Why Clients Stay:
Ethical Decision Making and Clinical Pitfalls in Domestic Violence Cases

Angie Galyean, LPC-MHSP
Renovated Heart Counseling

TLPCA 2026 Counseling and Therapy Summit
May 30, 2026

Disclosure

Financial Disclosure: Presenter offers domestic violence consultation and training services related to this subject matter.

Conflict of Interest Statement: No commercial funding or sponsorship was received for this presentation.

Educational Purpose Statement: This presentation is for educational and informational purposes only and does not constitute legal advice, forensic opinion, or individualized clinical supervision.

Confidentiality Statement: Any case material is fictional, composite, or modified for educational purposes to protect confidentiality.

This session focuses on the ethical and clinical complexity of working with survivors who remain in abusive relationships.

The goal is not to convince clients to leave. The goal is to provide **trauma-informed, risk-informed, and ethically grounded care** that supports safety, clarity, agency, and therapeutic alliance.

Domestic violence work requires therapists to understand that clinical interventions can either increase safety or unintentionally increase danger.

LEARNING OBJECTIVES

Participants will be able to:

1. Identify patterns of coercive control and psychological abuse
2. Describe factors that contribute to survivor ambivalence
3. Apply trauma-informed and ethically grounded interventions in domestic violence cases

Understanding the Reality of Domestic Violence

Why traditional clinical assumptions fail in coercive control dynamics

What Is Intimate Partner Violence?

Intimate partner violence (IPV) includes:

- Physical violence
- Sexual violence
- Stalking
- Psychological aggression

Can occur in:

- current or former intimate relationships.
- isolated incidents to chronic patterns.

(Centers for Disease Control and Prevention [CDC], 2024a)

IPV Statistics

- More than **1 in 3 women** and **1 in 6 men** have experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.

- **1 in 5 homicide** victims are killed by an intimate partner.

- **More than 50%** of female homicide victims are killed by a current or former male intimate partner.
  (CDC, 2024a)

- Risk factors that increase odds of being a victim include individual, relationship, community, and societal risk factors.
  (CDC, 2024b)

IPV Is Not Always Obvious

(obj. 1)

Danger is not determined by visible injury.

Survivors may experience significant danger and coercive control even when:

- physical violence is infrequent
- injuries are not visible
- abuse is minimized or denied

Therapists who rely primarily on physical violence may underestimate risk.

(Australian Institute of Family Studies [AIFS], 2023; Tolmie et al., 2024)

Recognizing Coercive Control

(obj. 1)

Coercive control is a patterned system of domination that targets autonomy and behavior.

It may involve:

- Monitoring and surveillance
- Financial control
- Restriction of communication or movement
- Isolation from supports
- emotional intimidation
- threats and stalking

Instead of asking “**What happened?**”, ask “**What is the pattern?**”

(Tolmie et al., 2024)

Common Clinical Blind Spot

Danger is often assessed based on visible injury.

This can lead to:

- underestimating risk
- minimizing coercive control
- misunderstanding survivor behavior
- overlooking escalation risk

Coercive control shapes behavior, decision-making, and perceived options.

(Tolmie et al., 2024)

Reframing the Question

Instead of asking:
“Why doesn’t she leave?”

A more clinically accurate question is:
“What makes staying feel safer or more possible right now?”

Survivor decisions are shaped by:

- escalation
- financial dependence
- children
- housing instability
- lack of safe alternatives

(CDC, 2024b; Tolmie et al., 2024)

Ethical Framework

- Promote client welfare (A.1.a)
- Avoid harm (A.4.a)
- Avoid imposing values (A.4.b)
- Protect confidentiality (B.1.c)

(American Counseling Association [ACA], 2014)

When Insight Isn’t Enough

Understanding client behavior through a real case

Case Introduction: Maya

Maya is a 34-year-old woman with two children, ages 5 and 9.

She reports that her partner monitors her phone, controls most of the money, criticizes her parenting, and becomes intimidating when she disagrees. She describes one incident where he “put his hands around my neck but didn’t choke me.”

Maya says:
“I know this isn’t healthy, but I’m not leaving right now.”

Discussion

What is your immediate clinical response to Maya?

What type of intervention could unintentionally increase danger if used too early?

Applying Coercive Control to Maya

(obj. 1)

Maya's experiences reflect a **pattern of coercive control** rather than situational conflict.

Her partner monitors communication, restricts finances, limits social contact, and escalates when she asserts herself.

Her behavior is shaped by **anticipated consequences**, not preference.

Compliance in this context may represent **adaptive safety behavior** rather than passivity.

(Tolmie et al., 2024)

Discussion

What do you usually assume when a client stays?

Do you assume:

- fear
- low self-worth
- denial
- trauma bonding
- financial dependence
- poor judgment

What if staying is the most rational option available under the current risk conditions?

Why Clients Stay

Understanding attachment, fear, and competing realities

Psychological Abuse

Psychological abuse, including **gaslighting**, targets

- perception
- identity
- reality testing

.

Survivors may:

- question their memory, judgment, and interpretation of events.
- minimize harm to preserve attachment or safety
- rely on partner's version of reality to reduce conflict.

Confusion in abusive relationships may reflect
adaptation to chronic destabilization rather than lack of insight.

(Lohmann et al., 2023; Darke et al., 2025)

Internal Barriers

Internal barriers are not simply emotional attachment.

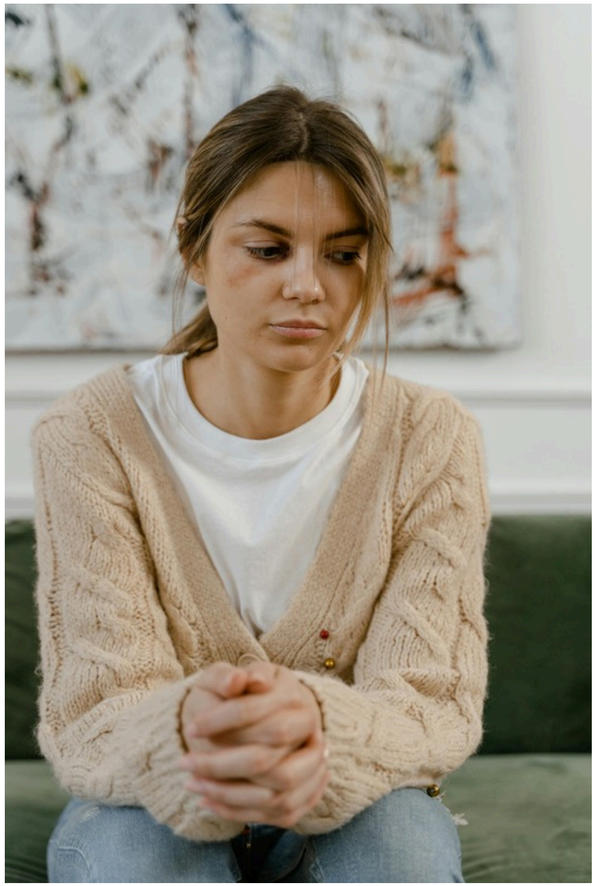
They include:

- Erosion of self-trust
- Confusion about what is “real”
- Responsibility for the partner’s emotional state
- Fear of making the wrong decision

These are **not** personality traits.

They are **survival responses** developed to maintain safety and reduce conflict.

(Lohmann et al., 2023; Tolmie et al., 2024)



Economic Abuse

Economic abuse is a form of coercive control that limits a survivor's ability to leave or increase safety.

Common forms:

- Restricted access to money
- Controlled or monitored spending
- Employment interference or sabotage
- Forced debt or financial dependence
- Control of transportation, housing, or insurance

Economic abuse limits available choices.

(Johnson et al., 2022)

Survivor Ambivalence

(obj. 2)

Ambivalence is not simply confusion.
It often reflects competing realities.

A survivor may experience:

- love for partner
- fear of partner
- hope for change
- concern for children
- financial dependence
- fear of legal outcomes
- shame
- awareness of harm

“I know this isn’t healthy, but leaving doesn’t feel safe either”

(Tolmie et al., 2024; Johnson et al., 2022)

Trauma Bonding

(obj. 2)

Fear and distress may become intertwined with moments of relief, comfort, or connection.

Attachment may be reinforced through:

- Intermittent kindness
- Apologies and reconciliation
- Temporary reductions in tension or fear
- Hope that the abuse will stop

These cycles can **strengthen** emotional attachment **and complicate** separation.

(Effiong et al., 2022)

Clinical Implications of Trauma Bonding

(obj. 2)

Client may:

- recognize harm
- remain emotionally attached
- feel pulled back toward the partner
- struggle to disengage

Attachment in abusive relationships may involve survival, fear, hope, and intermittent reinforcement occurring simultaneously.

Insight alone does **not** disrupt attachment or behavior.

(Effiong et al., 2022; Lohmann et al., 2023)

Leaving Can Increase Risk

(obj. 2)

- Leaving is **not always the safest point**.
- Risk may increase when control is threatened.
- Separation is a **high-risk period** for serious harm.

(Campbell et al., 2003; Johns Hopkins School of Nursing, n.d.)

When Therapy Can Increase Danger

Understanding risk, escalation, and clinical impact

When Risk Increases

(obj. 2)

Risk may **increase** when client:

- files legal action
- gains independence (work, money)
- reconnects socially
- starts therapy
- hides resources or plans to leave

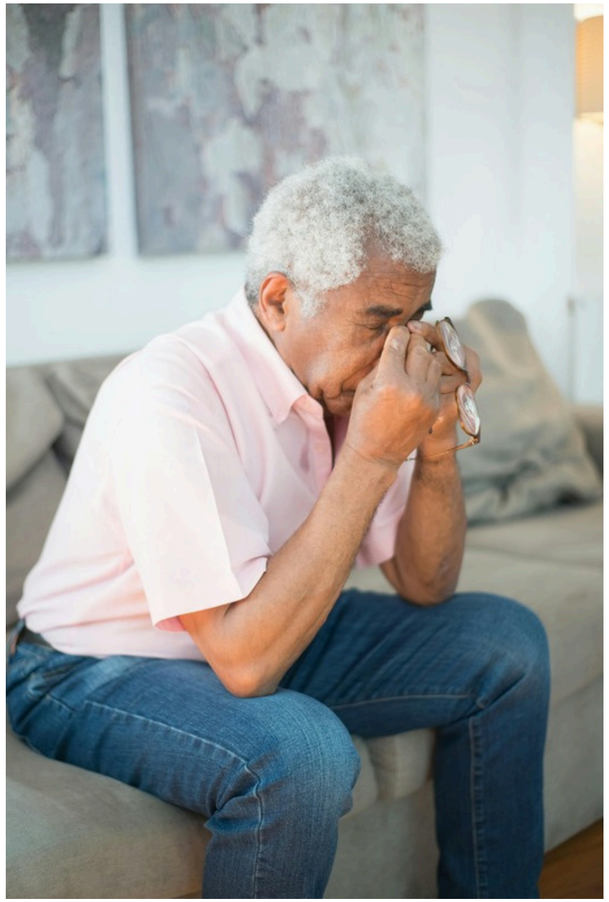
These actions may signal **loss of control** to the abusive partner.

(AIFS, 2023; Campbell et al., 2003)

Clinical Implications
(obj. 2)

Leaving is **not** a simple intervention

- Do not assume leaving = safety
- Assess risk **before and during** separation
- Pace decisions based on safety, not urgency
- Plan for safety, not just exit



(Campbell et al., 2003)

Ethical Tension in Practice

(obj. 2)

autonomy
vs.
safety

- respect client choice
- risk may be increasing

avoid harm
vs.
avoid control

- intervening can increase danger
- not intervening can ignore escalation

empowerment
vs.
risk reality

- support independence without pushing unsafe action

(ACA, 2014)

Common Therapist Pitfalls

(obj. 2)

Therapists may unintentionally increase risk by:

- Pushing for change too quickly
- Remaining overly neutral
- Overcorrecting toward empowerment
- Responding from personal values

In coercive control dynamics, interventions that **overlook retaliation risk** may unintentionally increase danger.

(ACA, 2014; Tolmie et al., 2024)

Clinical Pitfall: Treating as Mutual Conflict

This may lead to:

- Shared responsibility framing
- Focus on communication over safety
- Emphasis on “relationship skills”
- Minimization of coercive dynamics

In coercive control relationships, these approaches may:

- Reinforce imbalance
- Shift responsibility onto the survivor
- Obscure fear, intimidation, and safety concerns

Do not assume mutuality or equal power.

(Stark & Hester, 2019; Tolmie et al., 2024)

Couples Therapy Requires Careful Assessment

Conjoint approaches require careful assessment when IPV is present.

Therapists should assess for:

- Fear or intimidation
- Coercive control or power imbalance
- Retaliation risk after sessions
- Ability to speak freely and safely
- Escalation or ongoing abuse
- Survivor safety outside the therapy room

Standard couples approaches may be inappropriate when **safety**, **coercion**, and **unequal power** are present.

(Keilholtz & Spencer, 2022)

Clinical Pitfalls: Lived Experience

(obj. 2)

Lived experience can strengthen clinical insight and attunement, but it can also shape how a therapist interprets and responds to risk.

Potential clinical challenges may include:

- Over-identification with the client
- Emotional reactivity or urgency
- Difficulty tolerating ambivalence or staying
- Countertransference reactions
- Responses shaped by personal meaning rather than client safety

Ongoing self-awareness, supervision, and reflective practice are essential in IPV work.

(Andersson, 2022)

Clinical Stance

(obj. 2)

- slow down decision-making
- assess risk continuously
- prioritize safety over certainty
- respond with precision, not reaction

(ACA, 2014)

Discussion

Where do you feel pulled most: autonomy or safety?

What does balanced ethical practice look like in Maya’s case?

Clinical Application and Risk-Informed Practice

What to do different in real sessions

Therapists Are Not Neutral In Impact

(obj. 3)

Therapist actions can influence client behavior and partner response.

Words, documentation, referrals, and pacing may affect safety.

Clinical considerations:

- Acknowledge that interventions are not neutral
- Assess how change may be perceived and responded to
- Consider retaliation risk when encouraging change
- Pace interventions based on safety, not urgency

(Tolmie et al., 2024)

When Interventions Increase Risk

(obj. 3)

Risk may increase when there is:

- Rapid boundary setting
- Confrontation or disclosure
- Pressure toward separation or independence
- No assessment of retaliation risk

Attempts to increase autonomy or reduce control may trigger escalation in coercive control relationships.

(Tutty et al., 2024)

Language Risk

Some well-intended therapist statements can increase risk if repeated at home or acted on quickly.

Higher-risk statements include:

- “ You need to leave.”
- “ You deserve better.”
- “ You need to set boundaries.”
- “ You can’t let him control you.”
- “ You need to take your power back.”

These statements may be emotionally true, but clinically unsafe if they bypass danger assessment.

(American Psychiatric Association, 2019)

Discussion Exercise

Advice giving statement:

“You need to set boundaries.”

Risk-informed exploration

“Before we talk about boundaries, we need to understand what happens when he experiences you as saying no.”

High-Risk Clinical Decision Making

Where assessment, safety, and intervention directly impact danger

Trauma-Informed Intervention

(obj. 3)

Trauma-informed care includes:

- safety
- trust
- choice
- collaboration
- empowerment

In DV work, these principles must be applied alongside ongoing risk assessment and safety planning.

Validation alone does **not** ensure safety.

(Tolmie et al., 2024)

Rethinking Empowerment

(obj. 3)

Empowerment does not mean:

- directing disclosure, confrontation, or immediate action
- equating separation with success
- defining progress for the client

Empowerment means:

- supporting survivor-defined goals
- increasing clarity, options, and autonomy
- recognizing real safety and structural constraints
- helping clients make informed decisions at a sustainable pace

(Sullivan, 2018; American Psychiatric Association, 2019)

The Risk of Getting It Wrong

(obj. 3)

Critical risk:

- Premature empowerment can increase danger
- Visible change can trigger retaliation
- Action without risk assessment is unsafe

Pace empowerment based on safety, not urgency

(Tutty et al., 2024)

Discussion

What small decision could create the biggest risk for Maya this week?

In DV work, micro-decisions are not minor.

They can shift the abusive partner’s perception of control.

Safety Planning for Clients Who Stay

(obj. 3)

Plan for staying safely:

- Safer areas and exit access
- Avoiding weapons and confined spaces
- Protecting children during escalation
- Code words or signals
- Access to critical documents
- Limiting digital/written traces

Must be:

- Practical and realistic
- Discreet and low visibility
- Personalized to the client
- Updated as risk changes

(AIFS, 2023; National Domestic Violence Hotline, n.d.)

Structured Risk Assessment Framework

(obj. 3)

Effective assessment includes:

- Pattern of violence
- Level of control
- Retaliation and escalation risk
- Entrapment factors
- Psychological impact
- Barriers to safety or leaving

Risk assessment should move beyond isolated incidents and consider the survivor's broader relational and environmental context.

(Tolmie et al., 2024; Campbell et al., 2003)

The Danger Assessment

(obj. 3)

The Danger Assessment is a validated tool for assessing lethality risk in IPV.

- Escalation
- Weapon Access
- Threats to Kill
- Strangulation
- Forced Sex
- Jealousy & Control
- Separation-related Anger

(Campbell et al., 2009; Johns Hopkins School of Nursing, n.d.)

Clinical Use of the Danger Assessment

(obj. 3)

Use to:

- Organize and clarify risk
- Identify high-lethality factors
- Guide safety planning

Important:

- Does not replace clinical judgment
- Reduces reliance on intuition or minimization
- Ensure appropriate training and competency for use.

(Campbell et al., 2009; Johns Hopkins School of Nursing, n.d.)

Lethality Indicators Therapists Miss

(obj. 3)

In addition to indicators captured in the Danger Assessment:

- Stalking and surveillance behaviors
- Threats of suicide or homicide
- Violence during pregnancy
- Threats involving children or pets

The point is not to frighten the client.
It is to help recognize and contextualize risk.

(Campbell et al., 2003; Campbell et al., 2009; Johns Hopkins School of Nursing, n.d.)

When Clients Minimize Risk

(obj. 3)

Approach

- Ask direct, behavioral questions
- Clarify frequency, severity, escalation
- Do not rely on vague or softened language

Clinical Importance

- Do not accept minimization at face value.
- Assess risk based on behaviors and context, not labels alone

(Campbell et al., 2009)

Strangulation Must Never Be Minimized

(obj. 3)

Maya said, “**He put his hands around my neck, but he didn’t choke me.**”

Many survivors do not use the word strangulation. They may say:

- “Choked”
- “Grabbed my throat”
- “Held me down”
- “I couldn’t breathe”

Visible injury may be minimal or absent, but strangulation is associated with serious medical and lethality risk.

(Muir et al., 2022; Glass et al., 2008)

Assessing for Strangulation

(obj. 3)

Ask directly:

- Did they apply pressure to your neck?
- Did you have trouble breathing?
- Did you feel dizzy or lose consciousness?
- Did your voice change afterward?
- Did you have pain, trouble swallowing, or confusion?

Do **not** rely on client language/wording when assessing strangulation. Assess the behavior and physical impact directly.

(Alliance for HOPE International, 2025)

Technology-Facilitated Abuse

(obj. 3)

Technology-facilitated abuse means your client may have little or no private space and even your communication may increase risk.

Common monitoring methods:

- Shared Apple IDs or Google accounts
- Phone plans and location sharing
- AirTags, smart watches, smart home devices
- Social media or email access
- Spyware, cameras, therapy portal access

(National Network to End Domestic Violence [NNEDV], 2018)

Clinical Responsibility

(obj. 3)

When working with the client:

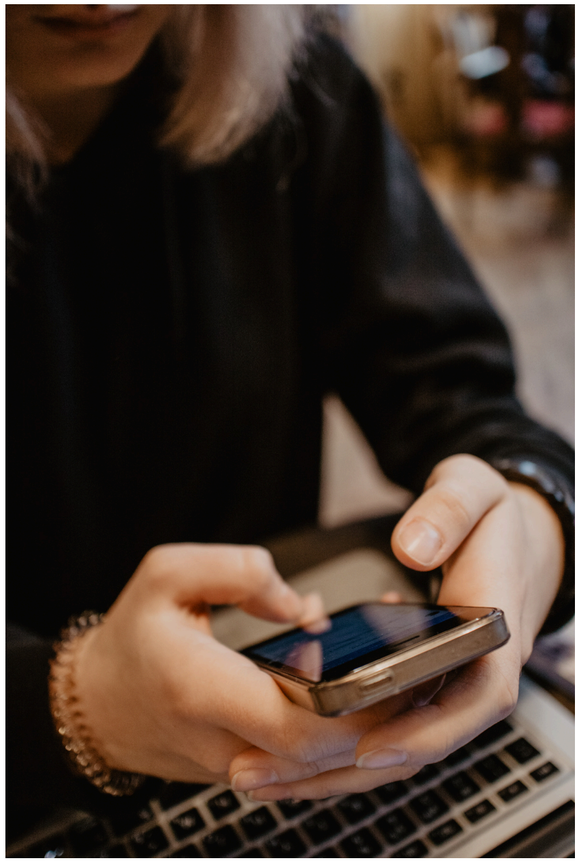
- Do not assume communication is private
- Assess whether digital access is safe

Before sending:

- Resources or worksheets
- Appointment reminders
- Safety plans or emails

Always consider: Can this be accessed without increasing risk?

(NNEDV, 2018)



Telehealth Safety

(obj. 3)

Telehealth increases access but also surveillance risk, and therapists **should not assume privacy**, as a partner may be off-camera, nearby, or monitoring.

Check safety:

- “Is this still a safe time to talk?”
- “Is anyone close enough to hear us?”
- “Do we need to use neutral language?”
- “What should I do if someone enters?”
- “Is there a safer way to contact you?”

(Warshaw et al., 2020)

Suicide Risk within DV Context

(obj. 3)

Survivors may experience suicidal thoughts in the context of experiencing:

- Entrapment and perceived lack of escape
- Chronic fear and psychological exhaustion
- Shame, humiliation, and identity erosion
- Financial control and dependency
- Isolation from support systems

Suicide risk assessment in IPV contexts should include coercive control, safety constraints, and perceived options.

(McManus et al., 2022)

Assessing Suicide Risk

(obj. 3)

Therapists should assess for:

- Passive death wishes
- Active suicidal ideation
- Access to means
- Prior attempts
- Substance use
- Partner threats of suicide
- Murder-suicide threats
- Recent escalation in abuse

Suicide risk assessment in IPV contexts should include coercive control, escalation, isolation, and perceived lack of safe options.

Don’t just ask, “Do you want to end your life?”

Ask, “What is making death feel like the only way out?”

(Kafka et al., 2022)

Children: Part of the Control Pattern

(obj. 3)

Children may be used within control dynamics to:

- Monitor
- Threaten
- Manipulate
- Punish
- Maintain access to the survivor

This extends coercive control beyond the intimate relationship and into **parenting, custody, and family systems.**

This is not simply “parenting conflict.”

(Tutty et al., 2024)

Children: Risk Changes

(obj. 3)

Separation is not automatically safer and may increase risk.

Shared parenting may require ongoing contact, increasing exposure to coercive control and continued abuse.

Abuse may continue through:

- custody processes
- exchanges
- legal systems
- child-related communication

(Tutty et al., 2024; Hardesty et al., 2016)

Documentation Risks

(obj. 3)

When working with survivors, documentation must be **intentional**.

Records may be:

- Requested or subpoenaed
- Used in custody, legal, or protective-order proceedings

Best practice

- Use behavioral descriptions
- Include client language when possible
- Document observed presentation
- Note risk assessment and safety planning
- Record resources offered and referrals provided

(ACA, 2014; World Health Organization [WHO], 2013)

Documentation Pitfalls

(obj. 3)

Avoid judgmental or minimizing language:

- “Client refuses to leave”
- “Client is dependent”
- “Client has poor insight”
- “Client continues toxic relationship”

Instead:

- Describe specific behaviors, context, and risk
- Use observable actions, not labels (e.g., avoid “partner is abusive”)
- Maintain neutral, objective language
- Reflect complexity without assumptions

(ECRI, 2023; ACA, 2014)

Documentation Example 1

(obj. 3)

I**nstead of:**
“Client refuses to leave abusive relationship.”

Use:
“Client reports concern that leaving at this time may increase risk due to partner’s prior threats, financial control, and monitoring behaviors. Safety options reviewed.”

Documentation Example 2

(obj. 3)

Instead of:
“Client is dependent.”

Use:
“Client reports partner controls access to income, transportation, and household financial decisions.”

Documentation should protect clinical accuracy without shaming the survivor.

Cultural and Systemic Context

(obj. 3)

Decisions shaped by:

- Systemic and structural barriers
- Racism and marginalization
- Immigration and disability
- Community and family pressure
- Poverty, access, and rural isolation
- Distrust of systems and institutions

Context does not excuse abuse.
It shapes what feels possible, safe, and survivable.

Ask what leaving, staying, or reporting means **in this client's world.**

(Wathen & Mantler, 2022)

Final Reflection: Maya

Maya is still staying. But now, you have:

- Identified coercive control and escalation patterns
- Assessed strangulation, suicide, and technology risks
- Named economic barriers and safety constraints
- Developed discreet, safer strategies

Success is not defined by leaving. It is measured by:

- Increased safety
- Reduced shame
- Stronger reality testing
- Greater access to options
- Informed decision-making

Key Takeaways

- **Coercive control** changes how therapists must assess risk, safety, and autonomy.
- **Survivor ambivalence** is expected when attachment, fear, hope, children, finances, and danger coexist.
- **Trauma-informed DV intervention** must include structured risk assessment, safety planning, careful language, documentation awareness, technology safety, and respect for client self-determination.

Closing

The question is not:
“Why does she stay?”

The better question is:
“Can I practice with enough precision that my help does not become another source of danger?”

That is the ethical burden of working with DV survivors.

Thank You

References

Alliance for HOPE International. (2025). *Strangulation/suffocation investigative worksheet.* https://www.allianceforhope.org/training-institute-on-strangulation-prevention/resources/strangulationsuffocation-investigative-worksheet

American Counseling Association. (2014). *ACA code of ethics.* https://www.counseling.org/resources/ethics

American Psychiatric Association. (2019). Treating women who have experienced intimate partner violence: A professional guide for health care providers and mental health professionals. https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/IPV-Guide/APA-Guide-to-IPV-Among-Women.pdf

Andersson, P. (2022). Countertransference and therapeutic holding: Working with a perpetrator of domestic violence. Psychodynamic Practice, 28(3), 275–295. https://www.researchgate.net/publication/363091055_Countertransference_and_therapeutic_holding_Working_with_a_perpetrator_of_domestic_violence

Australian Institute of Family Studies. (2023). Coercive control literature review. Australian Government Attorney-General's Department. https://aifs.gov.au/all-research/research-reports/coercive-control-literature-review

Campbell, J. C., Webster, D., & Glass, N. (2009). The danger assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. Journal of Interpersonal Violence, 24(4), 653–674. https://pmc.ncbi.nlm.nih.gov/articles/PMC7878014/

References

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C. R., 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://pmc.ncbi.nlm.nih.gov/articles/PMC1447915/

Centers for Disease Control and Prevention. (2024a, May 16). About intimate partner violence. https://www.cdc.gov/intimate-partner-violence/about/index.html

Centers for Disease Control and Prevention. (2024b, February 8). Risk and protective factors. https://www.cdc.gov/intimate-partner-violence/risk-factors/index.html

Darke, L., Paterson, H., Dhillon, H. M., & van Golde, C. (2025). Defining gaslighting in intimate partner violence: Insights from victim survivors and support service providers. Psychology, Public Policy, and Law, 31(4), 375–392. https://www.researchgate.net/publication/391387339

ECRI. (2023). Recognizing and responding to intimate partner violence. https://www.indianapca.org/wp-content/uploads/2023/09/RecognizingandRespondingtoIntimatePartnerViolence.pdf

Effiong, J. E., Stewart, S. L., & Boutilier, S. (2022). Traumatic bonding in victims of intimate partner violence is associated with childhood maltreatment, alexithymia, and symptoms of depression, anxiety, and stress. Journal of Social and Personal Relationships, 39(12), 3531–3553. https://doi.org/10.1177/02654075221106237

Glass, N., Laughon, K., Campbell, J., Block, C. R., Hanson, G., Sharps, P. W., & Taliaferro, E. (2008). Non-fatal strangulation is an important risk factor for homicide of women. The Journal of Emergency Medicine, 35(3), 329–335. https://pmc.ncbi.nlm.nih.gov/articles/PMC2573025/

References

Hardesty, J. L., Crossman, K. A., Khaw, L., Raffaelli, M., & Ogolsky, B. G. (2016). Marital violence and coparenting quality after separation. Journal of Family Psychology, 30(3), 320–330. https://pmc.ncbi.nlm.nih.gov/articles/PMC4816654/

Johns Hopkins School of Nursing. (n.d.). *The danger assessment.* https://www.dangerassessment.org

Johnson, L., Chen, Y., Stylianou, A., & Arnold, A. (2022). Examining the impact of economic abuse on survivors of intimate partner violence: A scoping review. BMC Public Health, 22(1), 1014. https://pmc.ncbi.nlm.nih.gov/articles/PMC9121607/

Kafka, J. M., Moracco, K. E., & Taheri, C. (2022). Intimate partner violence victimization and perpetration as precursors to suicide. SSM - Population Health, 18, 101079. https://doi.org/10.1016/j.ssmph.2022.101079

Keilholtz, B. M., & Spencer, C. M. (2022). Couples therapy and intimate partner violence: Considerations, assessment, and treatment modalities. Practice Innovations, 7(2), 124–137. https://www.apa.org/pubs/journals/releases/pri-pri0000176.pdf

Lohmann, S., Lohmann, J., & DiLillo, D. (2023). The trauma and mental health impacts of coercive control: A systematic review and meta-analysis. Trauma, Violence, & Abuse. Advance online publication. https://pmc.ncbi.nlm.nih.gov/articles/PMC10666508/

McManus, S., Walby, S., Barbosa, E. C., Appleby, L., Brugha, T., Bebbington, P. E., Cook, E. A., & Knipe, D. (2022). Intimate partner violence, suicidality, and self-harm: A probability sample survey of the general population in England. The Lancet Psychiatry, 9(7), 574–583. https://doi.org/10.1016/S2215-0366(22)00151-1

References

Muir, K. J., Donahue, C., Broshek, D. K., Resch, J., Solenski, N., & Laughon, K. (2022). Neuropsychological and balance symptoms of abused women who have experienced intimate partner violence-related strangulation: A feasibility and acceptability study. Neurotrauma Reports, 3(1), 491–500. https://doi.org/10.1089/neur.2022.0047

National Domestic Violence Hotline. (n.d.). *Safety planning while living with an abusive partner.* https://www.thehotline.org/resources/safety-planning-while-living-with-an-abusive-partner/

National Network to End Domestic Violence. (2018). Technology safety plan: A guide for survivors and advocates. Safety Net Project. https://www.techsafety.org/resources-survivors/technology-safety-plan

Stark, E., & Hester, M. (2019). Coercive control: Update and review. Violence Against Women, 25(1), 81–104. https://files.santaclaracounty.gov/migrated/Coercive-Control-Article-Update-Review-Evan-Stark-Marianne-Hester.pdf

Sullivan, C. M. (2018). Understanding how domestic violence support services promote survivor well-being: A conceptual model. Journal of Family Violence, 33(2), 123–131. https://doi.org/10.1007/s10896-017-9931-6

Tolmie, J., Smith, R., & Wilson, D. (2024). Understanding intimate partner violence: Why coercive control requires a social and systemic entrapment framework. Violence Against Women, 30(1), 54–74. https://doi.org/10.1177/10778012231205585

Tutty, L. M., Radtke, H. L., & Nixon, K. L. (2024). “He tells people that I am going to kill my children”: Post-separation coercive control in men who perpetrate IPV. Violence Against Women, 30(11), 2853–2876. https://doi.org/10.1177/107780122311664

References

Wathen, C. N., & Mantler, T. (2022). Trauma- and violence-informed care: Orienting intimate partner violence interventions to equity. Current Epidemiology Reports, 9, 233–244. https://doi.org/10.1007/s40471-022-00307-7

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf