
Intimate Partner Sexual Violence: Interventions



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Synonyms

[Intimate partner sexual violence treatments](#); [Marital rape interventions](#)

Definition

Intimate partner sexual violence interventions are interventions that may target psychological and/or sexual health concerns for both survivors and perpetrators of sexual violence in intimate relationships.

Introduction

Intimate partner sexual violence (IPSV), or sexual violence that occurs between intimate partners, has been variably defined across the literature (Bagwell-Gray et al., 2015). It has been categorized as a type of intimate partner

violence (IPV) that may include more forceful sexual acts, such as sexual assault or rape, or more subtle behaviors, such as reproductive abuse, forced pornography use, or the use of coercion or blackmail to obtain sexual acts (Bagwell-Gray et al., 2015; Tarzia et al., 2019). In the United States, nearly 1 in 5 women (19.6% or 24.5 million) report experiencing some type of contact sexual violence by an intimate partner (i.e., rape, sexual coercion, and unwanted sexual contact) in their lifetime (Basile et al., 2022). Although IPSV may impact individuals of all identities, women are up to 20–40 times as likely to be victimized than men (Breiding et al., 2011; Sinha, 2013). Additionally, individuals in same-sex relationships are just as or even more likely than those in opposite-sex relationships to experience IPSV (Nowinski & Bowen, 2012; Tjaden, 2000). Other risk factors for IPSV include the presence of intimate partner physical abuse, being pregnant, being ill or recently discharged from the hospital, being separated or divorced, or having recently attempted to leave the relationship (Bergen & Barnhill, 2006). The consequences of IPSV are wide-ranging; it confers risk for a number of deleterious outcomes for survivors and society at large. In this entry, we review the impact of IPSV on physical, psychological, interpersonal, and societal well-being, barriers to treatment, and interventions for both survivors and perpetrators of IPSV.

Outcomes

In terms of physical health impacts, there appears to be an increased risk of sexually transmitted infections with IPSV as risk-reduction practices, such as condom use, may be less frequent between intimate partners (El-Bassel et al., 2001). Recurrent IPSV is also associated with severe gynecological conditions, such as cervical cancer, as well as genital bleeding and pain (Coker, 2007). Survivors of IPSV may also experience other negative sexual health outcomes such as miscarriage, unintended pregnancy, and induced abortion (McFarlane et al., 2005). In addition to experiencing sexual health problems, IPSV survivors endure a range of chronic health conditions that may persist even after they leave the abusive relationship, such as headaches, back pain, abdominal pain, gastrointestinal problems, and sleep disturbances (Campbell, 2002).

In addition to the many physical health issues associated with IPSV, survivors may also endure serious psychological difficulties, such as PTSD (posttraumatic stress disorder), anxiety, depression, eating disorders, substance use disorders, and suicidality (as cited in Kelly and Stermac, 2012). In a large community study conducted across three American states, Edwards et al. (2009) found that IPSV survivors experience a sevenfold increase in serious psychological distress, which has been associated elsewhere with elevated suicidal thoughts (Ellsberg et al., 2008) and suicide attempts (Pico-Alfonso et al., 2006) compared to non-abused women. PTSD appears to be a common mental health diagnosis among IPSV survivors, and McFarlane and Malecha (2005) found that survivors of IPSV experience more PTSD symptoms than those who have experienced physical abuse alone.

IPSV is also associated with many deleterious effects on social functioning. Survivors may experience isolation from their friends, family, and communities, often as a result of the abuser's threats and manipulation (Kelly & Stermac, 2012). When IPSV occurs in families, breakdown of parental care is common due to the psychological and physical effects of the abuse (Chiesa

et al., 2018). Additionally, some research suggests that children of parents who experience IPSV have an elevated risk of mental health difficulties and often go on to experience some kind of abuse themselves (Chiesa et al., 2018; National Resource Center on Domestic Violence, 2002).

IPSV is also associated with serious adverse consequences at the societal level. The lifetime economic burden of intimate partner violence, including IPSV, is estimated at \$3.6 trillion dollars in the United States (Peterson et al., 2018) based on 43 million US adults with victimization history. This figure includes labor losses, as well as the costs of many types of care, including psychological and medical care. Decreased productivity, diminished labor, and job instability have been associated with recurrent abuse (Riger & Staggs, 2004), which have downstream deleterious effects on tax revenue, and consequently, the economy.

Barriers to Treatment

Invalidation and minimization of IPSV has historically impeded help-seeking for many women (National Resource Center on Domestic Violence, 2002), although women who do seek support are less likely to experience IPSV victimization in the future (Wright et al., 2021). It is important to consider that perspectives on rape within intimate partnerships have been formed within the context of historical legislation, such as the first common law marital rape exemption enacted in 1736 by Sir Matthew Hale, a chief justice in England (Hale, 1736). This exemption made it impossible for husbands to be accused of raping their wives and was formally adopted by the US legal system in the 1857 *Fogarty v. Commonwealth* decision. In 1987, some states still operated under laws which made rape within marriages legal in the United States (Searles & Berger, 1987). Such legislation has perpetuated the erroneous notion that marital rape is not "real rape" and has resulted in the invalidation that many survivors of IPSV experience (Bennice & Resick, 2003). Indeed, four out of five survivors of intimate partner rape did not label their experience as "rape" in a recent study

(Jaffe et al., 2021). However, those who experience more frequent IPSV are more likely to seek help, especially in legal and medical settings (Leone et al., 2007). This provides legal professionals and medical providers a unique and crucial opportunity to support IPSV survivors by connecting them with appropriate treatment resources. Given that medical professionals are often among the first to receive disclosures from IPSV survivors (Leone et al., 2007), it is advised that they routinely screen patients for IPSV. Since many IPSV survivors do not label their experiences as “rape” or “assault,” asking specific, behavior-oriented questions might increase the likelihood that they receive help (Jaffe et al., 2021).

Interventions

There is no “one-size-fits-all” intervention strategy for IPSV. In fact, an approach that is effective for one individual may pose serious safety risks for another, as illustrated in a study of the consequences of IPSV survivors’ safety strategies (Goodkind et al., 2004). For instance, while 52% of women in Goodkind et al.’s sample reported worsened abuse following an attempt to physically fight back, 24% reported reduced abuse. However, of the women who reported seeking formal counseling services, over half reported that their situation improved, and only 5% reported that their situation worsened. Importantly, no intervention can be effectively delivered until safety concerns are addressed (Kelly & Stermac, 2012). If a survivor stays with the abuser, it is crucial to collaboratively implement a safety plan. Safety planning may include connecting survivors to domestic violence hotlines and shelters, providing referrals for medical and/or psychological services, and developing escape plans, such as keeping a spare car key and essential personal items in a discrete location (Goodkind et al., 2004). It is important to note that unacknowledged (versus acknowledged) rape is associated with a greater likelihood of staying with the perpetrator, which subsequently increases risk for revictimization (Jaffe et al., 2021).

IPSV revictimization risk may be reduced by leaving the abusive relationship, but may result in retaliation by the abuser, and is associated with elevated risk for intimate partner homicide (Campbell et al., 2003). Despite this, in a qualitative study of IPSV survivors’ experiences, survivors reported that leaving the abusive relationship was crucial for improving sexual health practices and addressing psychological concerns (Bagwell-Gray et al., 2015), two areas of challenge that many IPSV survivors face. Providers may consider implementing motivational interviewing (Miller & Rollnick, 2012), an evidence-based technique that involves identifying, examining, and resolving ambivalence about change to facilitate movement toward a specific goal. When implemented with IPSV survivors, motivational interviewing may help illuminate the survivor’s reasons for staying in the abusive relationship, as well as motivations for leaving (“Guiding as Practice,” 2010). This technique has previously been shown to increase readiness for change and treatment engagement for both survivors and perpetrators of IPV (Soleymani et al., 2018). While interventions tailored specifically for IPSV are lacking, several empirically supported interventions exist for HIV risk reduction and IPV more broadly.

Sexual Health Interventions for Survivors

While HIV risk reduction is an important area of intervention among IPSV survivors, few HIV interventions are tailored to the unique needs of this population (Prowse et al., 2014). However, several empowerment-based HIV risk-reduction interventions incorporate themes that are applicable to IPSV survivors, such as increasing a sense of empowerment, initiating condom use, and reducing sexual violence. For example, Women Fighting Infection Together (Women FIT) is a manualized, four-session intervention focused on the prevention of HIV, but it includes a module on sexual violence (Gollub et al., 2010). The initial sessions include education on female anatomy, the risks of HIV infection, women’s greater susceptibility to sexually transmitted infection, and the necessity for women to initiate the use of barrier

protection methods during sex. The final session focuses on reducing sexual violence and involves a discussion and practice of physical defense techniques, as well as preparation of escape plans. Encouragingly, Gollub et al. (2010) found that participants in Women FIT exhibited significantly greater condom use compared to those in the control group. However, the intervention's effectiveness for reducing sexual violence was not assessed, nor was the intervention tested among IPSV survivors in specific.

Conversely, an intervention that combines a poverty reduction program with a curriculum on gender roles, HIV, and IPV – Intervention with Microfinance for AIDS and Gender Equity (IMAGE) – resulted in decreased IPV victimization among South African study participants when compared to control; however, it did not reduce the incidence of HIV (Pronyk et al., 2006). Within the IMAGE intervention, female survivors of IPV were given loans to increase their economic well-being and sense of empowerment before taking part in a structured training on AIDS and domestic violence. The trainings included role-playing conversations about HIV prevention with partners, disclosing domestic violence experiences to family members, and broaching topics of gender roles with female friends in a supportive manner. Pronyk and colleagues concluded that women's economic participation is crucial for decreasing gender inequity and intimate partner violence in South Africa.

Fogel et al. (2015) tested another HIV-intervention program, Providing Opportunities for Women's Empowerment, Risk-Reduction, and Relationships (POWER), which includes a module on sexual violence. Compared to the control group, participants in POWER reported significantly less frequent vaginal intercourse without condoms, increased health-protective communication with sexual partners, and a decreased incidence of intimate partner physical abuse. POWER consists of eight interactive group sessions that include education about HIV risk, the importance of initiating the use of protective barrier methods (e.g., condoms), and sexual violence awareness. Sessions included role-playing exercises in order to increase comfort and

confidence when broaching sexual communication with partners. During the session focused on sexual violence, participants learned about abuse patterns, finding safety in abusive circumstances, and mental health struggles that may result from the abuse.

While these interventions may prove useful for survivors whose primary concern is sexual risk prevention, other survivors may require interventions that focus on psychological concerns. Indeed, Bagwell-Gray (2019) found that IPSV survivors in her study had sufficient sexual and relationship health knowledge, including how to reduce sexual risks and what a healthy relationship looks like. Based on her qualitative interview findings, Bagwell-Gray contends that IPSV interventions should focus on addressing the emotional trauma of current IPSV as well as past childhood sexual abuse, where applicable.

Psychological Interventions for Survivors

Research has illuminated a clear relationship between IPSV and PTSD (posttraumatic stress disorder), anxiety, depression, and suicidal ideation (Bagwell-Gray et al., 2015; Barker et al., 2019; Bennice & Resick, 2003; Logan et al., 2015). Tarzia's (2021) results from an in-depth interview study demonstrate a need for clinicians to focus on the unique experiences of IPSV survivors, including an acute sense of betrayal, self-blame and shame, as well as the chronic impacts of IPSV on sexual and relational functioning. Though they have yet to be tested among survivors of IPSV specifically, several therapeutic modalities, including sexual-schema expressive writing interventions, cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR), incorporate many of these elements and have proven effective in treating the psychological concerns of individuals with trauma history.

Expressive writing is an accessible and cost-effective intervention that has demonstrated promising results in reducing psychopathological symptoms as well as sexual problems among women with histories of childhood sexual abuse. In a randomized clinical trial, Meston et al. (2013) compared a sexual-schema expressive writing

intervention, in which participants were prompted to write about how their history of sexual abuse has impacted their thoughts, feelings, and beliefs about sexuality, to a trauma-focused expressive writing intervention, wherein participants were asked to write about their deepest thoughts and feelings about how a trauma has impacted their beliefs about safety, trust, power, and control. While women in the sexual schema condition demonstrated a greater likelihood of, and quicker time to, recovery from sexual dysfunctions (i.e., female sexual arousal disorder and hypoactive sexual desire disorder), women in both conditions experienced similar decreases in PTSD and depressive symptoms. Meston and associates (2013) concluded that sexual-schema expressive writing yielded alterations in maladaptive sexual schemas that appeared to generalize to schemas associated with PTSD and depression. This result could be attributed to the fact that PTSD and depression are integrally linked to maladaptive sexual schemas in women with childhood sexual abuse histories.

Cognitive processing therapy (CPT) is a cognitive behavioral therapy originally developed for female survivors of rape (Resick & Schnicke, 1993) that has proven to be effective in reducing PTSD symptoms, as well as comorbid anxiety and depression (Asmundson et al., 2019). CPT helps patients to understand and reappraise their trauma by changing maladaptive cognitions, or “stuck-points” (e.g., believing that the trauma is one’s own fault, believing that no one can be trusted), that impede recovery by promoting avoidance behaviors and secondary emotional responses (e.g., shame, guilt). A decrease in posttraumatic cognitions has been identified as a mechanism of action for reducing PTSD and depressive symptoms during CPT (Schumm et al., 2015), which supports the treatment’s proposed theoretical mechanisms of change (Resick & Schnicke, 1993). More specifically, Schumm and colleagues found that reductions in self-blame (e.g., “The event happened because of the way I acted,” “Somebody else would not have gotten into this situation,” and “There is something about me that made the event happen”) and negative beliefs about the self (e.g., “I am a weak person,” “I

can’t rely on myself,” “I have no future,” and “I have permanently changed for the worse”) precede reductions in PTSD and depressive symptoms. Recent research suggests that CPT delivered in a collapsed timeframe (i.e., five consecutive treatment days) is just as efficacious as the traditional delivery of 12 weekly sessions in reducing PTSD symptoms among IPV survivors (Galovski et al., 2022). This finding has important implications for women who may have a short timeframe in which they are able to access treatment.

Eye movement desensitization and reprocessing therapy (EMDR), an approach developed by American psychologist Francine Shapiro (Shapiro, 1989), also serves to alter unhelpful responses to traumatic memories. Dual attention tasks are one of the most distinguishing elements of EMDR, wherein the client focuses on the worst image of a traumatic memory while simultaneously performing an external task, such as visually following the therapist’s fingers. Clients who are unable to engage in visual tracking may instead perform bilateral tactile taps (i.e., tapping in a rhythmic left-right pattern) or follow auditory tones. Following the dual attention task, the clinician aids the client in forming a more positive cognition about herself. In a recent study, EMDR effectively reduced PTSD, anxiety, and depressive symptoms in a sample of women who had experienced either domestic or sexual violence (Schwarz et al., 2020). While the field has yet to reach an agreement on candidate mechanisms underlying treatment gains in EMDR, a review of the literature suggests that an integrative model may be necessary to capture the effect of multiple mechanisms that may work together (e.g., short-term increases in parasympathetic relative to sympathetic activity, dual-attention tasks, and exposure to the traumatic memory) to produce therapeutic change (Landin-Romero et al., 2018).

Psychoeducation is a useful strategy for increasing knowledge about IPSV and targeting societal rape scripts (Jaffe et al., 2021; McOrmond-Plummer, 2014). While many support groups exist for IPV and sexual assault, IPSV survivors often feel out of place in either of these settings (Levy-Peck, 2013).

Psychoeducational groups specifically tailored to IPSV offer the chance for survivors, who often feel alone in their experiences, to connect with and support one another (Levy-Peck, 2013). The first session should prioritize laying ground rules about confidentiality and commitment to the sessions, and sessions involving more sensitive topics (e.g., sexuality) should take place after the group has built rapport with one another and the facilitator (Levy-Peck, 2013). In order to facilitate healing within these groups, it is essential to emphasize that the abuser's sexual tactics were used to control and demean, and the abuse was not the survivor's fault (Bennice et al., 2003). Levy-Peck (2013) also highlights the importance of using a consistent, predictable session format for all group meetings in order to enhance a sense of safety for group members. Toward this end, one curriculum format suggestion from Levy-Peck (2013) includes starting sessions with a check-in (e.g., "What was one positive thing that happened in the last week?") and ending with a checkout, another light-hearted, brief prompt that group members respond to before transitioning back into their daily lives.

Interventions for Perpetrators

While research on interventions for perpetrators of IPSV is lacking, there is a rich literature on interventions for perpetrators of IPV. Without the implementation of tailored intervention strategies, the likelihood that abusers continue to enact violent behaviors in current and future relationships is quite high (Manita & Matias, 2016). The two most common intervention approaches for IPV offenders that have been employed to date are psychoeducational approaches (i.e., the Duluth model; Pence et al., 1993) and cognitive-behavioral approaches. The recommended duration of Duluth-style and CBT interventions ranges from 12 to 52 weeks depending on the needs of the perpetrator (Babcock et al., 2004). A meta-analysis revealed no significant differences in effectiveness between the two approaches (Babcock et al., 2004). The same review revealed that these interventions yielded a 5% reduction in recidivism, which calls for improvements in this domain.

Duluth-style approaches are informed by the premise that IPV is the result of socially sanctioned aggressive male behavior. Therefore, this intervention incorporates psychoeducational techniques that address patriarchal ideology, as well as gendered expectations of power and control. It is delivered in group settings wherein the eight central themes of the model are addressed: nonviolence, nonthreatening behavior, respect, support and trust, accountability and honesty, sexual respect, partnership, and negotiation and fairness (Pence et al., 1993). In this approach, the "power and control wheel," which lists methods by which men exert power over women (e.g., examples of physical, sexual, emotional, and financial abuse), is compared to an "equality wheel," which provides examples of respectful and nonviolent behaviors (e.g., "communicating openly and truthfully," "making money decisions together," and "supporting her goals in life"). This activity is aimed at challenging perpetrators' false belief that dominating and controlling a partner with abuse is acceptable, while offering alternative behaviors that promote healthy relationships.

Cognitive behavioral therapy (CBT) has been implemented as another approach for reducing IPV perpetration wherein perpetrators learn skill-building exercises that target maladaptive cognitive and behavioral patterns that may lead to violence (Murphy & Eckhardt, 2005). During treatment, skills are developed in domains that have been empirically linked with IPV perpetration, such as emotional dysregulation, cognitive distortions, and deficits in relationship skills (as cited in Eckhardt et al., 2013). The first phase of treatment aims to increase the client's motivation for change. During this stage, motivational interviewing techniques are often implemented to decrease resistance, develop goals for personal change, and establish a working alliance between the clinician and patient. The goal of the next stage of treatment is to eliminate physical and sexual abuse in the relationship by implementing a functional analysis of abusive behaviors, wherein causes and consequences of the abusive behavior are identified. Clinicians incorporate cognitive restructuring of beliefs that may maintain abusive behaviors at this stage, as well. The

third phase of treatment involves enhancing relationship functioning by teaching communication and problem-solving skills and magnifying positive attributions about one's partner. The final stage of treatment aims to promote relationship trauma recovery and prevent relapse. The therapist may incorporate techniques from CPT to help the client process traumatic experiences within the relationship, as well as help the client to identify triggers for returning to abusive behavior.

Conclusion

IPSV poses serious threats to psychological, physical, relational, and societal thriving. IPSV impacts individuals in same-sex relationships at the same or higher rates as those in opposite-sex relationships. Although it impacts individuals of all walks of life, it appears to impact women more commonly than men. Given the prevalence of negative sexual health outcomes as well as psychological concerns such as PTSD, anxiety, depression, and suicidality among IPSV survivors, it is crucial for this population to receive sufficient treatment. Empowerment-based HIV interventions may be useful for increasing safe sex practices, and some have shown utility in reducing IPV. While sexual-schema expressive writing interventions, cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), and psychoeducational groups appear to be promising treatment modalities to address the psychological concerns of IPSV survivors, there is a paucity of systematic research testing their effectiveness among this unique population specifically. As such, future studies are needed to provide support for the use of these approaches among IPSV survivors. With regard to treatments for perpetrators, Duluth-style psychoeducation and cognitive-behavioral approaches are two common intervention modalities that have been implemented among IPV offenders. While these modalities seem to yield similar results, improvements on these interventions are needed to effect more substantial decreases in recidivism among this population.

References

- Asmundson, G. J. G., Thorisdottir, A. S., Roden-Foreman, J. W., Baird, S. O., Witcraft, S. M., Stein, A. T., Smits, J. A. J., & Powers, M. B. (2019). A meta-analytic review of cognitive processing therapy for adults with posttraumatic stress disorder. *Cognitive Behaviour Therapy*, 48(1), 1–14. <https://doi.org/10.1080/16506073.2018.1522371>
- Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, 23(8), 1023–1053.
- Bagwell-Gray, M. E. (2019). Women's healing journey from intimate partner violence: Establishing positive sexuality. *Qualitative Health Research*, 29(6), 779–795. <https://doi.org/10.1177/1049732318804302>
- Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence, & Abuse*, 16(3), 316–335. <https://doi.org/10.1177/1524838014557290>
- Barker, L. C., Stewart, D. E., & Vigod, S. N. (2019). Intimate partner sexual violence: An often overlooked problem. *Journal of Women's Health*, 28(3), 363–374. <https://doi.org/10.1089/jwh.2017.6811>
- Basile, K. C., Smith, S. G., Kresnow, M., & Leemis, R. W. (2022). *The National Intimate Partner and Sexual Violence Survey: 2016/2017 report on sexual violence*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Bennice, J. A., & Resick, P. A. (2003). Marital rape: History, research, and practice. *Trauma, Violence, & Abuse*, 4(3), 228–246. <https://doi.org/10.1177/1524838003004003003>
- Bennice, J. A., Resick, P. A., Mechanic, M., & Astin, M. (2003). The relative effects of intimate partner physical and sexual violence on post-traumatic stress disorder symptomatology. *Violence and Victims*, 18(1), 87–94. <https://doi.org/10.1891/vivi.2003.18.1.87>
- Bergen, R. K., & Barnhill, E. (2006). *Marital rape: New research and directions*. National Resource Center on Domestic Violence, Pennsylvania Coalition . . .
- Breiding, M., Smith, S., Basile, K., Walters, M., Chen, J., & Merrick, M. (2011). *Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—National intimate partner and sexual violence survey, United States* (Morbidity and mortality weekly report). Surveillance summaries (Washington, DC: 2002).
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359(9314), 1331–1336.
- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case

- control study. *American Journal of Public Health*, 93(7), 1089–1097. <https://doi.org/10.2105/AJPH.93.7.1089>
- Chiesa, A. E., Kallechey, L., Harlaar, N., Rashaan Ford, C., Garrido, E. F., Betts, W. R., & Maguire, S. (2018). Intimate partner violence victimization and parenting: A systematic review. *Child Abuse & Neglect*, 80, 285–300. <https://doi.org/10.1016/j.chiabu.2018.03.028>
- Coker, A. L. (2007). Does physical intimate partner violence affect sexual health?: A systematic review. *Trauma, Violence, & Abuse*, 8(2), 149–177. <https://doi.org/10.1177/1524838007301162>
- Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse*, 4(2), 196–231. <https://doi.org/10.1891/1946-6560.4.2.196>
- Edwards, V. J., Black, M. C., Dhingra, S., McKnight-Eily, L., & Perry, G. S. (2009). Physical and sexual intimate partner violence and reported serious psychological distress in the 2007 BRFSS. *International Journal of Public Health*, 54(1), 37–42.
- El-Bassel, N., Gilbert, L., Rajah, V., Foleno, A., & Frye, V. (2001). Social support among women in methadone treatment who experience partner violence: Isolation and male controlling behavior. *Violence Against Women*, 7(3), 246–274. <https://doi.org/10.1177/1077801022182433>
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, 371(9619), 1165–1172.
- Fogel, C. I., Crandell, J. L., Neevel, A. M., Parker, S. D., Carry, M., White, B. L., Fasula, A. M., Herbst, J. H., & Gelaude, D. J. (2015). Efficacy of an adapted HIV and sexually transmitted infection prevention intervention for incarcerated women: A randomized controlled trial. *American Journal of Public Health*, 105(4), 802–809. <https://doi.org/10.2105/AJPH.2014.302105>
- Galovski, T. E., Werner, K. B., Weaver, T. L., Morris, K. L., Dondanville, K. A., Nanney, J., Wamser-Nanney, R., McGlinchey, G., Fortier, C. B., & Iverson, K. M. (2022). Massed cognitive processing therapy for post-traumatic stress disorder in women survivors of intimate partner violence. *Psychological Trauma: Theory, Research, Practice, and Policy*, 14(5), 769–779. <https://doi.org/10.1037/tra0001100>
- Gollub, E. L., Morrow, K. M., Mayer, K. H., Koblin, B. A., Peterside, P. B., Husnik, M. J., & Metzger, D. S. (2010). Three city feasibility study of a body empowerment and HIV prevention intervention among women with drug use histories: Women FIT. *Journal of Women's Health*, 19(9), 1705–1713. <https://doi.org/10.1089/jwh.2009.1778>
- Goodkind, J. R., Sullivan, C. M., & Bybee, D. I. (2004). A contextual analysis of battered women's safety planning. *Violence Against Women*, 10(5), 514–533. <https://doi.org/10.1177/1077801204264368>
- Guiding as practice: Motivational interviewing and trauma-informed work with survivors of intimate partner violence motivational interviewing and intimate partner violence workgroup. (2010). *Partner Abuse*, 1(1), 92–104. <https://doi.org/10.1891/1946-6560.1.1.92>
- Hale, M. (1736). *Historia placitorum coronae: The history of the pleas of the crown*. Gyles, Woodward, and Davis.
- Jaffe, A. E., Steel, A. L., DiLillo, D., Messman-Moore, T. L., & Gratz, K. L. (2021). Characterizing sexual violence in intimate relationships: An examination of blame attributions and rape acknowledgment. *Journal of Interpersonal Violence*, 36(1–2), 469–490. <https://doi.org/10.1177/0886260517726972>
- Kelly, T. C., & Stermac, L. (2012). Intimate partner sexual assault against women: Examining the impact and recommendations for clinical practice. *Partner Abuse*, 3(1), 107–122. <https://doi.org/10.1891/1946-6560.3.1.107>
- Landin-Romero, R., Moreno-Alcazar, A., Pagani, M., & Amann, B. L. (2018). How does eye movement desensitization and reprocessing therapy work? A systematic review on suggested mechanisms of action. *Frontiers in Psychology*, 9, 1395. <https://doi.org/10.3389/fpsyg.2018.01395>
- Leone, J. M., Johnson, M. P., & Cohan, C. L. (2007). Victim help seeking: Differences between intimate terrorism and situational couple violence. *Family Relations*, 56(5), 427–439. <https://doi.org/10.1111/j.1741-3729.2007.00471.x>
- Levy-Peck, J. Y. (2013). Forming and facilitating support groups for survivors of intimate partner sexual violence. In *Intimate partner sexual violence: A multidisciplinary guide to improving services and support for survivors of rape and abuse* (p. 124). Jessica Kingsley.
- Logan, T. K., Walker, R., & Cole, J. (2015). Silenced suffering: The need for a better understanding of partner sexual violence. *Trauma, Violence, & Abuse*, 16(2), 111–135. <https://doi.org/10.1177/1524838013517560>
- Manita, C., & Matias, M. (2016). Programas para agressores: Modificar comportamentos abusivos no âmbito das relações de intimidade e prevenir a reincidência. In AI Sani & S. Caridade (Coords.), *Práticas de Intervenção Na Violência e No Crime*. PACTOR.
- McFarlane, J. M., & Malecha, A. (2005). *Sexual assault among intimates: Frequency, consequences & treatments*. U.S. Department of Justice.
- McFarlane, J., Malecha, A., Watson, K., Gist, J., Batten, E., Hall, I., & Smith, S. (2005). Intimate partner sexual assault against women: Frequency, health consequences, and treatment outcomes. *Obstetrics & Gynecology*, 105(1), 99–108. <https://doi.org/10.1097/01.AOG.0000146641.98665.b6>
- McOrmond-Plummer, L. (Ed.). (2014). *Intimate partner sexual violence: A multidisciplinary guide to improving*

- services and support for survivors of rape and abuse (p. 339). Jessica Kingsley.
- Meston, C. M., Lorenz, T. A., & Stephenson, K. R. (2013). Effects of expressive writing on sexual dysfunction, depression, and PTSD in women with a history of childhood sexual abuse: Results from a randomized clinical trial. *The Journal of Sexual Medicine*, 10(9), 2177–2189. <https://doi.org/10.1111/jsm.12247>
- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. .
- Murphy, C. M., & Eckhardt, C. I. (2005). *Treating the abusive partner: An individualized cognitive-behavioral approach*. Guilford Press.
- National Resource Center on Domestic Violence. (2002). *Children exposed to intimate partner violence: An information packet*. National Resource Center on Domestic Violence.
- Nowinski, S. N., & Bowen, E. (2012). Partner violence against heterosexual and gay men: Prevalence and correlates. *Aggression and Violent Behavior*, 17(1), 36–52. <https://doi.org/10.1016/j.avb.2011.09.005>
- Pence, E., Paymar, M., & Ritmeester, T. (1993). *Education groups for men who batter: The Duluth model*. Springer.
- Peterson, C., Kearns, M. C., McIntosh, W. L., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime economic burden of intimate partner violence among U.S. adults. *American Journal of Preventive Medicine*, 55(4), 433–444. <https://doi.org/10.1016/j.amepre.2018.04.049>
- Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, 15(5), 599–611.
- Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, C., Busza, J., & Porter, J. D. (2006). Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: A cluster randomised trial. *The Lancet*, 368(9551), 1973–1983. [https://doi.org/10.1016/S0140-6736\(06\)69744-4](https://doi.org/10.1016/S0140-6736(06)69744-4)
- Prowse, K. M., Logue, C. E., Fantasia, H. C., & Sutherland, M. A. (2014). Intimate partner violence and the CDC's best-evidence HIV risk reduction interventions. *Public Health Nursing*, 31(3), 215–233. <https://doi.org/10.1111/phn.12076>
- Resick, P. A., & Schnicke, M. (1993). *Cognitive processing therapy for rape victims: A treatment manual* (Vol. 4). Sage.
- Riger, S., & Staggs, S. (2004). *The impact of intimate partner violence on women's labor force participation*. US Department of Justice.
- Schumm, J. A., Dickstein, B. D., Walter, K. H., Owens, G. P., & Chard, K. M. (2015). Changes in posttraumatic cognitions predict changes in posttraumatic stress disorder symptoms during cognitive processing therapy. *Journal of Consulting and Clinical Psychology*, 83(6), 1161.
- Schwarz, J. E., Baber, D., Barter, A., & Dorfman, K. (2020). A mixed methods evaluation of EMDR for treating female survivors of sexual and domestic violence. *Counseling Outcome Research and Evaluation*, 11(1), 4–18. <https://doi.org/10.1080/21501378.2018.1561146>
- Searles, P., & Berger, R. J. (1987). The current status of rape reform legislation: An examination of state statutes. *Women's Rights Law Reporter*, 10, 25–43.
- Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2(2), 199–223. <https://doi.org/10.1002/jts.2490020207>
- Sinha, M. (2013). *Family violence in Canada: A statistical profile* (p. 2011). Statistics Canada.
- Soleymani, S., Britt, E., & Wallace-Bell, M. (2018). Motivational interviewing for enhancing engagement in intimate partner violence (IPV) treatment: A review of the literature. *Aggression and Violent Behavior*, 40, 119–127. <https://doi.org/10.1016/j.avb.2018.05.005>
- Tarzia, L. (2021). “It went to the very heart of who I was as a woman”: The invisible impacts of intimate partner sexual violence. *Qualitative Health Research*, 31(2), 287–297. <https://doi.org/10.1177/1049732320967659>
- Tarzia, L., Wellington, M., Marino, J., & Hegarty, K. (2019). “A huge, hidden problem”: Australian health practitioners' views and understandings of reproductive coercion. *Qualitative Health Research*, 29(10), 1395–1407. <https://doi.org/10.1177/1049732318819839>
- Tjaden, P. G. (2000). *Extent, nature, and consequences of intimate partner violence*. US Department of Justice, Office of Justice Programs, National Institute of Justice.
- Wright, E. N., Anderson, J., Phillips, K., & Miyamoto, S. (2021). Help-seeking and barriers to care in intimate partner sexual violence: A systematic review. *Trauma, Violence, & Abuse*, 152483802199830. <https://doi.org/10.1177/1524838021998305>