ISSN 2380-727X

PSYCHOLOGY AND COGNITIVE SCIENCES
Open Journal

Openventio PUBLISHERS

Review

Examining the Rise of Intimate Partner Violence during COVID-19: A Call to Action for Psychologists as Social Advocates

Miranda Landfield, MA; Naqsh Ali, MA; Shahrzad Azarafza, MA; Shelly Baer, PsyD; Anushree Belur, PsyD; Naomi Griffin, MA; Dilara Kosak, MS; Jennifer Lerch, MA; Rose Patatanian, MA; Elizabeth Quintero, MA; Stephanie Scott, MA; Guy Balice, PhD*; Melia Leibert, MA

The Chicago School of Professional Psychology, Los Angeles, CA, USA

Corresponding author
Guy Balice, PhD
Professor, Department of Clinical Psychology, The Chicago School of Professional Psychology, 617 W 7th Street, Los Angeles, CA 90017, USA;
E-mail: gbalice@thechicagoschool.edu

Article information
Received: September 18th, 2023; **Revised:** October 13th, 2023; **Accepted:** October 16th, 2023; **Published:** November 2nd, 2023

Cite this article
Landfield M, Ali N, Azarafza S, et al. Examining the rise of intimate partner violence during COVID-19: A call to action for psychologists as social advocates. *Psychol Cogn Sci Open J.* 2023; 9(1): 8-16. doi: 10.17140/PCSOJ-9-169

ABSTRACT

The circumstances of the coronavirus disease-2019 (COVID-19) pandemic and the resulting confinement of persons culminated in political unrest, demonstrations for social justice, and increases in crime, including intimate partner violence. The pandemic gave intimate partner abusers free reign to monitor the activities, movements, and communications of domestic abuse survivors, restricting access to planning and implementing an escape route. This resulted in the need for psychologists to provide psychological services, some of which were restricted by the limitations of the pandemic. With psychologists providing this assistance, it appears clear that they are in a unique position to inform policy, political decisions, and social justice based on their training, clinical practice, and expertise in human behavior and human suffering. This paper addresses the need for psychologists as social advocates, arguing that they occupy a vital position in both treatment and research that enables them to represent those affected by intimate partner violence (IPV), as well as inform legislation on this issue.

Keywords
COVID-19; COVID-19 pandemic; Intimate partner violence (IPV); Psychologist advocacy.

PSYCHOLOGIST AS ADVOCATE

The circumstances of the coronavirus disease-2019 (COVID-19) pandemic and the multi-occurring events during this time, including political unrest and demonstrations for social justice, have created a need for psychologists to emerge as social advocates. It is perhaps more important now than ever that psychologists step forward into the public sphere and advocate on behalf of not only their clients but also the social issues that impact them. By way of example, these authors will use the issue of intimate partner violence (IPV) during the COVID-19 pandemic to illustrate that psychologists can and should play a role in social advocacy. This paper will go beyond theoretical recommendations to outline specific examples of how psychologists have been and can continue to be social advocates.

Psychologists are uniquely positioned to inform policy, political decisions, and social justice based on their training, clinical practice, and expertise in human behavior and human suffering. The American Psychological Association's (APA) Ethics Code[1] provides an indication of this position. Principle E (Respect for People's Rights and Dignity) urges psychologists to respect the dignity and worth of all people and the rights of individuals to privacy, confidentiality, and self-determination. It states that psychologists should be aware of and respect varying intersections of identity and not knowingly participate in or condone the activities of others based on prejudice. The ethics code guides psychologists in decision-making and holds them accountable to high ethical standards. These principles set forth in the ethics code suggest a further purpose than merely a responsibility to individual clients; they demand that psychologists actively participate in societal macrosystems that inform the circumstances of their lives, their clients' lives, and the communities of which they are a part.

Openventio PUBLISHERS

Bronfenbrenner's ecological systems theory[2] suggests that individuals are impacted by the macrosystems within which they operate, including political, economic, and social forces. Psychologists understand that individuals are impacted by these larger systems, including their families, communities, and society at large. As psychologists appreciate this impact, they also have a responsibility to advocate on behalf of their clients for systems that are just and equitable and that provide resources and spaces for individuals to feel safe and empowered to thrive. The implications of this model are bidirectional—just as social circumstances impact individuals, so too can individuals enact change in broader systems. For example, psychologists can empower their clients by helping them to acknowledge and overcome systemic barriers to their psychological health and well-being.[3] In addition, psychologists can engage in dismantling systems of power and oppression by choosing to work with agencies that share a commitment to working with underserved and marginalized individuals, including those with limited access to health care and other resources. Psychologists can impact larger macrosystems that might otherwise pose barriers to treatment by providing access to individuals and seeking to reach a wider spectrum of clients based on socioeconomic status.

Various studies have examined the role of psychologists in making changes that link their client relationships to broader social changes. Ali et al[4] examine the role of psychologists in addressing poverty by integrating therapeutic change and economic justice through Anti-Oppression Advocacy (AOA). Hoagwood et al[5] examine the role of psychologists in advocating for health policies that can improve children's mental health, especially in the context of post-pandemic life. While these examples highlight admirable instances of psychologists advocating for specific populations, little research has focused on the central position of social advocacy in the occupation of the psychologist. For example, Sommers-Flanagan et al[6] highlight a cross-disciplinary mantra for multicultural preparation: "Awareness-Knowledge-Skill-Advocacy", but discuss advocacy as little more than an afterthought—something that psychologists are only sometimes involved in, and only in certain cases.

The idea of the psychologist as a social advocate was captured in Dr. Martin Luther King Jr.'s seminal speech to the APA in 1967. Dr. King urged psychologists and other mental health professionals to help address contemporary, pressing social issues.[7] Unfortunately, many psychologists do little to address the social circumstances that undermine the well-being and mental health of their clients. Kinderman states that it is the duty of psychologists to understand the social contexts that give rise to mental distress and ultimately contribute to the disorders they treat. His plea to psychologists is that they acknowledge their role in fostering positive social change, speaking out against injustice, and educating others about the social factors that influence behavior and contribute to maladaptive responses. Kinderman implores psychologists to educate the public about political, economic, and social policies that have a direct impact on individuals and bring evidence of this impact to policymakers. His call to action upholds the fact that human beings are products of society, and there is a great need to explore systemic solutions to psychological problems.[7]

One way the APA has addressed such a call to action is by publishing a list of advocacy priorities each year. Public statements such as these are useful, but only insofar as they provide an action plan for psychologists to address these pressing social issues. Such a path must be both bottom-up and top-down, with the APA describing opportunities for social advocacy and psychologists determining for themselves how their expertise can be leveraged to advocate for social change.

PSYCHOLOGIST AS ADVOCATE FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE

IPV describes physical and sexual violence, stalking, and psychological harm by a current or former partner.[8] IPV is characterized by "*an ongoing pattern of behaviors in which a batterer uses violence as one of many means to exert power and control over an intimate partner*".[9] According to the National Coalition Against Domestic Violence (NCADV), an estimated 10 million IPV victimizations occur annually in the US.[10] This violence results in a significant public health problem, and the ramifications for survivors can include physical injury, psychological consequences, housing and economic instability, as well as an ongoing fear for their safety.[11] The most severe consequence of IPV is death—US crime reports reveal that approximately 1 in 5 homicide victims are killed by an intimate partner.[8] The estimated lifetime economic burden to society because of IPV-related injuries, which include medical, mental health, and other costs, was $3.6 trillion in 2020.[8] Additionally, data reveal that approximately 8 million days of paid work are lost due to IPV victimization.[10] The personal harm caused to survivors of IPV and the economic burden this issue places on society underscore that this is an urgent social issue in need of attention and advocacy. Furthermore, the medical, psychological, and economic burden of IPV is likely higher than estimated due to the underreporting of IPV by survivors.[12]

The description of IPV and those who experience it is an issue of vital importance because it impacts how it is perceived as a societal issue; more importantly, it impacts the survivors of IPV, including intimate partners and their families. Survivors of IPV are sometimes referred to as "victims" when they self-identify as, or others consider them to be, "victims" of the abuse.[13] Other organizations and individuals who have experienced IPV approach this "victimization" through a more positive lens, appreciating and empowering "victims" by referring to them instead as "survivors" of abuse, thus highlighting the strengths demonstrated by their bravery in experiencing such harrowing acts of abuse.[14,15] Using the term "survivor" also serves to remediate stigma towards those who experience IPV.[16] Whereas the word "victim" is often used by law enforcement and in courtroom proceedings, organizations that serve those who have experienced IPV often prefer to use the word "survivor" because it suggests a sense of empowerment.[17] However, it is important that the person seeking support determine how they self-identify as a "victim" or "survivor," and that others respect their choice given that the journey of healing from such an experience is unique to each person. Many people are beginning to use the term "Victim/Survivor (V/S)" to underscore this complexity and the necessary element of personal identification. In this paper, we will refer to individuals and families who have experienced abuse as survivors

Openventio PUBLISHERS

to highlight the capacity of psychologists as advocates to support the resilience of those who have experienced IPV.

The concept of psychologists as advocates for survivors of IPV rests largely on two factors: being able to closely observe the effects of IPV and having the expertise to treat them. For example, psychologists' training usually involves psychological assessment, which helps them understand how the trauma of IPV can affect individuals and families.[18,19] Psychologists as advocates rely on their expertise—their knowledge and experience—in the assessment and treatment of IPV.[20] Research demonstrates that therapy reduces anxiety,[21] depression[21,22] and other symptoms of trauma that may occur in the aftermath of IPV.[23,24]

Psychologists can see how IPV not only affects the survivor but also how it impacts families and communities. For example, psychologists can observe the financial costs to persons in families who cannot work because of traumatization,[25] or that parents often cannot be with their children when the parents are depressed or emotionally depleted–common effects of trauma.[26] If lawmakers are to create legislation that helps people, they should consult psychologists because they see up close what survivors need[27,28]; and they are uniquely qualified to inform this process. This dual focus of the psychologist–the helper of individuals and the observer of the damage to communities because of IPV–places them in a position to influence society in both the micro and macro systems.

Psychologists are uniquely positioned to increase public awareness about IPV because they have a vantage point that lawmakers and others who influence legislation do not.[29] Psychologists are knowledgeable in evidence-based practice with survivors, which lawmakers need to use when informing legislation.[30,31] Psychologists also understand more about the etiology of IPV, which is important in creating effective intervention programs. The lack of psychologists consulting lawmakers has had detrimental effects on the prevention and treatment of IPV perpetration.[32] For example, state standards for IPV treatment have not followed evidence-based theories, resulting in ineffective legislation meant to address IPV risk factors.[33] Psychologists can apply their research and scientific expertise to make recommendations to lawmakers about how to more effectively address IPV. Psychologists can also utilize the media to inform the public about their research about IPV and related issues. They can address this public health concern from their personal experience supporting survivors as well as from an understanding of how macrosystems such as laws and public policy impact survivors and their families.[29] Due to their experience working with survivors of IPV and/or perpetrators of IPV, psychologists are in a position to offer insight into the issues surrounding IPV.[34] The hope then would be that psychologists' voices would be influential in informing the legislative process.

RISE OF IPV DURING COVID-19

While the COVID-19 pandemic has affected people psychologically in many negative ways,[18,35] one serious health issue the virus has impacted is IPV.[27] Recent data indicate that IPV has risen since the quarantine began.[36] The data reveal an "*increase in 25-50% in hotline calls, 150% in website traffic, and 12.5% increase in IPV police activity*" since 2019.[36] Additional data suggests there is an increase in the severity of physical IPV compared to three years ago.[37] This increase in IPV suggests that it has become a serious social issue, affecting individuals,[38] families[39] and communities.[40] Although psychologists have always worked with survivors of violence, the increase in IPV has led to a greater need for mental health professionals to work even more closely with them.[41]

RISK FACTORS FOR INCREASED IPV DURING COVID-19

"Safer-at-Home" Orders and Quarantine

Psychologists, as advocates, can work more closely with survivors, even in situations where they are confined to their homes. The "safer-at-home" orders that were enforced during COVID-19 were not safe for victims of IPV. In fact, the home can be the most dangerous place for victims of domestic violence because it is a private space—the one place that is without observation and judgment from anyone not immediately in the family unit or couple. This privacy allows the abuser to manipulate the power dynamic in the household by using threats, physical violence, emotional and mental torment, and isolation from friends and family, among other tactics, to obtain total control over their victim, who is essentially trapped with them in the home.[27] The quarantine and isolation that were widely promoted during the pandemic for health reasons increased the potential for IPV, abuse, and trauma.[42] Consequently, the COVID-19 pandemic has given abusers even more free reign to monitor the activities, movements, and communications of domestic abuse survivors, further restricting access to planning and implementing an escape route. Psychologists bear the responsibility to reduce violence and save lives even in environments and situations where help for the survivor seems useless and options are limited. The pandemic has highlighted that mental health resources and domestic violence interventions must branch out beyond the therapy office and domestic violence shelters. What can psychologists do to protect survivors while they are at home? How can they further empower survivors in these situations and help them maintain self-efficacy? Even though the home is abusive, psychologists can work with survivors by providing support and empowering them to advocate for themselves through psychoeducation and role plays around communication and de-escalating violence. Psychologists can also contribute through research to determine better ways to support survivors under such challenging circumstances when options seem limited, and specifically to determine effective ways to prevent a violent situation from happening, de-escalate violence when it occurs, and gain access to resources to support their and their family's safety and well-being.

Survivors of IPV often utilize text and hotlines for support; however, during the pandemic, these people have been in close and constant proximity to violent partners, which likely made it harder for them to reach out for help.[43] Many survivors might not call for help until violence has escalated to the point that calling 911 is the deciding factor between life and death, making 911 the last line of defense. This may result from the fact that calling 911 can make severe abuse more likely.[43]

The pandemic poses a unique and distressing paradox for survivors: if they decide to or are forced to stay home, they risk the danger of enduring or worsening violence, and even if they can leave, they risk exposure to a highly infectious and deadly virus.[43] Furthermore, even if survivors chose and were able to leave their unsafe home environments, many domestic violence shelters were forced to limit their capacity during the pandemic in order to prevent the spread of COVID-19, which meant that women and children who were stuck with their abusers at home faced the reality of being turned away by these shelters that were formerly a safe haven. These domestic violence shelters were underfunded before COVID-19, and they faced even more financial strain as a result of the pandemic. Finding alternate housing may be near impossible for many survivors of IPV due to the economic decline many families experienced during the pandemic and the scarce availability of apartment units and barriers to moving in. As a response to the increase in domestic violence calls in some countries, for example, Italy and Spain have converted hotel rooms into safe havens for domestic violence survivors who had nowhere else to go.[44] This is another example of an opportunity for psychologists to advocate for resources for survivors of domestic violence. If similar programs were implemented in the United States during the pandemic, hotel rooms that were not being used during the pandemic could have provided safe housing to survivors and their families.

In addition to an overall increase in IPV during the pandemic, individuals with certain minority identities, including gender and sexual minorities, were more likely to experience IPV during this time.[45] Transgender and non-binary (TGNB) people were more likely to experience IPV for the first time during the pandemic, and trans people face increased barriers to accessing shelters, a resource that became significantly less accessible during this time.[46,47] White individuals reported the lowest rates of IPV during the pandemic, while Native American individuals reported the highest.[46] Research suggests that for Black, Indigenous, and People of Color (BIPOC) individuals, especially Black trans women, the rise in racism and police brutality during the pandemic complicated IPV safety planning and intervention.[45] For example, black IPV survivors reported a hesitance to call domestic violence agencies for fear of police brutality and retraumatization.[47]

Perpetrators of IPV commonly use isolation tactics to distance victims from their support networks, like their family and friends.[27] COVID-19 provided an easy justification for forced isolation. This only worsens the shame and isolation that many survivors of IPV deal with, as they often hide their circumstances from friends and family.[48] There have also been reports of abusers leveraging COVID-19 to instill fear and compliance in their partners, making victims less likely to seek medical care for IPV-related injuries.[41,49] Despite there being enough research suggesting that disasters increase the frequency and intensity of IPV, prior research did not explore IPV in a social isolation and home confinement context.[48] COVID-19 can serve as a focal point and a catalyst for focusing interventions to aim past simple awareness and policy-making and interventions that will effectively protect the survivor from harm in real-time, within the home with the perpetrator.

IPV Survivors' Best Interests

COVID-19 has accelerated the transition of services from in-person to telehealth in order to provide services despite stay-at-home orders. Although this platform has been shown to be effective and satisfactory for many patients, there are still barriers to overcome.[50] While studies have shown high satisfaction and therapeutic alliances through telehealth, there are still ongoing legal and practical concerns with respect to privacy.[51] Legal privacy concerns include compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[51] The practical elements of not having privacy are more concerning as they relate to the patient's physical and emotional safety and include risks of being overheard or of having virtual communications intercepted or read.[52] Individuals experiencing violence at home may find it difficult to disclose it to their providers and feel uncomfortable sharing private information as they may be closely monitored by their partners. Individuals may not have a safe space to speak freely as they would in their provider's office setting. With telehealth, providers are not able to ensure the privacy of the individual and may inadvertently say something that can be overheard by the perpetrators of IPV, which could potentially cause more harm.

The Canadian Women's Foundation created a campaign known as "Signal for Help", which is described as a simple hand gesture that can be used during video calls or any kind of visual communication to alert others that one is in danger.[53] This campaign was created in response to the COVID-19 pandemic and subsequent increase in domestic violence. It is a hand gesture in which you point your palm to the camera and tuck your thumb in, then you "trap" your thumb with your remaining fingers, making an upward fist. The psychologist may advocate here by calling the proper authorities—an arrangement that the client and psychologist can agree to during the informed consent process. Moreover, this safety signal may also be useful to teach children code words, keywords, gestures, or symbols to alert them to get to safety and when to call 911.[54] Using hand signals, code words, gestures, etc. was an option before the pandemic; however, this organization helped adapt it to telecommunication. Psychologists can go beyond spreading awareness and use techniques such as discreet, nonverbal signals and communication to potentially reduce the survivor's exposure to severe violence and offer them a way to alert for help.

So, though emotional support and securing housing—the typical ways in which psychologists have advocated for survivors of IPV—are greatly helpful, psychologists can also advocate for telehealth clients in other ways. For example, they can use the online format to ally with clients to help develop plans for longer-term housing, receive appropriate healthcare, and develop a better connection to the community of IPV survivors.[55] Psychologists can likewise act as providers who can coordinate different professionals (e.g., accepting referrals from other healthcare providers)[56] as part of a multicomponent intervention. These interventions naturally require that psychologists take proactive roles to partner with survivors, but in so doing, psychologists may act to represent clients' rights.

THE VIOLENCE AGAINST WOMEN ACT

Psychologists are in a unique position to inform and promote legislation, particularly about matters of the human condition such as IPV, due to their role as researchers of scientific literature. Empirical data should influence the creation of federal policy because scientific literature determines which policies are efficacious and which policies should be amended. For example, an examination of the IPV literature would suggest that the policies regarding IPV prevention and treatment should be amended due to their lack of efficacy in protecting and supporting survivors.

The Violence Against Women Act (VAWA) of 1994 was one of the original pieces of legislation that brought national attention to the issue of IPV.[57] VAWA addressed violence against women by creating new laws to prosecute offenders and provide services to survivors.[58] Despite the increases in protections, IPV remains ubiquitous and has increased over the years,[36,58,59] including since the start of the COVID-19 pandemic.[37] Several factors may contribute to this increase, particularly how VAWA frames the way society has responded to IPV. Critics of VAWA have suggested it is not efficacious in remediating IPV because it puts too much emphasis on incarceration rather than prevention.[60] VAWA also negatively influences the treatment of IPV offenders because it labels IPV as gender-based violence circumscribed by patriarchal beliefs rather than scientific data.[33] Psychologists should inform the amendments of VAWA because they know the risk factors of IPV and the psychological processes that prevent people from perpetrating IPV due to their role as researchers.[60] The role of the psychologist as a social advocate entails using objective knowledge from research to inform how IPV should be responded to by the government. Psychologists should advocate for programs that are intended to target the known-risk factors associated with IPV, such as physical, psychological, and sexual abuse during childhood, lack of feeling protected, exposure to IPV, and a higher overall composite of Adverse Childhood Experiences (ACEs).[60,61] By adhering to a "treatment" for offenders that is not efficacious, the cycle of violence cannot be remediated. An injustice is being perpetuated for all individuals impacted by IPV until psychologists use their platform to advocate for macro-level changes.

Immigrant Experience of IPV during COVID-19

The immigrant population has been severely affected during the pandemic due to increased unemployment, delayed processing of immigration forms, and the inability to receive government assistance due to immigration status.[62] During the pandemic, some victims worried about having nowhere to go because people they knew might not take them in for fear of infection.[62] Women who were interviewed by Sabri et al[62] reported that they encountered an increase in controlling behaviors by their abusers during the pandemic. These behaviors included abusers trying to get their partner pregnant, threatening to have them exposed to COVID-19, and limiting access to finances. These stressors contributed to a rise in IPV in this population,[62] suggesting that psychologists should also use their expertise to advocate for the immigrant population. For example, several protections have been made for immigrant survivors of domestic abuse. The Battered Immigrant Women Protection Act (1999) granted survivors the ability to leave an abusive relationship (married or non-married) without the fear of being deported.[63] These immigrants are granted specific visas (U Visas or T Visas) for a limited amount of time as well as protections for their children. Unfortunately, many immigrant survivors may not know about these protections and subsequently refrain from reporting. This alludes to the importance of advocacy among psychologists to inform the public of protections that could potentially be lifesaving.

DISCUSSION AND CONCLUSION

It is evident from the increase in IPV during the pandemic that abuse thrives in silence. While survivors have been negatively impacted by the isolation and may feel as if they do not have a voice, psychologists can mitigate this effect by advocating for their needs. This paper addresses various ways psychologists can use their expertise to advocate for macro-level and micro-level change in order to serve those impacted by IPV.

Regarding macro-level change, psychologists should advocate for social change by influencing legislation. Psychologists have the credibility to influence the law due to their role as evaluators of scientific knowledge. For example, research showing the increase in IPV phone hotline use and police activity during COVID-19[36] should direct policy funding to train crisis interventions for hotline workers and law enforcement. Psychologists should advocate for funding to be channeled into prevention efforts that have been shown to deter IPV perpetration, such as programs encouraging healthy parenting,[64,65] programs engaging men as fathers[66] and programs that are school-based athletic interventions.[67-70] Psychologists should advocate for proper amendments to VAWA that follow suggestions based on the objective needs of survivors as cited by the literature, not the subjective assumptions created by policymakers who may be far removed from the roots of the problem.

Regarding micro-level change, psychologists have the power to advocate for IPV survivors through their relationship with them as mental health professionals. The increase in IPV during COVID-19 has shifted the need for psychologists to provide services *via* telehealth because many survivors cannot leave their homes. Psychologists know that "safer at home" orders are not safer for IPV survivors, so it is the duty of the psychologists to advocate for their clients by spreading awareness of this paradox and helping their clients to maintain safety at home if leaving is not an option. Therefore, psychologists should advocate for the immediate needs of their clients in a situation where escape might not be possible: a platform to communicate, a safety plan, and discussing strategies that may be helpful in de-escalating conflict and seeking safety.

The COVID-19 pandemic has had an exacerbating effect on the ongoing pandemic of intimate partner violence. Psychologists are perfectly positioned to bring awareness to the needs of those impacted by IPV due to their unique knowledge and understanding of the human condition. This paper strives to empower psychologists to use their platform to bring justice to individuals,

families, and communities impacted by these devastating cycles of violence.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

REFERENCES

1. American Psychological Association (APA). Ethical principles of psychologists and code of conduct. 2017. Website. https://www.apa.org/ethics/code/. Accessed September 16, 2023.

2. Bronfenbrenner U. Toward an experimental ecology of human development. *American Psychologist*. 1977; 32(7): 513-531. doi: 10.1037/0003-066X.32.7.513

3. Kozan S, Blustein DL. Implementing social change: A qualitative analysis of counseling psychologists' engagement in advocacy. *The Counseling Psychologist*. 2018; 46(2): 154-189. doi: 10.1177/0011000018756882

4. Ali A, Lees KE. The therapist as advocate: Anti-oppression advocacy in psychological practice. *Journal of Clinical Psychology*. 2013; 69(2): 162-171. doi: 10.1002/jclp.21955

5. Hoagwood KE, Purtle J, Spandorfer J, Peth-Pierce R, Horwitz SM. Aligning dissemination and implementation science with health policies to improve children's mental health. *The American Psychologist*. 2020; 75(8): 1130-1145. doi: 10.1037/amp0000706

6. Sommers-Flanagan J, Sommers-Flanagan R. *Clinical Interviewing*. 6th ed. NY, US: Wiley Publishers; 2017.

7. Kinderman P. The role of the psychologist in social change. *International Journal of Social Psychiatry*. 2014; 60(4): 403-405. doi: 10.1177/0020764013491741

8. Centers for Disease Control and Prevention (CDC). Preventing intimate partner violence. Violence Prevention. 2020. Website. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Retrieved September 25, 2021. Accessed September 16, 2023.

9. Mitchell C, Anglin D, Nicolaidis C, Paranjape A. Defining intimate partner violence: Controversies and implications. In: *Intimate Partner Violence: A Health-based Perspective*. Oxford, UK: Oxford University Press; 2009.

10. National Coalition Against Domestic Violence (NCADV). Domestic violence. ncadv.org. 2020. Website. https://assets.speakcdn.com/assets/2497/domestic_violence-2020080709350855.pdf?1596811079991. Retrieved September 25, 2021. Accessed September 16, 2023.

11. Dyar C, Messinger AM, Newcomb ME, Byck GR, Dunlap P, Whitton SW. Development and initial validation of three culturally sensitive measures of intimate partner violence for sexual and gender minority populations. *J Interpers Violence*. 2021 36(15-16): NP8824-NP8851. doi: 10.1177/0886260519846856

12. Deo KM. The likelihood of reporting intimate partner violence: A comparison between same-sex couples and heterosexual couples. Michigan, USA: ProQuest Dissertations Publishing; 2014.

13. Williamson J, Serna K. Reconsidering forced labels: Outcomes of sexual assault survivors versus victims (and those who choose neither). *Violence Against Women*. 2018; 24(6): 668-683. doi: 10.1177/1077801217711268

14. Liang B, Goodman L, Tummala-Narra P, Weintraub S. A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *Am J Community Psychol*. 2005; 36(1): 71-84. doi: 10.1007/s10464-005-6233-6

15. Papendick M, Bohner G. "Passive victim - strong survivor"? Perceived meaning of labels applied to women who were raped. *PLoS One*. 2017; 12(5): e0177550-e0177550. doi: 10.1371/journal.pone.0177550

16. Gagné P, Renfro-Sargent M. Introduction: Social movements in the new century. *Sociological Focus*. 2004; 37(3); 187-193. doi: 10.1080/00380237.2004.10571241

17. Women Against Abuse. The Language We Use. 2022. Website. https://www.womenagainstabuse.org/education-resources/the-language-we-use. Accessed September 16, 2023.

18. Burns SC, Kogan CS, Heyman RE, et al. Evaluating the relationship between intimate partner violence-related training and mental health professionals' assessment of relationship problems. *J Interpers Violence*. 2022; 37(15-16): NP14262-NP14288. doi: 10.1177/08862605211005154

19. Bridges AJ, Karlsson M, Lindly E. The effect of brief, passive psychoeducation on knowledge and ratings of intimate partner violence in the United States and Argentina. *J Interpers Violence*. 2015; 30(2): 272-294. doi: 10.1177/0886260514534775

20. Todahl J, Walters E. Universal screening for intimate partner violence: A systematic review. *J Marital Fam Ther*. 2011; 37(3): 355-369. doi: 10.1111/j.1752-0606.2009.00179.x

21. Hameed M, O'Doherty L, Gilchrist G, et al. Psychological therapies for women who experience intimate partner violence. *Cochrane Database Syst Rev*. 2020; 7(7): CD013017. doi: 10.1002/14651858.CD013017.pub2

22. Iverson KM, Gradus JL, Resick PA, Suvak MK, Smith KF, Monson CM. Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *J Consult Clin Psychol*. 2011;

79(2): 193-202. doi: 10.1037/a0022512

23. Birkley EL, Eckhardt CI, Dykstra RE. Posttraumatic stress disorder symptoms, intimate partner violence, and relationship functioning: A meta-analytic review: PTSD, IPV, and relationship functioning. *J Trauma Stress*. 2016; 29(5): 397-405. doi: 10.1002/jts.22129

24. Perez S, Johnson DM, Wright CV. The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters. *Violence Against Women*. 2012; 18(1): 102-117. doi: 10.1177/1077801212437348

25. Merino GA, Mueller J, O'Brien-Milne L, Ghaus K, Duvvury N, Scriver S. The social costs of violence against women and girls on survivors, their families and communities in Pakistan. *Pakistan Journal of Women's Studies*. 2020; 26(1): 1-20. doi: 10.46521/pjws.026.01.0013

26. Murray KW, Bair-Merritt MH, Roche K, Cheng TL. The impact of intimate partner violence on mothers' parenting practices for urban, low-income adolescents. *Journal of Family Violence*. 2012; 27(6): 573-583. doi: 10.1007/s10896-012-9449-x

27. Bradbury-Jones C, Isham L. The pandemic paradox: The consequences of COVID-19 on domestic violence. *J Clin Nurs*. 2020; 29(13-14): 2047-2049. doi: 10. 1111/jocn.15296

28. Grych J, Swan S. Toward a more comprehensive understanding of interpersonal violence: Introduction to the special issue on interconnections among different types of violence. *Psychology of Violence*. 2012; 2(2): 105-110. doi: 10.1037/a0027616

29. Manring T. Minding the gap in domestic violence legislation: Should states adopt course of conduct laws? *The Journal of Criminal Law & Criminology*. 2021; 111(3): 773-803.

30. LeBlanc AN, Mong MD. The double standard of accountability: A call for treatment integrity of IPV offender programs. *Partner Abuse*. 2021; 12(1): 94-108. doi: 10.1891/PA-D-20-00005

31. Babcock, J, Armenti, N, Cannon, C, et al. Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse*. 2016; 7(4): 355-460. doi: 10.1891/1946-6560.7.4.355

32. Corvo K, Spitzmueller M. Domestic violence policy, forensic mental health, and the revival of rehabilitation: Crossroads or cross purposes. *Partner Abuse*. 2017; 8(3): 315-328. doi: 10.1891/1946-6560.8.3.315

33. Cannon C, Corvo K, Buttell F, Hamel J. Barriers to advancing evidence-based practice in domestic violence perpetrator treatment in the United States: Ideology, public funding, or both? *Partner Abuse*. 2021; 12(2): 221-237. doi: 10.1891/PA-2020-0008

34. Yaxley R, Norris K, Haines J. Psychological assessment of intimate partner violence. *Psychiatry, Psychology, and Law*. 2018; 25(2): 237-256. doi: 10.1080/13218719.2017.1356211

35. Alzueta E, Perrin P, Baker FC, et al. How the COVID□19 pandemic has changed our lives: A study of psychological correlates across 59 countries. *J Clin Psychol*. 2021; 77(3): 556-570. doi: 10.1002/jclp.23082

36. Jetelina KK, Knell G, Molsberry RJ. Changes in intimate partner violence during the early stages of the COVID-19 pandemic in the USA. *Injury Prevention*. 2021; 27(1); 93-97. doi: 10.1136/injuryprev-2020-043831

37. Gosangi B, Park H, Thomas R, et al. Exacerbation of physical intimate partner violence during COVID-19 pandemic. *Radiology*. 2021; 298(1): E38-E45. doi: 10.1148/radiol.2020202866

38. Lagdon S, Armour C, Stringer M. Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *Eur J Psychotraumatol*. 2014; 5(1): 24794-24812. doi: 10.3402/ejpt.v5.24794

39. Burnette CE, Cannon C. "It will always continue unless we can change something": Consequences of intimate partner violence for indigenous women, children, and families. *Eur J Psychotraumatol*. 2014; 5(1): 24585-24588. doi: 10.3402/ejpt.v5.24585

40. Dichter ME, Cerulli C, Bossarte RM. Intimate partner violence victimization among women veterans and associated heart health risks. *Women's Health Issues*. 2011; 21(4): S190-S194. doi: 10.1016/j.whi.2011.04.008

41. Moreira DN, Pinto da Costa M. The impact of the COVID-19 pandemic in the precipitation of intimate partner violence. *International Journal of Law and Psychiatry*. 2020; 71: 101606-101606. doi: 10.1016/j.ijlp.2020.101606

42. Jones DS. COVID-19, history, and humility. *Centaurus*. 2020; 62(2): 370-380. doi: 10.1111/1600-0498.12296

43. Kofman YB, Garfin DR. Home is not always a haven: The domestic violence crisis amid the COVID-19 pandemic. *Psychol Trauma*. 2020; 12(S1): S199-S201. doi: 10.1037/tra0000866

44. Taub A. A new COVID-19 crisis: Domestic abuse rises worldwide. The New York Times. 2020. Website. https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html. Retrieved April 20, 2020. Accessed September 16, 2023.

45. Lipp NS, Johnson NL. The impact of COVID-19 on domestic violence agency functioning: A case study. *J Soc Issues*. 2023; 79(2): 735-746. doi: 10.1111/josi.12549

46. Peitzmeier SM, Fedina L, Ashwell L, Herrenkohl TI, Tolman R. Increases in intimate partner violence during COVID-19: Preva-

lence and correlates. *J Interpers Violence*. 2022; 37(21-22): NP20482-NP20512. doi: 10.1177/08862605211052586

47. Ragavan MI, Risser L, Duplessis V, et al. The impact of the COVID-19 pandemic on the needs and lived experiences of intimate partner violence survivors in the United States: Advocate perspectives. *Violence Against Women*. 2022; 28(12-13): 3114-31341. doi: 10.1177/10778012211054869

48. Buttell F, Ferreira RJ. The hidden disaster of COVID-19: Intimate partner violence. *Psychol Trauma*. 2020; 12(S1): S197-S198. doi: 10.1037/tra0000646

49. Davis M, Gilbar O, Padilla-Medina DM. Intimate partner violence victimization and perpetration among U.S. adults during the earliest stage of the COVID-19 pandemic. *Violence and Victims*. 2021; 36(5): 583-603. doi: 10.1891/VV-D-21-00005

50. Shachar C, Engel J, Elwyn G. Implications for telehealth in a post-pandemic future: Regulatory and privacy issues. *JAMA*. 2020; 323(23): 2375-2376. doi: 10.1001/jama.2020.7943

51. Chiauzzi E, Clayton A, Huh-Yoo J. Videoconferencing-based telemental health: Important questions for the COVID-19 era from clinical and patient-centered perspectives. *JMIR Mental Health*. 2020; 7(12): e24021 doi: 10.2196/24021

52. Ghidei W, Montesanti S, Tomkow K, Silverstone PH, Wells L, Campbell S. Examining the effectiveness, acceptability, and feasibility of virtually delivered trauma-focused domestic violence and sexual violence interventions: A rapid evidence assessment. *Trauma, Violence, Abuse*. 2023; 24(3): 1427-1442. doi: 10.1177/15248380211069059

53. Signal for help. (n.d.). Canadian Women's Foundation. Website. https://canadianwomen.org/signal-for-help/. Retrieved April 2, 2022. Accessed September 16, 2023.

54. Slakoff DC, Aujla W, PenzeyMoog E. The role of service providers, technology, and mass media when home isn't safe for intimate partner violence victims: Best practices and recommendations in the era of COVID-19 and beyond. *Archives of Sexual Behavior*. 2020; 49(8): 2779-2788. doi: 10.1007/s10508-020-01820-w

55. Sullivan CM, Goodman LA. Advocacy with survivors of intimate partner violence: What it is, what it isn't, and why it's critically important. *Violence Against Women*. 2019; 25(16): 2007-2023. doi: 10.1177/1077801219875826

56. Rivas, C, Ramsay, J, Sadowski, L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev*. 2015; 3(12): CD005043. doi: 10.1002/14651858.CD005043.pub3

57. Messing JT, Ward-Lasher A, Thaller J, Bagwell-Gray ME. The state of intimate partner violence intervention: Progress and continuing challenges. *Social Work*. 2015; 60(4): 305-313. doi: 10.1093/sw/swv027

58. Moore AM, Gover AR. Violence against women: reflecting on 25 years of the violence against women act and directions for the future. *Violence Against Women*. 2021; 27(1): 3-7. doi: 10.1177/1077801220949693

59. Morgan RE, Oudekerk BA. Criminal victimization, 2018. U.S. Department of Justice. 2019. Website. https://www.bjs.gov/content/pub/pdf/cv18.pdf. Accessed September 16, 2023.

60. Goodmark L. Reimagining VAWA: Why criminalization is a failed policy and what a non-carceral VAWA could look like. *Violence Against Women*. 2021; 27(1): 84-101. doi: 10.1177/1077801220949686

61. Avent E, Wilber K, Gassoumis Z. Predictors of late-life physical IPV using Adverse Childhood Experiences and the Wisconsin Longitudinal Study. *Innov Aging*. 2018; 2: 470-471. doi: 10.1093/geroni/igy023.1759

62. Sabri B, Hartley M, Saha J, Murray S, Glass N, Campbell JC. Effect of COVID-19 pandemic on women's health and safety: A study of immigrant survivors of intimate partner violence. *Health Care for Women International*. 2020; 41(11-12): 1294-1312. doi: 10.1080/07399332.2020.1833012

63. CONGRESS.GOV. H.R.3083 - Battered Immigrant Women Protection Act of 1999. 106th Congress (1999-2000). 1999. Website. https://www.congress.gov/bill/106th-congress/house-bill/3083?s=1&r=2. Accessed September 16, 2023.

64. Bair-Merritt, M. H, Jennings, J. M, Chen, R, et al. Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the hawaii healthy start home visitation program. *Arch Pediatr Adolesc Med*. 2020; 164(1): 16-23. doi: 10.1001/archpediatrics.2009.237

65. Duggan A, Fuddy L, McFarlane E, et al. Evaluating a statewide home visiting program to prevent child abuse in at-risk families of newborns: Fathers' participation and outcomes. *Child Maltreatment*. 2004; 9(1): 3-17. doi: 10.1177/1077559503261336

66. Flood M, Howson R, Aavik K, Hamilton A. *Engaging Men in Building Gender Equality*. Newcastle upon Tyne, UK: Cambridge Scholars Publishing; 2015.

67. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the safe dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health*. 2004; 94(4): 619-624. doi: 10.2105/AJPH.94.4.619

68. Miller LE, Howell KH, Graham-Bermann SA. Potential me-

diators of adjustment for preschool children exposed to intimate partner violence. *Child Abuse Negl.* 2012; 36(9): 671-675. doi: 10.1016/j.chiabu.2012.07.005

69. Wolfe DA, Wekerle C, Scott K, Straatman A-L, Grasley C, Reitzel-Jaffe D. Dating violence prevention with at-risk youth: A controlled outcome evaluation. *J Consult Clin Psychol.* 2003; 71(2): 279-291. doi: 10.1037/0022-006X.71.2.279

70. Wolfe DA, Crooks C, Jaffe P, et al. A school-based program to prevent adolescent dating violence: A cluster randomized trial. *Arch Pediatr Adolesc Med.* 2009; 163(8): 692-699. doi: 10.1001/archpediatrics.2009.69