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# Factors that Impact Level of Suicide Risk among College Students

Jocelyn Novella & Jessica Samuolis

There is a critical need to examine factors related to suicide risk level among college students who experience suicidal ideation, particularly as mental health providers use risk level to determine treatment. The current study used a large national undergraduate dataset to examine factors distinguishing risk level among students who reported suicidal ideation. The results showed that newer factors, such as financial stress, sleep difficulty, marijuana use, flourishing/languishing, and prescription medication use, should be considered when assessing college student suicidality.

*Keywords:* suicide risk level, college counseling, suicidal ideation, college mental health

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Suicidal ideation is common among college students (ACHA, 2020; Eisenberg et al., 2018), and suicide is the second leading cause of death among 15- to 24-year-olds (Centers for Disease Control, 2020). The Healthy Minds Study (2020), a large national study, reported that 13% of college students in the U.S. indicated suicidal ideation in the past year, 6% had made a suicide plan, and 1% attempted suicide in the past year. Data from college counseling centers also show the severity of this public health issue. For example, the Association for University and College Center Directors (AUCCCD) reported a strain on service capabilities due to the recent increase in suicidal crisis calls, resulting in 48% of college counseling centers needing to triage clients for severity of issues (AUCCCD, 2020). The COVID-19 pandemic has exacerbated both the rate and extent of mental health symptoms among college students (Center for Collegiate Mental Health, 2020), and university budget cuts due to the pandemic have strained the college mental health system even further (St. Amour, 2020). Understanding factors that are associated with level of suicide risk among college students is more critical now than ever and can inform prevention and treatment efforts.

Existing research has identified sociodemographic and psychological factors associated with suicidality among college students. Sociodemographic factors include sexual orientation (homosexual, bisexual, not sure) (Hill & Pettit, 2012; Shadick et al., 2015), ethnic minority status (Shadick et al., 2015), and financial stress (Assari, 2018). Research also has established that mental health issues among college students, such as depression (Pigeon et al., 2012), anxiety (Duffy et al., 2019), and non-suicidal self-injury (Liu et al., 2018) are associated with increased risk of suicidality. Further, some research has shown that college students who engage in substance use, such as binge drinking and drug use, are more likely to report suicidality (Assari, 2018; Oh et al., 2021; Wilcox et al., 2010).

While the extant literature has examined factors associated with suicidality among college students, more research is needed. Emerging studies on college student mental health have resulted in new findings on factors impacting mental health, such as sleep (Bozzay et al., 2016), prescription drug use (Brower et al., 2010), and flourishing/languishing (Duffy et al., 2019). In terms of suicidality, researchers found initial evidence for the association between insomnia (Gunnell et al., 2013), hypnotic/sedative prescription use (Pae et al., 2011), and low flourishing scores (Duffy et al., 2019) with suicide death. However, more research is needed to better understand the role these factors play in suicide risk among college students.

## Importance of Risk Level

It is particularly important to understand suicide risk among those students that report suicidal ideation. Research on suicide often involves the examination of risk level (ideation, plan, and attempt) combined as one construct, "suicidality," or the examination of each risk

students that report suicidal ideation, and thus less is known about both well-established and less-established factors associated with suicide risk level among these students. The use of the national dataset from the 2017—2018 Healthy Minds Study enabled a focus on a large sample of students reporting suicidal ideation and yielded a large number of students reporting past suicide attempt(s), a group that is most at risk for suicide death. Additionally, the dataset also enabled an examination of some factors that have emerged as important in college health research but have not been examined fully in regard to suicide risk. The purpose of the current study is to examine a range of sociodemographic, mental health, and substance use factors in terms of their association with suicidal ideation, having made a suicide plan, and past suicide attempts among students who reported suicidal ideation. The following is the research question: are there characteristics/factors that are associated with higher risk levels (having a suicide plan or making a suicide attempt) among those students with suicidal ideation? This will inform college counselors in considering possible new characteristics/factors when determining suicide risk level.

# Method

## Participants

The Healthy Minds Study (HMS) is a web-based survey administered annually to college and university students over the age of 18 across the United States. The current study examines data from the 2017-2018 academic year which included a total sample of 68,427 students surveyed from 60 campuses (23% response rate). Depending on school size, campuses either surveyed their entire student body or surveyed a random selection of 4,000 students. Campuses were required to obtain IRB approval to participate. Students who were between the ages of 18 to 25, reported enrollment in an undergraduate program, responded yes to having thoughts of suicide in the past year, and completed two additional suicide-related items (regarding plan and attempt) were included in the current study. The final sample of 4,793 students was comprised of a majority female (74.2%), white (71.3%) students with an average age of 20.07 (SD=1.583) and included 1st year (27.4%), 2nd year (25.5%), 3rd year (24.3%), 4th year (17.1%), and 5th year or more/other (5.6%) students. The majority of students were full-time (94.7%) and lived in campus/university housing (52.3%). The final sample included relatively high percentages of students who identified as transgender (10.6%) and non-heterosexual (44.5%).

## Measures

The Healthy Minds Study (HMS) combines a variety of well-established measures with general questions regarding characteristics of participants.

### *Sociodemographic Characteristics*

Demographic items from the HMS were used to categorize students based on the sociodemographic characteristics of interest in the current study. Gender identity was categorized as female or male and as transgender or not transgender. Sexual orientation was categorized as heterosexual or non-heterosexual (lesbian, gay, bisexual, questioning, self-identify). Race/ethnicity was also dichotomized as non-minority (white) and minority (African American/Black, American Indian or Alaska Native, Hispanic or Latino/a, Native Hawaiian or Pacific Islander, Middle Eastern/Arab/Arab American, or other). Stress regarding financial situation and the importance of religion also were dichotomized (Oh et al., 2021). Current financial stress was dichotomized by combining the ‘always stressful’ and ‘very stressful’ responses and combining sometimes, rarely, and never stressful responses. Similarly, the importance of religion was created by combining the ‘very important’ and ‘important’ responses and combining ‘neutral,’ ‘unimportant,’ and ‘very unimportant’ responses. Items were dichotomized to ensure adequate numbers in these categories, given that only those participants with levels of suicide risk were included.

### *Mental Health*

Well-established measures were used to assess current depression (Patient Health Questionnaire-9 (PHQ-9) (Kroenke, et al., 2001), and anxiety (Generalized Anxiety Disorder-7) (Spitzer et al., 2006) and composite scores were created by totaling the respective scale items. Lifetime diagnosis of a mental illness (depression, anxiety, attention disorder or learning disability, eating disorder, psychosis, personality disorder, and/or substance use disorder) was assessed with a select all that apply item that included a ‘none’ response choice which enabled a coding of yes

(one or more diagnoses) or no (no diagnoses). Similarly, non-suicidal self-injury was assessed with a 'select all that apply' option regarding a range of self-injurious acts (i.e., burned myself, bit myself, punched myself) and included a 'none' response choice. This enabled a coding of yes (one or more self-injurious acts) or no (no self-injurious acts). Sleep difficulty was assessed using one item from the PHQ-9 regarding trouble falling asleep, staying asleep, or sleeping too much over the past two weeks (Kroenke et al., 2001) and was used as a continuous score. The eight-item Flourishing Scale (Diener et al., 2010) was used to create a composite score on flourishing.

***Substance Use***

Items assessing binge drinking during the past two weeks, with drink amounts respective to male (5 or more drinks), female (4 or more), and not male or female (4 or 5 or more), were utilized to categorize students as yes or no on binge drinking. Responses to a select all that apply item assessing past 30 day use of a variety of illegal drugs (marijuana, cocaine, heroin, methamphetamines, other stimulants, ecstasy, and other drugs without a prescription) were used to categorize students as current marijuana users and as using one or more other drugs.

***Prescription Medication Use***

Use of prescribed sleep, anxiety, and/or depression medications in the past 12 months were assessed based on a 'select all that apply' item that asked about use several times a week. Students' responses were coded as yes or no for each of the three medications.

***Suicidality***

Three items assessing suicidal ideation, suicide plan, and suicide attempt in the past year were used to create the three groups of interest in the current study, in addition to the PHQ-9 question #9. Based on yes or no responses to all three items, students were categorized as suicidal ideation (no plan or attempt), suicide plan (no attempt), or past suicide attempt.

## Analytical Plan

Following the elimination of cases from the dataset that did not match the desired sample characteristics, students were categorized into one of the three groups (suicidal ideation only, suicide plan but no attempt, or past suicide attempt) as described above. Categorical variables were dichotomized as described earlier in the Measures section and descriptive statistics were examined for the continuous variables. Chi-square and Analysis of Variance (ANOVA) analyses were used where appropriate to examine status in one of the three suicide risk level groups and the selected sociodemographic, mental health, substance use, and prescription medication use variables. Post hoc analyses using the Bonferonni correction were examined following ANOVA analyses.

# Results

Demographic characteristics regarding age, year of enrollment, and housing are noted above. Descriptive statistics regarding race/ethnicity, gender, sexual orientation, financial status, and religiosity are listed in Table 1. Of note is the relatively high percentage of students reporting transgender status (10.6%) and the high percentage of students who reported a non-heterosexual sexual orientation (44.5%). Additionally, approximately half (51.3%) of the sample reported an often stressful or always stressful current financial situation. Religiosity did not differ across the three groups.

Descriptive statistics for the mental health, substance use, and prescription medication use variables of interest in the current study are detailed in Table 1. The high percentage of lifetime diagnosis of a mental illness (67.9%) and the high percentage of students who reported one or more acts of non-suicidal self-injury (66.9%) were notable. Additionally, substance use was common with 70% reporting binge drinking in the past two weeks and 38.8% reporting marijuana use in the past month. Over a third (35.9%) of students in the current sample reported use of prescription depression medication.

As described previously, the current sample was selected based on students' affirmative response to 'ever seriously thinking about attempting suicide in the past year.' Among the 4,793 students that replied yes to this item, 2,748 (57.3%) were categorized as suicidal ideation only, 1,584 (33%) were categorized as having a plan for suicide (but no attempt), and 461 (9.6%) were categorized as having attempted suicide based on the two follow-up questions to the initial item.

Table 1
*Sociodemographic, mental health, and substance use factors by level of suicide risk*

| | Total N (%) | Suicide Ideation (N=2,748) N (%) | Suicide Plan N=1,584 N (%) | Suicide Attempt N=461 N (%) | $\chi^2$ / F | *p* |
|---|---|---|---|---|---|---|
| Sociodemographic | | | | | | |
| Race/ethnicity (minority) | 1,374 (28.7) | 749 (27.3) | 469 (29.6) | 156 (33.8) | 9.314 | .009 |
| Gender identity male/female | 3,177 (74.2) | 1,820 (73.6) | 1,053 (74.5) | 304 (76.6) | 1.717 | .424 |
| Transgender | 507 (10.6) | 273 (9.9) | 170 (10.7) | 64 (13.9) | 6.538 | .038 |
| Sexual orientation (non-heterosexual ) | 2,126 (44.5) | 1,146 (41.8) | 745 (47.2) | 235 (51.3) | 21.236 | .000 |
| Financial stress (often/always stressful) | 2,460 (51.3) | 1364 (49.7) | 851 (53.7) | 245 (53.1) | 7.332 | .026 |
| Religiosity (important/very important) | 1,221 (25.5) | 699 (25.5) | 407 (25.7) | 115 (25.0) | .095 | .954 |
| Mental Health | | | | | | |
| Anxiety (score) | 11.67 (5.58) | 11.16 (5.42) | 12.15 (5.69) | 13.08 (5.73) | 31.709 | .000 |
| Depression (score) | 15.02 (6.38) | 14.24 (6.15) | 15.85 (6.46) | 16.84 (6.75) | 52.682 | .000 |
| Lifetime diagnosis mental illness | 2,805 (67.9) | 1,501 (63.8) | 971 (71.2) | 333 (80.4) | 54.371 | .000 |
| Non-suicidal self injury | 3,134 (66.9) | 1,625 (60.9) | 1,138 (73.0) | 371 (81.2) | 111.862 | .000 |
| Sleep difficulty (score) | 1.96 (1.03) | 1.88 (1.04) | 2.04 (1.01) | 2.17 (.98) | 22.015 | .000 |
| Flourishing (score) | 36.28 (9.40) | 37.42 (8.80) | 34.96 (9.76) | 34.06 (10.56) | 49.223 | .000 |
| Substance Use | | | | | | |
| Binge drinking | 2,079 (70.0) | 1,209 (68.9) | 661 (70.6) | 209 (74.6) | 4.005 | .135 |
| Marijuana use | 1,400 (38.8) | 826 (39.7) | 421 (35.7) | 153 (44.3) | 10.066 | .007 |
| Other drug use | 393 (10.9) | 227 (10.9) | 117 (9.9) | 49 (14.2) | 5.052 | .080 |
| Prescription Medication Use | | | | | | |
| Sleep medication | 391 (8.5) | 165 (6.2) | 149 (9.8) | 77 (17.5) | 66.939 | .000 |
| Anxiety medication | 767 (16.6) | 387 (14.6) | 270 (17.8) | 110 (25.0) | 31.528 | .000 |
| Depression medication | 1,654 (35.9) | 819 (30.9) | 591 (38.9) | 244 (55.5) | 107.892 | .000 |

### Sociodemographic

Among the sociodemographic characteristics examined, students who reported a past suicide attempt were more likely to be a racial/ethnic minority (p=.009), transgender (p=.038), and report a non-heterosexual orientation (p=.000) based on chi-square analyses. Chi-square analyses also indicated that students who reported making a suicide plan (no attempt) were more likely to rate their financial situation as often or always stressful (p=.026).

### Mental Health

As expected, students who reported a past suicide attempt had the highest average scores on measures of anxiety symptoms, depression symptoms, and sleep difficulty compared to students who reported suicidal ideation only and students who reported making a suicide plan (no attempt). ANOVA analyses yielded significant results on all these variables and post hoc analyses indicated that all three groups were significantly different from each other on anxiety and depression symptoms. Students who reported suicidal ideation only were significantly different on sleep difficulty from students who reported making a suicide plan (no attempt) and students who made a suicide attempt. However, students who made a suicide plan were not significantly different from students who made a suicide attempt on sleep difficulty. Based on chi-square analyses, students who reported a past suicide attempt were more likely to report one or more acts of non-suicidal self-injury in the past year (p=.000) and a lifetime diagnosis of mental illness (p=.00). The ANOVA analysis on flourishing showed that students who reported suicidal ideation only had the highest scores on flourishing compared to the other two groups. Post hoc analyses indicated that the significant ANOVA result was due to the difference between suicide ideation and suicide plan groups and the difference between the suicide ideation and suicide attempt groups.

### Substance Use

The likelihood of suicidal ideation, suicide plan, and past suicide attempt were not associated with having engaged in binge drinking in the past two weeks. Students who reported a past suicide attempt were more likely to report current marijuana use (p=.007). Students who reported suicidal ideation only were more likely to report current marijuana use than those students who reported having made a suicide plan but no suicide attempt. The same pattern of results was found for other drug use with the highest proportion among students who made a suicide attempt and the second highest proportion among students who reported suicidal ideation only.

### Prescription Medication Use

Students who reported having made a past suicide attempt were more likely to report use of prescription depression medication (p=.00), prescription anxiety medication (p=.00), and prescription sleep medication (p=.000).

## Discussion

This study involved the use of a national data set to examine factors associated with levels of suicide risk: suicidal ideation only, suicide plan, and past suicide attempt among college students who reported suicidal ideation. The findings of the current study are key to informing college mental health providers and health promotion professionals working to address the growing public health concern of suicide among college students. Using a large sample of students reporting suicidal ideation, findings showed that well-established variables (i.e. minority status, mental health issues, non-heterosexual orientation) were associated with level of risk for suicide in college students as might be expected from the existing research on these factors (Hill & Pettit, 2012; Shadick et al., 2015; Wilcox et al., 2010). Variables, such as flourishing, sleep difficulty, marijuana use, and prescription drug use, which have emerged as related to college students' mental health, were also associated with suicide risk and add to the literature on this topic.

The sample of college students with suicidal ideation was characterized by many students of non-heterosexual orientation, consistent with what others have found in terms of the heightened risk for mental health issues among these students (Liu et al., 2018). Non-heterosexual oriented students were more likely to report a past suicide attempt, the highest level of suicide risk. Transgender students also reported a higher level of suicide risk than their cisgender counterparts, consistent with previous studies (Dawson et al., 2017). Other sociodemographic features, such as minority status and financial stress, were associated with increased risk. Interestingly, financial stress was associated with

making a suicide plan but not with a past suicide attempt. While past research has linked financial stress to suicidal ideation (Oh et al., 2021), the current study, which utilizes a sample of students who reported suicidal ideation, found financial stress to be associated with the higher risk level of making a suicide plan.

As expected, students with past suicide attempts had the highest average scores in terms of mental health indicators, such as anxiety and depression (Table 1), and these findings are consistent with past research on suicidality (Duffy et al., 2019; Pigeon et al., 2012). In addition, non-suicidal self-injury was associated with increased suicide risk level, as others have found (Liu, 2018). Students' scores on flourishing were the highest among those students who reported suicidal ideation only, as might be expected. However, follow-up analyses indicated that students who reported a past suicide attempt were significantly different on flourishing from those students reporting suicidal ideation, while students who reported a plan were not significantly different from those students who reported a suicide attempt. These results suggest that this less-examined variable may be helpful in determining suicide risk. A growing body of research has begun to examine flourishing as an important factor across multiple domains of psychosocial functioning among college students (i.e., mental health, substance use, adjustment). For example, researchers have found a lack of flourishing among college students to be linked with mental health symptoms, such as anxiety and depression (Dore´ et al., 2020). Also, sleep difficulty increased as level of suicide risk increased, which may provide an important factor when assessing suicide risk.

The examination of substance use and the use of prescription medication in terms of suicide risk level helps to address current gaps and inconsistencies regarding these factors. Although some researchers have found an association with binge drinking and suicidality (Assari, 2018), others have found no association between alcohol use and suicidality (Gauthier et al., 2017). The current findings add to the literature suggesting that alcohol use is not a key factor in determining suicide risk. Interestingly, students who reported suicidal ideation only and those students who reported past suicide attempt(s) had a higher likelihood of marijuana use than those students who made a suicide plan, which complicates the understanding of the impact of this factor. Additional research on the level or frequency of use, as well as context of use, may provide clarity on this. In terms of prescription medication use, students with past suicide attempts were more likely to report use of all three medications examined (depression, anxiety, and sleep medications). The role of sleep medications, or hypnotics/sedatives has been examined in studies with adult populations (Gunnell et al., 2013); however, it has been understudied among college students. The current findings highlight the importance of additional research on prescription medication use and mental health among college students. College mental health providers and health promotion professionals can ensure these new factors are considered when focusing on suicide risk evaluation and suicide prevention.

## Limitations

Although the use of a national dataset and a large number of participants were strengths of the current study, there were limitations. These limitations include the inability to draw causal conclusions due to the use of cross-sectional data, and the fact that the dataset was over five years old. Therefore, the impact of the Covid-19 pandemic on college student mental health cannot be evaluated through this data. In addition, several of the factors examined were assessed with a single question. While combining factors into a single question is often necessary to reduce response burden, research with more comprehensive scales for these factors is needed. Substance use frequency and level of use were not assessed and thus not considered in the current study. Future research should explore the role of frequency and level of substance use on suicide risk level, with approaches involving daily tracking cards or severity rating scale logs likely to provide valuable insight. Certain under-represented groups, such as non-heterosexuals, were a large proportion of the sample used in the current study. Although research is needed on under-represented groups, the sample composition does impact the generalizability of the results. Finally, all mental health variables were self-reported and not established through clinical interviews.

## Conclusion

The findings of the current study suggest that there are additional suicide risk factors that need to be evaluated by treatment professionals as part of a thorough suicide assessment. The inclusion of the assessment of financial stress, sleep quality, flourishing, marijuana use, and prescription medication use are indicated. The findings also point to the need for college health promotion professionals to provide suicide prevention programming that is broad-based, promoting wellness (i.e. sleep, anxiety management) as well as life skills (i.e. financial management). Additionally, mental health and health promotion professionals should focus on addressing the rising rates of marijuana and prescription medication use as part of suicide prevention efforts. Further research exploring factors associated with various suicide risk levels among college students will provide valuable information to campus professionals working to address the public health issue of suicide among college students.

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# An Affirmative Approach to Counseling Fat Women: Recommendations for Counselors

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Fat women experience anti-fat bias in a variety of areas, and the discrimination of fat women contributes negatively to their mental health; however, fatness is seldomly discussed as an identity in counseling. Fatness as an intersectional identity will be examined in this article, including fat women's experiences of discrimination. Recommendations for affirmative counseling approaches will be provided that center around a fat liberationist framework. Specific individual interventions, such as building community, exposure, knowledge, safety, and fat embodiment, as well as systemic interventions such as advocacy and psychoeducation will also be addressed.

*Keywords*: anti-fat bias; intersectionality; fat women; affirmative approach; empowerment

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Size is a unique identity characteristic often overlooked in counseling literature and rarely taught in counselor education (McHugh, 2019), but fat people experience marginalization. When size (i.e., fatness) intersects with gender (i.e., female), marginalization increases (Smith, 2019). For fat women, the stigma and prejudice experienced is magnified because of Western society's obsession with thinness and what it means to be an attractive woman (Smith, 2019). Even the term fat is seen as pejorative, yet most fat activists reclaim the word fat as merely an adjective used to describe body type or size (Henry & Walters, 2020). The way society views fatness is what has transformed the word from simply a description to a derogatory expression, from a characteristic to a character trait (Smith, 2019).

It is imperative counselors recognize the unique experiences of women, including sexualization and stigmatization when it comes to their bodies. For fat women, these intensify because they do not fit the thin body ideals Western society deems attractive (Smith, 2019). When women are viewed as attractive, objectification decreases (Kellie et al., 2019). Additionally, fat women are often sexually fetishized and heterosexual men being attracted to fat women is taboo (Fabrizio, 2014). Heterosexual men only find it socially acceptable to be attracted to thin women (Fabrizio, 2014). Fat women also experience stigmatization and anti-fat bias, leading to decreased physical and mental health (Olson et al., 2019; Puhl et al., 2018). Anti-fat bias can be used interchangeably with weight bias or weight stigma and refers to the negative attitudes, beliefs, stereotypes, and discriminatory behaviors directed towards fat people (Olson et al., 2019). Internalized stigma has been correlated with heightened physical pain, depression, diminished self-esteem, and body dissatisfaction (Olson et al., 2019; Puhl et al., 2018).

The Council for the Accreditation of Counseling and Related Education Programs (CACREP, 2015) recommends counselor preparation programs address characteristics among diverse populations (F.2.a.) and strategies for identifying and eradicating systemic oppression (F.2.h). The majority of American women (about 67%) wear plus size clothing, and they would be considered fat by fashion industry standards (Rogers, 2023). If the majority of American women are considered fat and likely to experience individual and systemic oppression, fat women's lived experiences deserve increased attention in the counseling profession. When working with fat women, counselors can use an affirming, empowering approach, which includes individual and systemic interventions.

## Language and Terminology

Language is an important component of any cultural identity and using affirmative language is important when counseling fat women (Gordon, 2021). Terms, such as obese and overweight, are derived from BMI definitions. These terms lead to increased stigmatization of fat people despite the BMI being problematic (Gordon & Hobbes, 2021). The BMI classifies individuals as

underweight, normal, overweight, and obese based solely on one's height and weight (World Health Organization, 2021). The BMI fails to consider muscle mass, bone density, and health markers, such as blood pressure and cholesterol levels (Smith, 2018). Rather than using the terms obese and overweight, I will use the term "fat" throughout this article unless referring to professional literature explicitly using those terms. Fat activists have reclaimed the word fat as merely a description rather than a derogatory term (Smith, 2019). Although many fat activists use the word fat as a sense of empowerment, counselors will still want to check in with their clients surrounding what terminology they are most comfortable using (Meadows & Daníelsdóttir, 2016). Fat is still stigmatized and carries many negative connotations because of how society views fatness.

Another controversial term is that of fatphobia. Fatphobia is often used to indicate dislike towards fat people, but because of its ableist nature, it is problematic (Forristal et al., 2021). Scholars suggest using the term fatmisia instead because its literal translation is hate or dislike of fatness and can help acknowledge the hatred and mistreatment of fat bodies (Forristal et al., 2021; Rinaldi et al., 2019). Fat stigma is another term mentioned frequently in this article and it concerns the devaluing of fat bodies and considering them inferior to thin bodies (Smith, 2019). Stigma is a belief resulting in implicit and explicit weight discrimination and anti-fat bias, meaning fat people are discriminated against or treated poorly because of their size and/or weight (Kinavey & Cool, 2019).

## Fatness as an Intersectional Identity

Size is given little to no attention when discussing multiculturalism or cultural diversity in counselor training literature and textbooks (e.g., Sue et al., 2022), despite evidence that fat people experience marginalization (Rinaldi et al., 2019). Size is often overlooked as a distinct identity factor. This is because fatness is not commonly recognized as a marginalized identity, with many individuals believing being fat is a choice. In a recent nationwide study of 1,059 Americans, 46% of those surveyed thought being obese was a lifestyle choice (Ethicon, 2018). In essence, an individual chooses to be fat and could choose to lose weight; however, researchers found very few diets, weight-loss programs, or even weight-loss surgeries have lasting impact (Ge et al., 2020). In a recent study, Ludwig et al. (2021) argued despite persistent efforts by society and medical professionals encouraging fat people to eat less and move more, obesity rates continue to rise. In their study, they consider biological mechanisms causing one to gain weight and argue obesity may be caused by hormonal and metabolic issues.

When examining body size as a cultural identity, thin individuals hold the power in society (van Amsterdam, 2013). Western society values thinness over fatness and views smaller body types as ideal, attractive, and healthy, while considering fat bodies as lazy, dirty, and undesirable (Williams, 2017). Consider seating in airplanes, restaurants, and waiting rooms as evidence where thin individuals have more privilege than fat people. The majority of fat people in a recent study categorized small spaces, seating, or other features making it difficult for fat people to maneuver as a threat cue. This means these spaces signaled weight-based discrimination and they communicated fat people were of less value because of their weight (Oswald et al., 2021).

This valuing of thinness has led fat people to experience anti-fat bias in a variety of areas leading to their marginalization. A study by Elran-Barak and Bar-Anan (2018) found individuals had higher levels of explicit anti-fat bias if they held the belief most people prefer thin people compared to fat people. A survey by Ethicon (2018) found one third of the surveyed U.S. population reported knowing someone who had experienced fat shaming in the previous year, and Puhl et al. (2008) reported the rates of weight-based discrimination are comparable to racial discrimination in the United States. Fat people experience fat bias and discrimination in many areas, including but not limited to healthcare (Williams, 2018), mental health (Akoury et al., 2019), and social media (Clark et al., 2021).

## Stigmatization and Anti-Fat Bias

Fat women experience weight-based discrimination and anti-fat bias in a variety of areas daily (Seacat et al., 2016). On an individual level, this includes being called names or treated disrespectfully, which has intensified

with the phenomenon of anonymous posting on social media (Wanniarachchi et al., 2022). Fat women experience an average of one to three stigmatizing events each day (Seacat et al., 2016; Vartanian et al., 2018). This includes experiencing physical barriers, disparaging comments virtually or in person, glares, job discrimination, and even being physically attacked. Weight bias and stigmatization impact women psychologically (Craven & Fekete, 2021), physically (Himmelstein et al., 2018), and romantically (Cote & Begin, 2020). On a systemic level, anti-fat bias impacts fat women when receiving medical treatment (Hart, 2022), earning less wages (Shinall, 2015), and their portrayal in media (Kozlowski, 2018).

## Stigmatization and Anti-Fat Bias in Media

Anti-fat bias is prominent in media, such as television, movies, and magazines. Kozlowski (2018) analyzed popular media targeting millennials during their childhood and adolescent years, such as television, movies, and online magazines. They identified two predominant archetypes of fat women: one portrayed as sad, unloved, and lonely, and the other depicted as hypersexual and deviant. Fat women are inundated with continual, negative messages about their bodies on social media. Social media outlets such as Instagram are built upon body comparison and reinforcement from comments and likes (Brust, 2020). Wanniarachchi et al. (2022) analyzed Twitter, YouTube, and Reddit and found social media comments reflected "social, body, and gender objectification that is based on an evaluation of the individual's weight" (p. 7). There are even YouTube experiments where men set up fake Tinder profiles with fat girls and are shocked whenever attractive men are interested in their fake profile, commenting these men must be desperate (Playing with Fire, 2022).

For some already marginalized identities, anti-fat bias intensifies existing systems of oppression and magnifies weight-based discrimination experienced (Gerend et al., 2022). Whitesel (2017) argues, "American society fears and devalues an individual when black and fat intersect within [their] body" (p. 431). This intersectional oppression is evident in the frequent disregard for fat Black women, exemplified by the negative comments directed at the musical artist Lizzo on social media. These comments have been deemed abusive and have led to their removal from platforms such as Instagram and Facebook for violating standards (BBC, 2021). Such instances highlight the intersection of race and body size in perpetuating discrimination and marginalization.

## Stigmatization and Anti-Fat Bias in Relationships and Sexual Encounters

Fatness intersects with gender in the absence of romantic relationships, the formation of romantic relationships, and experiences when in romantic relationships. Fat women who are not in relationships report higher levels of depression (Craven & Fekete, 2021). Fat women are often told to lose weight by their dates (Wanniarachchi et al., 2022). When in marriages with men, fat women experience weight stigma from their husbands. Elevated perceptions of weight stigma are associated with (1) decreased marital satisfaction, (2) increased levels of depression, (3) lower evaluations of a wife's mate value, and (4) decreased alignment with her husband's ideal mate (Carels et al., 2022).

Women of all sizes are objectified sexually, and when sexualized they are also dehumanized and viewed as less kind and less intelligent than non-sexualized women (Biefeld et al., 2021; Biefeld et al., 2022). This dehumanization is magnified for fat women whenever society deems them as deserving of being sexually assaulted because they are not worthy of sexual attention or that fat women are lying when stating they were assaulted (Fabrizio, 2014). This sexual dehumanization of fat women became visible in popular culture whenever R&B artist Usher was accused of giving a fat woman herpes, but social media commenters stated Usher "wouldn't hit" it because she was fat (BET, 2017). This represents the phenomenon of hyper(in)visibility where fat women's bodies are intensely scrutinized but simultaneously devalued. In other words, they are seen as deserving of sexual assault, yet it is hard to believe that anyone would desire them sexually (Gailey & Harjunen, 2019).

Researchers also found results exemplifying the sexual dehumanization of fat women. In scenarios where participants were provided profiles of overweight rape victims, both men and women were more likely to blame the victim, hold male attackers less responsible, and judge the assault as less serious when the female victims

were overweight versus normal weight (Gotovac & Towson, 2015). Similarly, Zidenberg et al. (2021) found participants had more sympathy for perpetrators and were more likely to excuse perpetrators behavior when the victim was overweight.

Another way fat women are dehumanized sexually is when having sex with fat women is viewed as a fetish, resulting in its own pornography category (Fabrizio, 2014). Some women find this category, Big Beautiful Women (BBW), as empowering, while others find it humiliating (Klumbyte & Smiet, 2015). This humiliation is further evident in the practice of hogging. Hogging occurs whenever men have sex with women, hogs, they find as fat or unattractive simply for amusement or sexual gratification (Prohaska & Gailey, 2010). Men who participate in hogging report it was used for entertainment purposes for both the men who participated as well as their friends who were spectators. Additionally, they made objectifying comments towards these fat women seeing them only as sexual objects and unworthy of relationships. These comments "indicated that they felt that these women deserved mistreatment and showed little remorse for their actions" (Prohaska & Gailey, 2010, p. 22).

## Stigmatization and Anti-Fat Bias in Healthcare and Mental Health

Although some individuals believe fat people can be shamed into health, the exact opposite occurs. The extent to which an individual identifies as fat and internalizes weight bias impacts one's psychological distress (Curll & Brown, 2020). The more weight stigma one reports, the lower their psychological well-being (Himmelstein et al., 2018). Fat women with higher levels of internalized weight stigma report increased symptoms of depression and anxiety and lower levels of sleep quality (Craven & Fekete, 2021). Internalized weight bias also influences disordered eating habits, such as skipping meals and participating in food restriction to lose weight, which negatively impacts one's physical health (Himmelstein et al., 2018; Levy et al., 2021).

Weight bias in healthcare perpetuates the negative physical health of fat women, including fat women delaying pelvic and breast examinations because of anticipated judgment (Russell & Carryer, 2013). Fat women experience bias whenever there are no sizable gowns to fit, when weight limits to operating tables exist, and whenever Magnetic Resonating Image (MRI) machines have coils too small to fit breasts bigger than a C cup (Hart, 2022). Additionally, fat women receive less attention and treatment for their actual health concerns (Davis & Bowman, 2015). Their medical symptoms are often overlooked and misattributed to being fat rather than an underlying health condition (Rinaldi et al., 2019). Weight bias is also present in healthcare and adversely affects fat women when they are patronized and treated disrespectfully by medical providers (Alberga et al., 2019).

Discrimination resulting from the intersections of fatness with gender identity and sexual and affectional orientation can be observed most visibly in medical treatment. In reproductive medicine, fat cisgender women and transgender men with uteruses may be refused treatments like in vitro fertilization if their BMI is too high according to their healthcare provider's arbitrary standards (Kelley et al., 2019). For transgender people, weight stigma impacts their ability to receive gender affirming surgery because the BMI is used to determine eligibility for surgery (Castle et al., 2022). For fat LGBTQ individuals, Paine (2021) used the phrase "fat broken arm syndrome" to represent when medical providers tell patients to lose weight indicating their weight is the cause for their presenting health issues, rather than providing them with adequate medical care" (p. 1).

Anti-fat bias directly impacts counselors-in-training (CITs) and professional counselors. Anti-fat bias affects CITs when they diagnosis assumed fat clients with more severe Major Depressive Disorder (MDD) than thin clients (Forristal et al., 2021). Moreover, fat individuals experience anti-fat bias in psychotherapy. They face microaggressions from their counselors, such as perceived disinterest and excessive focus on weight (Akoury et al., 2019). Additionally, counselors may exhibit disbelief that a fat woman could love herself (Kinavey & Cool, 2019). These experiences highlight the pervasive nature of anti-fat bias within the counseling profession and its detrimental effects on both clients and counselors.

# An Affirmative Approach to Counseling Fat Women Using Individual and Systemic Interventions

Fat women face anti-fat bias in many areas of life, including when seeking mental health treatment (Akoury et al., 2019). Their unique experiences navigating Western culture deserve attention in the counseling profession. Drawing from affirmative approaches for LGBTQ clients, an affirmative approach to counseling fat women includes validating their unique challenges and worldview and advocating for their unique needs (Hinrichs & Donaldson, 2017). An affirmative approach to counseling means a counselor appreciates their client's fat body and recognizes fat women have the right to remain fat and also appreciate their bodies (Tovar, 2018). Williams (2017) shared that using a fat acceptance framework means recognizing fat people have the freedom to make decisions, including what they eat "without being judged on the moral validity of their body's existence" (p. 3). People of all sizes may not engage in regular exercise or consume healthy foods, yet those who are thin are not typically labeled as immoral, lazy, or demonized. This phenomenon, described by Meleo-Erwin (2012) as "moralizing, healthiest discourse," highlights the tendency to morally judge fat people based on health behaviors but thin people do not receive the same judgment (p. 393).

As previously noted, anti-fat bias negatively impacts the physical and mental health treatment of fat women, so counselors must first work to be aware of their own bias to avoid imposing their beliefs and harming their clients (ACA, 2014, A.4.b.). Henry (2022) recommends three ways counseling professionals can examine their own attitudes towards fatness, including inventorying their intra- and interpersonal histories, analyzing their reaction to a scenario of a fat client, and ranking their beliefs of anti-fat statements. It is important to analyze one's own attitudes because being unaware of one's own anti-fat bias can result in misdiagnosing and assigning more severe pathology to fat clients (Forristal et al., 2021; Kinavey & Cool, 2019).

If professional counselors determine they are biased against fat people after examining their own histories and biases, they will need to do their own work. This work includes education, exposure, or working with a fat positive therapist to dismantle their biases ensuring they can operate from an affirmative counseling approach (Henry, 2022). Next, they will want to become familiar with both individual and systemic interventions that will empower their fat clients (Gladding & Newsome, 2017), because fat women experience both individual and systemic bias in their daily life (Rinaldi et al., 2019). Additionally, it is necessary counselors recognize the importance of systemic interventions, because only systemic change can create an environment where fat women can be free to love and appreciate their bodies without judgment (Gordon & Hobbes, 2020).

## Individual Interventions

Using a fat liberation framework is one way to ensure counselors are using individual interventions from an affirmative approach. Cooper (2021) suggested fat liberation centers the voices of intersectional fat people, promotes policy change, and facilitates cultural disruption of weight bias and stigma. The four tenets of therapeutic fat liberation include community, exposure, knowledge, and safety (Stansberry, 2023a). Using interventions aligned to these tenets can help empower fat women, while simultaneously dismantling systemic barriers preventing women from living freely, appreciating their bodies, and being treated with the same rights and dignity as people who are not fat (Cooper, 2021).

### *Community*

Similar to the experiences of other marginalized populations, community nurtures acceptance, safety, belonging, and resiliency (Hill, 2022). Helping fat women create and connect with other fat women with similar experiences and values is one step in empowering fat women and can help decrease internalized stigma (Sturgess & Stinson, 2022). These communities can be found in online (See Table 1, item 14) or in-person support groups; however, these groups are scarce. If a client cannot find a support group, helping them create one is another way to help fat women find community.

### *Exposure*

Social media endorses weight stigma and has detrimental effects to a fat person's sense of self and mental health (Clark et al., 2021); therefore, exposing fat women to other happy, successful, and confident fat women who love their bodies can help challenge a client's internalized anti-fat rhetoric (Stansberry, 2023a).

Fat acceptance blogs led to the formation of the fatosphere, which is an online community or movement that advocates for body positivity, fat acceptance, and the rights of people of all size (Dickins et al., 2011). It has expanded since its formation in the early 2000s to include other platforms such as Instagram with mental health therapists (Table 1, item 12), sex therapists (Table 1, item 13), and physical therapists (Table 1, item 11) who all operate from a fat positive perspective. Helping clients find social media content appreciating fat women's bodies is one way to help normalize and validate their bodies and can help decrease internalized stigma, increase community and connection, and improve mental health (Matacin & Simone, 2019). In addition to social media, exposing fat clients to fat art and fat talent can also help normalize their views of their bodies (Stansberry, 2023a). Additionally, providing a resource list of podcasts, influencers, books, and TED Talks with models of fat positivity is another intervention to empower fat female clients (See Table 1).

***Knowledge***

Counselors first need to recognize how anti-fat beliefs intersect with racism, ableism, and capitalism in order to provide psychoeducation surrounding this issue with fat clients. Historically, thinness has been associated with white bodies. Black, Indigenous, and People of Color (BIPOC) have been stigmatized for having larger bodies perpetuating the idea that white bodies are superior (Hart et al., 2016). The viewing of fat bodies as inherently unhealthy and lacking self-control is based on assumptions about physical ability, reinforcing the marginalization of people with disabilities (Cooper Stoll & Egner, 2021). Additionally, capitalism fuels anti-fat beliefs by promoting diet and weight loss products as a profitable industry, while simultaneously perpetuating the myth fat women are individually responsible for their weight and health outcomes based on choices they make. This ignores systemic issues such as food insecurity (Pan et al., 2012), limited access to healthcare (Mylona et al., 2020), and biological influences (Ludwig et al., 2021). Therefore, challenging anti-fat beliefs requires addressing the interconnected systems of oppression reinforcing those beliefs and centering the experiences and voices of marginalized communities.

***Safety***

Promoting safety for fat female clients is another way counselors can use an affirmative approach. Counselors can ensure their office has safe spaces, such as accessible, expansive waiting room chairs (Henry, 2022). Having a spacious office and restrooms accommodating larger bodies can help fat women feel safe and avoid experiencing a threat cue (Oswald et al., 2021). Additionally, using wall art or sculptures representing diverse bodies can help fat clients feel comfortable (Stansberry, 2023b). Another way counselors can promote the feeling of safety in the counseling room is by helping clients explore communities and loved ones around them who perpetuate anti-fat bias and then helping them implement boundaries with those individuals (Stansberry, 2023a). This can include online communities they are a part of, religious institutions (e.g., Post, 2021), or with family and friends who speak negatively about their own bodies and about others' fat bodies.

***Fat Embodiment***

Helping clients move beyond body acceptance to body appreciation and what Sturgess and Stinson (2022) describe as fat embodiment is necessary for any affirmative counselor. Internalized stigma contributes to feelings of hatred towards one's body leading to the sense of disembodiment, the separation of self from one's body (Sturgess & Stinson, 2022). Building a positive body identity can help clients appreciate and love their bodies. Using exercises critiquing the thin-ideal, such as those found in *The Body Project* (Stice et al., 2013), help decrease internalized stigma and improve one's mental health. Counselors can also use body affirmations. Matz (2020) recommends the following affirmations to promote body appreciation: "My worth is not based on my body size" (para. 9), "I will gently reject the weight stigma that I've internalized as my own beliefs" (para. 11), and "I will treat my body with kindness and compassion" (para. 8). Helping clients restructure their negative thoughts about their bodies and use positive language describing their bodies promotes positive body images (Alleva et al., 2015). Another practice to help promote a positive body identity is yoga, which can be used to reduce stress and improve self-esteem and body image among women (Neumark-Sztainer et al., 2018; Park & Kim, 2014).

Table 1
*Intersectional Fat Positive Resources*

| Type | Resource |
|---|---|
| Books | |
| | 1. Cooper, C. (2021). *Fat activism: A radical social movement*. (2nd ed). Intellect Books. |
| | 2. Dionne, E. (2022). *Weightless: Making space for my resilient body and soul*. Ecco. |
| | 3. Gordon, A. (2021) *What we don't talk about when we talk about fat.* Beacon Press. |
| | 4. Gordon, A. (2023). *"You just need to lose weight" and 19 other myths about fat people*. Beacon Press. |
| | 5. Lupton, D. (2018). *Fat* (2nd ed.). Routledge. |
| Fat Yoga Influencers | |
| | 6. Burns, L. [@radicalbodylove]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/radicalbodylove/ |
| | 7. Jessamyn. [@mynameisjessamyn]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/mynameisjessamyn/ |
| | 8. Rihal, J. [@jessicajadeyoga]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/jessicajadeyoga/ |
| Instagram Accounts | |
| | 9. Abraham, V. [@fatfabfeminist]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/fatfabfeminist/ |
| | 10. Enneking, C. [@fatgirlflow]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/fatgirlflow |
| | 11. Folden, L. [@healthyphit]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/healthyphit/ |
| | 12. Stansberry, K. [@fatpositivetherapist]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/fatpositivetherapist/ |
| | 13. Sonalee. [@thefatsextherapist]. (n.d.). *Posts* [Instagram profile]. Instagram. https://www.instagram.com/thefatsextherapist/ |
| Online Support Groups | |
| | 14. Reclaiming Beauty. https://www.reclaimingbeauty.com/fat-friend-peer-support-group. |
| Organizations | |
| | 15. Association for Size Diversity and Health (ASDAH). https://asdah.org/ |
| | 16. National Association to Advance Fat Acceptance (NAAFA). https://naafa.org/ |
| Podcast & TED Talks | |
| | 17. Gordon, A., & Hobbes, M. (Hosts & Producers). (Oct. 11, 2020-present). *Maintenance phase* [Audio podcast]. https://www.maintenancephase.com/ |
| | 18. TEXxTalks. (2017, June 6). *What comes after loving yourself? Advice from a fat fly brown girl, Yesika Salgado, TEDxCalStateLA* [Video]. YouTube. https://www.youtube.com/watch?v=2oP3STw2jC8 |
| | 19. TEDx Talks. (2017, July 19). *Lose hate not weight, Virgie Tovar, TEDxSoMa* [Video]. YouTube. https://www.youtube.com/watch?v=hZnsamRfxtY |

*Note*: Counselors can use these resources to increase their knowledge and exposure to dismantle their biases, and they can also be used as a resource list to provide clients.

## Systemic Interventions

From a systems level, counselors, in collaboration with other professions such as social work, psychology, public policy, and medicine, need to work together to create a culture where fat women can have high self-esteem and appreciate their bodies (Gordon & Hobbes, 2020). Counselors can facilitate groups or workshops focusing on deconstructing the thin ideal and promoting body acceptance and appreciation. Consciousness-raising groups, which emerged from the Women's Liberation Movement, provide a safe, empowering space for fat women to connect and discuss their feelings and needs openly and without judgment (Brown, 2010). Counselors can also advocate to change policies discriminating against fat women, such as BMI stipulations on reproductive assisted services (e.g., IVF), and to create weight discrimination laws preventing employers from discriminating in the hiring, promotion, and pay of fat women in the workplace (Shinall, 2015).

Anti-fat bias is pervasive and when men who marry women possess this bias, it impacts their wives' mental and relationship well-being (Carels et al., 2022). Psychoeducation targeting men who perpetuate weight-based discrimination and illuminating what causes fatness may reduce stigma similar to findings in healthcare students and professionals (Talumaa et al., 2022). This can take place at in-person or virtual workshops, couples counseling, or via social media. In collaboration with social media influencers and even creating their own social media content, counselors can work to reduce stigma in media and increase the number of fat women positively represented, because when fat individuals are represented positively in media, weight stigma decreases in the public (Yale News, 2012).

## Conclusion

Fat women encounter stigmatizing events daily, and this stigmatization has detrimental effects on their mental health. Fat women's bodies are dismissed while simultaneously scrutinized publicly on social media. These experiences cause stigma to then be internalized, further exacerbating mental health issues and negatively impacting body image and acceptance. Counselors use affirmative practices empowering fat women to appreciate their bodies. By using systemic interventions and advocating for positive representations in media, laws to protect workplace discrimination, and changes to discriminatory medical policies, anti-fat stigma may decrease and ultimately contribute positively to the wellness of fat women.

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# Attitudes, Motivations, Rates, and Services of Intimate Partner Violence Among Same-Sex and Opposite-Sex Couples

Kelly A. Goria & Ben T. Willis

The costs for survivors of Intimate Partner Violence (IPV) are significant and varied. The stigmatization of IPV has forced many survivors to remain in these unsafe and violent relationships, especially survivors of IPV in same-sex relationships. The needs, costs, resources, and services of IPV survivors are described to enhance the work counselors are providing to members of this population.

*Keywords:* Intimate partner violence, same-sex relationships, abuse, intimate partner violence resources

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Intimate partner violence (IPV) impacts at least 25% of females (Banks & Fedewa, 2012; Centers for Disease Control and Prevention, 2022; Sardinha et al., 2022) and has significant psychological, physical, financial, and societal costs (Bogat et al., 2023; Cho & Kwon, 2018; Peterson et al., 2018). IPV is a type of domestic violence that is characterized as "…acts of physical, psychological, and sexual aggression" (Elmquist et al., 2014, p. 360) towards an intimate partner. This type of violence between partners is a significant crime that impacts people of all ages worldwide (Capaldi et al., 2012; Sardinha et al., 2022; World Health Organization, 2013). IPV has been documented to lead to symptoms of anxiety, depression, posttraumatic stress, and substance abuse (Coker et al., 2000; Lagdon et al., 2014; Smith et al., 2017). IPV directly impacts an estimated 43 million adults in the United States with a lifetime cost of around $3.6 trillion (about $11,000 per person in the US) from medical costs, lost productivity, criminal justice activities, and other consequences (Peterson et al., 2018). Without intervention or support, survivors of IPV, rape, stalking, and physical assault can have significant adverse costs that exceed $5.8 billion each year (Centers for Disease Control and Prevention, 2022; Craven et al., 2023).

The effects of IPV are even more significant for individuals in same-sex relationships (Hubbell, 2024). IPV significantly impacts persons of all genders and has an effect on individuals' wellbeing (Hubbell, 2024). American society views same-sex IPV as less important to explore than opposite-sex IPV (Banks & Fedewa, 2012; Hubbell, 2024). The reasoning behind why society views same-sex IPV as less important stems from the heterosexism and homophobia in American culture (Human Rights Campaign, 2022; Peterman & Dixon, 2003). As a result, topics regarding members of the lesbian, gay, bisexual, transgender, queer – plus (LGBTQ+) community often fall through the cracks. There are often fewer resources for individuals in the LGBTQ+ population, and therefore, they often experience worse outcomes from IPV, including a weaker immune system, increased likelihood of mental illness (i.e., anxiety, depression, and posttraumatic stress disorder), isolation, decreased self-esteem, and even suicidality (Banks & Fedewa, 2012; Lawson, 2003; Merino et al., 2019).

This manuscript explores only the experience of cisgender individuals in same or opposite-sex monogamous partnerships. This delimitation was chosen due to the limited research regarding transgender individuals in same-sex or opposite-sex relationships (Peitzmeier et al., 2020; Sardinha et al., 2022). Not only that, research on the rates of IPV committed by and against transgender individuals is not as well known (Peitzmeier et al., 2020). The purpose of this manuscript is to provide greater understanding of IPV, its costs, how it impacts different populations, recommended treatments, and services available in Pennsylvania to aid professional counselors to provide stronger support for survivors of IPV.

## What is IPV?

There are five categories of IPV which include physical, emotional, financial, psychological, and sexual abuse (Banks & Fedewa, 2012; Hammel et al., 2023). IPV can happen in dating, in couples close to marriage (i.e., cohabitation or engaged), and married relationships (Cho & Kwon, 2018). Regardless of the age, type of IPV, or relationship status, it is important to understand that IPV can happen to anyone. The perpetrator of IPV takes control from and over the survivor that can lead to a cascading effect on the survivor's life and the lives of people close to the survivor (Lawson, 2003).

IPV is expressed through two different forms: expressive and instrumental violence (Hammel et al., 2023). Expressive violence is done by an abuser because of increased emotional arousal, and it can happen gradually. Often, "there is…clear involvement of both partners in the escalation process, and mutual and reciprocal violence is counter to the couple's value system" (Lawson, 2003, p. 20). As a result, partners that utilized expressive violence take out their emotional hurt on their partner by means of physically violence. A common example of expressive violence in IPV includes physical assault by one partner towards the other partner when emotionally escalated. On the other hand, instrumental violence is done with the purpose of gaining control and punishing the survivor (Lawson, 2003). Different from expressive violence, instrumental violence has a rigid escalation process, and the perpetrator shows almost no remorse with no motivation to change. An example of instrumental violence in intimate relationships is when one partner intentionally becomes aggressive towards the other partner so that they give them sole financial custody in the relationship (Lawson, 2003).

Interestingly, Hammel and colleagues (2023) found increases in both expressive and instrumental violence in intimate relationships by about one-third when a partner is under the influence of drugs or alcohol. Being under the influence of substances lessens an individual's memory, inhibitions, and perceptions (Gasparyan et al., 2023), which then could contribute and/or exacerbate the violence in the relationship (Williams et al., 2022). According to the Bureau of Justice Statistics, there is a strong positive correlation between increased drug and/or alcohol usage and IPV (Cafferky et al., 2018; Radcliffe et al., 2021). When comparing same-sex and opposite-sex couples, rates of substance abuse, especially alcohol abuse, are higher amongst same-sex couples and members of the LGBTQ+ community when compared to heterosexuals (Stults et al., 2015). This increased prevalence of drinking in the LGBTQ+ community has been equated to increased attendance at bars as historically they were one of the few safe spaces for this community (National Institute on Drug Abuse, 2024). Most of the research on IPV has been done about opposite-sex couples. However, there has been increased research conducted comparing IPV in same-sex and opposite-sex partners. Some of this research suggests that 25%-33% of heterosexual couples experience at least one type of domestic abuse and same-sex couples experience the same or even higher rates of at least one type of domestic abuse while in a relationship (Hubbell, 2024). It is thought that perpetrators engage in IPV "to control the thoughts, beliefs, and behaviors of an intimate partner or to punish the partner resisting one's control" (Peterman & Dixon, 2003, p. 41). An individual's need for power and/or control increases the likelihood of IPV in a relationship. The power, control, and violence over the survivor of IPV can have several significant costs.

## Costs of IPV on Survivors

There are many costs for individuals who are survivors of IPV, including costs on personal, familial, and societal levels. The most overt cost of IPV occurs on a personal level. These personal costs include physical injuries to the body like broken bones and bruises as well as mental health consequences such as development of anxiety, depression, suicidal ideation, and posttraumatic stress disorder, or PTSD (Cho & Kwon, 2018). Brown and Groscup (2009) found that the severity of the IPV experienced impacts the overall effect it has on the survivor's mental health. Some of these consequences include substance abuse issues, anxiety disorders, depressive disorders, and trauma disorders (Coker et al., 2000; Lagdon et al., 2014; Smith et al., 2017). The greater the severity of the IPV experiences (e.g., choking and threatening with a knife), the more serious the mental health outcome, such as suicidal ideation, chronic PTSD, or even death (Cho & Kwon, 2018).

Additionally, financial issues are another cost of IPV. If an individual is financially abused in a relationship, they may lose their own financial foothold (Hamel, 2023). It is common for abusers to keep control of financial resources, maintain their name on financial assets, and maximize the debt for survivors. As a result, the survivor experiences a cognitive distortion that they must be completely dependent on their abuser to live (Peterman & Dixon, 2003). This can lead to a codependent relationship, in which the survivor no longer knows or can live their own life or make their own decisions while in a romantic relationship. Moreover, IPV may create additional costs, including separate living arrangements and additional supportive services for the family and society in general.

Engagement in social events decreases after experiencing IPV (Cañete et al., 2024). Some of the most substantial social consequences include isolation and limited communication with social support (Merino et al., 2019). In other words, being a survivor of IPV increases social isolation which can lead to withdrawal from family members, social events, and even work (Peterman & Dixon, 2003). This isolation tactic is utilized by both same-sex and opposite-sex abusers to distance their partner from social supports and to remain in control over their partner to continue the cycle of abuse (Cañete et al., 2024).

## Needs of IPV Survivors

The methods of IPV among same-sex and opposite-sex partners are alike in many ways, and there are similar needs for both populations. These needs include physical, financial, and emotional needs. It can be helpful to utilize Abraham Maslow's hierarchy of needs to assist clients with multilayered needs (Rolling & Brosi, 2010). Starting with more basic needs of survival, physiology, and safety will be important before moving to higher level emotional and esteem needs.

Lawson and colleagues (2003) suggested survivors of IPV need a safe place, which is more than just safe housing. This is essential so that the survivors can be removed from the violence, and safe housing includes access to food, hygiene products, and clothing to guarantee their basic needs are met (Pennsylvania Coalition Against Domestic Violence [PCADV], 2019a). Part of what helps survivors meet their basic needs is addressing financial assistance. Financial abuse is a form of IPV that encompasses 98% of abusive relationships (PCADV, 2020b). The financial needs of survivors can vary and include aspects such as food, housing, healthcare, childcare, attorney bills, and credit.

When housing and financial needs are met, counselors can focus on mental and emotional needs (Rolling & Brosi, 2010). Mental health care is often utilized to meet survivors' emotional needs. Survivors can utilize mental health services to work through the psychological and emotional effects of IPV as well as provide social support and services to grow their support system (Cho & Kwon, 2018). Cognitive behavioral therapy (CBT), relationship education, and arts-based interventions have been found to be beneficial to address these needs (Craven et al., 2023).

The most significant similarity between these two populations is the finding that emotional abuse is the most utilized method of abuse (Peterman & Dixon, 2003). Despite both partnerships having emotional abuse as the most prevalent type of abuse used in IPV, there are differences in what may be communicated. For example, in same-sex partnerships, the abuser tends to threaten exposing their partner's affectional orientation to different individuals in their life (Banks & Fedewa, 2014). By extension, this abuser can create extreme isolation for the survivor if the survivor is not fully "out of the closet" and has no one else for support. The abuser "outing" their partner leads to an abuse crisis by causing an identity crisis for some survivors. This could then result in additional discrimination, loss of support systems, etc. for the same-sex relationship survivor (Parry & O'Neal, 2015). Consequently, in opposite-sex partnerships the abuser has been found to tell the survivor they are stupid, worthless, unlovable, and ugly (Parry & O'Neal, 2015). By being told statements such as those, a decrease in self-esteem is likely to occur which can cause a crisis state in the survivor by creating an overwhelming sense of loneliness that can manifest into a plethora of mental health issues, such as anxiety, depression, PTSD, etc. (Capaldi et al., 2012).

### Gendered Needs of IPV Survivors

Another major dimension to IPV is the gender differences among men and women initiating the IPV in the relationship. Researchers have found that men may

be more motivated by power and control (Langhinrichsen-Rohling et al., 2012). Different from men, women have been seen to be motivated for IPV out of self-defense, wanted attention from their partner, and poor emotional and anger management skills (Elmquist et al., 2014). As a result, these motivations are imperative for professional counselors to keep in mind when working with perpetrators of IPV. Despite these gender differences, there still is another critical difference among the motivations for IPV in same-sex partnerships. In same-sex partnerships the motivation for IPV derives from the incessant "…control over their partner due to their feelings of self-hatred and victimization by the homophobic world" (Peterman & Dixon, 2003, p. 82). Specifically, the motivation for IPV in same-sex relationships comes from less of a personal place and more from a societal place (Strenio, 2020). Since heterosexism is common in American society (Worthen, 2014), IPV in same-sex couples seems connected to internalized homophobia (Davis, 2022).

### Needs of Homosexual Survivors of IPV

A survivor of IPV in a same-sex relationship also tends to have fewer support systems as compared to a survivor in an opposite-sex relationship. Same-sex relationship survivors are already an individual from marginalized group (Banks & Fedwa, 2012; Cañete et al., 2024). Therefore, risks such as being disowned by their family and having smaller social circle often occur.

A major difference between the needs of same-sex partner and opposite-sex partner IPV is the additional needs that same-sex partner survivors require. Same-sex IPV survivors often require more advocacy than opposite-sex IPV survivors since their IPV is viewed as less severe and prevalent, despite the evidence to the contrary (Human Rights Campaign, 2022; Peitzmeier et al., 2020; Strenio, 2020). Also, survivors of IPV in same-sex relationships are "…less likely to report abuse and more likely to stay with their partner because of homophobia, heterosexism, and ignorance in community regarding domestic violence…" (Peterman & Dixon, 2003, p. 40). Finally, same-sex IPV rates are increasing at greater rates now (Human Rights Campaign, 2022; Peitzmeier et al., 2020; Strenio, 2020). It is speculated that this is because of increased same-sex relationships among younger individuals who have fewer protective resources (Human Rights Campaign, 2022). As a result of the widespread myths and increasing rates, it is apparent that the needs for same-sex IPV survivors must be focused on more than those of opposite-sex IPV survivors.

Overall, IPV is a major issue that does not discriminate among different affectional orientation groups. Researchers have found that same-sex partners experience slightly higher levels of IPV than opposite-sex partners (Breiding et al., 2013; Peitzmeier et al., 2020). Although the rates are similar in both populations, the motivations, and violent actions, such as emotional abuse among these two groups differ in what is said to the survivor. The services available for same-sex and opposite-sex partners' experiencing IPV are not equal (Breiding et al., 2013). Heterosexual partners and women have more resources available to them in comparison to LGBTQ+ and men. Future resources need to be implemented to ensure that men and LGBTQ+ survivors of IPV have adequate and effective services to help educate and support them (Breiding et al., 2013). Also, it is important that counselors are aware of the different services available and how they might help meet the needs of IPV survivors.

## Services Available for Survivors

There are local and national IPV resources for survivors and perpetrators of same-sex or opposite-sex IPV. These resources require providers to have various education and training levels depending upon the services they provide for survivors and/or abusers. Professional counselors will provide some of these services, though they should be aware of other types of services for survivors and perpetrators of IPV. It is important to note that there are far fewer resources specifically for same-sex survivors of IPV as compared to opposite-sex survivors of IPV (Human Rights Campaign, 2022). This section will provide information on different services available to same-sex survivors of IPV to help counselors link survivors with needed resources.

### Women's Resource Centers

There are many services offered to help survivors of IPV throughout the country. For example, there are Women's Resource Centers (WRC) used by survivors across the country. These centers commonly provide services and information for survivors (WRC, 2021).

Some of these services include legal assistance, housing, healthcare assistance, childcare, transportation, education/work, income assistance, mental health counseling, etc. (WRC, 2021). WRCs do not provide all these services themselves per se, but they have connections with organizations and individuals that can assist survivors with these services. For example, the WRC in Scranton, PA has a team of counselors, lawyers, social workers, and other trained advocates. While WRCs are traditionally gender-conscious and designated for women, some have moved towards accepting more gender minority survivors. For women and/or gender minority survivors to acquire services from these centers they can contact the center by calling the number listed on their websites or by physically showing up to the center. Either way, the survivor is connected to an individual who can direct them towards the proper professional(s). Another key point about WRCs is that these centers are also available throughout Pennsylvania in different counties. For example, there are WRC's in Allegheny, Centre, and Wayne counties.

In Pennsylvania, Women's Resource Centers are an effective service for some survivors of IPV. It is necessary to point out that there are often restrictions on who can stay in the shelters associated with these centers (WRC, 2021). Men, teenage men, and sometimes even gender queer individuals are turned away from these services. This is an issue because a same-sex partner or an opposite-sex partner who identifies as a male cannot use these shelters as a safe space to seek help leaving a violent partnership. As a result, it is imperative that shelters like these are created and become more prevalent to ensure that males have the same access to help. It is important to keep in mind that different states have different policies on individuals that can use WRC's. The above information is true for parts of the state of Pennsylvania. Survivors of violence in Pennsylvania can reach out to the Office of Victims' Services to be connected with community resources like a WRC (Pennsylvania Commission on Crime and Delinquency, 2024).

Furthermore, WRCs addresses are often not posted on the Internet to keep the survivors safe from abusers. WRCs also help survivors with various crises. Not only do they provide survivors with legal help, housing, at least for a brief time, but access to food and childcare (WRC, 2021). Also, WRCs have community contacts that can connect survivors to assistance for mental health services, career, financial coaching, and so on. From the onset of WRC creation, the services and funding have increased, and more survivors have been helped leave violent settings.

## Hotlines

Survivors of IPV have access to call or message many hotlines. Some of these include GLBT National Hotline (888-688-5428), National Domestic Violence Hotline (800-799-7233), National Dating Abuse Helpline (800-799-7233), National Sexual Assault Hotline (800-656-4673), National Center for Victims of Crime (202-467-8700), National Coalition for the Homeless (888-358-2384), National Resource Center on Domestic Violence (800-799-7233), Futures Without Violence: The National Health Resource Center on Domestic Violence (https://www.futureswithoutviolence.org/health/), National Center on Domestic Violence, Trauma and Mental Health, and National Runaway Safeline (National Coalition Against Domestic Violence, n.d.). These hotlines all have specific numbers for survivors to call to assist them in finding a safe shelter, transportation, safety planning, referrals to mental health providers, referrals to medical care, etc. Also, survivors experiencing firsthand IPV or a loved one or neighbor of a survivors of IPV can utilize these hotlines to find help. The individuals who answer the phone calls must undergo extensive crisis and domestic violence training before being allowed to answer calls. The hotlines mentioned above are most frequently used by survivors of IPV once the violence against them becomes evident towards them and/or are ready to seek some help to exit an abusive relationship.

Survivors of IPV receive a lot of support from hotlines. Hotlines have grown tremendously since they began. Now, there are multiple hotlines that can assist survivors in obtaining resources to exit their violent relationships. In addition, unlike WRCs, these hotlines are open to all survivors regardless of gender or affectional orientation. This helps all survivors of IPV get the direction and resources necessary to leave their abusive relationship (National Coalition Against Domestic Violence, n.d.). Like the WRCs, the hotlines do help same-sex and opposite-sex survivors of IPV receive direction for mental health services, housing, childcare, financial assistance, food, and safety planning.

Hotline services are outlined in the different subsections on the websites. For example, on the National Coalition Against Domestic Violence Hotline (n.d.) website, the subsections write about safety planning for survivors, their children, and their pets along with alternate subsections that outline ways to find shelters nearby to the survivor. The biggest suggestion to this specific hotline website would be to incorporate more LGBTQ+ resources so that survivors of same-sex IPV have increases access to supports.

## Mental Health Services

Finally, survivors of IPV also have mental health services available for them. These services include individual counseling and/or group counseling. Each type of counseling can provide survivors with psychoeducation and support about safety planning and exiting abusive relationships (Craven et al., 2023; Leedom et al., 2019). These services can be held in outpatient, private practice, or in-patient settings. In these settings, survivors or clients can meet with a counselor one-on-one or in a group setting with one or two counselors and other IPV survivors (Eckhardt et al., 2013). The counselors who work with survivors in this setting must have a master's degree in counseling or a related human service field as well as experience and/or expertise in crisis-related domestic violence work (Commonwealth of Pennsylvania, 2022). Survivors of IPV have been seen to use individual counseling at higher rates overall compared to group counseling (Santos et al., 2017). Craven and colleagues (2023) advocated for tailoring interventions to the individual's specific situations and symptoms. Helping to reduce symptoms, increase safety, provide psychoeducation, and meet client specific needs is important for IPV survivors. A range of mental health services, including individual counseling, group counseling, psychoeducation, case management, and safety planning, can be beneficial to meet their needs (Craven et al., 2023; Flasch et al., 2019; Leedom et al., 2019).

These mental health services are essential to helping survivors overcome their crises related to their violent partnerships (Eckhardt et al., 2013). IPV survivors commonly benefit from validation of their experiences, affirmations of their strengths, encouragement about the healing process, skills training, and symptom management (Leedom et al., 2019). Counseling services include individual and group counseling, and some interventions found to be beneficial are CBT, psychoeducation, relational education, and art-based therapy (Craven et al., 2023). These services and interventions can help survivors increase their self-esteem and independence along with symptoms of mental health diagnoses. Group counseling settings afford survivors the opportunity to connect with other survivors who have experienced similar situations, which can provide a sense of commonality, support, confidence, and self-discovery. Providing information on the Duluth Power and Control Wheel has been found to be beneficial in some cases, but not enough (Bohall et al., 2016; Craven et al., 2023).

Helping survivors to better understand relational dynamics, providing career support, utilizing expressive therapy for difficult thoughts and emotions, and providing cognitive restructuring for beliefs about their responsibility for the abuse and other thoughts connected to guilt, shame, anxiety, depression, and self-esteem can be beneficial (Craven et al., 2023). Flasch et al. (2019) found that focusing on learning to trust, navigating boundaries and control, healthy communication, sexual exploration in new relationships, and caring for children were important topics for IPV survivors starting new partnered relationships. They recommended that counselors help clients navigate new relationships by utilizing the client's strengths, reflect on their IPV history and recovery experiences, and discuss relevant topics like trust, boundaries, safety, intimacy, and sexuality. Also, there is some evidence that increasing self-compassion is beneficial for trauma symptom reduction (Scoglio et al., 2018) and that narrative exposure therapy can be effective for decreased symptom severity as well (Orang et al., 2018). For situational violence scenarios of IPV, couple interventions also have some evidence to decrease incidence of IPV, though there is danger in having the perpetrator in treatment with the survivor (Bradley & Gottman, 2012). Solution-focused therapy has also been shown to be an effective approach in individual or group settings (Santos et al., 2017).

## Domestic Abuse Intervention Programs

Trying to increase the prevalence of IPV services for perpetrators is important. The services included in this manuscript are accessible in Pennsylvania. The Duluth Domestic Abuse Intervention Project (DAIP, 2017) offers a comprehensive framework that many

organizations have emplaced in their service centers. DAIP offers a program for nonviolent perpetrators of IPV and domestic violence who are court ordered to their program. In this program, classes and mental health services are offered over 24 weeks (about 5 and a half months). During this time, the aim is to help explain the cycle of abuse, reasons for violence, and coping strategies to perpetrators to help end their violent behaviors (DAIP, 2017).

### *Batterer Intervention Programs*

Batterer intervention programs (BIPs) were introduced to hold batterers accountable without incarcerating them (Wesley Family Services, 2020). BIPs follow a cognitive behavioral group therapy approach that is intended to increase perpetrators functionality by working on anger management and changing the ways they think and act. These programs use negative and positive reinforcements to change thoughts and actions. A BIP in the state of Pennsylvania is Wesley Family Services, in western Pennsylvania, and Men Against Abuse Program, in eastern Pennsylvania (Wesley Family Services, 2020). Wesley Family Services requires a referral prior to acceptance into the program. Once in this program, perpetrators attend 24 classes with a holistic approach. Classes assist with anger management, stress relief, and emotional regulation (Wesley Family Services, 2020). Moreover, the Men Against Abuse Program is a 26–30-week course that works towards eliminating men's violent and abusive behaviors. This course covers intimidation, coercion, emotional abuse, male privilege, using children, etc. via videos, self-reflections, presentations, and homework assignments (United Way of Pennsylvania, 2022). One limitation of these programs is that both are programs for men only. These programs discriminate assisting females and same-sex relationship violence. Thus, additional research and BIPs for females and LGBTQ+ perpetrators must be created. Another service for perpetrators of IPV can be found on the Course of Violence website. There are state-specific domestic violence classes offered in all the Pennsylvania counties. A choice of four-hour, eight-hour, 12-hour, or 16-hour courses are offered that cover materials related to changing violent behavior, prevention, victim impact, intimate partner abuse education, etc. (North American Learning Institute, 2023).

## Summary

IPV impacts over 43 million American adults (Peterson et al., 2018) and has significant personal, familial, and societal costs. Counselors need to be prepared to help provide mental health services and link them with other services to meet their safety, financial, educational, and housing needs. The needs are often higher for homosexual survivors, and fewer resources are typically available for them. While advocacy work can help to change this, in the meantime, counselors can be aware of their local resources and provide service that are evidence-based, such as psychoeducation, CBT, art-based therapy, and relational education (Craven et al., 2023; Santos et al., 2017).

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# JPCA Test to Earn CE Credit

*Note:* Earn 2.0 Free Continuing Education Credits by reading selected articles in this issue. Read the articles identified below and answer 8 of the 10 questions correctly to earn 2 CE credit.

**Factors that impact level of suicide risk among college Students (pp. 3-11 )**

1. Based on this article, all of the following are examples of factors for increasing risk in those college students who have expressed suicidal ideation EXCEPT:
- ☐ a. Prescription drug misuse
- ☐ b. Sleep difficulty
- ☐ c. Financial stress
- ☐ d. Roommate Issues

2. This study provides new information about suicide risk in college students because:
- ☐ a. It included mostly students in the southeast
- ☐ b. It examined only those students who indicated some level of suicide risk
- ☐ c. It explored students' socioeconomic status in depth
- ☐ d. It included participants from community colleges

3. The article indicated that non-heterosexual sexual orientation is NOT a risk factor for suicide in college students.
- ☐ a. True
- ☐ b. False

4. This paper examined results based on which of the following questionnaires:
- ☐ a. National College Health Assessment
- ☐ b. National Suicide Risk Survey
- ☐ c. Healthy Minds Study
- ☐ d. Center for Collegiate Mental Health Study

**An Affirmative Approach to Counseling Fat Women: Recommendations for Counselors (pp. 12-24)**

5. Which of the following statements accurately reflects societal attitudes towards fatness?
- ☐ a. Society predominantly views fatness as a marginalized identity and actively seeks to address weight-based discrimination.
- ☐ b. Fatness is widely recognized as a cultural identity factor, and societal values prioritize inclusivity and acceptance of diverse body sizes.
- ☐ c. Western society tends to value thinness over fatness, associating smaller body types with attractiveness and health, while stigmatizing fat bodies as undesirable.
- ☐ d. Fatness is generally considered a neutral characteristic in society, with little impact on individuals' social experiences or access to privileges.

6. Which of the following accurately describes the impact of weight-based discrimination and anti-fat bias on fat women's experiences?
- ☐ a. Fat women typically experience weight-based discrimination only in professional settings such as healthcare and employment.
- ☐ b. Fat women face weight-based discrimination primarily in virtual spaces such as social media, while their experiences in physical environments remain relatively positive.
- ☐ c. Weight-based discrimination and anti-fat bias affect fat women psychologically, physically, and romantically, impacting their mental health, physical well-being, and relationships.
- ☐ d. Fat women predominantly experience weight-based discrimination in romantic relationships, while their experiences in other areas of life are relatively unaffected.

7. Which of the following best defines the concept of hyperinvisibility?
- ☐ a. Hyperinvisibility refers to the increased visibility and representation of marginalized individuals in mainstream media and society.
- ☐ b. Hyperinvisibility is the phenomenon where individuals with marginalized identities, such as fat women, experience heightened scrutiny and attention, yet are simultaneously devalued and marginalized.
- ☐ c. Hyperinvisibility describes the state where individuals with privileged identities are excessively visible and celebrated in society, leading to further marginalization of minority groups.
- ☐ d. Hyperinvisibility refers to the deliberate erasure of marginalized individuals and their experiences from public discourse and media representation.

**Attitudes, Motivations, Rates, and Services of Intimate Partner Violence Among Same-Sex and Opposite-Sex Couples (pp. 25-39)**

8. Intimate partner violence (IPV) impacts an estimated _____ adults in the United States?
- ☐ a. 22 million
- ☐ b. 43 million
- ☐ c. 56 million
- ☐ d. 100 million

9. Which approach was mentioned that is effective to use with people who have perpetuated IPV?

☐ a. art-based therapy
☐ b. cognitive behavioral group therapy
☐ c. narrative exposure therapy
☐ d. solution focused therapy

10. Which of the following was not mentioned as a beneficial psychoeducational topic for survivors of IPV?

☐ a. Power and control
☐ b. Boundaries
☐ c. Healthy communication
☐ d. Accountability

---

☐ I certify that I have completed this test without receiving any help choosing the answers.

**Feedback**

Please rate the following items according to the following scale:

5 – Superior 4 – Above Average 3- Average 2 – Below Average 1 – Poor

| | Superior | Above Average | Average | Below Average | Poor |
|---|---|---|---|---|---|
| The authors were knowledgeable on the subject matter | ☐5 | ☐4 | ☐3 | ☐2 | ☐1 |
| The material that I received was beneficial | ☐5 | ☐4 | ☐3 | ☐2 | ☐1 |
| The content was relevant to my practice | ☐5 | ☐4 | ☐3 | ☐2 | ☐1 |
| This journal edition met my expectations as a mental health professional | ☐5 | ☐4 | ☐3 | ☐2 | ☐1 |
| How would you rate the overall quality of the test? | ☐5 | ☐4 | ☐3 | ☐2 | ☐1 |

Comments/Suggestions?

**Instructions**

**Email:** Complete the test, sign the form, and email to: **PCA.profdev@gmail.com.** Allow 2-4 weeks for processing.

**For further assistance, please contact Kenya Johns, Professional Development Chair of the Pennsylvania Counseling Association at PCA.profdev@gmail.com**

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The *Journal of the Pennsylvania Counseling Association (JPCA)* is a professional, refereed journal dedicated to the study and development of the counseling profession. The Editor invites scholarly articles based on existing literature that address the interest, theory, research, and innovative programs and practices of professional counselors. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. All submissions are blind peer reviewed and authors should expect a decision regarding a manuscript within three months of acknowledgement of receipt. Following are guidelines for developing and submitting a manuscript. Any submissions that do not adhere to the following guidelines will be returned without review.

**Specific Requirements**

1. Manuscripts should not exceed 30 pages, including references.
2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) with 1" margins on all sides.
3. **Title Page:** Identify the title page with a running head. The title page should include title (not more than 80 characters), author, affiliation, and an author's note with contact information. Author's note should be formatted exactly as it appears in this example:

   > Author Name, Department of _____, University Name [or Company affiliation].
   > Correspondence concerning this article should be addressed to Author Name, Department of _____, University, Street address, City, State, zip code (e-mail: xxxxx@xxxx.edu).

4. **Abstract:** Begin the abstract on a new page and identify the abstract page with the running head and the number 2 typed in the upper right-hand header of the page. The abstract should not exceed 75 words.
5. **Keywords:** Keywords should follow the abstract on page 2 and are limited to 5 words.
6. **Text:** Begin the text on a page 3 and identify the text page with the running head and page number 3 typed in the upper right-hand header of the page. Type the title of the article centered at the top of the page and then type the text. Each subsequent page of the text should carry the running head and page number.
7. **Tables and Figures:** No more than 3 tables and 2 figures with each manuscript will be accepted. Do not embed tables or figures within the body of the manuscript. Each table or figure should be placed on a separate page following the reference list.
8. **References:** References should follow the style detailed in the APA Publication Manual. Check all references for completeness, including the year, volume number, and pages for journal citations. Please be sure to include DOI numbers as necessary. Make sure that all references mentioned in the text are listed in the reference section and vice versa and that the spelling of author names and years are consistent.
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