
Treating Women Who Have Experienced Intimate Partner Violence

Intimate partner violence (IPV) is one of the most common form of violence against women. It could be physical, sexual, and emotional abuse and controlling behaviors by an intimate partner and occurs in all settings and among all socioeconomic, cultural and religious groups. IPV may lead women to negative health consequences, including mental health disorders. Therefore, it is important to implement IPV screening and counselling safely and effectively throughout the health care delivery system. It can be achieved by educating health care professionals in IPV screening and counseling techniques.

The following sections discuss screening, safety assessment, treatment options and best practices in treating women who have experienced IPV.

Screening for IPV Survivors in Mental Health Settings

Women with mental health symptoms or disorders (depression, anxiety, post-traumatic stress disorders (PTSD), self-harm/suicide attempts) should be screened for IPV in health care settings as part of best clinical practice. Survivors should be evaluated for safety and homicide risk and undergo a general health screening. Other areas to assess include history of substance abuse/misuse and social support.

In 2007, the Centers for Disease Control and Prevention released the screening tool Intimate “Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1,” that is widely used by providers.

Safety Assessment

A vital role for health care providers is to assess the safety of a survivor and develop a plan to ensure immediate safety of the survivor. Health care providers may connect survivors to a nurse, social worker, advocate, community resource, or health care workers who are trained in violent prevention.

Suicide Assessment

Studies have found a link between the number of previous traumatic events and the risk of attempting suicide. Mental health providers should conduct a suicide risk assessment in all interactions with IPV survivors. Mental health care providers should:

- Conduct the assessment in a private, confidential space.
- Provide interpreters as needed.
- Discuss the reasons for assessment with your patients. It will reduce their fear, anxiety and the risk of aggression.

- Describe with as much detail as possible what is happening or going to happen which will increase a sense of control and decrease fear and anxiety.
- De-brief with staff involved in the process.
- Work with the patient on a safety plan. This will increase a sense of control and collaboration.
- Focus on coping strategies for risky situations. It will help survivors' identity and reinforce strengths, social supports and motivations to seek help. Available safety planning resources can be found at <http://www.sprc.org/resources-programs/patient-safety-plan-template>

Danger Assessment

Every year 1,500-1,600 women in the US are killed by their intimate partners. About 1 in 5 women killed or severely injured by an intimate partner had no previous warning; the fatal or life-threatening incident was the first physical violence they had experienced from their partner. The following tools are used to help determine this risk.

- **The Danger Assessment** is a widely validated tool that determines the level of danger an abused woman has of being killed by an intimate partner.
 - It consists of two sections: a calendar and a 20-item scoring instrument. The calendar records the severity and frequency of IPV during the past year.
 - The 20-item instrument uses a weighted system to score “yes” or “no” responses to risk factors associated with intimate partner homicide.
 - The tool is available in English, Spanish, Portuguese and French. Training and certification are available in many forms including an online version.
 - It is also available in the form of a smartphone application for users who want to learn about the level of risk in their current relationships.
- **The Danger Assessment-Revised (DA-R)** is a tool that was also found to predict re-assault in abusive female same-sex relationships. This tool is also available, and it predicts only re-assault, not lethality.
- **The Lethality Screen for First Responders** is an assessment tool that was developed using the Danger Assessment as a guide. The instrument is currently being used by law enforcement in Maryland.
- Training options for the Danger Assessment are available at: <https://www.dangerassessment.org/TrainingOptions.aspx>

Treatment

Psychotherapies

Psychotherapies may be used to address the multiple stressors of IPV survivors, including the immediate need for safety and resources, loss of an intimate relationship, social isolation, and parenting issues.

The following psychotherapies that have demonstrated effectiveness in large randomized controlled trials for PTSD.

Cognitive Behavioral Therapy (CBT)

Present-focused non-exposure Cognitive Behavioral Therapy (CBT) helps people attain safety while helping to reduce trauma/PTSD symptoms and substance misuse. It can be delivered in the group and individual formats, in both adults and adolescents.

Seeking Safety, an evidence-based, integrative treatment approach is often used to help IPV survivors attain safety from trauma and PTSD. The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping patients attain safety in their relationships, thinking, behavior, and emotions)
2. Integrated treatment (focus on both trauma and substance abuse)
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse
4. Four content areas: cognitive, behavioral, interpersonal, case management
5. Attention to clinician processes (clinicians' emotional responses, self-care, etc.)

STAIR (Skills Training in Affective and Interpersonal Regulation)

STAIR is an evidence-based skills-focused CBT for PTSD treatment. STAIR was initially developed for individuals with PTSD related to childhood abuse (though not formally tested in IPV survivors). It can be implemented in both individual and group modalities. While this psychotherapy can be complemented with an exposure component, it is primarily focused on reframing cognitions that have emerged as a result of a traumatic experience. STAIR focus on:

1. Psychoeducation about the impact of trauma on emotions and relationships
2. Emotion regulation skills
3. Effective expression of negative emotions
4. Interpersonal skills related to appropriate assertiveness
5. Development of flexibility in regard to interpersonal expectations, actions and reactions. Treatment also includes recognition of achievements during treatment and exercises in self-compassion.

Interpersonal Psychotherapy (IPT)

IPT has been shown to be an effective non-exposure-based treatment for PTSD. Many PTSD symptoms reflect interpersonal difficulties such as emotional withdrawal from relationships and individuals, sometimes resulting in “interpersonal hypervigilance.” IPT directly addresses these areas by focusing on four interpersonal areas:

1. Grief, role disputes (disagreements with significant others)
2. Role transitions (changes in life circumstances)

3. Interpersonal deficits (persistent loneliness)
4. Social supports to improve well-being

Cognitive Processing Therapy (CPT)

CPT is an effective treatment for reducing PTSD and depression symptoms following interpersonal victimization, including physical and sexual assault. CPT focuses on:

1. Education of PTSD symptoms
2. Effect of traumatic events
3. Connections between trauma-related thoughts, feelings, and behaviors
4. Remembering the traumatic event and experiencing the emotions associated with it
5. Ability to challenge maladaptive thoughts about the trauma
6. Reduction of negative thinking patterns and motivation to learn new, healthier ways of thinking
7. Exploration of how core themes have been impacted by trauma.

Eye movement desensitization reprocessing (EMDR)

The EMDR integrates techniques from cognitive behavioral, psychodynamic, and body-oriented therapy. Processes identified in EMDR include mindfulness, somatic awareness, free association, cognitive restructuring, and conditioning. These processes may interact to create the positive effects achieved with EMDR. The therapy is conducted without detailed descriptions of traumatic events.

HOPE (Helping to Overcome PTSD through Empowerment)

It is a short-term non-exposure CBT specifically developed for battered women with PTSD living in domestic violence shelters. The therapy focuses on stabilization, safety, and empowerment. HOPE focuses on the following:

- Immediate physical and emotional risks
- PTSD symptoms, behaviors, and cognitions that interfere with achieving shelter and treatment goals
- PTSD symptoms and behavioral and cognitive patterns that interfere with quality of life
- Post-shelter goals and safety.

Relapse Prevention and Relationship Safety (RPRS)

- RPRS addresses IPV and relationship safety and reduces drug use, PTSD, depression, and risky sexual behaviors. Treatment is culturally specific to low-income Black and Latina women.

- The program does not try to pressure women into leaving the abusive relationship. It focuses on empowerment and safety tactics, within or outside of the relationship.

Grady Nia Project

It is a culturally competent intervention developed for low-income African American IPV survivors who are also suicidal. “Nia” derives its name from the Kwanza term that means “purpose.” It focuses on intrapersonal factors and women’s support networks and communities. The program aims to help women:

1. Build skills and enhance self-efficacy
2. Increase social connectedness
3. Decrease trauma-related distress through gender focused, Afrocentric empowering practices
4. Access comprehensive mental health care

Cognitive Trauma Therapy for Battered Women (CTT-BW)

CTT-BW was developed for IPV survivors who had no desire to reconcile with their abusive partners. The intervention includes psychoeducation about PTSD, stress management, and components to address:

1. Trauma-related guilt about failed relationships, effects on children, decisions to stay or leave
2. Histories of other traumatic experiences
3. Risk for subsequent re-victimization
4. Negative beliefs about self

The intervention also helps survivors with strategies for best interacting with former partners around child custody and visitation

Psychopharmacologic Treatment

- Psychopharmacological treatment can be used when treating mental health consequences of IPV, such as mood and/or anxiety symptoms
- Antidepressants, anxiolytics, and hypnotics are used to treat major depressive disorders (MDD) and PTSD associated with IPV. Combination of CBT and antidepressants is often used for treating PTSD.
- A full list of pharmacological interventions and psychotherapies can be viewed at "[Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors.](#)"

Best Practices

IPV survivors may feel misunderstood and unsupported during their interactions with mental health professionals. Labeling survivors with psychiatric conditions may cause them to feel as though their abusive situation is not understood. This may lead to mistrust of health care providers.

Using a trauma-informed model, health care providers can ensure a positive engagement between patients and providers. Trauma-informed principles include: 1) Acknowledgement; 2) Safety; 3) Trust; 4) Choice and Control; 4) Compassion; 5) Collaboration; and a 6) Strengths-based Focus.

- Mental health providers should build a therapeutic relationship based on respect, trust and safety. The following are recommendations for treating survivors:
 - Conduct interviews in private, confidential spaces.
 - Provide language interpreters, if needed.
 - Frame and ask questions and statements with empathy and nonjudgment.
 - Be mindful of the language or communication you use. (See glossary in Table 1 which can serve as a tool to improve communication.)
 - Try not to discuss too quickly the trauma that survivors endured. It can increase the risk of dissociation and feeling overwhelmed.
 - Conduct a suicide risk assessment and danger assessments.
 - Focus on a collaborative approach. After appropriate concerns are obtained, other service providers should be involved in the patient's care.
 - Consider incorporating culturally sensitive care to survivors.
 - Document all interactions, especially those in which the survivor presents psychological distress, dissociative symptoms or substance misuse.
- If survivors are ready to leave their partners, mental health providers should connect them with available resources that can provide multidisciplinary support in this process. These resources include crisis hotline, shelters, legal services, and community organizations.
- It is important to inquire about their children's safety at home. Law mandates mental health providers to report child maltreatment.
- Providers may discuss the dangers of exposing children to an abusive environment and ways to handle child protective services re-referrals, if needed.

Table 1. IPV and Trauma-Sensitive Practices -Strengths-based Language

Deficit-based/Inappropriate Language	Strengths-based Language
Domestic dispute, crime of passion, anger issues, wife beating	Intimate-Partner Violence (IPV): violence between intimate partners regardless of whether they cohabit/are married or still in a relationship in an ongoing pattern of coercive control perpetrated by one partner over another
Victim, Battered Woman	Survivor: Person who has experienced IPV regardless of gender.
“It’s a personal matter.” “It’s private; it’s between the two of you.”	“It’s not your fault.” “That was a crime.” It’s important to reinforce that IPV was wrong in a non-judgmental way
“So, you’re here because you’ve been abused?”	Build a rapport naming the abuse or the survivor’s experience. If the survivor is describing abuse without naming it, take time to listen and validate before providing psychoeducation on abuse: “What you’re describing sounds like abuse. It’s <i>not</i> okay that he/she said/did those things to you.”
“perpetrator,” “batterer,” “abuser,” “wife beater,” “offender”	It is more helpful to refer to the behavior rather than characterizing a person and defining them by using those terms. It is suggested to use languages such as “behaved abusively” or “abusive partner.”
“He’s a bad guy/she is a bad woman.” “He/she’s evil; I don’t know how he/she can live with himself.”	Some survivors have powerful attachments to their abusive partners and/or feel preoccupied with discussing or seeking treatment for their partner.
“So, it was just a misunderstanding.”	Abusive partners generally minimize and deny the abuse and blame survivors for the abuse. Survivors may come to believe that they are at fault, that they are “too sensitive” or that they deserved the abuse. Never assume that the violence or abuse is not serious.
“Why did you allow him/her to do that to you?” “Why didn’t you fight back?”	Recognize and reinforce that the survivor’s struggles leaving a relationship. Do ask “What did he/she do to you?”

<p>“Why didn’t you just leave?” “You chose to stay.”</p>	<p>Some of the survivors may not be willing or able to leave their abusive partners. Some may not want to leave their abusive partners though they want the violence to stop. Do ask “What were the reasons you felt you couldn’t leave?” “What gave you the courage to leave?”</p>
<p>“Really? Did that really happen that way?”</p>	<p>Believe survivors. IPV survivors may already have experienced minimization and invalidation of their experience. It’s important not to overtly question their narrative, especially the first time they share it with you.</p>
<p>“You are mentally ill”</p>	<p>Avoid pathologizing survivors. When discussing possible psychiatric diagnoses and treatment with IPV survivors, keep in mind that abusive partners often use such language to belittle survivors (e.g. mental health coercion).</p>

Appendix

Traumatic Brain Injury (TBI)

- TBI is a form of acquired brain injury that occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.
- The prevalence of TBI in IPV survivors seeking emergency shelter or presenting to the Emergency Department ranges from 30% to 74%.
- Mild to severe TBI can cause irreversible physical and mental health consequences.
- Individuals who experience IPV are more likely to have multiple TBIs. As these accumulate, the likelihood of recovery dramatically decreases. (For more information and resources on TBI please visit <http://www.ninds.nih.gov/disorders/tbi/tbi.htm>).
- Some individuals may not lose consciousness and still have significant sequelae because of the TBI.
- Mental health providers may be unaware of TBI in their patients. Subtle injuries may not be evident with brain imaging but still, lead to significant impairment. Therefore, proper referrals for evaluation and services should be given when TBI is suspected in IPV survivors.
- Patients with significant neurologic sequelae may need to apply for long term disability.
- A brief screening tool for TBI is available at:
http://www.doj.state.or.us/victims/pdf/traumatic_brain_injury_and_domestic_violence.pdf

Non-fatal Strangulation (Choking)

- Non-fatal strangulation (choking) is one of the most lethal forms of IPV as it can lead to temporary loss of consciousness and sometimes death. Strangulation accounts for 15-20% of deaths associated with IPV in the United States
- Symptoms of strangulation include nausea, vomiting, lightheadedness, headache, involuntary urination and/or defecation, as well as difficulty in breathing, speaking, or swallowing.
- Individuals who have been strangled may appear “normal” after the event. Therefore, a physical examination for strangulation injuries in survivors may be necessary.
- Non-fatal strangulation is a felonious assault in most states and may be considered an attempted homicide.
- Patients need to be educated about the seriousness of strangulation, risk of homicide and long-term consequences of strangulation.
- Mental health providers should connect strangulation survivors to advocacy organizations to receive help to understand legal rights.

- Training on non-fatal strangulation response is available at The Training Institute on Strangulation Prevention (Institute) a program of Alliance for HOPE International:
<http://www.strangulationtraininginstitute.com/what-we-do/>

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