker, this website was used and frequently is used in therapy settings to develop resources for every social care situation a client(s) might face.

5. Trauma-Informed Care is necessary due to the emotional and psychological trauma endured by Mark and his children.

   Foster a therapeutic relationship where Mark feels heard and validated without judgment. Normalize his experiences as a male IPV survivor and challenge societal stigmas around male victimization.

6. IPV often results in Post-Traumatic Stress Disorder (PTSD), Anxiety, and Depression.

   Use evidence-based approaches to help Mark process the abuse and its impact on his identity, such as mindfulness and grounding techniques to manage symptoms of anxiety and hypervigilance. Encourage Mark to set personal goals and establish a vision for his future post-relationship.

Emphasize his role as a loving father, reinforcing his ability to provide his children with a stable and nurturing environment. While highlighting his role as a father, he suggests and provides resources for his children to receive appropriate therapy, including play therapy, child-focused CBT, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to address their trauma. TF-CBT, specifically designed for children, can help them process their experiences and develop healthy coping mechanisms. This is necessary so that the trauma and attachment patterns do not persist intergenerationally, leading to the children choosing unhealthy relationships. Often, children feel stuck in the middle of disputes between parents, and child therapists can use games and other specific interventions to explore their coping patterns and emotional responses to parental conflict. This is particularly relevant in cases where a permanent separation leads to custody battles. A word of caution for mental health professionals: as helping professionals, lines can become blurred when treating clients with children who have experienced IPV, making it essential to maintain clear professional boundaries.

Ethically, as a therapist, the alliance is with the therapist's client. In this case, the therapist should not provide therapy services to the children as it is a conflict of interest. While there is limited scholarly literature explicitly advising therapists against concurrently treating domestic violence (DV) victims and their children, concerns about potential conflicts of interest and the complexities of dual relationships are well-documented. The National Association of Social Workers (NASW) Code of Ethics emphasizes the importance of maintaining clear professional boundaries to avoid conflicts that could impair professional judgment or increase the risk of harm to clients. Specifically, Standard 1.06(a) advises social workers to be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. In the context of

providing therapy to both a DV victim and their children, therapists must carefully consider these ethical guidelines to ensure that the therapeutic needs of all parties are addressed without compromising professional integrity or client well-being (*Code of Ethics*, 2021).

Mark's case highlights the complex interplay of attachment, trauma, and societal stigma surrounding male IPV survivors. A comprehensive approach integrating attachment theory, safety planning, and trauma-informed care can empower Mark to break free from the abusive cycle, protect his children, and build a healthier, more fulfilling life.

Empowering IPV Victims Toward Resilience

Empowering individuals to escape intimate partner violence (IPV) and break the cycle of abuse requires a multifaceted approach that addresses immediate safety, psychological resilience, and long-term independence. Recent scholarly literature highlights several effective strategies in summation.

Trauma-Informed Care (TIC)

Wathen and Mantler (2022) emphasize that implementing trauma-informed care (TIC) principles is crucial in supporting IPV survivors. TIC is centered on understanding the pervasive and multifaceted impacts of trauma and creating an environment that fosters safety, empowerment, and healing. Key components include promoting emotional safety, restoring choice and control, facilitating healing connections, supporting coping mechanisms, responding to individual identity and context, and building on the survivor's strengths. These principles help survivors regain autonomy and resilience, which are essential for breaking free from abusive situations.

One of the foundational elements of TIC is creating a physically and emotionally safe environment for IPV survivors. This involves fostering a nonjudgmental atmosphere where survivors feel secure in sharing their experiences without fear of stigma or blame. Additionally, helping survivors rebuild a sense of control and agency is vital. By emphasizing collaboration and respecting their choices, TIC helps IPV survivors navigate their own path to recovery, empowering them to make informed decisions about their lives and relationships.

Moreover, TIC acknowledges the role of systemic and cultural factors in IPV and trauma. Wathen and Mantler (2022) highlight the importance of tailoring interventions to the unique identities and contexts of survivors, including cultural, racial, gender, and socioeconomic considerations. This individualized approach ensures that care is inclusive, equitable, and responsive to the diverse needs of survivors. By integrating these principles, TIC not only addresses the immediate impacts of IPV but also supports long-term healing and resilience, enabling survivors to rebuild their lives and relationships in meaningful and sustainable ways.

Economic Empowerment

Research by Stöckl et al. (2021) highlights that economic independence is a crucial factor in enabling survivors to leave abusive relationships. Access to employment opportunities and financial resources provides the means to establish autonomy, allowing survivors to regain control over their lives. Employment services that are intersectional and trauma-informed are particularly effective in addressing the unique barriers faced by IPV survivors, such as discrimination, stigma, and histories of trauma. These services go beyond traditional workforce development programs by incorporating an understanding of the psychological and social

impacts of IPV, creating a supportive environment where survivors feel empowered to achieve financial stability.

Moreover, economic empowerment helps survivors rebuild self-esteem and reduce their dependence on abusive partners. By fostering a sense of self-efficacy, survivors are more equipped to navigate challenges and advocate for their rights, both in the workplace and in relationships. Financial independence also reduces the risk of re-victimization, as survivors have the resources to seek legal assistance, safe housing, and support services without the fear of economic instability. This comprehensive approach to economic empowerment not only supports immediate safety but also lays the foundation for long-term healing and resilience.

Social Support and Community Resources

Strong social networks and community support play a vital role in empowering IPV survivors. Support from family, friends, and community associations can provide emotional support, practical help, and a sense of belonging. These bonds create a safety net that helps survivors feel valued and supported as they navigate their healing process. Additionally, society-based interventions and resources that offer safe housing, legal assistance, and counseling services are instrumental in supporting survivors' transitions to safety and independence. These resources address the multifaceted needs of survivors, allowing them to rebuild their lives while maintaining dignity and self-determination. Many of them can also be found through the use of websites such as Find Help (*Find Help*, 2024b). A search can be conducted using a client or patient’s zip code and social care resources populate for essential needs such as financial assistance, food pantries, medical care, and other free and reduced-cost services, including mental health and substance abuse treatment resources.

Research by Yusof et al. (2021) emphasizes the importance of integrating community-based solutions into IPV intervention strategies. Their study highlights how community organizations play a crucial role in providing holistic support tailored to the specific needs of survivors. These organizations not only address immediate safety concerns but also offer long-term support that fosters empowerment and resilience. By working collaboratively, communities can develop a comprehensive network of resources that enhance survivors' access to essential services.

Furthermore, community support helps to reduce the isolation often experienced by IPV survivors. Isolation can exacerbate feelings of helplessness and dependence, making it difficult for survivors to seek help or make decisions about their well-being. Through the formation of supportive networks, survivors are empowered to engage in self-advocacy and gain access to resources that promote their overall well-being. This collective approach creates an environment where survivors feel more connected and capable of building a stable future free from abuse.

Coping Strategies and Psychological Support

Developing effective coping strategies is essential for survivors dealing with the aftermath of IPV. Qualitative studies reveal that survivors exercise various coping practices, including seeking social support, engaging in self-care activities, and utilizing professional counseling services. Tailored psychological support that acknowledges individual experiences and cultural contexts can enhance these coping strategies, facilitating recovery and empowerment (Yusof et al., 2021b).

In addition to individual coping strategies, building supportive networks within communities plays a crucial role in helping survivors navigate their healing journeys. Community resources, such as support groups and peer counseling

programs, offer safe spaces where survivors can share experiences, gain insights, and develop strategies to cope with the challenges they face. These collective efforts create a supportive environment where survivors feel understood and validated, fostering a sense of solidarity and resilience that is critical for sustained recovery. By integrating both individual and community-based approaches, survivors are better equipped to manage the complexities of healing from IPV.

Specific coping strategies, such as boundary setting, journaling, mindfulness practices, and assertive communication, are effective tools for survivors to regain control over their lives. Setting clear personal boundaries helps survivors establish limits with abusive partners or other harmful relationships, creating a safer space for emotional and physical well-being. Additionally, engaging in activities like journaling allows survivors to process their experiences, reflect on their emotions, and document their progress, promoting a sense of empowerment and self-awareness. These varied approaches empower survivors to reclaim their autonomy and rebuild a sense of self-confidence in their healing process.

Boundary setting is a fundamental aspect of reclaiming control over one's life. It allows survivors to distinguish between healthy and unhealthy relationships, ensuring that they prioritize their well-being and safety. Establishing boundaries creates a visual representation of personal space, both emotionally and physically, and serves as a protective barrier against further harm. The practice of setting and maintaining boundaries supports survivors in fostering healthier, more supportive connections while minimizing interactions that could lead to retraumatization.

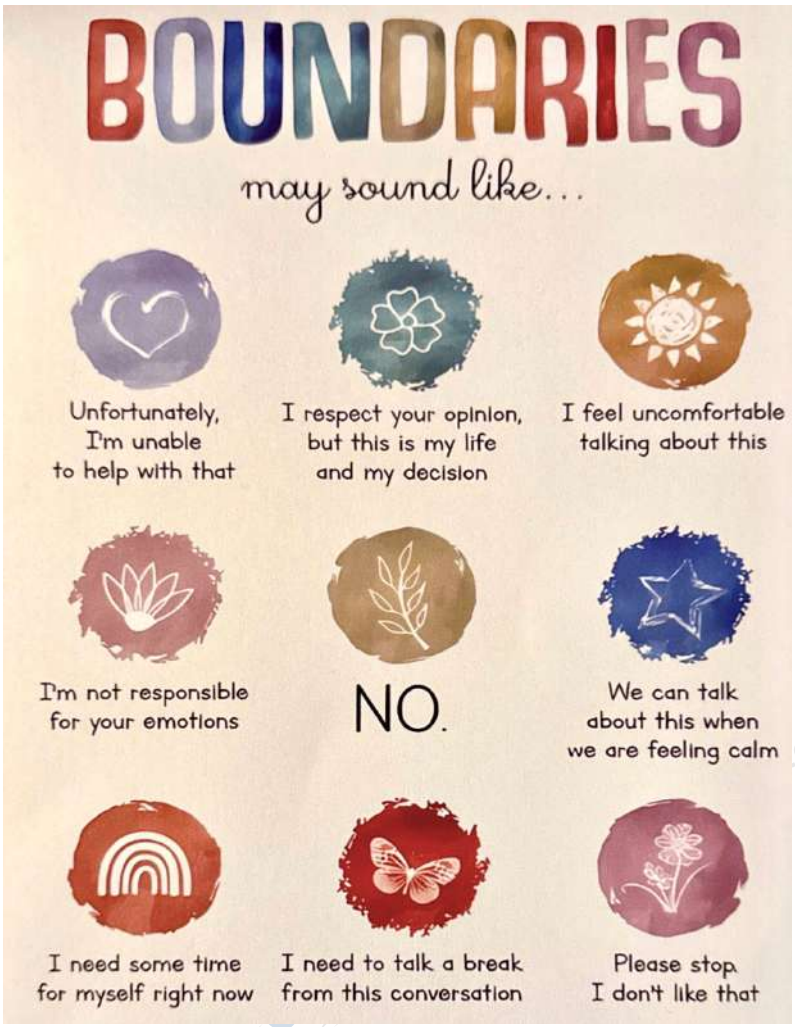

Figure 7. Chen, A., LMSW *Safe Harbor Behavioral Care*

Mindfulness practices, including grounding techniques like the 5-4-3-2-1 exercise, are also beneficial for survivors. This technique involves focusing on the present moment by identifying five things you can see, four things you can touch, three things you can hear, two things you can smell, and one thing you can taste. Engaging in this exercise helps ground individuals, reducing feelings of anxiety and dissociation, and promoting a sense of control and presence. Regular practice of such mindfulness exercises can enhance emotional regulation and resilience, supporting survivors in managing stress and trauma-related symptoms (Calm Editorial Team, 2024).

Legal Advocacy and Policy Support

Dziewa and Glowacz (2021) stress that access to judicial resources and advocacy is essential in safeguarding survivors and holding perpetrators responsible. Legal support can assist with obtaining restraining orders, determining custody issues, and understanding rights. Policy reforms that prioritize survivor safety and perpetrator liability are essential components of an extensive strategy to address IPV.

In addition to legal resources, trauma-informed counseling, as mentioned, plays a vital role in helping survivors deal with the emotional and psychological aftermath of IPV. Counseling that incorporates trauma-informed practices ensures that survivors are supported in a safe and understanding environment, where their experiences are acknowledged and validated. These modalities help survivors process their trauma at their own pace, providing the tools needed to heal and regain a sense of power over their lives that IPV took from them. By integrating legal advocacy with trauma-informed care, survivors are better positioned to navigate the intricacies of rebuilding their lives while ensuring accountability for their abusers.

Furthermore, community-based support groups are integral to fostering resilience and long-term recovery for IPV survivors. These networks offer a variety of services, such as peer support groups, education on healthy relationships, and access to housing and employment opportunities. When communities work together to create thorough resources that address the various needs of survivors, they contribute to a more holistic approach to healing, promoting sustained safety and self-sufficiency. By leveraging both legal and community support, survivors are empowered to reclaim their autonomy and rebuild fulfilling, violence-free lives.

In conclusion, empowering IPV survivors to escape abusive situations involves a comprehensive approach that integrates trauma-informed care, economic empowerment, social support, psychological resilience, and legal advocacy. Implementing these strategies, informed by recent scholarly insights, can facilitate survivors' journeys toward safety and autonomy. Trauma-informed care plays a critical role in addressing the emotional and psychological impact of IPV by creating a safe, supportive environment that prioritizes the survivor’s needs. By understanding the complex effects of trauma, therapists and advocates can provide tailored interventions that promote healing and recovery.

Additionally, economic empowerment is essential for survivors to establish independence and self-sufficiency. Access to employment opportunities, financial resources, and skills development programs allows survivors to regain control over their lives and reduce their vulnerability to further abuse. Research highlights that survivors who are economically empowered are more likely to leave abusive relationships and build stable, fulfilling futures (Stöckl et al., 2021).

Furthermore, social support systems significantly contribute to the healing process. Survivors who receive consistent emotional and practical support from family, friends, and community organizations are better equipped to manage the challenges they face during recovery. Social networks provide a safety net, enabling survivors to navigate legal systems, secure housing, and access necessary resources, thereby enhancing their overall resilience and well-being. By fostering connections and strengthening these support systems, survivors are empowered to move forward with confidence, reducing the risk of retraumatization and creating a pathway toward lasting recovery.

References

About intimate partner violence. (2024, May 16). Intimate Partner Violence Prevention. https://www.cdc.gov/intimate-partner-violence/about/index.html

Adams, A., Huttunen, K., Nix, E., & Zhang, N. (2024). The dynamics of abusive relationships. *The Quarterly Journal of Economics*, *139*(4), 2135–2180. https://doi.org/10.1093/qje/qjae022

Arseneault, L., Brassard, A., Lefebvre, A., Lafontaine, M., Godbout, N., Daspe, M., Savard, C., & Péloquin, K. (2023). Romantic attachment and intimate partner violence perpetrated by individuals seeking help: The roles of dysfunctional communication patterns and relationship satisfaction. *Journal of Family Violence*, *39*(8), 1557–1568. https://doi.org/10.1007/s10896-023-00600-z

Calm Editorial Team. (2024, October 28). *5-4-3-2-1 grounding: How to use this simple technique for coping with anxiety — Calm Blog*. Calm Blog. https://www.calm.com/blog/5-4-3-2-1-a-simple-exercise-to-calm-the-mind

Campbell, L., Tan, R. K. J., Uhlich, M., Francis, J. M., Mark, K., Miall, N., Eleuteri, S., Gabster, A., Shamu, S., Plášilová, L., Kemigisha, E., Olumide, A., Kosana, P., Hurtado-Murillo, F., Larsson, E. C., Cleeve, A., González, S. C., Perrotta, G., Albamonte, V. F., . . . Tucker, J. D. (2023). Intimate partner violence during COVID-19 restrictions: A study of 30 countries from the I-SHARE Consortium. *Journal of Interpersonal Violence*, *38*(11–12), 7115–7142. https://doi.org/10.1177/08862605221141865

Chen, A., LMSW. (2024). *Cognitive Behavioral Therapy Trauma Validation Table*. https://www.safeharborbc.com/counselors/april-chen-lmsw/

Code of Ethics. (2021). https://www.socialworkers.org/About/Ethics/Code-of-Ethics

Collins, K., Sebastian, S. K., & Franck, G. (2023). Improving Domestic Violence Screening and Follow-Up in a Community Health Clinic. *Journal of Primary Care & Community Health*, *14*. https://doi.org/10.1177/21501319231189074

Davis, L. L., & Hamner, M. B. (2024). Post-traumatic stress disorder: the role of the amygdala and potential therapeutic interventions – a review. *Frontiers in Psychiatry*, *15*. https://doi.org/10.3389/fpsyt.2024.1356563

Decker, H., MD, Schwab, M., MD, Shao, S., MD, Kaki, D., BA, Melhado, C., MD, Cuschieri, J., MD, FACS, & Bongiovanni, T., MD, MPP, MHS. (2024). Screening for Intimate Partner Violence in Trauma: Results of a quality Improvement project. *Journal of Surgical Research*, *295*. https://www.journalofsurgicalresearch.com/article/S0022-4804%2823%2900615-7/fulltext

Dziewa, A., & Glowacz, F. (2021). "Getting out from Intimate Partner Violence: Dynamics and Processes. A Qualitative Analysis of Female and Male Victims' Narratives". *Journal of Family Violence*, *37*(4), 643–656. https://doi.org/10.1007/s10896-020-00245-2

Family Justice Center. (2024). https://fjcsafe.org/services/about-domestic-violence/

Find Help. (2024). Find Help. https://www.findhelp.org/

Gedefa, A. G., Abdi, T., Chilo, D., Debele, G. R., Girma, A., & Abdulahi, M. (2024). Intimate Partner Violence, prevalence and its consequences: a community-based study in Gambella, Ethiopia. *Frontiers in Public Health*, *12*. https://doi.org/10.3389/fpubh.2024.1412788

Gillette, H. (2022, July 15). *The 4 stages of the cycle of abuse: From tension to calm and back*. Psych Central. https://psychcentral.com/health/cycle-of-abuse

Gillis, K., LCSW. (2024, April 14). Increasing understanding of a form of trauma that leaves many misunderstood. *Psychology Today*. https://www.psychologytoday.com/us/blog/invisible-bruises/202404/isolation-a-common-Result-of-surviving-family-trauma

Guiguet-Auclair, C., Boyer, B., Djabour, K., Ninert, M., Verneret-Bord, E., Vendittelli, F., & Debost-Legrand, A. (2021). Validation of the French Women Abuse Screening Tool to routinely identify intimate partner violence. *European Journal of Public Health*, *31*(5), 1064–1069. https://doi.org/10.1093/eurpub/ckab115

Hamilton, G., Ridgway, A., Powell, A., Heydon, G., & RMIT University. (2023). *Family violence and sexual harm*. RMIT University. https://static1.squarespace.com/static/5b7ea2794cde7a79e7c00582/t/6527e956f0812c09b9afbf7e/1697114455930/Family+violence+and+sexual+harm.pdf

Iqbal, J., Huang, G., Xue, Y., Yang, M., & Jia, X. (2023). The neural circuits and molecular mechanisms underlying fear dysregulation in posttraumatic stress disorder. *Frontiers in Neuroscience*, *17*. https://doi.org/10.3389/fnins.2023.1281401

Jain, D., Esopenko, C., Dorman, K., Gurrapu, S., & Marshall, A. D. (2024). Experience of intimate Partner Violence-Related head trauma and its association with posttraumatic stress disorder and depression symptoms among community dwelling women and men. *Journal of Interpersonal Violence*. https://doi.org/10.1177/08862605241301789

Kisely, S., Najman, J. M., & Strathearn, L. (2024). Childhood Maltreatment and Intimate Partner Violence: 30-Year Follow-Up of A Birth Cohort Study. *Journal of Aggression Maltreatment & Trauma*, *33*(7), 844–863. https://doi.org/10.1080/10926771.2024.2343941

Larsson, A. L., Olsson, H., & Strand, S. J. M. (2024). Challenges and opportunities in collaborative approaches to responding to intimate partner violence: insights from social workers and police in Sweden. *Journal of Social Work Practice*, *38*(2), 143–157. https://doi.org/10.1080/02650533.2024.2327038

Lock, E., Reeves, K., & Vujcich, D. (2024). Methods and tools to screen and assess risks for intimate partner violence among women from culturally and linguistically diverse backgrounds in six high-income countries: A scoping review. *Journal of Family Violence*. https://doi.org/10.1007/s10896-024-00682-3

Los Angeles Center for Law and Justice. (2022). *Domestic Violence Awareness Month (DVAM) statistics infographic* [Infographic]. Los Angeles Center for Law and Justice. https://www.laclj.org/wp-content/uploads/2022/10/DVAM-Stats.png

Mazza, M., Marano, G., Del Castillo, A. G., Chieffo, D., Monti, L., Janiri, D., Moccia, L., & Sani, G. (2021). Intimate partner violence: A loop of abuse, depression and victimization. *World Journal of Psychiatry*, *11*(6), 215–221. https://doi.org/10.5498/wjp.v11.i6.215

Miller, C. J., Adjognon, O. L., Brady, J. E., Dichter, M. E., & Iverson, K. M. (2021). Screening for Intimate partner violence in Healthcare Settings: An Implementation-oriented Systematic review. *Implementation Research and Practice*, *2*. https://doi.org/10.1177/26334895211039894

Olsson, H., Larsson, A. L., & Strand, J. M. S. (2023). Social Workers' Experiences of Working with Partner Violence. *The British Journal of Social Work*, *54*(2), 704–722. https://doi.org/10.1093/bjsw/bcad240

Positive affirmations for when life feels too hard | HealthyPlace. https://www.healthyplace.com/insight/quotes/positive-affirmations

Relationship attachment type. (n.d.). https://www.theaoc.org.uk/using-attachment-theory-in-therapy-a-guide-for-clients/

Roland, N., Delmas, N., Khoury, F. E., Bardou, A., Yacini, L., Feldmann, L., Hatem, G., Mahdjoub, S., & Bardou, M. (2024). Post-traumatic stress disorders in women victims-survivors of intimate partner violence: a mixed-methods pilot study in a French coordinated structure. *BMJ Open*, *14*(1), e075552. https://doi.org/10.1136/bmjopen-2023-075552

Spencer, C. M., Keilholtz, B. M., & Stith, S. M. (2020). The Association between Attachment Styles and Physical Intimate Partner Violence Perpetration and Victimization: A Meta-Analysis. *Family Process*, *60*(1), 270–284. https://doi.org/10.1111/famp.12545

Speranza, A. M., Farina, B., Bossa, C., Fortunato, A., Vergano, C. M., Palmiero, L., Quintigliano, M., & Liotti, M. (2022). The role of complex trauma and attachment patterns in intimate partner violence. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.769584

Stöckl, H., Hassan, A., Ranganathan, M., & Hatcher, A. M. (2021). Economic empowerment and intimate partner violence: a secondary data analysis of the cross-sectional Demographic Health Surveys in Sub-Saharan Africa. *BMC Women S Health*, *21*(1). https://doi.org/10.1186/s12905-021-01363-9

Wathen, C. N., & Mantler, T. (2022). Trauma- and Violence-Informed Care: Orienting Intimate Partner Violence Interventions to equity. *Current*

Epidemiology Reports, *9*(4), 233–244. https://doi.org/10.1007/s40471-022-00307-7

Wood, S. N., Perrin, N., Akumu, I., Asira, B., Clough, A., Glass, N., Campbell, J., & Decker, M. R. (2024). Risk for severe intimate partner violence in Nairobi's informal settlements: Tailoring the danger assessment to Kenya. *Global Health Science and Practice*, *12*(1), e2300116. https://doi.org/10.9745/ghsp-d-23-00116

Yusof, M. M., Azman, A., Singh, P. S. J., & Yahaya, M. (2021). A qualitative analysis of the coping strategies of female victimization after separation. *Journal of Human Rights and Social Work*, *7*(1), 84–90. https://doi.org/10.1007/s41134-021-00199-5