Effective Evidence-Based Therapeutic Interventions for Women Who Have Experienced Intimate Partner Violence

By

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Abstract

This capstone investigated the various psychological interventions that are used when working with female victims of IPV and best supported within the clinical literature. This research project explored which therapeutic interventions are most effective for victims of IPV, and how literature findings can be applied to improve the effectiveness of these therapeutic interventions. This was explored through a literature review in which key studies were selected and analyzed in order to identify key themes related to the topic of exploration. This review identified a number of findings regarding the effectiveness of interventions Cognitive Behavioral Approaches (CBT, CPT, and TF-CBT), Interpersonal Therapy and Eye Movement Desensitization and Reprocessing. The findings were that these approaches demonstrated efficacy in aiding female victims of IPV and a number of cognitive, behavioral, and emotional changes were identified. In particular, Cognitive Behavioral Approaches have the most support and were the most promising psychological intervention within the literature, however more investigation into newer approaches such as EMDR show promise for working with female victims of IPV. The selected articles were also critiqued regarding their methodology through a systematic process, investigating and analyzing their strengths and limitations.

Keywords: *intimate partner violence, physical abuse, emotional/psychological abuse*

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Chapter One - Introduction

Background

Intimate Partner Violence (IPV) is an all too common occurrence within western society, with four in ten women and one in three men having experienced IPV during their lifetime (Cotter, 2021). The World Health Organization defines intimate partner violence as "one of the most common forms of violence against women and includes sexual, and emotional abuse and controlling behaviors by an intimate partner" (WHO, 2012). Issues with IPV have been further exacerbated during the rise of COVID-19, which has increased vulnerabilities related to IPV, such as increased isolation and financial difficulties (Moffitt et al., 2020). It is also important to note the gendered aspect of IPV, as 79% of police-reported victims of IPV are women, which influences interventions and how they are applied to the general public (Burczycka, 2019).

Victims of IPV often experience control over their home environment with perpetrators often dictating how they interact with the world, interact with the world, speak, eat, dress, or engage in household tasks (Stark, 2009). Perpetrators of IPV often dissuade partners from obtaining or maintaining a job leading to increased financial control and power differential within the relationship (Postmus et al., 2020). This form of economic abuse within the home can result in women having limited access to resources, hindering their ability to escape from IPV situations. Economic abuse can also serve to isolate women, inhibiting social connections with others and their ability to reach out to others for help (Giesbrecht, et al., 2023). Perpetrators also engage in physical violence alongside tactics such as control, isolation, and intimidation in order to dominate their partner (Stark, 2009). Substances may often be used by the victims at home, such as alcohol, to cope with difficult emotions and thoughts, which has been demonstrated to hinder help-seeking behaviors (Martin et al., 2008) and exacerbate mental health issues (Mason & O'Rinn, 2014). The cycle of IPV within the home often exacerbates these mental health issues,

leading to increased coping behaviors and further effects on mental health outcomes (Machisa et al., 2017). Perpetrators often enact patterns of abusive behavior followed by apologetic and improved behaviors with promises to change, resulting in cycles of calm periods followed by further abuse (Rakovec-Felser, 2014). Harassment methods may involve social media monitoring, public harassment, impersonation, hacking, abusive emails, revenge porn, and phone calls bypassing protection orders (Al-Alosi, 2017). IPV perpetrators also commonly stalk their victims, often motivated by a desire to seek revenge, and reconcile with their partners, with male former intimate partners making up the most significant number of stalkers on and offline (Dragiewicz et al., 2018). Even upon leaving an abusive relationship, IPV survivors often experience cycles of resource loss and financial difficulties which can exacerbate mental health problems and PTSD (Arroyo et al., 2017). Victims also commonly experience difficulties with the legal system as wait times are prolonged, allowing manipulation and abuse to continue (Hing et al., 2021).

Meta-analyses and studies have identified several impacts of IPV on victims, such as increased depression, anxiety, substance abuse, and PTSD (Dekel et al., 2020; Spencer et al., 2019; Sullivan et al., 2016). Victims may experience shame, guilt, and fear, making it difficult to leave the abusive relationship or seek help (Cravens et al., 2015). Even when considering leaving the relationship, victims may feel hopeless and helpless, experiencing low self-esteem, self-blame, and self-doubt (Karakurt et al., 2014). The trauma of experiencing IPV can also lead to difficulty in trusting others and forming healthy relationships in the future (Rakovec-Felser, 2014). In a study by Hing et al. (2021), women's narratives illustrated impacts on finances, relationships, and mental health that were prolonged far after the abuse. These narratives also revealed that due to IPV crisis support being focused on short term interventions through shelters

and short-term treatments, this may not consider the long-term effects of IPV on victims (Hing et al., 2021).

This is a particularly relevant topic for counsellors who are engaging in providing services to women who have experienced IPV. Counsellors who serve this population will be working with women who have many co-occurring mental health, interpersonal and substance abuse issues that are often bidirectional and intricately linked (Mason & O'Rinn, 2014). Understanding the complex nature of IPV and how victims experience and manage their mental health during and after these experiences is crucial in providing clients the most effective therapeutic services.

There are several intersectionality elements that bear further investigation in order to understand IPV further. Firstly, it is important to note that IPV is particularly relevant for immigrants who are new to Canada and have limited options for financial and social connections. The isolation and control of social interaction often found within IPV situations further isolates newcomers with limited English language abilities and inhibits their ability to find work, increasing financial dependence on their abuser (Giesbrecht, et al., 2023). This leaves immigrants to be particularly vulnerable to IPV and merits consideration if counsellors begin to work with these diverse clients in clinical practice. It is also important to note that cross-culturally, women may seek out different forms of support, with Satyen et al. (2019) finding Latina and African American women more likely to utilize law enforcement and hospital services. In contrast, Caucasian women were more likely to access mental health resources which is particularly relevant for counsellors serving diverse populations who have experienced IPV. Women from certain cultures may be less willing to seek out mental health resources and being aware and attentive to these cultural narratives can be helpful for counsellors in aiding individuals from these populations. Socioeconomic status also influences the prevalence of

violence in IPV with those of lower socioeconomic status having a higher likelihood of IPV (Reichel, 2017). IPV and coercive control has also been viewed through a feminist lens, with IPV behaviors being an extension of patriarchal control based upon sexual inequity (Stark, 2009). Stark (2009) stresses women's vulnerability in personal life, with men seeking to subordinate women as per traditional patriarchal values. It is essential to be aware of gender dynamics and cultural narratives around power in relationships and how this may be impacting women experiencing IPV.

This topic is particularly relevant to my therapeutic work as my internship at the YWCA primarily serves women and LGBTQ+ clientele who have experienced IPV. Further exploration of this topic will aid in understanding the phenomenon of IPV and conceptualizing how to aid clients struggling with the aftermath of abuse. I also have seen firsthand how destructive IPV can be in these clients' lives, and it would be helpful to understand it further to help prevent revictimization for my clients in the future. Within my practice, there have been several scenarios where women have experienced IPV in the past which demonstrated the depth of learning needed to aid my clients more effectively in navigating these scenarios. It is beneficial to investigate a range of therapeutic interventions for IPV in order to better expand my own practical understanding of IPV and to better serve my clients at the YWCA and within my clinical practice in the future.

Research Problem

Numerous therapeutic interventions have been applied to victims of IPV and while there is an expanding basis of scientific literature, the overall body of research on empirically supported interventions for IPV is relatively small (Trabold et al., 2018). There are however several therapeutic interventions which have been demonstrated to be effective at treating IPV concerns, including cognitive behavioral therapy, integrative therapies such as interpersonal

psychotherapy and motivational interviewing, dialectical behavior therapy, and many others (Arroyo et al., 2017). Cognitive behavioral approaches thus far have demonstrated the most support in improving mental health with reductions in PTSD, anxiety, and depressive symptoms (Trabold et al., 2020). Integrative therapies such as interpersonal therapy and motivational interviewing were also very prevalent and demonstrated preliminary positive outcomes, with women victims having reduced symptoms of depression (Cort et al., 2014; Zlotnick et al., 2011) and symptoms of PTSD being reduced to nonclinical levels (Falsetti et al., 1993).

There are also general treatment suggestions within the literature for mental health professionals emphasizing the importance of gaining knowledge of the dynamics that underlie partner violence to develop effective therapeutic treatments for victims of IPV (Sorrentino et al., 2021). As suggested by the research, it is crucial to understand the partner dynamics and preferences of the client so that therapeutic interventions match the needs and priorities of the client (Norcross & Wampold, 2018). A 2014 meta-synthesis by Trevillion et al. also found clients experienced a number of concerns such as acknowledging of stigma regarding receiving a mental health diagnosis when reporting domestic violence, giving the client's space to work through their problems at a slower pace and feeling like clinicians did not allow them autonomy regarding treatment. Sorrentino et al. (2021) also investigated survivor narratives which identified provider flexibility, allowing clients the autonomy to make their own life choices, and actively supporting clients with external and internal resources to be beneficial in client outcomes.

Victims of IPV often experience a variety of comorbid mental health and substance abuse issues which makes intervention from counsellors complex and multifaceted (Mason & O'Rinn, 2014). This complex and multifaceted nature of this therapeutic population necessitates a thorough understanding of evidence-based interventions, in order to elicit better outcomes as

clinicians. Unfortunately, the recurrence of IPV is common, with studies finding rates as high as 30% in the first six months regardless of the intervention used for IPV victims (Stover et al., 2009). These high rates suggest that further research needs to be undertaken to develop and modify treatment interventions to support IPV victims.

This capstone intends to explore the literature on psychological interventions for victims of IPV in order to recommend better practices for counsellors who work with clients who have experienced IPV. This paper will aim towards fulfilling several objectives such as increasing understanding of the current literature on evidence-based therapeutic interventions of IPV, gain insight into the change processes of the selected interventions and to apply these insights to clinical practice.

Purpose of Study and Research Question

The purpose of the study is to investigate the various psychological interventions that are used when working with female victims of IPV and best supported within the clinical literature. Thus the research question is: Which therapeutic interventions are most effective for victims of IPV, and how can literature findings be applied to improve the effectiveness of these therapeutic interventions?

Justification

The topic of IPV is particularly salient, especially in the context of the COVID-19 pandemic, where public health responses such as social distancing and lockdown restrictions have resulted in increased rates of social isolation, unemployment, and financial difficulties (Kawohl & Nordt, 2020). These issues may lead to individuals falling into alcohol use and worsening mental health difficulties which may potentially increase IPV risk (Campbell, 2020). Early reports have suggested that IPV has seen an increase over the course of the pandemic, with more clients reporting an escalation in violence and disclosing IPV (McLean & McIntosh, 2021).

IPV is also a particularly relevant topic for indigenous populations, where indigenous women are at a higher risk of experiencing IPV primarily due to historical trauma (Brownridge et al., 2017). It has also been noted within the literature that marginalized groups such as LGBTQ+, Indigenous and individuals who spoke a language other than English at home were at a higher risk of abuse (Henry et al., 2020). These findings within the literature suggest that to increase treatment effectiveness, treatment interventions may benefit from being more culturally specific to their diverse populations.

This topic is very relevant to the counselling profession in that it investigates the best evidence-based practices for working with victims of IPV which can be directly applied to practical clinical practice. It is the responsibility of the counsellor to engage in ethical practice which includes being competent in providing services to the population in question (CPA, 2017). The Standards of Practice states that if the therapist does not yet have competency working with a certain population or clinical issue they should be engaging in learning, demonstrating that they are working to acquire these competencies and engaging in ongoing supervision (CAP, 2019).

It is also important to note the ethical and cultural considerations when working with this particular clinical population as there are a variety of cultural stereotypes and narratives around IPV survivors. Ethically psychologists are to be culturally sensitive to the client's sociocultural context, to minimize harm and to modify therapy to meet the needs of the client (CPA, 2017). Due to the vulnerable position of many victims of IPV it is important for psychologists to engage in ethical advice seeking from peers and supervisors alongside setting up safeguards to protect the rights of the peoples involved. Psychologists have a duty of care to their clients under Principle II: Responsible Caring and it is important to engage in self-reflection regarding their own attitudes, values, biases, and social context to increase the likelihood their work will benefit rather than harm their clients (CPA, 2017). Responsible Caring is also relevant in providing the

best evidence-based practices when working with clients and investigating which psychological interventions are most supported by the scientific literature. Furthermore, in the Code of Ethics under Principle III: Integrity in Relationships it is stressed that through self-reflection the psychologist can attempt to be as unbiased and objective as possible, thereby minimizing potential harm. All of these ethical and cultural considerations are very relevant when working with a vulnerable population such as victims of IPV and merits consideration when investigating the best evidence-based interventions and how to apply them in clinical practice.

Significance of the Study

An investigation of IPV interventions can aid these populations by having therapists more fully understand the nature of IPV and more effectively apply evidence-based interventions to populations experiencing IPV. The current literature on psychological interventions for IPV is quite extensive with a wide variety of treatment approaches being applied by counsellors (Arroyo, 2015). However, researchers have identified the need for more replication of findings, larger sample sizes and more rigorous methodology in order to expand generalizability of these findings. Another meta-analysis has also identified a common trend of many studies having weak methodologies and designs, with greater consistency needed regarding inclusion criteria and follow up timing (Hameed et al., 2020). This study will aid in filling that gap by investigating the current methodological rigor of the literature and which treatment approaches are most supported within the literature. Research findings from this study can be integrated into clinical practice through identifying effective treatment approaches so that practitioners can apply the best evidence-based practices for victims of IPV. Certain therapeutic approaches may target specific symptomology that IPV victims experience and these strengths can be utilized by clinicians in their practice. Furthermore, certain therapeutic approaches may resonate with clients over others especially if they come from different familial backgrounds and cultural groups so knowledge of

multiple therapeutic interventions for IPV can be very beneficial for clinicians. These findings can also be used by aspiring practitioners to better serve their clientele, by being informed about the potential approaches to treat victims of IPV and what elements of therapeutic interventions may be beneficial. Especially in the early stages of becoming a counsellor learning effective and well-structured therapeutic interventions can aid in providing high quality services to clients. This evidence-based therapeutic practices can serve as a solid foundation for aspiring clinicians to then build upon throughout their clinical career. This study can also help policy makers, graduate students doing research, community members awareness and women who are affected by IPV.

Theoretical Framework

How different interventions theoretically conceptualize the problems elicited by IPV is particularly relevant to this investigation. This research project intends to explore a number of common treatment frameworks for survivors of IPV: Cognitive Behavioral Approaches, Interpersonal therapy, and a newer form of treatment in Eye Movement Desensitization and Reprocessing. It is important to note that within all these approaches counsellors have a responsibility to engage in collaborative safety planning with the client and to connect them to other service providers, which expands their options in IPV situations if they seek to leave their abusive partner (Murray & Graves, 2013). Furthermore, in cases of IPV counsellors have an ethical duty to report if they believe there is danger to their client, others, or a vulnerable person/child (CPA, 2017). Counsellors by engaging with an ethical decision-making process should look to the best interests of their clients and will benefit from consultation, supervision and contacting their supervisory bodies when working with victims of IPV (CAP, 2019).

Cognitive Behavioral Approaches

While varying in focus and delivery, cognitive behavioral approaches conceptualize mental health concerns through cognitive theory which focuses on the connection between thoughts and emotions and aims to restructure thoughts to alleviate psychological suffering (Beck, 2021). Cognitive Behavioral Approaches include Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The model was developed by Aaron Beck in the 1970s and posited that our thoughts, feelings, and behaviors are interconnected and that mental health issues result from negative or maladaptive thoughts and behaviors (Beck, 1976). According to this model, negative thoughts can lead to negative emotions, such as anxiety or depression, and influence behavior. CBT techniques identify and challenging problematic cognitions and beliefs leading to improvements in emotions and overall functioning (Morland et al., 2015). CBT explains the impact of IPV to be arising from maladaptive thought patterns and core beliefs. IPV survivors often demonstrate cognitive distortions such as black and white thinking, catastrophizing, and overgeneralization that can cause emotional distress and lead to maladaptive coping (Butler et al., 2006). The therapeutic process of CBT for IPV typically involves identifying negative or distorted thoughts and beliefs, challenging these thoughts and beliefs with evidence, and developing more adaptive ways of thinking and behaving (Fenn & Byrne, 2013). CBT is a goal-oriented, structured, and time-limited form of therapy that emphasizes the individual's active participation in the therapeutic process (Beck, 2021).

Interpersonal Therapy (IPT)

Interpersonal therapy conceptualizes mental health issues in the context of interpersonal difficulties and follows the interpersonal theory of Harry Sullivan (Lipsitz & Markowitz, 2013). Interpersonal theories of depression argue that behavior in social situations of depressed people, such as having difficulty responding and identifying nonverbal cues, often elicits rejecting

responses, thus leading to an increased chance of depression onset, persistence, and recurrence (Cort et al., 2014). Psychiatric disorders and interpersonal problems are seen as reciprocal, where increased isolation and decreasing social connections lead to perpetuating the depressed state (Lipsitz & Markowitz, 2013). Interpersonal therapy, like many other forms of therapy, focuses on empathetically engaging with the patient, letting them feel understood, and assisting with ongoing problem-solving to improve their mental health (De Mello, 2005). There is also recognition within this theory of the impact of broader social contexts on mental health (Sullivan, 1954) which is very relevant in the cases of IPV where lack of external social support can inhibit help-seeking behaviors. The therapy is goal-oriented and structured, focusing on specific problem areas in the individual's life, such as grief, role transitions, and relationship conflicts (Weissman et al., 2008). IPT aims to help individuals develop adaptive coping skills, resolve conflicts with others, and improve their overall well-being and functioning (Weissman et al., 2017).

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a therapeutic modality first developed in the 1980s by Francine Shapiro (Shapiro, 2018). EMDR seeks to help clients experiencing trauma symptomology by unblocking maladaptively stored material and helping the client’s internal system integrate these memories (Schwarz et al., 2021). EMDR uses a theoretical model called Adaptive Information Processing (AIP), which states that memory networks holding trauma experiences must be processed and be connected to networks that hold information of adaptive nature (Shapiro & Laliotis, 2011). AIP asserts that there is an inherent system to process information towards mental health, and this system can be used to integrate past experiences in a more adaptive state (Shapiro, 2002). When individuals experience an adverse event, this can overwhelm the information processing system, resulting in the memory becoming maladaptively encoded (Hase, 2021). These inadequately

processed experiences are what generate PTSD symptomology and become the target of treatment in EMDR (Shapiro, 2018). In the case of IPV this theory is particularly relevant in that victims often have inadequately processed experiences that took place during the victim's time within the abusive relationship. These maladaptively encoded experiences can result in a variety of PTSD symptoms that victims of IPV experience and hinder the natural healing of the system towards mental health. EMDR can then be used to process these maladaptively encoded experiences thus improving PTSD symptomology. Through bilateral stimulation of the brain, using auditory tones, physical hand taps, or eye movements, the information-processing system is activated, thereby decreasing the intensity of negative images, affect and cognitions, images, and affect while increasing the power of positive images, affect and cognitions (Shapiro, 2018).

These theoretical frameworks guide the treatment of IPV victims within the three treatment modalities chosen and demonstrate how psychological treatments are very heterogeneous in their approaches to victims of IPV.

Key Concepts

Intimate Partner Violence (IPV). IPV is termed as "any behavior within a relationship that causes physical, psychological or sexual harm, to those in the relationship" (WHO, 2012). This includes physical, psychological, emotional, and financial abuse and is used to control a partner within the relationship. IPV is also used interchangeably with a number of other terms such as partner violence and domestic violence.

Physical Abuse. A commonly accepted definition of physical abuse is behaviors that threaten or inflict physical harm (Tjaden & Thonnes, 2000). Physical abuse may also vary in severity from mild threats all the way to severe physical violence or demanding sexual acts (Murray et al., 2013).

Emotional/Psychological Abuse. Emotional and psychological abuse involves reoccurring acts of aggression and criticism towards their partner often leading to the partner to be fearful and have low self-esteem (O'Leary, 1999). Psychological abuse often uses words or body language to enact harm or to control another individual (Breiding et al., 2014). Examples of psychologically abusive behaviors include treating their partner like property, isolation, verbal humiliation, and jealousy (Tjaden & Thonnes, 2000). Psychological and emotional abuse has been associated with a variety of severe mental health problems (Breiding et al., 2014) and is a strong predictor of later physical IPV (Baker & Stith, 2008).

Researcher Positionality

My current internship is at the YWCA where I work with a predominantly female population who have frequently experienced IPV over the past five years. Due to the population of the YWCA being almost exclusively women, I often see IPV from a female victim's perspective with a clear male perpetrator, female victim dynamic. Common themes and stories I encounter with victims involve custody issues and ongoing contact due to children alongside the mental health effects of the previous abuse. Many of my clients are navigating complex situations where they are forced to maintain contact with an abuser due to shared custody of children or issues such as the abuser refusing to pay child support. This leaves many of my clients open to manipulation and guilt from the abuser, and I've had several instances where they will return to their abuser to escape the harassment the abuser is engaging in. It is important to consider my biases and assumptions regarding this topic as I may not be as sensitive to the perpetrator's perspectives regarding the motivations for abuse or how to work with them in a treatment setting.

Furthermore, it is important to note that the traditional view of female victims and male perpetrators has been brought into question by the scientific literature (Breiding et al., 2014).

Although my experience has largely been with female victims, it is essential to acknowledge that men may face similar challenges in IPV situations. Female perpetrators and male victims are not uncommon (Breiding et al., 2014; Hines & Douglas, 2009), and it is important to consider that IPV occurs at comparable rates in same-sex and heterosexual relationships (Rollè et al., 2018; Stanley et al., 2006). There is also the possibility that I may display confirmation bias when discussing research findings due to my exposure already working with the research population in question. While fitting into my anecdotal experiences working with clients, the manner in which IPV is conceptualized within the articles may not incorporate alternative viewpoints or avenues for intervention with clients. In regard to potential academic biases I may display confirmation bias in my research of the subject matter, selecting articles that fit with my arguments and ignoring those that disprove it. I may also be more inclined to be interested in studies or results that are surprising and/or novel however these findings could potentially be due to chance or difficult to replicate. It will be crucial during the research process that I am engaging in academically rigorous methodology that considers my potential biases and balances both the evidence for and against my arguments.

My biases toward a more cognitive approach are also a potential issue as I practice primarily from an Acceptance and Commitment Therapy lens (A third wave cognitive behavioral therapy), which may result in me having a positive bias toward cognitive behavioral approaches within my research. It will be essential to consider alternative conceptualizations such as those put forward by Interpersonal therapy and thoroughly investigate non-CBT approaches to the treatment of IPV to ensure my biases are not affecting my research findings. It is important to be aware of these potential biases, and it will be crucial to control them to prevent their influencing the findings of this research.

Chapter Two: Methodology

The criteria and methods utilized for selecting the 10 articles used in the methodological critiquing process will be covered within this methodology section. These articles, alongside additional supplementary articles, will be utilized for the literature review process. This section will be utilized to set the context for article selection and in helping readers comprehend the author's thought process. Numerous publications were reviewed and examined during this process, with ten articles being chosen for the capstone's methodological critique, alongside numerous others that were integrated into the literature review. These papers were selected because they place a strong emphasis on psychological treatments for female IPV victims, utilizing a variety of interventions such CBT, CPT, TF-CBT, IPT, and EMDR. This literature review will be beneficial in providing a reader with a thorough understanding of the different psychological treatments for IPV victims and the psychological changes elicited for victims. In the following section, the literature search process will be described, such as how the articles were selected and retrieved by the authors.

Literature Search Process

The research process utilized a literature review design and critiquing the methodology of scientifically published studies. For this study, ten primary research articles were selected in order to critique methodology and additional studies were utilized for a thorough topical analysis. The studies were mainly sourced through Google Scholar, Psychology and Behavioral Sciences Collection, PsycInfo, PsycArticles, PubMed, Academic Search Premiere, and the City University of Seattle's library. Key search terms included “Domestic violence", “Therapeutic Interventions IPV", "Psychological Interventions IPV", "CBT for IPV", "EMDR for IPV", “CPT for IPV”, “TF-CBT for IPV”, "IPT for IPV", “IPV Impacts”, “IPV Treatments", "IPV

Interventions", "IPV Impacts", "IPV Experiences", "IPV Causes", “Counselling Modalities “ and “Effect of IPV”.

Inclusion and Exclusion Criteria

Inclusion criteria focused on having an evidence-based therapeutic intervention that; demonstrated its effectiveness with female participants who had been victims of IPV, were at the individual or group level, and whose participants were over 18 years old. Studies using the treatment methods of Cognitive Behavioral Approaches, Interpersonal therapy (IPT), and Eye Movement Desensitization and Reprocessing (EMDR) were selected to focus the selection of articles, and other treatment methods were excluded. Other exclusion criteria included studies older than six years old to ascertain the most recent effective treatment interventions. However, one exception by Cort et al. (2014) was chosen as it is one of the best-known studies illustrating the efficacy of interpersonal therapy for IPV victims. The selected studies were chosen due to their quantitative approaches to investigate the efficacy of psychological interventions, with two studies utilizing a mixed-method approach. Quantitative studies were chosen due to the research topic of investigating the efficacy of psychological treatments for female IPV victims, with different change processes depending upon the intervention utilized by the researchers. All of the selected studies met the inclusion and exclusion criteria, explored the research topic, and aided in further understanding of the research question of this capstone.

Selection of Articles

Regarding the selection of articles, there were numerous studies within the scientific literature regarding interventions for IPV, both from a victim treatment approach and also for perpetrator interventions. A challenge that was encountered during the research process was that many interventions being investigated were advocacy and other forms of shelter approaches, rather than standalone psychological interventions by mental health providers. These advocacy

and shelter approaches, were often more systemic in nature, focusing on providing resources and practical support to IPV survivors. This literature review focused mainly on studies investigating psychological interventions utilized by mental health providers rather than other forms of advocacy and shelter interventions. This was done so as to better inform therapeutic interventions for IPV victims for counsellors and other mental health providers. This literature review therefore aimed to focus on psychological interventions for victims and explored articles that demonstrate psychological changes for victims following treatment. Table 1 below shows the ten articles that were utilized in the methodological critique of the capstone, alongside an exploration of the articles within the findings section.

Table 1
Reference List of Studies Reviewed

Author	Year	Title	Journal	Type
Andersson et al.	2021	Individually tailored Internet-delivered cognitive-behavioral therapy for survivors of intimate partner violence: A randomized controlled pilot trial.	*Internet Interventions*	Experimental Quantitative
Cort et al.	2014	Interpersonal psychotherapy for depressed women with histories of intimate partner violence.	*Psychological Trauma: Theory, Research, Practice, and Policy*	Experimental Quantitative
Crespo et al.	2021	Analysis of effectiveness of individual and group trauma-focused interventions for female victims of intimate partner Violence.	*International Journal of Environmental Research and Public Health*	Experimental Quantitative
Galovski et al.	2022	Massed cognitive processing therapy for posttraumatic stress disorder in women survivors of intimate partner violence.	*Psychological Trauma: Theory, Research, Practice and Policy*	Experimental Quantitative

Greene et al.	2019	Developing an integrated intervention to address intimate partner violence and psychological distress in Congolese refugee women in Tanzania.	*Conflict and Health*	Experimental Mixed Methods
Harris et al.	2018	A pilot study with Spanish-speaking Latina survivors of domestic violence comparing EMDR & TF-CBT group interventions.	*Open Journal of Social Sciences*	Experimental Quantitative
Latif & Khanam	2017	Effectiveness of cognitive behaviour therapy in reducing anxiety, depression and violence in women affected by intimate partner violence: a randomized controlled trial from a low-income country.	*Journal of Postgraduate Medical Institute*	Experimental Quantitative
Latif et al.	2021	Culturally adapted trauma-focused CBT-based guided self-help (CatCBT GSH) for female victims of domestic violence in Pakistan: feasibility randomized controlled trial.	*Behavioural and Cognitive Psychotherapy*	Experimental Quantitative
Meffert et al.	2021	Interpersonal psychotherapy delivered by nonspecialists for depression and posttraumatic stress disorder among Kenyan HIV–positive women affected by gender-based violence: Randomized controlled trial.	*PLoS Medicine*	Experimental Quantitative
Schwarz et al.	2021	EMDR for survivors of sexual and intimate partner violence at a nonprofit counseling agency.	*Journal of EMDR Practice and Research*	Experimental Mixed Methods

Data Analysis Procedures

The ten selected studies will be critiqued regarding their research problems, research design/paradigms, role of the researchers, participant selection/sampling, data collection and data analysis. Methodological critiquing is beneficial in that each article has particular assumptions and decisions made regarding their research processes, which may influence the discussion and

findings of the articles. Limitations will also be explored regarding each article, and ethical considerations, research findings, and recommendations for future research will be discussed.

Furthermore, this literature review will follow a descriptive review process by analyzing and synthesizing the current findings related to psychological interventions for IPV (Paré & Kitsiou, 2017). This will serve to aid in answering this capstone's research question, by exploring the current scientific knowledge on the topic and identifying themes that arise within the literature. Implications will then be derived from these identified themes, such as ramifications for counselling practice when working with victims of IPV within a therapeutic setting.

Chapter Three: Review of Literature and Findings

Literature Review

It is important to consider the overarching literature on the topic of IPV interventions regarding the treatments of Cognitive behavioral approaches, Interpersonal Therapy, and EMDR. Treatment approaches will be investigated as to the current scientific literature on their efficacy and how these approaches are applied to female IPV survivors.

Cognitive Behavioral Approaches

Cognitive behavioral approaches include a number of different forms of cognitive-based therapy such as Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These therapies share a common cognitive focus when working with patients and seek to identify and challenge problematic beliefs and thoughts (Watkins et al., 2018). Each of the three therapies employs a variety of methods to assist clients in controlling their symptoms and enhancing their functioning, including exposure therapy, cognitive restructuring, and behavioral activation. Although there are some parallels across the three therapies, it's crucial to remember that each therapy has its own focus and method of treatment.

Cognitive Behavioral Therapy

Firstly, cognitive behavioral therapy has been one of the most dominant approaches in research and practice in the past few decades, often viewed as the gold standard for therapeutic interventions (Leichsenring & Steinert, 2017). CBT has been applied widely to general populations and has demonstrated decreases in anxiety, depression, and PTSD symptomology (Bisson et al., 2013). CBT has a variety of core tenants such as challenging maladaptive cognitions, developing healthier behaviors, and learning to identify feelings and thoughts (Lakin et al., 2022) which can be beneficial for victims of IPV who experience a variety of mental

health concerns such as anxiety, depression, and PTSD (Dekel et al., 2020; Dillon et al., 2013; Lagdon et al., 2014). A recent systemic review found a high strength of efficacy of standard CBT and CBT-mixed treatments in decreasing PTSD symptomology (Forman-Hoffman et al., 2018). Another meta-analysis by Arroyo et al. (2017) also found that CBT tailored for survivors of IPV using trauma-informed approaches was the most efficacious intervention with large effect sizes on depression, PTSD symptomology, anxiety, and self-esteem. CBT can be applied in an individual or group context, which can help to decrease wait times and reach a broader population of clients (Miller et al., 2014). CBT can also be applied in several different treatment modalities, such as by the internet which can be relevant for victims of IPV who may experience geographical and financial constraints alongside facing stigma, guilt, and shame regarding their experiences (Rempel et al., 2019).

CBT elicits change by helping clients gain insight into their own cognitive distortions and irrational beliefs which aids in identifying and ultimately challenging underlying core beliefs (Morland et al., 2015). This elicits a number of cognitive changes for victims of IPV who begin to challenge negative thinking patterns and beliefs such as “If my partner left me I wouldn’t be able to handle it”, “My partner hurt me because he actually loved me” or that the victim in some way deserved the abuse (Perangin-Angin et al., 2021). These negative automatic thoughts and core beliefs are commonly experienced by female victims of IPV and are a target for CBT techniques. Furthermore, the victim’s own negative appraisal of the traumatic experience can lead to an exaggeration of the current threat leading to a sustaining of PTSD symptomology (Ehlers & Clark, 2000). Victims of IPV may often engage in maladaptive coping strategies which temporarily gives relief from symptoms, however in the long term serves to maintain them. Through CBT techniques these maladaptive cognitions and behaviors are modified and

challenged resulting in decreases in emotional distress and increasing the victim's ability to engage with avoided situations, memories, and thoughts (Johnson et al., 2011).

Cognitive Processing Therapy

CPT, in contrast, was first developed for treating sexual violence survivors and is effective with a variety of trauma-exposed populations for the treatment of PTSD symptomology as well as demonstrating effects on anxiety and depression (Galvotski et al., 2020; Watts et al., 2013). CPT differs from other forms of CBT by focusing specifically on trauma and PTSD symptomology rather than more general cognitions, feelings, and behaviors (Resick et al., 2016). Several studies have found that CPT reduces PTSD symptoms in veterans (Haagen et al., 2015), military members (Resick et al., 2015), and sexual assault survivors (Haagen et al., 2015), providing substantial evidence for the treatment's efficacy in treating PTSD (Murray et al., 2018). CPT has been used in treatment with IPV survivors in several studies that have found efficacy in reducing PTSD, anxiety, and depressive symptoms (Galovski et al., 2020; Greene et al., 2019). Recent studies have begun experimenting with massive doses of CPT, which shortens treatment length, thereby overcoming barriers IPV survivors often encounter, such as limited resources and safety concerns that may interfere with accessing more standard treatment timings such as weekly therapeutic sessions (Ehlers et al., 2014; Foa et al., 2018; Galovski et al., 2022). CPT can also be combined with other treatment approaches, such as advocacy counselling which empowers clients to increase autonomy, strengthen connections within their community and find solutions to their problems while being supported by their counsellor (Trabold et al., 2020).

Many of the change processes used in CPT are similar to those in CBT, such as recognizing maladaptive beliefs and cognitions before guiding clients through cognitive strategies to challenge them (Resick et al., 2008). In addition to other cognitive techniques, clients are invited to offer a written description of their traumatic experiences as part of a written

component included by CPT (Resick et al., 2016). Following a traumatic event, victims try to make sense of what happened, which commonly leads to distorted cognitions about other people, the outside world, or even themselves (Resick et al., 2008). In an effort to reconcile the traumatic event with past schemas, victims sometimes assimilate information, changing it to conform to their preexisting beliefs (Watkins et al., 2018). In the context of IPV, this may result in cognitions related to self-blame for abuse, with beliefs such as "I could have fought harder so; therefore, it was my fault the IPV occurred" or "I didn't listen to what my partner said, therefore, I deserved the abuse." CPT also discusses the concept of over-accommodation, which is when victims change their beliefs to protect themselves from future trauma from occurring (Resick and Schnicke, 1992). This may appear in the context of IPV victims in beliefs such as "The world is an unsafe place and no one can be trusted" which can often lead to increased social isolation and difficulty trusting others (Watkins et al., 2018). CPT aims to activate the traumatic memory in order to identify maladaptive cognitions such as assimilated and over-accommodated beliefs. Within the context of IPV, CPT aids in shifting the victim towards accommodation which is the altering of beliefs to integrate new information from experiences (Resick and Schnicke, 1992). For example, an IPV victim through CPT may come to accommodate the new information they have received through their experiences by altering their belief regarding their responsibility within the IPV, shifting from "I should have stopped the abuse" and "Other people cannot be trusted" to "I am not responsible for my partner's actions towards me" and "Some people are not safe however there are still trustworthy people in the world".

Trauma-Focused Cognitive Behavioral Therapy

Another form of treatment in TF-CBT focuses on creating a supportive environment for clients to speak about their trauma and to teach skills to process their traumatic life experiences (Cohen et al., 2012). Like CPT, TF-CBT aims to process the meaning of the trauma, and

exposure to the traumatic memory is an integral part of the treatment process (Lowe & Murray, 2014). A recent finding within a meta-analysis by Keynejad et al. (2020) found that tailored approaches such as TF-CBT that focus on trauma may demonstrate more significant outcomes for female survivors of IPV than non-targeted interventions. TF-CBT has been used with various trauma populations and demonstrated efficacy in reductions in anxiety, depression, and PTSD symptomology (Bisson et al., 2013). TF-CBT has been applied specifically with IPV survivors in several studies that demonstrated large effect sizes in reducing PTSD, anxiety, and depressive symptoms (Crespo & Arinero, 2010; Crespo et al., 2021).

Change within TF-CBT involves a number of different areas, such as psychoeducation, relaxation training, exposure, and cognitive restructuring (Cohen et al., 2012). The aim is to modify cognitions (such as self-blame) regarding the trauma and to gradually lower the sensitivity of the client to the event and other related triggers (De Arellano et al., 2014). This is done by identifying unhelpful cognitions related to the trauma and using relaxation skills while exposed to trauma stimuli. This cumulative exposure lessens the distress brought on by these reminders and the emotions related to trauma. Much like CPT this can be done through a trauma narrative in which the client writes down the incident across many sessions, highlighting different thoughts the client is experiencing (Saunder et al., 2004). This is particularly relevant to victims of IPV who can begin processing their trauma through gradual exposure, lessening distress related to triggers, and learning new coping skills to engage more effectively with the world. This exposure takes place both imaginably and in vivo, with cognitive restructuring being used to identify maladaptive views of the trauma and swap them out for more adaptive perceptions (Lowe & Murray, 2014).

For example, IPV victims often hold maladaptive beliefs such as feelings of worthlessness and self-blame, often accompanied by mental health difficulties such as PTSD

symptomology, anxiety, and depression (Karakurt et al., 2014). TF-CBT engages the victim in psychoeducation related to IPV and its consequences then begins to use cognitive restructuring techniques to identify dysfunctional thoughts and thinking errors, replacing them with more adaptive beliefs regarding themselves and their world (Harris et al., 2018). For instance, a victim may shift their beliefs regarding their experienced IPV, modifying thoughts and feelings of guilt and self-blame into acknowledgment of their partner's responsibility for the IPV. The victims also are taken through structured graduated exposure to their traumatic experiences, using learned relaxation skills in order to manage distress (Harris et al., 2018). This leads to desensitization over time of trauma-related stimuli, resulting in significant reductions in anxiety, depression, and PTSD symptoms (Crespo et al., 2021).

Interpersonal Therapy

Interpersonal therapy (IPT) has strong cognitive roots; however, it specifically targets the relationships within the client's lives and how the social environment may contribute to their psychological suffering (Stuart, 2006). Through social support networks and developing interpersonal communication skills, IPT aims to help clients enhance their interpersonal functioning (Meffert et al., 2021). The current literature on IPT has demonstrated sizeable results in treating depression and comparable efficacy in reductions of PTSD symptomology to other forms of exposure therapies (Markowitz et al., 2015).

Due to its efficacy, the WHO has recommended that IPT be used as a treatment for depression and has developed a group IPT manual for clinicians (World Health Organization, 2016). IPT has also been applied to female IPV survivors, which demonstrated initial efficacy in reducing symptoms of depression (Cort et al., 2014; Meffert et al., 2021; Zlotnick et al., 2011). IPT can be applied in an individual or group format, with group therapy being an opportunity to obtain social skills that may inhibit further isolation for victims of IPV (MacKenzie & Grabovac,

2001). Meta-analyses suggest that the focus of IPT on interpersonal relationships may help specifically in cases of IPV however at this time there is a limited research base to support these findings (Lakin et al., 2022).

According to Weissman et al. (2008), IPT induces change by concentrating on four distinct areas: grief/role disputes, role transitions, interpersonal deficits, and social support. IPT argues that many mental health symptoms are actually a result of interpersonal difficulties such as emotional withdrawal which isolates individuals, cutting them off from social support (Lipsitz & Markowitz, 2013). This is particularly relevant for IPV victims as many experiences depression and other symptoms which inhibit social connectivity, often leading to a cycle of further isolation and mental health difficulties. As clients move through sessions of IPT, they begin to learn how to assert their own needs within interpersonal encounters, validate their own emotions as valid interpersonal signals, and to begin engaging in more healthy social connections (Markowitz & Weissman, 2004). Focus is often placed on current interpersonal disputes with non-abusive family/friends and maladaptive interpersonal patterns rather than role transitions and grief during IPT treatment, specifically for IPV victims (Cort et al., 2014). Participants in sessions explore relationship and feeling logs, which document interpersonal contacts from the previous week and any resulting emotional responses. The victims learn IPT strategies such as communication analyses of interpersonal conflicts and other methods of problem-solving to convey victim's needs as interpersonal patterns are further examined (Markowitz & Weissman, 2004). This results in a number of specific changes for victims of IPV who begin to engage in healthier social connectivity with those around them, thereby disrupting the isolation maintaining their depressive symptoms.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a form of exposure therapy that seeks to aid clients in processing their trauma by unblocking maladaptively stored memories through bilateral brain stimulation (Sharpiro, 2018). This is done through hand movements or other methods for the traumatic memories to be processed. The literature on EMDR thus far has been impressive, with research demonstrating sizeable reductions in PTSD symptoms, depression, and anxiety (Maxfield et al., 2020; Chen et al., 2015; Schubert et al., 2016; Russell et al., 2007). EMDR commonly shows PTSD symptom decreases in as little as one or two sessions (Welch, 1997) and is often lower cost than other interventions for PTSD, such as TF-CBT (Mavranezouli et al., 2020). The WHO, in their violence against women guidelines, stated that EMDR was an intervention particularly effective in addressing women's mental health concerns stemming from sexual violence (WHO, 2013). EMDR has been applied in the context of IPV in several studies, such as that of Mosquera & Knipe (2017), who found that EMDR can target the idealizations that IPV victims may often hold regarding their abusers and form a more accurate view of their relationship. Another study by Tarquinio et al. (2012) found that EMDR had higher levels of symptom reduction of PTSD than eclectic psychotherapy and had significantly less PTSD symptomology than the control group. EMDR may also be useful cross-culturally, with studies demonstrating PTSD symptomology decreases with various ethnic populations (Schubert et al., 2016). Treatments can be customized to meet the need of the particular cultural context of the client, and clinicians do not incorporate their own interpretations of EMDR, thereby not biasing the client's perception of the intervention process (Rittenhouse, 2000).

However, there are several limitations and concerns regarding EMDR as it requires intensive training and supervision for professionals, which can be quite expensive for therapy providers (Cuijpers et al., 2020). This concern of cost limits the number of therapists adequately

trained in EMDR, limiting its applicability for lower resource settings (Lakin et al., 2022). Furthermore, while being a highly effective treatment for PTSD, there is inadequate evidence to support that EMDR can treat other comorbid mental health symptoms (Cuijpers et al., 2020). Another issue is that there may be concerns about the research supporting EMDR having small effect sizes, potential selection bias, lacking standardization of the length or number of sessions, and lack of random assignment (Cuijpers et al., 2020). Furthermore, the use of EMDR on patients who are dissociative or have severe emotional instability has also been discouraged by experts (Rittenhouse, 2000). It is important when considering EMDR to teach the client emotional regulation tools before attempting processing, and the therapist should assess whether the client is sufficiently prepared before applying EMDR.

According to Shapiro (2018), EMDR induces change through a variety of processes including cognitive restructuring, conditioning, mindfulness, and somatic awareness. The AIP model, which contends that people have an innate information processing system that takes in new information and stores it in flexible memory networks, is the foundation of EMDR. According to Shapiro (2007), pathology develops when new information is inadequately processed and subsequently maintained in memory networks in an unhelpful way, along with associated changed thoughts, feelings, and sensations. This is particularly relevant for victims of IPV as they have often experienced trauma, resulting in a number of PTSD symptoms, thereby hindering the natural tendency of the system to mental health. One of the most popular hypotheses to explain the change processes found within EMDR is related to the evocation of a rapid-eye movement-like state within the brain, which results in the processing of distressing material through activation of the parasympathetic nervous system (Tarquinio et al., 2012). The rapid eye movements elicit a relaxation response within the client undergoing EMDR, thus allowing exposure and processing of the traumatic material. A recent study by Santarnecchi et al.

(2019) found connectivity changes in fMRI data within clients undergoing EMDR, with increased connectivity between bilateral temporal pole structures and prefrontal regions of the brain. The neurocognitive theory that emphazises greater top-down control as a key change mechanism in psychological recovery from trauma and anxiety disorders concurs with these increased prefrontal cortex connections (Malejko et al., 2017). Specifically in PTSD, prefrontal brain hypoactivation has been associated with decreased attention spans and the persistence of traumatic memories (White et al., 2015). EMDR techniques are utilized to process these maladaptively encoded experiences, allowing the natural tendency of the system to move toward mental health (Shapiro, 2018). This results in a number of changes such as increased behavioral flexibility when victims encounter trauma stimuli due to decreased levels of distress being elicited.

Literature Synthesis

All three therapeutic interventions demonstrate efficacy when working with female IPV victims showing a number of different cognitive, emotional, and behavioral changes post-treatment. Cognitive behavioral approaches, in particular, have a wide research base with various treatment modalities being used with clients. Cognitive behavior approaches also benefit from integration with other forms of treatment, such as advocacy counselling (Greene et al., 2019), which can be modified for clients of different cultural groups (Greene et al., 2019; Latif et al., 2021; Latif & Khanam, 2017), and has forms of treatment such as CPT and TF-CBT that targets trauma directly. Interpersonal therapy has been referenced by several meta-analyses as being a potentially effective therapeutic treatment for female IPV victims (Arroyo et al., 2017; Trabold et al., 2020). However, upon investigation, the scientific literature was lacking regarding the number of studies available with only 3 studies being done since 2011 (Cort et al., 2014; Meffert et al., 2021; Zlotnick et al., 2011). These studies however did demonstrate initial efficacy in

lowering depressive symptoms in female IPV victims and demonstrated positive outcomes with PTSD symptomology. In contrast, EMDR is a newer form of treatment that has been applied to female victims of IPV, and there are a number of newer studies (Mosquera & Knipe, 2017; Schwarz et al., 2021; Harris et al., 2018) investigating its treatment efficacy. The following findings section related to the topical literature review will explore how different psychological interventions elicit change for female IPV victims and to what extent treatment methods have been supported by the current scientific literature.

Thematic Findings from the Literature Review

There are several different relevant themes that arise when investigating the effectiveness of therapeutic interventions for female victims of IPV. Studies highlight several different cognitive, emotional, and behavioral-changes, with differing impacts depending upon the treatment modality investigated. A summary of the findings of the selected articles can be found in the chart below:

Table 2

Overview of Findings

Interventions	Psychological Changes		
	a. Cognitive Changes	b. Emotional Changes	c. Behavioral Changes
1. Cognitive Behavioral Therapy (CBT)	Self-Blame and Guilt Cognitions	Emotional Regulation	Disability and Engagement
2. Cognitive Processing Therapy (CPT)	Core Beliefs and Guilt Cognitions	Emotional Regulation	Engagement
3. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Trauma-Related Memories and Cognitions	Self-Esteem and Emotional Regulation	Reductions in Avoidance Behaviors and Hyperarousal

4. Interpersonal Therapy (IPT)	Awareness of Maladaptive Interpersonal Patterns	Disruption of Isolation and Depression Cycles	Interpersonal Communication and Social Connectivity
5. Eye Movement Desensitization and Reprocessing (EMDR)	Cognitive Functioning	Emotional Regulation	Reductions in Avoidance Behaviors

Discussion of the Findings

Cognitive Behavioral Therapy Changes

Cognitive. Firstly, victims of IPV experience a number of cognitive changes such as more accurate perceptions of their experiences and problems with a more adaptive thinking style (Perangin-Angin et al., 2021). Due to disputing of automatic thoughts and cognitive restructuring, clients reduce feelings of distress, improve their well-being, and have more adaptive core beliefs (Beck, 2021). This leads to a reduction in maladaptive thinking patterns and an increased ability to challenge negative thinking patterns caused by cognitive distortions. This was demonstrated in one study by Andersson et al. (2021) who used cognitive techniques to target trauma-related guilt cognitions within treatment regarding the victim's IPV. Higher level of self-blame has been associated with increased PTSD symptomology amongst trauma survivors and CBT's targeting of self-blame cognitions may aid in decreasing these symptoms (Reich et al., 2015). Common self-blame cognitions such as attributing the abuse as being the victim's fault are disputed through cognitive restructuring techniques, which are then replaced with more adaptive cognitions (Andersson et al., 2021). Furthermore, targeting maladaptive cognitions within CBT has been theorized to aid victims of IPV to have more positive and realistic beliefs regarding themselves, such as believing that one can mold their own life and be empowered to make decisions in their own best interest (Brosi et al., 2020). Anxiety symptomology also decreased with victims being able to manage thoughts more effectively,

seeing decreases in specific symptoms such as rumination and excessive worry (Andersson et al., 2021; Latif et al., 2021; Latif & Khanam, 2017). In regard to cognitive functioning, very few studies have specifically investigated how CBT treatment influences female victims of IPV, however with general populations there have been mixed findings, with studies finding inconsistent evidence regarding improvements in working memory, memory, and conflict adaptation (Schindler et al., 2020).

Emotional. As a result of these cognitive changes, this elicits a variety of emotional changes for victims of IPV. As maladaptive coping strategies and negative thoughts decrease in frequency, symptoms of PTSD often decrease such as emotional numbing, a common symptom that involves emotional suppression and an inability to feel emotions (Iverson et al., 2011). This results in an increased ability to experience positive emotions for victims of IPV who are more able to feel a wider range of emotions, such as hope, self-acceptance and have increased levels of confidence (Johnson et al., 2011). In the case of female IPV victims, it is significant to keep in mind that more frequent displays of positive emotions may be attempts to minimize the severity of abuse and serve as covert defense mechanisms, with victims possibly underestimating the effect of abuse on themselves (Procaccia & Castiglioni, 2022). Thus far, research on CBT interventions for IPV victims has mainly focused on identifying reductions in negative symptomology, focusing on pathology rather than improvements in positive emotions (Andersson et al., 2021; Latif et al., 2021; Latif & Khanam, 2017). Further research may benefit from investigating more fully the positive emotional changes of IPV victims and whether there may be specific additional considerations to make when measuring these treatment outcomes. Furthermore, due to the aforementioned changes in maladaptive cognitions depression symptoms decrease, with victims of IPV more effectively able to emotionally regulate and experience a lower frequency of negative emotions (Andersson et al., 2021; Latif et al., 2021). Studies have

found decreases in a number of different specific emotions such as feelings of helplessness, hopelessness, and feelings of impending doom (Latif & Khanam, 2017).

Behavioral. These changes in both cognitions and emotions often lead to behavioral changes, with victims of IPV being more able to engage in day-to-day living more effectively. For example, victims of IPV are able to more effectively emotionally regulate when approaching areas that remind them of the traumatic events and to engage less in avoidance behaviors (Johnson et al., 2011). Furthermore, victims are more fully able to engage with social support and more effectively engage in interpersonal relationships as a result of CBT's focus on problem-solving and communication skills (Johnson et al., 2011; Latif & Khanam, 2017). Another study by Latif et al. (2021) found decreased levels of disability on the WHO DAS, an assessment used by the World Health Organization to measure levels of engagement in daily activities, interactions with others, mobility, and self-care (Üstün et al., 2010). Furthermore, victims of IPV see increases in sleep hygiene, with a reduction in nightmares and less difficulty falling or staying asleep which is a common symptom of PTSD (Pigeon et al., 2022). CBT has also been demonstrated to be effective at reducing subsequent IPV for victims who are often at higher risk of re-abuse in the future (Iverson et al., 2011; Johnson et al., 2011). This has been attributed to victims no longer holding core beliefs leading to engaging in abusive relationships, such as viewing control behaviors as a form of love or engaging with new partners who share similar abusive traits as their past abuser.

Cognitive Processing Therapy Changes

Cognitive. As a result of the various change processes found within CPT such as exposure and cognitive restructuring, IPV victims experience a variety of cognitive changes. CPT can help in identifying and challenging negative beliefs about a victim's experienced IPV, such as beliefs that they deserved the abuse or were at fault for their partner's actions against

them (Watkins et al., 2018). The goal of CPT is to replace these unhelpful beliefs with ones that are more empowering and adaptable, such as the notions that all individuals are worthy of respect and that they as a person are intrinsically valuable. According to CPT, this shift towards more adaptive beliefs can result in higher self-esteem and confidence as the victim starts to establish a more accurate and positive view of who they are (Greene et al., 2019). Thus far however there has been little evidence within the CPT literature specifically supporting this finding within the population of female IPV victims however research on CPT for general trauma found participants to have increased self-worth, shifts in beliefs regarding self-efficacy and confidence in managing difficult situations (Price et al., 2016). CPT has also been demonstrated to be effective at reducing guilt-related cognitions which can then lead to a number of emotional changes for IPV victims (Resick et al., 2008).

Emotional. Much like in CBT, cognitive changes elicited by CPT result in a number of specific emotional changes. Due to the aforementioned changes in guilt-related cognitions, this allows IPV victims to feel less emotional distress, leading to an increase in mood and wellbeing (Resick et al., 2008). For instance, in the study by Galvotski et al. (2022) study participants following treatment reported an increased sense of emotional regulation and ability to dispute guilt-related cognitions related to their abuse. However, it is important to note that in regard to specific positive emotions, there has not been much research at this time and the large majority of the focus thus far within the CPT literature has been the reduction in negative symptoms such as anxiety and depression (Galvotski et al., 2022; Greene et al., 2019). CPT has been demonstrated to be effective at reducing both anxiety and depressive symptoms for victims of IPV, which can be seen as a byproduct of more effective disputation of maladaptive cognitions and increased ability to emotionally regulate when overwhelmed (Galvotski et al., 2022). Many

common specific depressive symptoms such as low mood, lethargy, and hopelessness were reduced, alongside reductions in rumination and situational anxiety.

Behavioral. These cognitive and emotional changes also result in behavioral changes such as reduced avoidance behaviors related to the victim's traumatic experiences (Galvotski et al., 2022). Through exposure to the trauma narrative systematically throughout CPT, victims become desensitized to the various cognitions and emotions that arise, resulting in an increased ability to engage in activities that previously would elicit strong triggers. This enables victims of IPV to engage more fully in day-to-day activities with research finding decreases in PTSD leading to increased functioning across many different life domains such as engaging with social supports, parenting, and employment (Galvotski et al., 2022).

Trauma-Focused Cognitive Behavioral Therapy Changes

Cognitive. TF-CBT elicits a number of cognitive changes such as experiencing a change in relationships with their memories related to trauma, lessening distress, and having an increased ability to have voluntary control over those memories (Shearing et al., 2011). Group TF-CBT also demonstrated clinically significant reductions in PTSD symptomology, such as unwanted memories or nightmares measured on a SPRINT scale (Harris et al., 2018). Within TF-CBT, this would be explained as occurring due to the gradual exposure of the participants to the trauma stimuli, resulting in decreasing levels of PTSD symptomology. Furthermore, due to the use of cognitive restructuring techniques and problem-solving skills, victims were more able to identify maladaptive cognitions such as self-blame/guilt and replace them with more adaptive cognitions such as self-acceptance (Crespo et al., 2021). Anxiety symptomology such as rumination and excessive worry was also shown to be reduced by TF-CBT with clients having more awareness of their thought patterns and being more effective at disputing irrational thoughts when they arose.

Emotional. These changes in cognition lead to numerous emotional changes for victims of IPV. For example, in a study by Crespo et al. (2021) victims of IPV were found to have significantly improved self-esteem with participants experiencing higher levels of self acceptance and self satisfaction at one month follow-ups. Furthermore, in the same study, both individual and group TF-CBT was found to significantly reduce symptoms of depression with victims of IPV experiencing less feelings of guilt, sadness and feeling more positive about the future. Specific depressive symptoms such as sadness and feelings of hopelessness decreased substantially with clients more effectively able to emotionally regulate and manage difficult emotions (Crespo et al., 2021).

Behavioral. TF-CBT has also demonstrated behavioral changes for victims of IPV that merit discussion. Firstly, there have been a number of changes in PTSD symptomology such as avoidance behaviors related to trauma triggers, such as avoidance of specific locations or memories of the victim's IPV (Harris et al., 2018). Furthermore, other elements of common PTSD symptomology such as nightmares and hyperarousal reduced which often interfere with sleep for victims of IPV (Crespo et al., 2021). This fits into TF-CBT's focus on exposure to traumatic stimuli which results in decreased distress to trauma triggers leading to a decreased need to engage in avoidance of certain trauma stimuli. One neutral finding within the literature was regarding family/social support for victims following TF-CBT treatment where a study by Crespo et al. (2021) found no differences between treatment groups. This may be due to the victims of IPV already having considerable levels of social supporting pretreatment; however future research may benefit from investigating whether TF-CBT treatment outcomes can be enhanced through additional focus on interpersonal relationship building and problem-solving.

Interpersonal Therapy Changes

Behavioral. Firstly, IPT treatment leads to behavioral changes in communication and connection to others which can help victims of IPV begin to engage in community and seek emotional support from others. The behavioral change of responding more effectively to others around them through identifying nonverbal cues and responding appropriately leads to increased connectivity with others (Weissman et al., 2017). This leads to improvements in overall functioning with IPV victims more effectively able to engage in relationships with others, demonstrated by decreased interpersonal dysfunction, such as over aggression and difficulties being assertive in relationships, amongst participants (Cort et al., 2014). IPT has also been found to be effective at reducing physical IPV for victims currently still within relationships, likely due to the treatment's focus on resolving interpersonal conflicts and victims becoming more confident in expressing their needs within relationships (Meffert et al., 2021). Within IPT this would be seen as resulting from the increased ability of participants to engage in more effective interpersonal communication such as expressing their needs within the relationship and seeking out social support from other family/friends (Weissman et al., 2017). It is however important to note that in another study by Zlotnick et al. (2011) IPT in comparison to standard care did not produce any significant reduction in IPV occurrence at three-month follow-ups. Further studies are necessary to confirm whether IPT can be beneficial in reducing future IPV for victims and whether there may be treatment alterations to improve these outcomes.

Emotional. There are also a number of emotional changes elicited for the victim as they become more interconnected with those around them and are able to manage interpersonal conflicts more effectively within their lives (Cort et al., 2014). This has been found within a number of studies (Cort et al., 2014; Meffert et al., 2021) to aid in lowering depressive symptoms for IPV victims who experienced fewer negative emotions post-treatment. For instance, in a

study by Cort et al. (2014), participants' depressive symptom ratings decreased from severe to mild in many common depressive symptoms such as feelings of helplessness and hopelessness. IPT treatment would see these changes as the result of improvement in the interpersonal relationships within the client's lives, resulting in a short-circuiting of the vicious depressive cycle IPV victims often face where depression leads to isolation, and further isolation leading to a worsening of depressive symptoms (Markowitz, & Weissman, 2004). In regard to positive emotional changes that IPV victims experience as a result of IPT treatment, there has been little research at this time as the focus has been on tracking and reducing negative symptomology rather than eliciting positive changes in emotions (Cort et al., 2014; Meffert et al., 2021; Zlotnick et al., 2011).

Cognitive. In contrast to many of the previous cognitive-focused interventions for IPV, IPT research thus far has not specifically focused on identifying cognitive changes for participants (Cort et al., 2014; Meffert et al., 2021; Zlotnick et al., 2011). However, there were findings by Meffert et al. (2021) that despite not being a target of IPT treatment, PTSD symptomology such as disturbing memories, thoughts, and images decreased. There has also been research in general populations that suggest IPT can aid in shifting clients' dysfunctional attitudes regarding interpersonal relationships, with clients more effectively able to identify maladaptive interpersonal patterns (Bernecker et al., 2014). This is particularly relevant to the population of female IPV victims as identification of the relationship, rather than the victim, being the problem may aid in revising prior self-blame regarding the victim's role within the IPV, resulting in clinical changes in mental health symptomology. PTSD symptomology decreases may also be attributed to an increased ability to engage in social support as the result of IPT treatment, with clients experiencing less isolation, which has been known to exacerbate other mental health issues (Cuijpers, 2016).

Eye Movement Desensitization and Reprocessing Changes

Cognitive. Firstly, victims of IPV experience a variety of cognitive changes as they process their trauma with participants being able to modify their internal self-beliefs within EMDR treatment with more positive core beliefs being installed while reducing other negative core beliefs (Schwarz et al., 2021; Harris et al., 2018). For instance, within a study by Schwarz et al. (2021) participants reported having adopted more adaptive core beliefs such as believing they have value and inherent self-worth which were systematically reinforced throughout EMDR treatment. A number of cognitive functioning improvements were also observed such as increased memory, mathematical ability, and reading ability following EMDR treatment. These changes may be partially explained by increased connectivity of the prefrontal regions of the brain, resulting in increased top-down control by the victim in a number of cognitive faculties (Santarnecchi et al., 2019). Group EMDR also demonstrated clinically significant reductions in PTSD symptomology with medium to large effects in SPRINT scores (Harris et al., 2018). Specific PTSD symptomology included decreases in emotional distress related to triggers, flashbacks to traumatic memories, and nightmares. A study by Mosquera & Knipe (2017) also identified that EMDR treatment can aid IPV victims in forming more accurate views of their previous relationships, by targeting idealizations victims often hold towards their abusers. By targeting these inaccurate idealizations, the victim is more effectively able to process posttraumatic images and feelings, leading to improvements in effective self-protection and an increased internal locus of control. This is particularly relevant for IPV victims still within abusive relationships as this idealization may interfere with them leaving their partner and/or prevent victims from engaging in self-protective behaviors.

Emotional. Studies have also demonstrated a number of emotional changes for victims of IPV post-treatment. Firstly, studies found clinically significant improvement in participants for anxiety and depressive symptomology (Harris et al., 2018; Schwarz et al., 2021). Participants experienced a variety of changes in specific depressive symptoms such as decreases in hopelessness and worthlessness while specific anxiety symptoms such as rumination also showed improvements. The study by Schwarz et al. (2021) also identified that participants had an increased sense of self-regulation and control over their emotions post-treatment which can be connected to EMDR's emphasis on teaching relaxation and grounding techniques within the treatment protocol (Shapiro, 2018). These changes can also be explained through the potential mechanism of exposure to traumatic memories, resulting in gradually decreasing emotional distress for victims. In regard to positive emotional changes for IPV victims, there has been very little investigation within the EMDR literature (Harris et al., 2018; Schwarz et al., 2021), focusing mainly on tracking reductions in negative symptomology rather than increases in positive emotions. However, one study by Schwarz et al. (2021) did identify a number of positive emotional changes for victims within their qualitative findings including increased insight into their own emotional states and an enhanced ability to engage with positive emotions such as joy following EMDR treatment.

Behavioral. Various changes in behavior also result for victims of IPV following EMDR treatment with decreases in avoidance behaviors to previously traumatic stimuli such as certain locations and situations (Harris et al., 2018). Qualitative findings in the interviews undertaken by Schwarz et al. (2021) also spoke to the theme of increased functionality and control in the victim's lives following EMDR treatment with victims reporting an increased ability to set boundaries and advocate for their needs to be met within relationships. Within EMDR this would be attributed to the processing of the maladaptively stored memories and trauma, leading to

increased behavioral flexibility as trauma stimuli no longer elicit similar levels of distress for clients (Shapiro, 2018).

Critical Discussion of the Findings

The above findings serve to demonstrate a number of different psychological changes found when applying treatment interventions to victims of IPV. CBA approaches such as CBT, CPT, and CBT-TF demonstrated efficacy in targeting dysfunctional beliefs and cognitions such as self-blame and guilt, leading to an increased ability to challenge and modify these cognitions (Andersson et al., 2021; Brosi et al., 2020; Galvotski et al., 2022). This leads to improvements in emotional regulation for victims who have an increased ability to engage in emotional regulation skills and to manage emotional distress, resulting in reduced depression and anxiety symptoms for victims (Andersson et al., 2021; Galvotski et al., 2022; Greene et al., 2019; Latif et al., 2021; Latif & Khanam, 2017). Victims also found decreased levels of disability and improved engagement with everyday living, with additional reductions in avoidance behaviors to previously traumatic stimuli (Galvotski et al., 2022; Harris et al., 2018; Johnson et al., 2011; Latif et al., 2021). IPT also demonstrated efficacy in aiding victims to become more aware of maladaptive interpersonal patterns and disrupting isolation/depression cycles that often trap victims in depressive episodes (Cort et al., 2014; Meffert et al., 2021). IPT's focus on improving interpersonal communication and social connectivity successfully aided victims in connecting with more interpersonal relationships and accessing support from family and friends, leading to reductions in depressive symptoms. Lastly, EMDR demonstrated efficacy in eliciting cognitive, emotional, and behavioral changes such as increasing cognitive functioning and emotional regulation for victims with additional improvements in reducing avoidance behaviors regarding previously distressing locations and situations (Harris et al., 2018; Schwarz et al., 2021). EMDR may also be beneficial in targeting IPV victims' idealizations of previous relationships, leading

to an increased ability to process post-traumatic events and an improved sense of control over their lives (Mosquera & Knipe, 2017). EMDR also elicited other behavioral changes in victims, with an increased ability to advocate for their needs within their relationships (Schwarz et al., 2021). When discussing the best evidence-based practices for working with female victims of IPV, further research needs to be done to confirm the initial findings of the IPT and EMDR studies. Additionally, regarding cognitive behavioral approaches, there still needs to be further research in regard to CPT and TF-CBT in how to modify these treatments to meet their clients' needs more effectively.

Methodological Critiquing

The selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) within this section will be critiqued regarding their research paradigm, role of the researchers, sampling and recruitment of participants, data collection and data analysis procedures. Furthermore, the methodological strengths and limitations of the selected quantitative and mixed-methods studies will be discussed in order to derive recommendations for future research.

Quantitative and Mixed-Methods Studies

Research Paradigm

Research paradigms are the lenses through which academics structure their studies using their own values and worldviews (Levitt et al., 2017). This has an impact on the approach used for the study and the techniques for data collection and analysis procedures (Creswell & Creswell, 2018). All ten of the selected articles (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) were positivistic in their paradigm

which follows the scientific method, starting with a hypothesis which is then tested systematically by collecting data to dispute or support a theory (Creswell & Creswell, 2018). Positivist paradigms follow empirical methods, aiming to collect numerical values to explore the relationships between variables. In order to collect data, structured instruments are used, such as clinician-administered instruments and self-report questionnaires which were employed in the ten selected studies. Self-report questionnaires are beneficial in that they are cost-effective, can obtain information from large groups, and gain insight into the perspective of the participants (Creswell & Creswell, 2018). Two studies (Greene et al., 2019; Schwarz et al., 2021) followed a mixed methods approach with participants being interviewed after treatment, alongside data collection with other standardized clinical instruments.

Role of the Researchers

Within all the selected studies, the researchers utilized several assessment tools, engaged in statistical analysis, and interpreted their findings. The role of the researcher within quantitative research methods is to come from an etic framework, seeking to capture an outside perspective on the subject being researched (Yilmaz, 2013). The researcher aims to be detached and objective to minimize biases and their potential influence on the research findings (Creswell & Creswell, 2018). An important element to note within the majority of the selected studies (Harris et al., 2018; Schwarz et al., 2021; Galovski et al., 2022; Latif & Khanam, 2017; Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Latif et al., 2021) was that there was a lack of clarification regarding the role of the researchers, such as whether the researchers were implementing the treatment interventions alongside recruited therapists. However, researchers within the selected studies were all involved in data collection, analysis, and interpretation of findings within the selected studies. Furthermore, regarding the selected studies there was a variety of education levels and expertise of the therapists providing treatment. In the majority of

the selected studies (Harris et al., 2018; Schwarz et al., 2021; Galovski et al., 2022; Latif & Khanam, 2017; Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Latif et al., 2021) the practitioners who applied psychological interventions had previous clinical experience and higher levels of education (typically at least a masters degree). However, in other studies (Meffert et al., 2021; Greene et al., 2019), the researchers led practitioners through a training process in the intervention approach who did not hold higher levels of education regarding psychological interventions.

Sampling and Recruitment of Participants.

Demographics

Age. The participants within the ten selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) ranged from 18 years of age to 72 years old. The articles specifically chose within this age range due to the frequency of women experiencing IPV to be within their intimate partner relationships during adulthood. All of the selected studies chose to include only women over 18 as children and adolescents' experiences would likely differ from those of adults.

Gender. All participants in the selected studies were female.

Ethnicity. The selected studies investigated several different ethnicities and cultures, with several studies investigating a wide variety of demographics such as Caucasian, African American, Latina, and Asian women (Galvotski et al., 2022; Schwartz et al., 2021; Cort et al., 2014). Several studies specifically investigated women from other countries and ethnic groups, such as American Latina (Harris et al., 2018), Congolese (Greene et al., 2019), Pakistani (Latif & Khanam, 2017; Latif et al., 2021), Kenyan (Meffert et al., 2021) and Spanish women (Crespo et al., 2021). This was particularly relevant in culturally adapting treatment protocols in several

studies (Latif & Khanam, 2017; Greene et al., 2019; Latif et al., 2021), which modified procedures to be more accessible and relevant for specific cultural groups. However, one study in Sweden (Andersson et al., 2021) did not explicitly discuss their participants' ethnicity or cultural background.

Socioeconomic Status (SES). The SES of the participants was only discussed in three studies (Galvotski et al., 2022; Crespo et al., 2021; Latif & Khanam, 2017), which described participants belonging mostly to middle to low social backgrounds. This is a critical consideration in the context of IPV as lower SES victims may have additional financial barriers regarding leaving IPV situations or accessing resources (Cotter, 2021). The participants in these studies came from two rural (Meffert et al., 2021; Greene et al., 2019) and eight urban (Cort et al., 2014; Andersson et al., 2021; Latif & Khanam, 2017; Galovski et al., 2022; Schwarz et al., 2021; Harris et al., 2018; Crespo et al., 2021; Latif et al., 2021) settings, which is a relevant factor in the case of IPV victims. The location of participants has the potential to influence access to resources as women in rural settings may face additional barriers to accessing shelters and other IPV resources (Woodlock et al., 2020).

Sampling Methods. The selected articles within this study (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) used non-probability sampling, which involved selecting participants rather than a randomized selection of the general population (Creswell & Creswell, 2018). A number of studies (Harris et al., 2018; Schwarz et al., 2021) used convenience sampling (a form of nonprobability sampling), which often is used in order to limit costs and reduce the complexity of data collection (Anupam et al., 2013). Creswell & Creswell (2018) explains convenience sampling as choosing participants due to their convenience and availability to the researchers. These sampling methods were beneficial

in that the researchers attempted to do pilot studies investigating the efficacy of different approaches for the specific population of female IPV victims, which can be further elaborated on by future research. The selected articles' sample sizes ranged from as small as 12 participants (Galvotski et al., 2022) to as large as 256 participants (Meffert et al., 2021). It is important to note that a number of the selected studies (Harris et al., 2018; Galvotski et al., 2021; Cort et al., 2014; Harris et al., 2018; Andersson et al., 2018; Crespo et al., 2021) had small sample sizes (less than 30 participants), often functioning as pilot studies intending to investigate or compare specific treatment interventions with the population of female IPV victims. As will be explored within the limitations section, these low sample sizes may limit the generalizability of the studies with additional research being required to confirm their findings.

Recruitment and Selection. Researchers, before engaging in recruitment of participants, must select exclusion and inclusion criteria to follow (Creswell & Creswell, 2018). By using inclusion criteria, the study's validity is increased, and confounding factors are reduced (Salkind, 2010). All ten selected studies studied female victims of IPV. Common inclusion criteria from the studies included being female, being over 18, having a history of IPV, and having current mental health issues stemming from IPV history. Common exclusion criteria included cognitive impairment, substance abuse issues, current IPV victimization, psychotic symptoms, and imminent risk of suicide. While experiencing current IPV was a common exclusion criterion within many of the studies, there were three studies (Greene et al., 2019; Meffert et al., 2021; Latif & Khanam, 2017) that did allow women who were currently experiencing IPV to participate in their study. The majority of the studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) collected their participants through local shelters, NGOs, online communities, and agencies, which helped to identify and recruit

participants. However, the study by Galvotski et al. (2022) recruited their participants from a recently completed study on PTSD for female IPV survivors (Galvotski et al., 2021). In regard to generalizability the recruitment methods used are generally adequate, in that participants were all IPV victims seeking out aid to a number of different communities and agencies. However, as will be explored within the limitations section there may be some concerns about generalizability to particular IPV victims, due to systemic barriers such as transportation, finances, and time commitments for therapy.

Data Collection

Systemic models of data collecting, such as verified clinical tools, questionnaires, and surveys, are frequently used in quantitative techniques (Yilmaz, 2013). Quantitative methods of data collection used by the studies were both experimental and quasi-experimental as some studies (Crespo et al., 2021; Andersson et al., 2021; Harris et al., 2018; Meffert et al., 2021; Latif & Khanam, 2017; Galovski et al., 2022; Latif et al., 2021) used random assignment to a treatment condition, while others (Cort et al., 2014; Greene et al., 2019; Schwarz et al., 2021) did not.

All of the selected studies used a variety of different validated tools in order to assess mental health outcomes. For depression, several different measurement tools were used, with self-report questionnaires such as the *Beck Depression Inventory (BDI-II), the Hospital Anxiety and Depression Scale (HADS), and the Depression and Anxiety Stress Scale (DASS-21)* being the most commonly used. Anxiety symptomology was also assessed using the *Beck Anxiety Inventory (BAI)* and the *Generalized Anxiety Disorder Questionnaire (GAD-7),* and the aforementioned *DASS-21.* One study by Latif & Khanam (2017) used the *Aga Khan Anxiety and Depression Scale (Urdu Version)* modified specifically for the particular indigenous population being studied. PTSD symptomology was commonly assessed using the *Posttraumatic Stress*

Disorder Checklist (PCL-5), Impact of Events Scale revised for PTSD (IES-R), and the *SPRINT Scale*. Two studies (Meffert et al., 2021; Latif & Khanam, 2017) also measured ongoing IPV within the household with the *Conflict Tactics Scale (CTS2)* and *HITS Scale*. Health outcomes were also assessed within three studies (Andersson et al. 2021; Cort et al., 2014; Galvotski et al., 2021) using the *Patient Health Questionnaire–9 (PHQ-9)* while another two studies (Meffert et al., 2021; Latif et al., 2021) used the *World Health Organization Disability Assessment Schedule (WHODAS 2.0)* which assesses for overall functioning, health and disability. Cort et al. (2014) also collected data with the *Inventory of Interpersonal Problems-32 (IIP-32)* assessing for interpersonal problems, a large focus of treatment within IPT interventions. Several studies (Galvotski et al., 2021; Andersson et al., 2021) also used clinician assessment tools such as the *Clinical Global Impression – Improvement (CGI-I*), *The Clinician-Administered PTSD Scale for DSM–5 (CAPS-5)* and *The Structured Clinical Interview for DSM–5 Disorders (SCID-5)*. Two studies (Schwarz et al., 2021; Greene et al., 2019), alongside their quantitative measurements, also engaged in the assessment of participants' experience through semi-structured interviews intending to identify themes. These interviews were recorded and transcribed, with interviewers giving participants opportunities to ask questions and clarify responses.

Validity and Reliability of the Instruments

Reliability is a measure of an assessment's internal consistency, its stability over time, and the uniformity of its administration and scoring (Creswell & Creswell, 2018). All of the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) used a variety of well-validated tools with ranges for internal consistency meeting optimal ranges. A scale's internal consistency is measured by Cronbach's alpha, a number ranging from 0 to 1 with optimal ranges for instruments being between 0.7 and

0.9 (Creswell & Creswell, 2018). For example, many commonly used instruments within the selected studies such as the BDI-II and BAI are known as the gold standard for valid data collection instruments and have been used with a variety of diverse populations, with strong internal consistency (Cusin et al., 2010).

Data Analysis

Quantitative research analysis procedures include reporting various information such as standard deviations, the raw information collected, and the different variables studied (Creswell & Creswell, 2018). Statistical techniques are frequently employed to examine study results before they can be presented in a visual aid like a figure or table (Creswell & Creswell, 2018). Within the selected studies, several different analysis procedures were used, with the majority of the studies using software such as SPSS (Harris et al., 2018; Andersson et al., 2021; Latif & Khanam, 2017; Latif et al., 2021; Schwarz et al., 2021), an intent-to-treat (ITT) approach (Crespo et al., 2021), SAS (Galvotski et al., 2022), and Stata 15 (Meffert et al., 2021). SPSS, SAS, and Stata are statistical software programs that researchers commonly employ to analyze data through rigorous statistical methods (Howitt & Cramer, 2017; O'Connor, 2004). SPSS is a widely known statistical software used by university researchers and is the industry standard for data analysis (Arkkelin, 2014; Harrison et al., 2020). In a similar vein, the ITT approach is a method for analyzing randomized studies and assessing treatment efficacy (McCoy, 2017). This method helps to preserve the randomization of the study, which may not be assumed when using other statistical methods of analysis. Another study (Greene et al., 2019) used Spearman rank order correlations to investigate the quantitative relationship between treatment interventions and the changes in symptomology for the participants.

Additionally, two studies (Schwarz et al., 2021; Greene et al., 2019) used a mixed methods approach and collected quantitative data using semi-structured interviews, which were

then coded to identify themes and interpret the collected data. This aided in developing a rich and meaningful description of the data collected, deepening the understanding of the phenomenon being investigated (Creswell & Creswell, 2018). However, it was unclear which software was used by Greene et al. (2019) for coding and thematic analysis, which may be an oversight on the part of the authors.

Methodological Strengths & Limitations

The following section explores the strengths and limitations of the selected quantitative and mixed methods articles. Both strengths and limitations of the selected studies are investigated, and a general overview was created to synthesize and integrate research findings.

Strengths of Quantitative and Mixed Method Studies

There are a number of different strengths that can be highlighted regarding the methods of the studies selected.

- The usage of the positivist approach by the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) is particularly helpful in the context of interventions for female IPV victims as positivist studies investigate the impacts of treatment and which are most effective through scientifically rigorous methodology. Positivist approaches are very effective at investigating which factors may contribute to a specific issue and ascertaining which interventions may be most effective for participants (Creswell & Creswell, 2018). This is particularly relevant for the selected studies when investigating intervention efficacy, as systemic methods of scientific investigation serve to identify specific symptomology changes for victims following psychological treatment. Two of the studies (Schwarz et al., 2021; Greene et al., 2019) also undertook a mixed methods approach which aided in

providing additional insights into the participant's experience of IPV and psychological treatment procedures. This mixed methods approach provided additional information to be collected from the participant to gain further insights into intervention efficacy and how treatments can be better modified to meet client needs.

- All of the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) undertook steps to standardize their samples with similar inclusion and exclusion criteria, which aided in comparing studies to investigate interventions for female IPV victims. The studies followed statistically valid data collection and data analysis procedures using well-supported instruments which aided in providing scientific rigor to their findings.
- Regarding the sampling and recruitment methods of the ten selected studies by focusing on common inclusion and exclusion criteria the researchers of all ten selected studies honed their research demographic.
- Furthermore, the majority of the studies (Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) acknowledged the influence of both culture and ethnicity upon the female IPV victims, which aided in modifying interventions for diverse populations. There are several different benefits of using quantitative data collection methods, as tools are validated using statistical means and tested for validity against other scales (Creswell & Creswell, 2018). Modifications to data collection tools, such as those made by Latif & Khanam (2017), who used a tailored data collection method for the Urdu population being studied, are beneficial when working with diverse research participants. Greene et al. (2019) also discussed modifying data

collection tools by removing elements irrelevant to the target population of Congolese women, such as farming or other income-generating activities, which are uncommon and thus not a good indicator of daily functioning. It is also important to note the strengths of the selected studies in using self-report methods as they aid the researcher in gaining insight into the client's perspective and worldview (Creswell & Creswell, 2018).

Limitations of Quantitative and Mixed Method Studies

Despite having many strengths, several limitations bear mentioning regarding the methodology of the selected studies.

- It is important to note that there are criticisms of positivist approaches in that while often being more objective, there may be biases within the methods used to collect information from participants (Michell, 2003). This is particularly relevant in the cases of the selected studies as they made little to no description of the potential limitations or biases of the research methods the researchers may have held.
- Furthermore, as noted earlier the role of the researchers was not clarified within the majority of the selected studies (Harris et al., 2018; Schwarz et al., 2021; Galovski et al., 2022; Latif & Khanam, 2017; Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Latif et al., 2021) such as whether researchers applied psychological interventions personally or recruited other therapists for their research. This is especially relevant when considering the allegiance effect where the investigator’s own theoretical/treatment preferences may influence research findings (Luborsky et al., 1999). This potential for bias can be limited through effective research design such as control groups however many of the selected studies (Galvotski et al., 2022; Crespo et al., 2021; Schwarz et al., 2021; Harris et al., 2018; Cort et al., 2014; Greene et al., 2019) lacked this element. This lack of control groups also may limit the generalizability of the findings within these

articles as improvements in symptomology may be due to the passage of time or other confounding factors.

- Furthermore, regarding the sampling methods used, the small sample sizes of a number of the studies (Harris et al., 2018; Galvotski et al., 2021; Cort et al., 2014; Harris et al., 2018; Andersson et al., 2018; Crespo et al., 2021) may limit their generalizability, in particular for IPT and EMDR interventions, who have fewer studies undertaken thus far with smaller sample sizes in comparison to cognitive behavioral approaches. According to Creswell & Creswell (2018), sample sizes for quantitative studies should be at minimum 30 participants and lower sample sizes such as 21 participants in Cort et al. (2014) and 19 participants in Harris et al. (2018) make it difficult to generalize the findings of these studies. Although these limitations are understandable due to the research being pilot studies investigating the initial efficacy for these treatment interventions, further research is needed to confirm and replicate their findings.
- Another limitation of these studies' small sample sizes is that there may be questions regarding whether these interventions are effective with participants from all cultures and socioeconomic statuses. There may be limitations in applying more manualized treatment modalities such as those found within the selected studies to marginalized populations as this may not fit the client's cultural worldview and be ethnocentric in their approach (Snow et al., 2016). However, it is important to note that two studies (Greene et al., 2019; Latif & Khanam, 2017) did tailor interventions and data collection for the specific cultural demographic of their participants. These modifications are beneficial in that there may be potential issues using interventions and data collection instruments for a new population, especially if there are cultural or demographic differences between the subjects (Quintana et al., 2001).

- In regard to inclusion and exclusion criteria, a notable limitation was found within Andersson et al. (2021), which required participants to own a computer and to have access to a stable internet connection. These criteria may be problematic as many IPV victims may not have access to the financial resources necessary for computer or internet access, limiting which participants were included in this study. Another study by Crespo et al. (2021) also added the exclusion criteria of meeting the diagnosis of PTSD within the DSM IV-TR and referred these potential participants to another parallel treatment specifically aimed at PTSD symptomology. There may be concerns regarding not including participants who met PTSD diagnosis, as it may limit the article's application to this specific population of female IPV victims. In contrast, other studies (Galvotski et al., 2022: Latif et al., 2021) specifically selected women who met a PTSD diagnosis which would more clearly support the usage of their treatment approaches when treating PTSD symptomology. However, this too may have influenced the results of these studies as participants with a diagnosis of PTSD may experience more functional impairment and PTSD symptomology which can lead to greater room for improvement on data collection instruments (Andersson et al., 2021).
- Furthermore, it is essential to discuss the recruitment methodology of some of the studies which recruited from specific settings such as refugee camps (Greene et al., 2019), private clinics (Schwarz et al., 2021), and previous studies on PTSD (Galvotski et al., 2021). This may create a bias within the study results as only certain women may have the resources available to access services from private mental health clinics, and recruitment from singular sources may limit generalizability to other female IPV victims (Creswell & Creswell, 2018). There were also challenges experienced by some researchers regarding dropout rates for participants, especially for group interventions,

where participants could not attend either due to transportation or financial limitations (Harris et al., 2018). This may have influenced the findings of the article, with IPV victims not being included within the study if they were experiencing these difficulties.

Summary

In summary, there were a number of methodological strengths and limitations within the selected articles (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021). The selected studies undertook steps to standardize their samples with similar inclusion and exclusion criteria, which aided in comparing studies to investigate interventions for female IPV victims. Two of the studies (Schwarz et al., 2021; Greene et al., 2019) also undertook a mixed methods approach which aided in providing additional insights into the participant's experience of IPV and psychological treatment procedures. The studies followed statistically valid data collection and data analysis procedures using validated tools which aided in providing scientific rigor to their findings. Despite having many strengths, several limitations bear mentioning regarding the methodology of the selected studies. Namely due to the small sample sizes of a number of the studies (Harris et al., 2018; Galvotski et al., 2021; Cort et al., 2014; Harris et al., 2018; Andersson et al., 2018; Crespo et al., 2021) there is a lack of generalizability for some treatment interventions, and further research needs to be undertaken to assess treatment efficacy. This is especially the case of IPT and EMDR interventions for IPV victims who have fewer studies and smaller sample sizes thus far within the scientific literature. The recruitment of research participants from singular sources such as private clinics and specific zones of refugee camps, alongside other forms of convenience sampling also limit generalizability, requiring follow-up studies to confirm research findings.

Ethical Considerations

Ethics is an integral part of research practice and is a very relevant issue when considering therapeutic interventions for female victims of IPV. This section will highlight the importance of research and clinical ethics related to therapeutic interventions, discuss the Tri-Council Policy Statement and the CPA/CAP resources for professional ethics. The Tri-Council Policy Statement is a set of rules for conducting ethical research that takes into account the three guiding ideals of justice, respect for human decency, and safeguarding the well-being of study subjects (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2018). The Tri-Council's rules for research are adhered to by ethics boards at Canadian universities, and proposals must be approved in accordance with their policy statement (Truscott & Crook, 2004). The Canadian Association of Research Ethics Board (CAREB) analyzes issues related to research ethics, including potential risks and benefits to participants, confidentiality measures, and informed consent processes which all vary from country to country (GOC, 2022). Researchers are also bound by their professional code of ethics, which for psychologists in Alberta is the Canadian Code of Ethics for Psychologists (CPA, 2017) and the College of Alberta Psychologists Standards of Practice (CAP, 2019). This code guides research and clinical practice to engage in ethical practice with participants and clients. This is a particularly relevant issue when investigating psychological interventions for female IPV victims as researchers have to consider ethical issues from both a research and clinical perspective as their participants are receiving services as clients while also participating in a research study. All ten of the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al.,

2021; Schwarz et al., 2021) were approved by their relevant ethical boards however it was never directly stated what standards needed to be met in order to receive approval. Several ethical considerations of the selected studies will now be discussed, such as informed consent and confidentiality, debriefing, protection of the participants, compensation, deception, and withdrawal.

Informed Consent and Confidentiality

When engaging with victims of IPV in a therapeutic context, it is essential to consider informed consent and the best practices for clients. The Canadian Code of Ethics for Psychologists (CPA, 2017) describes Principle I: Respect for the Dignity of Persons and Peoples, which focuses on the importance of adequate informed consent procedures. Informed consent within research involves informing clients of the limits of confidentiality, what the process of the research entails, how the data collected will be utilized, and how participants' information will be protected (CPA, 2017). Informed Consent also involves explaining to participants the potential benefits and risks of engaging in the research procedures, which is particularly relevant in the case of female IPV victims. Furthermore, the Tri-Council Policy in regard to informed consent and confidentiality states under the principle of Respect for Persons that researchers should respect the intrinsic value of participants as human beings and to engage in practices that protect and respect their autonomy as individuals (Canadian Institutes of Health Research et al., 2022). Engaging in psychological treatment for mental health concerns following IPV can be a difficult process, with participants discussing potentially triggering experiences of trauma which can exacerbate symptoms of anxiety, depression, and PTSD (Karakurt et al., 2022). All of the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) stated they followed informed consent procedures with clients

and highlighted the importance of participant's having full knowledge of potential benefits and risks to engaging in therapy. An interesting element of informed consent was found in Meffert et al. (2021), where researchers obtained thumbprint or verbal consent from their participants due to a lack of literacy among some participants. This modification enabled researchers to engage with a population that may not otherwise have been able to give informed consent through written methods. Confidentiality is also discussed within the CPA Code of Ethics in Principle II Responsible Caring which involves informing clients of how their privacy will be protected during publication and what procedures are being undertaken to protect the client's identity (CPA, 2017). This is a particularly relevant consideration in the case of female IPV victims, as inadequate protection of participants' identities during research publication could result in previous partners retaliating towards victims for engaging in treatment. Several studies took additional steps to protect client anonymity, such as through the use of numbers rather than names for participants (Schwarz et al., 2019; Harris et al., 2018) and publicly stating the intervention program as "a mental health talk" (Meffert et al., 2021). These processes added additional protections to the participant's identity and minimized the potential risks for retaliation or public shaming for engaging in treatment. However, Harris et al. (2018) was also the only selected study that discussed data storage security procedures such as through a locked file cabinet and using encrypted password-protected files when undertaking analysis. Although the selected studies may have undertaken many of these ethical steps to protect their client's privacy and confidentiality, it is important to explicitly state these elements when conducting research.

Debriefing

Several considerations bear discussion regarding debriefing procedures for the selected studies. In order to minimize harm and maximize the benefits of treatment Principle II

Responsible Caring refers to informing participants of how they have contributed to expanding knowledge through their research participation (CPA, 2017). The majority of studies (Andersson et al., 2021; Cort et al., 2014; Galvotski et al., 2022; Crespo et al., 2021; Latif et al., 2021; Schwarz et al., 2021; Greene et al., 2019; Meffert et al., 2021) explicitly stated they engaged in debriefing and follow up procedures with participants, with two of the studies (Schwarz et al., 2021; Greene et al., 2019) using qualitative interviews to end their interventions. For instance, the study by Latif et al. (2021) engaged in debriefing with participants and obtained informal feedback regarding intervention efficacy and input regarding participant's perspectives of treatment. The lack of mentioning debriefing in two of the selected studies (Latif & Khanam, 2017; Harris et al., 2018) is concerning in terms of ensuring participants benefited from treatment and minimizing potential harm. This may have been an oversight in regard to explicitly stating this within the article however debriefing is an important aspect of the ethical practice of research and should be integrated when researching psychological interventions. In regard to the Tri-Council policy, researchers should engage in adequate debriefing procedures with participants, especially if alterations to consent are undertaken, where the participants may not be informed of all details of the study in an effort to be transparent (Canadian Institutes of Health Research et al., 2022). The researchers in the selected studies did take steps to follow these guidelines; however, further elaboration of debriefing procedures would have been beneficial for many of the studies in regard to maximizing benefits and minimizing harms for participants.

Protection of Participants

As discussed earlier, protecting participants when engaging in research is of the highest priority. Principle II Responsible Caring is particularly relevant in highlighting the importance of protecting vulnerable populations such as female IPV victims (CPA, 2017). Furthermore, within the Tri-Council Policy, the principle Respect for Persons states that researchers should ensure

they are protecting their participants interests and wellbeing when engaging in research (Canadian Institutes of Health Research et al., 2022). These are important considerations when conducting research with IPV victims as engaging in treatment may cause a re-experiencing of trauma which may result in exacerbating mental health symptoms such as anxiety, depression, and PTSD symptomology (Karakurt et al., 2022). Many of the selected studies (Schwarz et al., 2021; Crespo et al., 2021; Harris et al., 2018; Latif & Khanam, 2017; Latif et al., 2021) did not explicitly discuss the potential risk of psychological interventions for participants which is concerning regarding the wellbeing of their participants during and post-treatment. Researchers may have included this discussion within their informed consent process however explicitly acknowledging the potential risks and benefits of engaging in therapy with the vulnerable population being studied would have been beneficial.

Another ethical concern was brought up by Galvotski et al. (2021), who engaged in massed CPT treatment for PTSD. This study tested an accelerated form of CPT on participants, which was applied within a shorter timeframe than typical therapy. This has its potential ethical issues in that participants may be exposed more intensely to memories and cognitions related to PTSD, which could risk re-traumatization if not properly managed by the researcher’s treatment design. Furthermore, due to the shortened duration of treatment, there is an ethical concern about whether the therapeutic alliance can be established adequately. Thankfully, the researchers addressed these concerns and also assessed the participants' experience of treatment and the therapeutic alliance, which was highly satisfactory (Galvotski et al., 2021). It is important to note that more studies need to be undertaken to assess the efficacy of massed CPT for PTSD and further studies should continue to be aware of these possible ethical issues when treating clients in more intensive and shortened timeframes.

Whether there is current IPV victimization is an ongoing dilemma faced by treatment providers for victims of IPV. Frequently when working with IPV victims experiencing abuse, there may be interruptions to treatment and additional safety concerns for clinicians to consider (Greene et al., 2019). The researchers that did include participants with ongoing IPV (Greene et al., 2019; Meffert et al., 2021; Latif & Khanam, 2017) engaged in additional safety planning with their participants and took additional steps to protect their identity, such as through the use of numbers instead of participant names. Whether to engage in therapy with women experiencing current IPV is an ethically difficult decision to make, and counsellors should engage in proper ethical decision practices to ensure the client's best interests are being served while delivering psychological treatments.

It is also important to discuss the importance of researchers in acknowledging potential power differentials between participants and researchers and how this may potentially impact research findings (CPA, 2017). Researchers often have the power of higher social status and educational backgrounds, which may create a power imbalance, especially when working with disadvantaged populations such as IPV victims (Creswell & Creswell, 2018). Clinicians, especially when taking the expert role within therapy, should engage in power-sharing behaviors to avoid power differentials which may include giving participants choices of where, how, and when to engage in therapy (Asnaani & Hofmann, 2012).

One study by Greene et al. (2019) engaged in these behaviors by recruiting practitioners from the local area who spoke the language and shared a similar culture to better serve the clinical population and reduce power differentials between practitioner and participant. However, it is important to note that this recruitment choice of practitioners may pose a risk of dual roles or a conflict of interest if these practitioners hold multiple roles within the local community. Principle III: Integrity in Relationships states that psychologists should refrain from engaging in

dual roles when working with clients and should avoid conflicts of interest when possible (CPA, 2017). However, dual roles are not always ethically unacceptable as there may be circumstances, such as in small communities with limited resources, where clinicians may hold multiple relationships with their clients (CAP, 2019). In these situations, acknowledgment of the potential ethical dilemmas that may arise due to dual roles is paramount, and proper ethical decision making practices should be utilized to provide the most ethical practice to clients and research participants.

Compensation

Compensation is an often discussed topic in regard to research, with some arguing that the use of compensation may be coercive, especially for those who are financially struggling (Fontes, 2004). However, compensating participants for their time and energy is also an ethical obligation for researchers as they provide meaningful data to improve treatment interventions (Creswell & Creswell, 2018). Only two of the selected studies (Cort et al., 2014; Galvotski et al., 2022) offered direct monetary compensation to their participants, with amounts ranging from $20-$75 given for each time point within the study. Two studies (Meffert et al., 2021; Galvotski et al., 2022) also provided compensation for transportation for participants, as this is often a barrier to engaging in therapy and research for victims of IPV. It is important to note that when discussing compensation for treatment interventions, participants almost exclusively receive therapy services for free or a heavily discounted cost. This does have its advantages regarding rewarding participants for their valuable time and effort in engaging with the study; however, this may also provide an incentive for participants to report higher impacts for treatment as a form of “quid pro quo” for receiving services (Grady, 2005). This is an important ethical consideration in regard to Principle II Responsible Caring where researchers should maximize benefits and minimize potential harm for participants (CPA, 2017). Furthermore, in relation to

the Tri-Council Policy, researchers should give compensation to participants when appropriate, however there should be particular care in regard to potential conflicts of interest (Canadian Institutes of Health Research et al., 2022). Researchers should weigh the positives and negatives of providing compensation to participants and engage in transparency regarding potential ethical issues arising from their decision-making process.

Deception

Deception is an important aspect of research that bears discussion concerning ethical practice. Within the Code of Ethics Principle III Integrity in Relationships highlights the importance of avoiding deception whenever possible within research and when incomplete disclosure may be appropriate within studies (CPA, 2017). The Tri-Council Policy states that deception may sometimes be necessary within research, such as withholding information from the participant or deceiving them regarding the nature of the experiment (Canadian Institutes of Health Research et al., 2022). However, additional steps should be undertaken such as debriefing to inform clients of the deception as soon as possible (Canadian Institutes of Health Research et al., 2022). Within the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) none of the researchers engaged in deception which is appropriate considering the vulnerable nature of the population of female IPV victims and the potential impacts on therapeutic efficacy.

Withdrawal

Withdrawal is an important element within ethical research practice, as participants should be educated during the informed consent process that they may withdraw at any time from therapy (CAP, 2019). None of the selected studies (Andersson et al., 2021; Cort et al., 2014; Crespo et al., 2021; Galovski et al., 2022; Greene et al., 2019; Harris et al., 2018; Latif et

al., 2021; Latif & Khanam, 2017; Meffert et al., 2021; Schwarz et al., 2021) explicitly stated they informed clients of the opportunity to withdraw from therapy at any time; however they did all engage in informed consent practice, which when done competently would include discussing the client's right to refuse services or withdraw from therapy at any time (CPA, 2017). The Tri-Council Policy has a similar emphasis upon participants being informed of the potential risks and benefits to engaging in research and have the opportunity to withdraw throughout the research process (Canadian Institutes of Health Research et al., 2022).

Overall, the selected studies showed concern with following the ethical guidelines set by the CPA (2017) and CAP (2019). These studies considered informed consent and took steps to protect participants and their confidentiality during and after the research. However, there were some ethical concerns in regard to potential issues of dual roles, potential drawbacks to providing compensation for participants, and adequately informing clients of the potential risks of engaging in therapy, especially when processing trauma.

In conclusion, this literature review thoroughly investigates the current literature on psychological interventions for female IPV victims, assesses findings, and critiques the methodology and ethics of the selected studies. The treatment approaches of Cognitive Behavioral Approaches (CBT, CPT, TF-CBT), IPT, and EMDR demonstrated efficacy in treating several mental health concerns for female IPV victims. The follow sections will explore potential applications to clinical practice, recommendations and conclusions related to the findings of this literature review.

Chapter Four: Application to Clinical Practice

When engaging within the literature review process it is important to consider the potential reflexivity of the research practitioner alongside potential clinical/therapeutic applications for research. This aids in better grounding research as a tool that has additional practical application to real-world circumstances and situations. Furthermore, it is beneficial to explore how research can aid in enhancing scientific knowledge, benefit society, and consider diversity and culture. The following section will explore the reflexivity of the research practitioner, the clinical and therapeutic implications for the findings and the importance of being aware of the researcher's own biases, culture, and worldview when engaging in research.

Reflexivity of the Research-Practitioner

In regard to reflexivity when engaging in research, it is important to consider how the researcher's own personal values and biases may influence interpretations of data and what potential steps can be taken to minimize these influences (Creswell & Creswell, 2018). For instance, it is often beneficial to investigate themes such as socioeconomic status, the researcher's own personal history, culture and gender when engaging in research. In regard to the selected topic of investigating psychological interventions for female IPV victims it is very relevant to consider my current therapeutic practice at the YWCA, as I work with this population in my own clinical work, which may lead to particular biases when investigating the literature on psychological interventions.

When discussing the different implications and recommendations below, it is important to consider my own biases when engaging in providing psychological services to clients. I have the tendency to prefer more cognitive and person-centered approaches when working with clients and am still in the early process of learning about other more systemic approaches, such as IPT. However, over the course of the research process, I have had an opportunity to immerse myself

within the psychological literature, learning more about the different processes of change within each of the theories, and come to a better understanding of how these therapies can benefit IPV victims. This has benefited me in expanding my own knowledge regarding psychological interventions and to have additional perspectives regarding client change processes. Furthermore, this increased insight into the different change processes has widened my own understanding of the theories, allowed a greater diversity of perspectives when investigating evidence-based interventions for IPV victims.

It is important to note the author's own biases and tendency towards ACT and other cognitive-focused therapies, alongside their experiences with this particular population, may impact how the research process was undertaken and how findings were interpreted. In order to engage within this research project from as unbiased and objective a perspective as possible, the author specifically sought out additional therapeutic approaches that were not CBT based. This enabled the author to explore additional perspectives and change processes that they were unfamiliar with, such as IPT and EMDR, instead of simply allowing their own bias and comfort towards cognitive approaches to impact their research findings. Furthermore, the author followed a systematic process in order to select articles, having specific criteria and seeking out information via multiple databases to widen the literature review findings. In regard to how successful these steps were in viewing the research in an objective manner, there were generally positive but with some mixed results. The majority of the literature on the topic of psychological interventions for IPV are cognitive-based, and it was more difficult to find the same number of studies on less cognitive-based interventions such as IPT and EMDR. However, by undertaking additional research and honing the criteria for article selection there was success in exploring these alternative perspectives and change processes, which does help to bring awareness to other ways of intervening with IPV victims.

Clinical/Therapeutic Applications

There are a number of different clinical applications for the findings of the research, especially in regard to the psychological treatment of female IPV victims. This research topic is directly applicable to clinicians, who can use different evidence-based practices to aid IPV victims. For instance, the research supports the efficacy of cognitive behavioral approaches, especially in the usage of cognitive restructuring and exposure for reducing psychopathology for victims of IPV (Andersson et al., 2021; Galvotski et al., 2022; Greene et al., 2019; Latif et al., 2021; Latif & Khanam, 2017). Clinicians can integrate different cognitive behavioral approaches such as CBT, CPT, and TF-CBT into their clinical work, enhancing their treatment efficacy and outcomes when working with female victims of IPV.

Furthermore, in regard to clinical practice, it is relevant to highlight the importance of social connection and community support when working with IPV victims. IPT studies found that there were improvements in not just depressive symptomology but also PTSD symptoms that were not targeted directly within treatment (Cort et al., 2014; Meffert et al., 2021). Even if practitioners are not specifically working from an IPT lens, integrating community supports, improving relationships with trusted others, and enhancing interpersonal problem-solving skills can be very beneficial for IPV victims. This may likely aid in connecting clients to other forms of social support, giving them more opportunities to express their feelings which likely influences therapeutic change over time.

Furthermore, EMDR shows a great deal of promise in regard to clinical practice, often being lower cost and more time efficient in showing reductions in PTSD symptomology (Mavranezouli et al., 2020). EMDR may also be particularly useful when working with clients who hold idealizations of their previous relationships, which can aid in the processing of trauma within therapy (Mosquera & Knipe, 2017). Clinicians can also engage in additional EMDR

training to better work with IPV victims who are experiencing a high level of PTSD symptomology, or those clients who would prefer an alternative to cognitive behavioral approaches.

Scientific Knowledge

When engaging in the literature review process it is important to consider how the findings may contribute to the scientific knowledge on the topic selected. This research process provides a thorough overview of many evidence-based psychological interventions for female IPV victims and highlights many of the psychological changes victims experience through therapy. The knowledge collected offers further empirical confirmation that psychological interventions are effective with this particular population, with reductions in many different symptoms over time. This literature review also identifies a number of different areas in which further research is needed such as additional confirmation of research findings through follow-up studies and to investigate additional areas such as potential gender differences in IPV interventions.

Well-Being of Society

In regard to the well-being of society, there are a number of gaps of understanding when engaging in psychological interventions with IPV victims. There are still a number of systemic barriers identified within the literature such as financial considerations, transportation, and time commitments for IPV victims to engage in therapy (Harris et al., 2018). This population often faces systemic barriers to treatment, with there often being cultural beliefs and attitudes regarding shame and guilt for having experienced IPV, which may disrupt the accessing or continuation of psychological services (Overstreet & Quinn, 2016). This highlights the importance of increasing the knowledge of clinicians providing psychological services to IPV victims, potentially aiding in reducing systemic barriers that may interfere with treatment

outcomes. Additionally, by becoming more aware of different psychological interventions, clinicians can be more effective in their clinical work, leading to the betterment of societal well-being by reducing psychological suffering for IPV victims. Counsellors can also play a role within society to advocate for awareness of IPV for the general public and to engage with policymakers in creating new programs for intervention for IPV victims both after but also in the prevention of IPV before it begins. Although the counsellor cannot disclose specific details or stories in order to keep the confidentiality of their client, counsellors can share approximations or sufficiently altered stories in order to better educate others within the community. Additionally, counsellors can help to support early intervention programs within high schools regarding abusive relationships or to educate police and other emergency services who may interact with IPV survivors regularly.

Cultural/Diversity Implications

Diversity is a very relevant aspect of therapeutic practice to consider when discussing the findings of the literature review. Different cultural and diverse backgrounds influence therapeutic interventions and how clinicians relate to their clients. There were a number of acknowledgments of this fact throughout the selected articles, where the researchers discussed potential alterations of the psychological intervention to better fit the client's own specific cultural background. For example, two studies (Greene et al., 2019; Latif & Khanam, 2017) adjusted both data collection procedures and therapeutic processes to be more culturally attuned in order to better meet the needs of their clients. This is particularly relevant for clinicians who by being more aware of cultural diversity, can better select interventions depending on the unique needs of the client in the moment. Furthermore, framing psychological interventions in culturally attuned ways likely would improve the therapeutic relationship and enhance outcomes for clients, who may be more likely to understand or incorporate therapeutic insights if they are culturally relevant. There may

also be diversity implications regarding particular cultural groups with individual clients experiencing different barriers to access services and different needs within therapy. For example, within certain Asian cultures, there may be cultural narratives regarding the more traditional role of the wife, with accessing therapy and other resources for IPV being looked down upon or even shameful. This may create additional issues and barriers for Asian women seeking help from organizations and governmental programs when experiencing IPV, who may not engage with more traditional program delivery formats. In contrast, Caucasian women may experience less stigma and shame when seeking out help during and following IPV which may increase their accessing of IPV resources. Counsellors by being sensitive to these cultural differences and narratives can engage in actions to create a more welcoming and inclusive space by empathizing with the client's struggles and being aware of these sensitive areas. IPV programs when delivering psychological services can also tailor their delivery formats for diverse populations, such as through additional confidentiality methods to protect client identities.

Chapter Five: Recommendation and Conclusions

There are several relevant conclusions and recommendations that can be derived from this literature review and methodological critiquing. This will be explored within this section by first looking at the conclusions derived from the literature analysis and methodological analysis. Lastly, recommendations at the clinical level will also be explored alongside future research that can be undertaken to expand knowledge on the topic of IPV.

Recommendations

Clinical/Therapeutic Level

There are a number of clinical recommendations that can be derived from the research findings 1) awareness of self-blame and guilt cognitions and beliefs 2) The importance of interpersonal relationships and community 3) The importance of exposure in psychological treatment.

1. When working with female victims of IPV it is important to consider the impact of self-blame, guilt cognitions, and core beliefs that may be influencing their current psychological suffering. Cognitive behavioral approaches focus on the cognitive restructuring of these cognitions and beliefs, which has demonstrated clinical efficacy when working with victims of IPV. Clinicians would benefit from considering how to dispute or manage these common cognitions and beliefs, either through cognitive behavioral techniques or other evidence-based practices.
2. Clinicians would also benefit from integrating more systems-oriented thinking when working in therapy with victims of IPV. This is illustrated in the efficacy of IPT in reducing a variety of symptomology by connecting victims with their community and safe family members to disrupt patterns of isolation and depression. Counsellors can integrate these themes into their own clinical work, encouraging their clients to engage in positive social connections with others and to build their support system.

3. Lastly, clinicians would benefit from being well-versed in evidence-based practices for PTSD when working with victims of IPV. The findings illustrate the efficacy of exposure in the treatment of PTSD, which is demonstrated in different cognitive behavioral approaches, and likely within EMDR based upon the theorized change process of systematic desensitization. Clinicians, when working with IPV victims, must consider the impact of trauma on their current psychological suffering and have tools to help clients work through PTSD symptoms if relevant.

Future Research

There are a number of different areas of future research that can be identified based on the research findings. These recommendations suggest further directions and areas for future research to investigate. By undertaking these additional considerations, research can further enhance psychological intervention efficacy for IPV victims and guide practitioners in applying evidence-based practices to their therapeutic work.

1. Further research on psychological interventions is needed to confirm the findings of the selected studies. This is needed due to the small sample sizes and lack of control groups which limit the generalizability and validity of the findings. More studies are needed to confirm if different forms of psychological treatment are effective for IPV victims, especially for IPT and EMDR, which lack many studies at this time.
2. Are there additional cultural considerations regarding women's experience of IPV, and how can treatment interventions be modified to aid clients more effectively from different cultural contexts?
3. Further research is needed into the gender-based differences for IPV victims and the additional barriers that may be faced due to cultural norms and beliefs. Men and

LGBTQ+ individuals may face additional barriers to treatment such as cultural stigma or shame, which may influence treatment interventions by counsellors.

4. Further research should focus on exploring individual versus group therapy differences in treatment efficacy for female IPV victims and whether there are benefits in one treatment approach over the other.
5. Future research may benefit in investigating potential differences between urban, rural, and suburban experiences of female IPV victims. This may aid in exploring potential cultural and locational differences that may help inform psychological interventions.
6. Future research can also investigate potential age differences between IPV victims and how generational views may influence victim's perceptions and reactions to IPV.

By exploring many of the above recommendations, researchers can better enhance the ability of clinicians to engage and understand the unique needs of IPV victims, leading to increased outcomes for psychological services.

In conclusion, this literature review process has highlighted the importance of engaging in evidence-based interventions when working with female victims of IPV and illustrated many change processes that occur within each of the selected approaches. However, there were a number of different limitations identified, such as low sample sizes and lack of control groups for many studies, and some treatment interventions, such as IPT and EMDR having small research bases at this time. This led to a number of different recommendations for future research, such as undertaking more studies with higher sample sizes and control groups to confirm the findings within the selected articles. Despite all the current knowledge on the effectiveness of psychological interventions for female IPV victims, further exploration is needed as IPV continues to be a growing concern within modern society.

Conclusions

This literature review highlights the importance of engaging in evidence-based practices for female IPV victims and identifies many of the cognitive, behavioral, and emotional changes that victims undergo within treatment. The treatment interventions of CBT, CPT, TF-CBT, IPT, and EMDR use different change processes when working with clients and demonstrate efficacy in improving psychological symptomology. This literature review has highlighted the importance of therapeutic diversity when working with clients and how there are many different routes to eliciting therapeutic change when working as a clinician. Clinicians should be adequately trained in evidence-based practices in order to deliver more effective psychological services to IPV victims, who often experience struggles following abuse.

From Literature Analysis

There are a number of different conclusions that can be derived from the findings.

1. Cognitive Behavioral approaches (CBT, CPT, and TF-CBT) demonstrated a number of cognitive, behavioral, and emotional changes for female IPV victims. These cognitive-behavioral approaches' use of cognitive restructuring and exposure provided an effective method of treatment for IPV victims who were able to dispute maladaptive cognitions and beliefs and to regulate their emotions more effectively. There was strong support for their efficacy in reducing psychopathology with reductions in a number of disorders such as anxiety, depression, and PTSD.

2. IPT interventions also elicited a number of cognitive, behavioral, and emotional changes for female IPV victims. IPT’s focus on improving interpersonal relationships and teaching awareness of patterns of interpersonal dysfunction disrupted cycles of isolation/depression that victims of IPV often experience. IPT demonstrated sizable impacts on victims’ depressive symptoms and showed significant reductions in PTSD symptomology.

3. EMDR interventions also demonstrated cognitive, behavioral, and emotional changes for female victims of IPV. EMDR aided clients to process their traumatic memories and experiences and demonstrated efficacy in targeting idealizations of past abusive relationships more effectively.

Methodological Analysis

There are several different conclusions that can be derived from a methodological standpoint.

1. The majority of the studies used methodologies that sought to understand the efficacy of psychological treatments for victims of IPV. Many studies, however, had small sample sizes and lacked control groups, which may limit their generalizability, with further research needed to replicate their findings and make stronger conclusions regarding intervention efficacy.
2. A number of studies engaged in mixed methods approaches, integrating semi-structured interviews into their research process to aid in understanding client outcomes. This was effective in more fully supporting their findings by having clients identify themes and which interventions they found most useful within treatment.
3. A number of the selected articles used convenience sampling for their recruitment procedures. This may be a concern due to a potential lack of generalizability of their findings, as only collecting information from one source (private clinics or specific zones of a refugee camp) may influence research findings.
4. In regard to the data collection and data analysis procedures, the selected studies used a variety of validated tools and methods to investigate their reseach questions. Data collection methods were modified in a number of studies to be more culturally relevant, and researchers used highly validated tools which have been used for a diverse set of participants.

5. In regard to ethical conclusions reached from the methodological analysis the selected studies in general did an adequate job following the professional guidelines regarding research ethics. However, there were some ethical concerns regarding whether researchers in all of the studies adequately engaged in additional measures to protect clients when processing trauma, considered potential dual roles and whether compensation was appropriate.

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