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Review of Conceptualizations, Peer Interventions, and Principles and Standards in Approaches to Intimate Partner Violence (IPV)

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Abstract

Intimate partner violence (IPV), a type of domestic violence, is a human rights issue that is considered a global health concern. The daunting statistics outline the immense need for principles and standards for approaches to IPV. The overarching goal of this review is to explore peer support and peer mentorship as a potential adjunct service to a comprehensive service program for IPV victim-survivors. Conceptualization, theory, and frameworks; social support and peer support; the self-identity of IPV victims; single versus integrative services; service enhancement; evaluation; and advocacy and interventions are investigated in relation to IPV services, in general, and peer support, specifically. Distinctive principles and standards become a theme across the domains examined. The call for an integrative framework for IPV approaches is also outlined. The applications for clinical mental health counseling are discussed.

Keywords: intimate partner violence, IPV, domestic violence, DV, peer mentorship, peer support, social support, self-identity, evaluation, theory of intimate partner violence, frameworks, integrated services, applications for clinical mental health counseling, survivor-centered, service delivery, principles and standards of care, trauma-informed services

Contents

Review of Effective Conceptualization and Peer-Centered Approaches to Intimate Partner Violence (IPV)

One of the most dangerous places for a woman is within her home (Bradbury-Jones & Isham, 2020; Hill, 2020; Snyder, 2019). Domestic violence (DV), an umbrella term, is referenced frequently in media and encompasses any domestic violence setting (Bradbury-Jones & Isham, 2020). When the perpetrator of the victim is a partner or ex-partner, the term intimate partner violence (IPV) is utilized to accurately portray the form of DV occurring. IPV is the type of DV that is commonly described in media. Therefore, the terms will be applied interchangeably throughout the review. IPV is not confined to marriages, nor are the victims only women. However, it is estimated that women encompass 85% (Snyder, 2019) to 95% (Berry, 2000) of DV victims. According to the data, females are disproportionately affected by this type of violence. Moreover, the majority of abusers are male (Snyder, 2019; Weiss, 2003). For this review, abusers will typically be referenced as males and victims will mostly be referred to as females. These designations reflect the statistical data available and are not meant to diminish the experience of any individual victimized by DV that does not correspond with the women-men statistical roles.

A focus of the feminist movement of the 1970s centered on sexual and domestic violence (Anyikwa, 2016; Taft et al., 2009). IPV is defined as a form of abusive, threatening, or coercive actions committed by a current or past intimate partner that causes harm including, but not limited to, physical, psychological, and/or sexual (Campbell et al., 2012; Reilly & D'Amico, 2011; Taft et al., 2009). Over 71% of females are impacted by some form of IPV before the age of 25 (Anyikwa, 2016). One in 10 women will experience rape. The lifetime prevalence for psychological abuse, for both men and women, is approximately 50%. These statistics begin to

demarcate the scale of the issue, however, many experts consider IPV incidents as underreported (Reilly & D'Amico, 2011).

The National Coalition Against Domestic Violence (NCADV) has collated even more alarming statistics regarding DV (*National Statistics,* n.d.). Over 10 million adults experience IPV each year in the United States (US). As indicated, IPV may take many forms including physical, sexual, emotional, verbal, economic, and digital abuse (Judd, 2013; Matheson et al., 2015). Public health campaigns and literature on IPV have typically focused on physical abuse; there is a beginning shift to expand the focus to the many other forms of IPV (Carlyle et al., 2019; Matheson et al., 2015). Many adverse health concerns are associated with IPV that includes both the psychological and physical domains (Anyikwa, 2016; Dienemann et al., 2000). Additionally, IPV victims commonly experience substance use disorders (SUD) (Anyikwa, 2016; Fearday & Cape, 2004).

Furthermore, intimate partner violence traverses all socioeconomic statuses and personality and demographic factors (Berry, 2000; Hill, 2020; Snyder, 2019). No single victim typology has been identified across copious research studies performed (Hill, 2020). For every woman murdered through DV, nine are almost killed (Snyder, 2019); 58% of murder victims are female (Anyikwa, 2016). IPV is experienced by one in three (Hill, 2020) to one in four (National Statistics, n.d.) American women each year. Over the life span, more than 23% of female victims suffer severe physical violence from an intimate partner. Additionally, one in five women requires medical care due to these experiences (National Statistics, n.d.). Moreover, for female victims, it is the cause of one in five suicide attempts (Hill, 2020). "Physical abuse may be the single most important etiological factor of female suicide" (Dienemann et al., 2000, p. 500). DV is the cause for more than half of women facing homelessness (Berry, 2000; Snyder, 2019).

Moreover, IPV is seldom confined to a single incident. The persistent and repetitive form of this abuse prompted experts to further classify IPV as one pathway leading to complex posttraumatic stress disorder (c-PTSD) (Anyikwa, 2016). Common outcomes of c-PTSD include, but are not limited to, mental health challenges and substance use problems (Anyikwa, 2016; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011; Taft et al., 2009). An additional complicating factor surrounding IPV conceptualization and treatment is a pattern of adverse lifespan experiences; this pattern has been termed "negative chain effects" (Reilly & D'Amico, 2011, p. 409). Typically, negative chain effects start with childhood abuse and includes probable later revictimization such as experiencing IPV that occurs across the victim's life. Thus, there is a risk of "a pathway of life-long accumulated adversity" (Reilly & D'Amico, 2011, p. 409). These risks include the likelihood of educational underachievement, relationship difficulties, adverse physical health outcomes, psychiatric diagnoses, self-harming behaviors, and homelessness among numerous other possible experiences (Anyikwa, 2016; Campbell et al., 2012; Dienemann et al., 2000; Matheson et al., 2015; Reilly & D'Amico, 2011; Taft et al., 2009).

While these outlined statistics and associations begin to portray the seriousness and prevalence of IPV for women in the US, IPV is a global concern (Bradbury-Jones & Isham, 2020; Rose, 2021). For instance, in Africa, from 2019 data, a female is reported rape and murdered by an intimate partner every three hours (Rose, 2021). In 2014, African reported data outlined that a woman was killed every eight hours. IPV is a significant national and worldwide crisis requiring counselors' and the mental health field's intense attention. Moreover, the COVID pandemic has intensified occurrences of DV and IPV (Bradbury-Jones & Isham, 2020). International DV reports increased from 20% to 40-50%.

Furthermore, IPV extracts a vast personal and public cost (Snyder, 2019). Annually, estimates place victims absent from work over eight million workdays; there is more than $8 billion in costs each year for health and medical expenses. This financial burden, alongside the other tolls DV exacts, spans victims, families, communities, taxpayers, and the justice system. In general, IPV amasses wide-ranging costs crossing personal, interpersonal, and societal domains (Eckhardt et al., 2013). IPV has been identified as a major public health matter (Reilly & D'Amico, 2011).

From 2016-2018, the number of IVP incidents increased by 42% (*National Statistics*, n.d.). As outlined, beyond the disturbing statistics, IPV also accrues extensive costs across personal, interpersonal, and societal domains (Eckhardt et al., 2013). There have been various models incorporating differing interventions created to address IPV. An important addition to a comprehensive IPV service model may be social support (Fearday & Cape, 2004; Matheson et al., 2015). The numerous types of social support include both peer support and peer mentoring. Both peer support and peer mentoring may be vital components in promoting social capital.

Review of Literature

Conceptualization, Framework, and Theory of IPV/DV

Decades before laws were passed against brutality to one's wife, the American Society Against the Cruelty to Animals was established (Snyder, 2019). The laws established in the United States in the last century were rarely upheld. If disputes were presented before the courts, rulings invariably supported the perpetrators. Only if the wife's injuries were permanent were exceptions to this pattern commonly made. In 1984, the Family Violence Prevention and Services Act was passed and provided funding for shelters as well as other resources for victims (Snyder, 2019). The passing in 1994 of the Violence Against Women Act (VAWA) became a considerable influence in how DV and IPV were treated within the United States. Prior to this, DV and IPV were not deemed concerns for the criminal justice system. The passing of VAWA had a significant impact; however, every five years, the act must be reauthorized.

Understanding DV and IPV is murky for many individuals (Weiss, 2003). Beyond this obscure conceptualization, there are powerful sociocultural narratives directed at women that impede leaving these situations (Hill, 2020; Snyder, 2019; Weiss, 2003). These narratives can include the wish and the pressure to maintain an intact family (Berry, 2000; Weiss, 2003); it takes two for a fight and, thus, the victim holds a certain level of blame for the abuse; and a sane person would leave if the abuse was truly that terrible (Weiss, 2003). A further barrier to even discussing DV and IPV, let alone receiving the necessary assistance, is the shame and embarrassment surrounding this phenomenon (Bradbury-Jones & Isham, 2020; Hill, 2020; Weiss, 2003). Regardless of the facts surrounding IPV, there is an incessant stereotype that only particular kinds of women allow themselves to become involved in abusive relationships (Berry, 2000; Weiss, 2003). Furthermore, the very protections and services that are offered to these

victims do not always protect them or even best serve them (Hill, 2020; Snyder, 2019). Often, the protective services serving children and victims run contrary to the family court system. Family court systems typically rule in favor of a father's parental rights while child protective services may threaten the removal of the child from the mother if she allows such contact. Moreover, the criminal justice system routinely favors the perpetrator and, oftentimes, provides little protection to the female survivor and concerned children (Hill, 2020; Snyder, 2019; Weiss, 2003).

Formulations regarding the philosophy, structure, and goals of IPV perpetrator interventions have utilized sociohistorical analysis of IPV (Eckhardt et al., 2013). This analysis has conceptualized IPV as an extension of common male behavior and socialization; therefore, there has been a reliance on gender re-education models rather than psychotherapeutic models focusing on identification of idiosyncratic causes of violence including traumatic experiences, behavioral deficits, or psychopathology. Within this conceptualization, feminist frameworks are foundational and violence mitigation is best accomplished through "exposing patriarchal/misogynistic attitudes, encouraging accountability and personal responsibility for coercive tactics in relationships, and promoting gender-egalitarian attitudes and behaviors" (Eckhardt et al., 2013, p. 198). Most programs as well as state laws and guidelines regulating IPV interventions embrace fundamental characteristics of feminist frameworks on both IPV etiology and intervention. However, some interventions integrating both traditional gender reeducation and psychotherapeutic models incorporate cognitive behavioral therapy (CBT) into a hybrid model. These theoretically-oriented approaches expound on the traditional treatment targets of "patriarchal socialization" (Eckhardt et al., 2013, p. 198) and include empirically-based treatment aspects.

A number of peer-reviewed research endeavors involved person-centered and/or feminist principles, theories, and frameworks regardless of the domain of inquiry (Anyikwa, 2016; Brown-Graham et al., 2022; Campbell et al., 2012; Fearday & Cape, 2004; S. J. Kulkarni et al., 2012; Matheson et al., 2015; McKenzie et al., 2021; Reilly & D'Amico, 2011; Sullivan, 2011). Regardless of whether the pursuit concentrated on ascertaining increased social capital or service outcome evaluation, the prevailing endorsement was for a survivor-centered framework. Other common themes within the literature included the identification and respect for cultural identities and context. A single explored study identified the framework as pragmatic (Taft et al., 2009). A feminist-aligned theory, trauma theory, was utilized for another reviewed research study (S. J. Kulkarni et al., 2012).

Moreover, there has been debates within the field regarding the core assumptions underlying the prevailing traditional approach and interventions regarding IPV, especially surrounding etiology and perpetrator motivations and characteristics (Bates & Taylor, 2019; Eckhardt et al., 2013). Namely empirical research has been challenging the assumptions that men commit IPV as means of controlling women and such perpetrators are fundamentally different from other violent offenders (Bates & Taylor, 2019). Empirical evidence supports that, indeed, certain types of IPV are perpetrated with the underlying desire for control as a core factor. Furthermore, aggressive coercive tactics without the use of violence including "humiliation, threats, degradation, and isolation" (Bates & Taylor, 2019, p. 13) may account for up to 80% of IPV incidents. Importantly, research also finds that IPV violence can be perpetrated without the patterned need for control.

This leaves us with the fact that a one size fits all approach is questionable within the literature as the best way to conceptualize and apply theoretical frameworks to IPV. Regardless,

"domestic violence is not a gender issue. It is a human rights issue" (Weiss, 2003, p. 7). IPV may, indeed, involve unique individuals with idiosyncratic core motivations for this type of abuse. Research is ongoing as to how these conceptualizations impact the multifaceted factors surrounding IPV (Bates & Taylor, 2019; Hill, 2020; Judd, 2013; Kenney, 2012; Snyder, 2019). As mentioned, the prevailing focus in the literature was on patriarchal influences and feminist frameworks for conceptualization, application of theory, guiding principles, and legislature surrounding IPV (Bates & Taylor, 2019; Eckhardt et al., 2013).

Beyond this focus on survivor-centered frameworks for intervention, sources discuss five prevailing theoretical frameworks utilized for explanatory purposes regarding IPV (Mitchell & Anglin, 2009). Psychological frameworks include psychoanalytic, frustration-aggression theory, social learning theory, and cognitive-behavioral theories. An example would be the earliest framework, utilized until the 1960s, grounded in psychoanalytic theory that placed blame on individual maladjusted personality dynamics, typically faulting the woman for the violence of the husband. Biobehavioral influences frameworks includes genetic and neurochemical mechanisms as influencing IPV. Feminist theory is another explanatory framework, discussed extensively in this review. Sociological frameworks focus on macro-social components including social norms and cultural expectations. Lastly, an integrative multidimensional framework incorporates the four nested layers of individual, family/primary relationships, community, and society as dynamic and interacting factors to explain IPV.

Mentorship and Peer Support

Social capital, or social support, may be defined as "the connections, networks or relationships among people and the value that arises from them" (Brown-Graham et al., 2022, p. 4). In general, social support is associated with psychological well-being (Brown-Graham et al.,

2022; Campbell et al., 2012). Many positive outcomes have been linked with social support including enhanced competency, empowerment, and increased validation and, at the same time, may also decrease feeling isolated and the impacts of stigmatization (Brown-Graham et al., 2022; Reilly & D'Amico, 2011). Moreover, social capital can increase trust levels while advancing towards shared goal attainment (Brown-Graham et al., 2022). These facets of social capital may be particularly significant for IPV victims (Anyikwa, 2016; Brown-Graham et al., 2022; Campbell et al., 2012; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011).

There is growing evidence within the literature for the effectiveness of peer support, a certain form of social capital, in mitigating the destructive impacts of IPV (Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015). The roots of peer support may be derived from the 1970s feminist practice of the consciousness-raising group process. One definition of a peer is "an equal, someone who has faced similar circumstances," while support may be defined as, "the kind of understanding and encouragement toward growth that people who struggle with similar issues can offer one another" (Blanch, A et al., 2012, p. 13). Fundamentally, such assistance requires that support is focused on growing and building beyond the current circumstances as well as help is offered within a sense of equality rather than in a hierarchical manner. Moreover, principles of peer support have been identified as voluntary, non-judgmental, empathetic, respectful, requiring honest and direct communication, involving mutual responsibility, sharing power, and is reciprocal (Blanch, A et al., 2012).

Furthermore, mentorship has been correlated with significant benefits across numerous domains (Anyikwa, 2016; Reilly & D'Amico, 2011; Taft et al., 2009; Vance, 1982). The characteristics and functions of a mentor may encircle teacher, sponsor, host and guide,

exemplar, and counselor (Vance, 1982). Another description of a mentor is a "visionary who sees in a person the potention of which the individual is frequently unaware" who also believes in and endorses the "neophyte's potential dreams for the future" (Vance, 1982, p. 8). Some of the more critical benefits for the mentee of the mentor-mentee relationship may include "greater personal satisfaction, increased self-confidence and enhanced self-esteem" (Vance, 1982, p. 9). When the mentee is paired with a mentor that has the same or similar lived experiences as the mentee the results is a peer support mentorship that adds a dimension to the traditional mentorship dynamic. There is growing evidence that peer support mentorship is efficacious for IPV survivors (Campbell et al., 2012; Fearday & Cape, 2004; Matheson et al., 2015; Taft et al., 2009). Moreover, there is increasing support within the literature linking positive outcomes and the use of peer support models applied to both the substance use and mental health disorder communities (Dienemann et al., 2000; Matheson et al., 2015). However, further studies are needed to synthesize the limited but growing researching connecting positive peer support services for IPV survivors as well as to clearly delineate effective framework parameters (Eckhardt et al., 2013; Eddie et al., 2019).

Both peer support and peer sponsorship, or mentorship, are an established tradition within self-help groups including Alcoholics Anonymous (Eddie et al., 2019). These facets of social capital may be a beneficial additional service within a holistic program for IPV victims (Fearday & Cape, 2004; Matheson et al., 2015). There is increasing literature studying peer support and peer mentorship utilized with IPV survivors (Anyikwa, 2016; Brown-Graham et al., 2022; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Taft et al., 2009). As noted, increased mental wellness is linked with increased social capital (Brown-Graham et al., 2022; Campbell et al., 2012). Moreover, studies support the numerous benefits to IPV victims

received from peer-delivered social support (Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011) and may be an important component of a survivor-centered approach to IPV and DV. Yet, there is a gap in recent additions to the literature and a need for further research (Eckhardt et al., 2013; Eddie et al., 2019; Mitchell & Anglin, 2009).

Self-Identity of IPV Survivors

Self-esteem may be conceptualized as "the evaluative and affective dimension of the self-concept, and is considered the equivalent to self-regard, self-estimation, and self-worth" (Matheson et al., 2015, p. 562). Furthermore, self-esteem provides the foundation of self-image, "whether a woman sees her self-value or self-worth either as positive or negative" (Matheson et al., 2015, p. 562). Self-esteem, self-concept, and self-identity are associated with mental wellness (Matheson et al., 2015). Each of these critical elements to wellbeing can be damaged by IPV. Therefore, self-identity may be a vital factor in recovery efforts for IPV survivors. The concepts of self-esteem, self-concept, and/or self-identity were components in several reviewed studies in conjunction with the advantageous outcomes from social support services in assuaging the deleterious effects of IPV (Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011). To expound on this conceptualization, Matheson et al. (2015) coined the term "identity deconstruction" (p. 561). This term comes from the fact that "scrutiny, mockery, and denial of the essence of the person comes alive in the abusive relationship and colors the daily moments of life" (Matheson et al., 2015, p. 564). Fundamentally, identity deconstruction is the erosion of the sense of self. Identity reconstruction efforts, part of which were obtained through peer support services, eased the impact of identity deconstruction.

Furthermore, the reaction of friends can have a large impact on young women who have experienced IPV (McKenzie et al., 2021). This study integrated narrative and feminist theories. Master cultural narratives were discussed as having an overarching influence on how IPV and IPV victims are perceived. The post-feminist influence on these cultural narratives is based on the viewpoint that gender equality has been achieved. Therefore, women can leave abusive relationships if they want to. While there are empowering elements in this master narrative, IPV victims that stay are seen as "weak, foolish, or lacking in self-esteem" highlighting individual characteristics and responsibilities. This narrative ignores the larger social, structural, and political dimensional interplay in power and how this impacts IPV victims (McKenzie et al., 2021). Based upon the reaction of friends, IPV victims utilized voices of either self-blame; agency; vulnerability and powerlessness; or of solidarity when describing their self-identity.

Moreover, a social constructionist perspective provides the conceptualization that identities and associated labels are social products (Eckstein, 2016). Furthermore, stigma is a part of social evaluation processes and interactions that can threaten one's "identity, communication abilities, and/or overall well-being" (Eckstein, 2016, p. 216). In less injurious contexts than IPV, stigmatization can increase susceptibility to depression and anxiety. IPV survivors may experience stigmatization as damaging to their identities. Potential outcomes from stigmatization include, but are not limited to, reduced educational attainment, malfunctions in interpersonal relationships, reduced income levels, psychological issues, as well as reduced housing opportunities, access to medical care, quality of care, and physical health. Importantly, IPV survivors, similarly to other hidden groups, find themselves in a double bind. For them, disclosure of the abuse jeopardizes their privacy while their silence decreases public stigmatization but inhibits aid (Eckstein, 2016).

The experience of IPV damages survivors' self-identity as does the reactions of friends; however, the overall stigma associated with being a survivor of IPV can produce additional destruction. Disclosure of the abuse, itself, can be an extremely negative experience for some (Mitchell & Anglin, 2009). The potential outcomes of stigmatization are almost always negative (Eckstein, 2016) and are almost identical to the listed potential outcomes of experiencing IPV, itself.

Single-Focused Versus Integrative Social Support Services

Fearday and Cape's (2004) primary hypothesis was that "integrated treatment for mental health, substance abuse, and trauma is more effective than treatment that fails to address trauma or addresses these problems separately" (p. 258). However, no explicit comparison or summarization was provided for the two groups covering the integrated services versus the non-integrated services. Their conclusion was to recommend the integrated service approach, but they did not provide statistical reasoning or research methodology supporting this statement. Many integrated social support service approaches were explored in the literature (Anyikwa, 2016; Dienemann et al., 2000; Matheson et al., 2015; Reilly & D'Amico, 2011; Taft et al., 2009). Anyikwa (2016) concentrating on trauma-informed interventions across systems and did not confine the study to IPV-specific services. The positive impact of education on victims was among the numerous topics discussed in another study focusing on the intersection of poverty and IPV (Matheson et al., 2015). The intersection of education and mentorship for abuse survivors was the focus of another reviewed study (Reilly & D'Amico, 2011). Dienemann et al. (2000) studied the integration of mental health and IPV services. Campbell et al. (2012) was the only study that was singularly focused on social support for IPV victims. Therefore, the current

literature supports integrated services with multiple concentrations including mental health, substance use, and parenting intersecting with IPV services.

Enhancing IPV Services

The literature highlighted assumptions and principles associated with enhanced social support services (Anyikwa, 2016; Brown-Graham et al., 2022). Within a trauma-informed framework, the six principles listed include *"safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender issues"* (Anyikwa, 2016, p. 488). These principles aligned with and were reiterated by other authors as peer support principles (Blanch, A et al., 2012), as best practice recommendations, and/or descriptions of participants' experiences of effective services (Anyikwa, 2016; Brown-Graham et al., 2022; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Mitchell & Anglin, 2009). Safety and trust are critical when working with survivors of IPV. The prevailing feminist and person-centered frameworks found throughout the literature reviewed also align with these outlined principles (Anyikwa, 2016; Brown-Graham et al., 2022; Campbell et al., 2012; Fearday & Cape, 2004; S. J. Kulkarni et al., 2012; Matheson et al., 2015; McKenzie et al., 2021; Reilly & D'Amico, 2011; Sullivan, 2011). Prevention of re-traumatization is another critical assumption within the reviewed literature (Anyikwa, 2016; Brown-Graham et al., 2022; S. J. Kulkarni et al., 2012).

Furthermore, even with the growth in IPV services, gaps in services remain especially for marginalized and vulnerable victim populations (S. Kulkarni, 2019). Changes over the past few decades have increased the service capacities of many organizations across the nation. However, these expanded IPV services have not always aligned with the diverse needs of survivors. Moreover, there has been a persistent gap nationally between requested services and available

services. Some experts are calling for an intersectional service delivery model that will narrow the gap between survivors expressed need requests and commonly offered IPV services. These intersectional service models combine the philosophical principles of intersectional feminism with trauma-informed care. These frameworks are "defined by four key elements–power sharing, authentic survivor-advocate relationships, individualized services, and robust systems advocacy" (S. Kulkarni, 2019, p. 55). Three service frameworks are listed as meeting these outlined needs: survivor-centered advocacy, full-frame approach, and culturally specific programs. The most beneficial aspect of these intersectional approaches is that they are purported to accentuate the ways that social labels and categories interplay and shape IPV experiences.

Evaluation

Interestingly, the first formal evaluation of IPV prevention programs did not occur until 1986, despite the fact that the social movement against IPV began in the early 1970s (Stith, 2006). This is just one example of how evaluation has evolved at a different pace than the guiding social movement and direct service provisions centered on IPV and how integral evaluation should be considered within all efforts addressing IPV. Moreover, there are several controversial facets to evaluating IPV services including, but not limited to, collecting information safely and respectfully; ensuring outcome evaluations are collected, not satisfaction information; at what point in the service process to collect information; and how the evaluation findings are used by funders (Sullivan, 2011). Evaluation information gathering is critical to increase the research knowledge base, increase likelihood of securing funding for services and agencies, and/or to confirm the provision of effective services. Similarly, principles for enhancing services align with the evaluation process including safety, respect, empowerment, and offering voice and choice. Numerous recommendations collected from international sources

were provided by Sullivan (2011). These recommendations provide a great foundation to begin the outcome evaluation process ensuring alignment with ethical and respectful practice.

Furthermore, there can be a discrepancy in expectations between service providers and IPV victim-survivors, notably surrounding what aid is considered most useful and what should be considered a success (S. Kulkarni, 2019). There may be some common incongruities between victims' stated values, inclinations, and needs and assumptions made by IPV service delivery programs. Some experts assert that one approach to alleviate these issues is to incorporate the key elements of intersectional frameworks (power-sharing, authenticity, individualized services, and systems advocacy) and integrate them throughout not only program design and implementation but also evaluation.

While evaluation may be approached as a means to secure funding, program evaluation could be viewed as a "meaningful strategy to ensure organizational self-accountability and quality improvement related to intersectional trauma-informed approaches" (S. Kulkarni, 2019, p. 60). Though planning, application, and evaluation activities occur successively, there would be added benefit to conceptualizing these elements as interconnected through a cycle of designing, implementing, and reflecting. Furthermore, collaboration with IPV researchers on evaluation processes would also be advantageous for service delivery programs.

Utilizing data gleaned from evaluation can highlight challenges, goal attainments, and illuminate unintended outcomes (S. Kulkarni, 2019). Best practices in evaluation would include multiple points of evaluation over time collected from survivors especially across multiple systems to ensure victim's experiences are captured but to also assess cross-system partnership effectiveness. Critical evaluative components will be measuring victims' progression as well as barriers to change.

Advocacy and Interventions: Needs, Barriers, and Benefits

Advocacy has been deemed the fifth force in the field of counseling (Hof et al., 2009). Furthermore, in the counseling profession, there has been a shift to the position that social advocacy is an ethical responsibility of counselors. Certain beliefs such as attaining personal moral growth and standing as well as accumulating extensive knowledge of social concerns may hinder entering into advocacy work (Roysircar, 2009). Instead, experts and social advocates assert that mere involvement is the starting point for advocacy work rather than any believed prerequisites regarding social advocacy. Advocacy, in addition to a clinical role, may be paramount for improving the mental health of IPV survivors (Mitchell & Anglin, 2009; Stith, 2006).

On average, a woman will attempt to leave seven times before actually escaping an abusive relationship (Hill, 2020). IPV touches every domain of the survivor's life (Snyder, 2019; Weiss, 2003). There is not a single factor that can address this issue and end the vicious cycle (Mitchell & Anglin, 2009; Snyder, 2019; Weiss, 2003). Instead, collaboration across community systems and institutions to provide a mutual response to IPV is required (Berry, 2000). Much like the effects of stigmatization outlined above, this organized response may consist of a hierarchy of need responses – immediate, secondary, peripheral, etc.

An important element that has facilitated in the prevention of IPV is the changing viewpoint of society regarding this issue (Berry, 2000; Stith, 2006). The dominant viewpoint has altered considering IPV as a private family matter to one that requires addressing by society (Berry, 2000). Prevention efforts in Duluth, Minnesota, placing them in a leadership position for both prevention and eradication efforts, is one avenue to tackle IPV. This approach provides educational seminars to groups throughout the community including governmental organizations,

counselors, and high school students. Hennepin County also established a comprehensive approach entitled the Domestic Abuse Project (DAP) (Berry, 2000). These two approaches as well as numerous other national efforts attempt to form service collaborations to attend to the multiple need domains for survivors.

Furthermore, targeted interventions may be beneficial for survivors (Mitchell & Anglin, 2009). One example of a targeted intervention for IPV survivors is a mentorship program that parallels the peer recovery specialist approach in the substance abuse field. There are a few programs presently operating in the US utilizing this form of intervention. A program entitled *her* Voice founded by Dr. Shana D. Lewis is operating in Texas (*About*, n.d.). An additional program named Domestic Abuse Survivor Help (DASH) founded by Kellie Jo Holly is an online peer support network pairing survivors with a peer mentor (*Get Relationship Abuse Recovery Help from DASH (Domestic Abuse Survivor Help)*, n.d.). Peer support specialists (PSSs) encompass a role that includes “helping others to develop coping and problem-solving strategies" (Rogers & Swarbrick, 2016, p. 194). PSSs couple empathy and lived experiences “to promote hope, insights, and skills; help engage in treatment, access community supports; and establish a satisfying life” (Rogers & Swarbrick, 2016, p. 194). A mentorship program as an adjunct to current group and individual work may be beneficial itself but could also be a viable option for survivors not able to make use of other resources or not ready for group work (Tutty, L et al., 2006).

As noted, DV and IPV is a horrendous experience for many American women that impacts numerous, if not, all areas of life (Snyder, 2019; Weiss, 2003). Many services and resources are available to assist these survivors. However, IPV is a multifaceted and enveloping life concern (Hill, 2020; Snyder, 2019; Weiss, 2003) that requires an equally multifaceted

solution incorporating both immediate and long-term approaches (Berry, 2000). IPV survivors may have numerous domains where assistance and aid is required (Berry, 2000; Snyder, 2019; Weiss, 2003). The urgent needs of shelter, food, and safety will require immediate responses and interventions, as applicable. Stigmatization and maladaptive sociocultural narratives impacting survivors and survivors' self-identity is another important consideration for intervention (Berry, 2000; Eckstein, 2016; Hill, 2020; Snyder, 2019; Weiss, 2003). If reporting has occurred with law enforcement, the consequences for the perpetrator have a large range from nearly none to exemplar (Hill, 2020). Ensuring a sense of validation for the IPV survivor may be a potent counterpoint to any negative experiences and a potentially powerful tool for recovery (Matheson et al., 2015; Mitchell & Anglin, 2009; Weiss, 2003).

A consistent mentor that shares the survivor's lived experience with IPV has the potential to be especially beneficial for survivors (S. Lewis, personal communication January 2021; Matheson et al., 2015; J. Rhodes, personal communication, January 24, 2022). In several mental health areas, both mentorship and peer support programs have been proven efficacy (Rogers & Swarbrick, 2016). Furthermore, international programs, such as those implemented in Canada and New Zealand, have begun to incorporate mentorship and/or peer support specialists in services provided to IPV victims (Matheson et al., 2015). The peer support helper should be provided training that includes a manual and a standardized training program as part of this service (Rogers & Swarbrick, 2016; Tutty, L et al., 2006).

Applications to Clinical Mental Health Counseling

When only considering physical forms of IPV, estimates range from 10 – 50% of women globally are being impacted (Ben-Porat & Sror-Bondarevsky, 2021). If financial and emotional abuse are included in the accounting, the numbers are much higher. Based upon the international

and national figures, mental health counselors are most likely to have IPV survivors in their clinical work. Overall, counselors should remain abreast of best practices in screening, ways to validate during the disclosure process, how to reduce re-traumatization at all stages of IPV work, and have knowledge of and contact information for community resources and referrals (Mitchell & Anglin, 2009). Moreover, integrating questions regarding other lifetime traumas within assessments will be important as well as assessing for strengths and goals of the survivor. Providing victim-survivors with agency and choice will be important in clinical work. As noted, advocacy efforts are paramount to prevention, treatment, and recovery from IPV (Mitchell & Anglin, 2009), even if it is just voting for legislature that supports IPV victims.

A major conceptualization to incorporate into the clinical care for survivors of IPV is that even if the survivor has left the situation, the journey is not over for her (Weiss, 2003). As clearly outlined in this review, survivors have a long path of healing in multiple domains and from multiple potential outcomes. Moreover, the IPV survivor is changed by her experience. She is not the woman she was before the abuse occurred. “Just as domestic abuse itself goes far beyond a curse or a slap, recovering from domestic abuse goes far beyond ending the relationship” (Weiss, 2003, p. 124). When working with a victim that has not left her abusive relationship, attention to and addressing the potential dangers in the victim seeking services is paramount.

A final consideration for clinical work with victim-survivors is that DV and IPV takes a devastating toll on the survivors themselves but also exerts a heavy impact on the victim’s social support network (Weiss, 2003). Education on self-care for the victim but also for their support network may be an important facet of treatment. Moreover, secondary traumatic stress is a term some experts use to encompass vicarious trauma, burnout, compassion fatigue, and/or traumatic

counter-transference and relates to “the negative psychological impact caring for trauma survivors among mental health professionals” (Mitchell & Anglin, 2009, p. 539). Research into prevention and treatment may be an equally integral factor for this type of clinical work. Current frameworks conceptualize an interplay of both individual and practice or organizational factors that result in the likelihood of developing secondary traumatic stress. Both factors are also, thus, components of treatment.

Discussion

There seems to be a line of inquiry into the mutuality of IPV and a call to reject the feminist paradigm (Bates & Taylor, 2019). However, as noted, feminist theory and frameworks were incorporated in research endeavors and survivor-centered interventions throughout this review. Indeed, feminism has been a historical aspect of not just conceptualizing IPV (Eckhardt et al., 2013) but also in the roots of peer support itself (Blanch, A et al., 2012). While the vast majority of victim-centered, peer-reviewed articles reviewed contained varying degrees of feminist theory and/or frameworks (Anyikwa, 2016; Brown-Graham et al., 2022; Campbell et al., 2012; Fearday & Cape, 2004; S. J. Kulkarni et al., 2012; Matheson et al., 2015; McKenzie et al., 2021; Reilly & D'Amico, 2011; Sullivan, 2011), there are other frameworks applied to this complex issue. Some researchers report five prevailing explanatory frameworks, "the psychological, the biobehavioral, the sociological, feminist theory, and an integrative multidimensional approach" (Mitchell & Anglin, 2009, p. 39). In fact, regarding explanations, one single theory is unlikely to provide an accurate portrayal of this complex issue. There are some experts calling for an integrated framework for service delivery as well (S. Kulkarni, 2019). Three such frameworks were listed as meeting this call including survivor-centered advocacy, full-frame approach, and culturally specific programs. Thus, conceptualization, interventions, and approaches will need to be equally diverse.

Social support, in general, is correlated with increased mental wellness (Brown-Graham et al., 2022; Campbell et al., 2012). It is also associated with positive outcomes including increasing a sense of competency, empowerment, and validation while also decreasing feelings of isolation and the influence of stigmatization (Brown-Graham et al., 2022; Reilly & D'Amico, 2011). There is promising data in the literature underscoring the effectiveness and benefits for

peer support and peer mentorship programs for IPV victim-survivors (Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011). Moreover, there is a larger literature base showing the effectiveness of these types of social capital for numerous medical and mental health domains (Rogers & Swarbrick, 2016). The long-standing tradition of peer support and peer sponsorship within self-help groups also lends credence to the potential benefits of applying these interventions as an adjunct service to a robust service delivery program for IPV survivors (Eddie et al., 2019).

As stated, self-identity is an important facet for interventions for IPV survivors. While the literature endorsed peer support interventions to mitigate the adverse effects to self-identity (Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011), it will remain important to understand there are numerous other factors involved in victims' self-identity such as the explored impact of friend responses (McKenzie et al., 2021) and overall stigmatization (Eckstein, 2016). Prevention and advocacy efforts will have influence and impact directly on IPV and victims' experiences (Mitchell & Anglin, 2009; Stith, 2006) but may also provide an influence on the sociocultural narratives that potentially multiple the adverse experiences of IPV (Eddie et al., 2019; Hill, 2020; Snyder, 2019; Stith, 2006). Moreover, social support, overall, and peer support, specifically, has been correlated with alleviating the devastating effects of erosion of self-identity and stigmatization associated with IPV (Anyikwa, 2016; Brown-Graham et al., 2022; Campbell et al., 2012; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Reilly & D'Amico, 2011).

As noted, many potential outcomes are linked to c-PTSD, a common diagnosis for IPV survivors, including mental health complications as well as and substance abuse problems (Mitchell & Anglin, 2009; Reilly & D'Amico, 2011). The negative outcomes directly related to

IPV include feelings of powerlessness, loneliness, depression, guilt, and shame; self-destructiveness; lowered self-esteem and deconstruction of self-identity; homelessness; educational and vocational underachievement; increased risk of revictimization overall; and the increased risk for the defined negative chain effects (Matheson et al., 2015; Reilly & D'Amico, 2011). The literature supports providing integrated services for IPV victims (Anyikwa, 2016; Dienemann et al., 2000; Matheson et al., 2015; Reilly & D'Amico, 2011; Taft et al., 2009). It seems important that IPV services address all aspects of the victim-survivors' unique needs and circumstances. This appears to parallel the shift in the substance abuse field to co-morbidity treatment (Capuzzi & Stauffer, 2016; Klott, 2013). Effectiveness of treatment appears to increase when both mental health and substance use disorders are treated concurrently.

There are numerous pathways and recommendations to enhancing IPV services. Foundationally, there are the six principles of a trauma-informed framework: safety, being trustworthy and transparent, peer support, collaboration and mutuality, empowerment, allowing the victim to have a voice and choices, and attending to relevant cultural, historical, and gender issues (Anyikwa, 2016). Moreover, these same principles are called for when offering peer support services (Blanch, A et al., 2012). Researchers further reiterate these principles and victim-survivors describe effective services as those that incorporate them (Anyikwa, 2016; Brown-Graham et al., 2022; Dienemann et al., 2000; Fearday & Cape, 2004; Matheson et al., 2015; Mitchell & Anglin, 2009). Despite these clear guidelines and the growth in IPV services, there remain gaps that most especially impact marginalized and vulnerable victim-survivors (S. Kulkarni, 2019). An example of such gaps is that IPV victims have been requesting family and/or couples' counseling for decades. Yet, service providers typically have little to offer in this

domain. Regardless of the gaps, overall, “survivors are satisfied with and appear to benefit from IPV services” (S. Kulkarni, 2019, p. 56).

Evaluation did not emerge and progress alongside the social movement aimed at IPV, at least not in the prevention domain (Stith, 2006). Furthermore, at times, evaluation may be viewed as the means to procure funding and a necessary evil (Sullivan, 2011). There are many factors and controversial aspects to the evaluation process regarding IPV. Yet, an alternative would be to view the evaluation process as an opportunity for growth. Integration in treatment approaches is not the only place that this concept played out in this review. The evaluation process would likely be enhanced if it was conceptualized as a part of the cycle within planning, implementation, and assessing (S. Kulkarni, 2019). Lastly, ensuring adherence to the common principles outlined in this review, most notably safety, respect, empowerment, and offering voice and choice, will further enhance the evaluation process.

Social advocacy, in the counseling profession, is starting to be considered a necessary and ethical responsibility for the mental health counselor (Hof et al., 2009). There are numerous misconceptions about prerequisites and requirements to begin advocacy work (Roysircar, 2009). Interestingly, the only prerequisite, according to some experts, is to just begin taking advocacy action. In addition to the clinical work of mental health counselors assisting IPV victim-survivors, advocacy efforts may well be a vital factor for improving the lives of IPV survivors (Mitchell & Anglin, 2009; Stith, 2006). There are innumerable routes and arenas for advocacy efforts regarding IPV. The horrifying statistical data enumerated throughout this review should thoroughly underscore the intense need for advocacy efforts for this vulnerable population. One critical area that all mental health practitioners can endlessly apply advocacy efforts is battling stigma (Berry, 2000; Eckstein, 2016; Hill, 2020; Snyder, 2019; Weiss, 2003). Furthermore, this

review focused on peer support and mentorship as a viable adjunct intervention to a comprehensive approach to IPV. Copious intervention pathways were outlined throughout.

Numerous gaps were listed throughout this review including, but not limited to, gaps in services, limited research regarding several domains in approaches to IPV, and a lack of clear parameters for peer support applied to IPV survivors. At least two service providers are currently providing peer mentorship services in the US. However, the founders have not yet published findings on their services (S. Lewis, personal communication January 2021; J. Rhodes, personal communication, January 24, 2022). Therefore, further research to outline effective parameters for peer support and peer mentorship for IPV survivors is greatly needed. Lastly, many of the peer-reviewed articles utilized qualitative methods, therefore, transferability may be limited. Considering that the principles and assumptions regarding IPV were found throughout the literature, both in textbooks as well as peer-reviewed literature, more credence and weight may be applied to these standards.

This review had a focus on peer support and peer mentoring for IPV victims. The review focused on numerous elements that correspond to intersecting this intervention with IPV treatment and recovery efforts. However, the factors outlined here are only a small fraction of impacts, efforts, and components that belong in a robust and comprehensive approach to IPV. The World Health Organization (WHO) published a comprehensive guidebook on best practices when conducting research with victims of IPV (Watts et al., 2001). The WHO was involved in textbooks devoted to this same topic (Ellsberg & Heise, 2005). There is a growing body of literature exploring how to prevent the perpetration of IPV. One longitudinal study examined continuity as well as potential protective and buffering factors for IPV perpetration (Greenman &

Matsuda, 2016). There are many experts in this field, and the knowledge base is continually growing.

Hopefully, further research will continue to illuminate the landscape of IPV and DV and our evolving understanding including prevalence rates, etiology, perpetrator typologies, and effective, nuanced approaches to both perpetrators and victim-survivors. Researchers, advocates, service providers, and supporters must remain open and flexible to new knowledge but must also not lose sight of the heart-rending shared experiences that brave IPV survivors disclose when they feel safe to do so (Matheson et al., 2015). One must also not forget the innumerable reports of those who do not survive (Kenney, 2012; Rose, 2021; Snyder, 2019) this horrendous human rights issue (Weiss, 2003).

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