Phoenix AUSTRALIA

Specific Populations and Trauma Types
Victims of Intimate Partner Violence (IPV)

This *Victims of Intimate Partner Violence (IPV)* information sheet addresses background issues and provides presentation, assessment and treatment advice for practitioners working with victims of IPV.

Background issues

Intimate Partner Violence (IPV) refers to any behaviour that occurs within an intimate relationship and causes physical, psychological or sexual harm, and includes acts of physical aggression, sexual coercion, and psychological abuse, as well as various forms of controlling behaviour (e.g., isolating a person from family and friends, monitoring movements).[1] The World Health Organization estimates around 30 per cent of women worldwide have ever been physically or sexually assaulted by their partner.[2] And while men are also exposed, there is evidence that women are most vulnerable to repeated and severe abuse, or violence that occurs in the context of controlling behaviours.[3,4] IPV is a major cause of physical and mental health conditions, and is the largest single cause of disease burden for Australian women aged 25 to 44.[5] Research indicates links with IPV exposure and various mental health conditions including depression, anxiety, and PTSD.[6] By way of illustration, studies have shown more than 80 per cent of victims who access specialist family violence services report PTSD,[7] while research also suggests cumulative effects of physical and psychological forms of IPV on mental health.[8-10] Studies of mental health service users indicate around 33 per cent of female outpatients have experienced IPV.[11]

Despite strong associations with PTSD, IPV can be heterogeneous and involve different types and severities of physical, sexual, and non-physical abuse that may be challenging to classify in terms of the stressor criteria that determine eligibility for relevant diagnoses in the DSM-5 and ICD-11. However, there are influential accounts of major 'sub-types' of IPV that highlight serious consequences of abuse and violence that occur in the context of coercive and controlling behaviour.[12] This coercive form of IPV may involve combinations of physical and sexual violence, with non-physical behaviours intended to gain or maintain control over victims, and is often based on threats of serious physical harm or other consequences (e.g., losing access to children).[13] Coercive IPV often follows chronic and escalating trajectories and may involve behaviours that include restricting access to resources (e.g., finances), monitoring and micro-regulating partner behaviour, as well as depriving victims of support needed to exercise independence. These coercive behaviours combined with actual or threatened physical violence are linked with experiences of generalised fear among victims,[14] and are the main form of abuse reported by women in specialist family violence services.[15] For current purposes, the term IPV will refer to coercive and controlling violence,

which, given actual and threatened harm, serious injury or sexual violence, may be suitably classified as a traumatic event in both the DSM-5 and ICD-11.

Presentation

The chronic and ongoing nature of coercive and controlling IPV suggests sustained and repeated exposures to trauma that may result in complex mental health problems. As described more fully in Chapter 7 the recent ICD-11 has incorporated a diagnosis of complex PTSD (CPTSD) in order to capture the additional problems that can result from sustained forms of trauma, which are distinguished by disturbances of self-organisation (DSO) symptoms.[16] These DSO symptoms include experiences of affective dysregulation (e.g., heightened emotional reactivity), negative self-concept (persistent beliefs about oneself as diminished or worthless), and interpersonal disturbances (difficulties in maintaining relationships or emotional engagement), which are additional to core symptoms of PTSD and predict greater impairment.[17,18] Such complex problems may also result from additional trauma exposures including violence by previous partners and childhood traumas, which are all reported commonly by IPV survivors.[19,20]

There are likely to be several explanations for the complicated trauma histories that are often reported by IPV survivors. For example, patterns of repeat victimisation may be partly due to the effects of specific trauma symptoms (e.g., emotional numbing), which can impair the ability of survivors to appraise and respond to threat cues (resulting in them being targeted by perpetrators).[19] Furthermore, the risk of multiple traumatic events may also be explained by broader social vulnerabilities that often intersect with IPV. By way of illustration, there are strong links with IPV victimisation and economic instability (e.g., low income, unemployment),[21] as well as minority status. For example, substantially increased risk of IPV is reported by people with disabilities and women from Aboriginal and Torres Strait Islander[22] or migrant and refugee backgrounds.[23] These intersections highlight consequences of entrenched social disadvantage and the complex experiences of violence for minority groups (e.g., migrants may be particularly susceptible to coercive IPV due to visa status and social isolation).[24,25] Social entrapment and marginalisation may lead to material barriers to leaving abusive relationships for vulnerable women.[26] These varied and co-occurring vulnerabilities can also contribute in complex ways to posttraumatic mental health problems, and create barriers and disparities in terms of access and engagement with mental health treatments.

Assessment

Physical and emotional safety should be a primary consideration when conducting assessments with clients who have experienced IPV. These assessments should be conducted in physical environments where clients feel safe to disclose abuse, and without potential perpetrators being present or nearby (e.g., driving the client to intake interviews, or being nearby while clients are assessed in person or over the telephone). Risk levels may change over time and ongoing assessments should be integral to therapy and treatment planning.

Violent or controlling behaviours may be present long after victims have left violent relationships; for example, when survivors manage shared custody of children or have contact with perpetrators through social or family relationships. Certain situations are associated with an increased risk of escalating violence and include pregnancy and the period during or immediately after leaving an abusive relationship. It is good practice to implement safety planning following risk assessments where current violence or potential escalations in abuse are identified. The risk of children being exposed to violence (e.g., witnessing) should

also be considered during risk assessments of clients with dependents. If a practitioner is a mandated reporter, then this may influence their ability to build trust given legal requirements to report risk to children. Being transparent about these responsibilities from the outset of treatment can help build and maintain trust.

Treatment planning may benefit from in-depth understanding of the nature of exposure to different types of violence, including controlling and threatening behaviours. Disclosures may be difficult for survivors because of shame and limited knowledge about what constitutes IPV. For this reason, it may be advisable to ask direct questions about specific behaviours or experiences (e.g., fear of partner, control of daily activities, threats to harm, being hit, slapped, kicked or otherwise physically hurt),[27] which may be informed by IPV measurement tools such as the Composite Abuse Scale.[28] Some forms of violence may be less readily reported because of stigma. For example, sexual violence may be rarely reported and require building additional rapport with the client (and direct questioning) in order to facilitate disclosure.

It is important to ask clients about their trauma history, in addition to IPV, and to explore the impacts of these experiences on mental health. Given links with IPV and significant social, financial and housing difficulties, it is also important that assessment and treatment planning consider the range of psychosocial needs and vulnerabilities of victims. For example, a survivor may have been systematically isolated from social networks and have limited access to informal supports. Other stressors commonly experienced by IPV survivors that can impact on engagement with treatment include involvement with child protection, family court proceedings, or managing ongoing protection or family violence intervention orders (which will often require interactions with police and the court system). These situations can produce high levels of distress and undermine trust in institutions and people in authority, which may include mental health practitioners.

Treatment

International guidelines recommend that all clients attending mental health services are asked about IPV, and that disclosures are responded to initially with a first line response characterised by 'Listening, Inquiring about needs, Validating experience, Enhancing safety and ensuring Support' (LIVES).[29] Research has shown that in mental health services this basic response may be lacking due to insufficient training on IPV for mental health workers.[30]

There is limited evidence currently regarding the effects of treatments for PTSD among IPV victims. Reviews suggest that brief psychological interventions can produce benefits for survivors relative to no intervention, and these may comprise short-term therapies grounded in established (e.g., cognitive behavioural) therapeutic models.[31] However, the nature of appropriate treatment may depend on the recency of IPV exposure and threat of re-victimisation. For victims who are currently in (or have recently left) abusive relationships, the assessment and promotion of immediate physical and emotional safety should be priority concerns. When survivors have established physical and emotional safety then there is evidence that present-centred and empowerment-focussed CBT can help to improve social support, depression and PTSD.[32-34] Preliminary studies have considered therapies involving cognitive restructuring and skill building, with additional components focussed on improving realistic threat appraisals and managing trauma symptoms. More recently, it has been suggested that narrative exposure therapy may be beneficial for IPV victims.[35]

Relative to other forms of trauma, IPV is unique in the sense that the lives of the victims may remain entangled with the perpetrator (e.g., due to parenting arrangements). Given that many IPV survivors have experienced sustained and repeated trauma, as well as potential historical (e.g., childhood) exposures, it is important to consider treatment options for complex PTSD. These may involve a preliminary 'stabilisation' phase for interventions to address affect and interpersonal dysregulation, which can precede engagement with traditional trauma-focussed therapies.[36]

Working with children

Several studies have demonstrated links with PTSD in children and exposure to parental IPV,[37-40] while the prevalence rates for relevant diagnoses among children who have been exposed vary widely from 13 to 60 per cent.[41-44] The risk of direct maltreatment is also high among children exposed to IPV, with about 30 to 60 per cent reporting at least one other type of abuse or neglect.[45-48] The cumulative effect of other types of abuse almost doubles the likelihood of PTSD diagnoses among children, when compared to those who have been exposed to IPV alone.[49]

For many children, exposure to parental IPV may be traumatic and their reactions will be similar to child victims of other traumatic events. These immediate reactions may include generalised anxiety, sleeplessness, nightmares, difficulty concentrating, increased aggression, increased anxiety about being separated from a parent, and intense worry about their safety or the safety of a parent.

In the treatment of trauma in children exposed to IPV, the first and foremost priority is to ensure the safety of the child and to work closely with relevant health and child protection professionals, particularly when the risk of exposure is ongoing. In some jurisdictions, child exposure to IPV may need to be reported to child protection authorities (although it is important to note that mandatory reporting laws vary across jurisdictions).

Treatment programs that include safety planning for children exposed to IPV typically involve mothers and children referred by health, advocacy, child protection or court services. Examples of relevant programs include Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)[50] and Child Parent Psychotherapy (CPP).[51] In both programs, children are made aware that their non-offending parent is seeking help and that professionals are available to help with safety considerations.

Mapping out the current living arrangements is crucial for appropriate safety planning. Where the non-offending parent is seeking treatment, the initial assessment should be conducted concurrently by a separate clinician and involve assessment of the parent's own exposure to violence (type and severity), including to what extent the child was exposed, either as a witness or victim or both. In terms of treatment planning, children should be consulted about the supports they will receive, considering both their age and developmental level. Where possible, empowering the child to have control of their own treatment options may be helpful to prevent a sense of loss of control that can re-traumatise a child with past exposure to coercive and controlling IPV.

Interventions for children affected by IPV exposure include group and individual therapy, and dyadic treatment involving the non-offending parent. There is a lack of systematic evidence about efficacious treatments in this context,[52,53] but a small number of trials suggests that TF-CBT and CPP may improve trauma symptoms in children. Both therapies involve working with the non-offending parent as well as the

child, and a strong relationship with this (non-offending) parent is a key factor in promoting recovery from the effects of IPV.

Mental health system reform

Trauma and violence-informed care is essential for survivors of IPV[54] and highlights the importance of 'system-level' responses within mental health services (given that isolated initiatives, such as staff training, are unlikely to improve patient outcomes). There is also a need for 'whole of system' responses to IPV,[55] which requires reform across multiple levels including:

- Health provider level: promoting cultures of gender equity; trauma-informed principles (respect, privacy, confidentiality, safety); sufficient consultation time; supportive environments with leaflets and posters; awareness of protocols and referrals.
- System level: ensuring coordination of internal and external referrals; protocols; workforce support and mentoring; appointment of champions; allocation of finances to family violence services; leadership and governance backed up with policies; appropriate design of spaces; and information systems for evaluation.

Future directions

There is a strong need for increased attention to the mental health needs of women and children exposed to IPV. This includes recognition by clinicians and regular questioning about IPV, as well as direct responses to safety-related and mental health concerns. It also includes recognition by policy makers of the treatment needs of IPV survivors through funding and commissioning of appropriate mental health services. There is a related need for additional research on the nature and appropriate classification of mental health problems that may develop in the context of IPV among female, male and non-binary victims (including those in same-sex relationships), as well as interventions which are acceptable and effective for promoting both safety and long-term recovery.

Finally, this *Victims of Intimate Partner Violence (IPV) and PTSD* information sheet has not addressed the potential role of PTSD and mental health problems generally in the perpetration of IPV, which was out scope. However, there is an additional need for improved understanding and attention to factors which may contribute to the usage of violence in relationships, which is a primary target for initiatives that are necessary to reduce and ultimately eliminate the harm to victims caused by IPV.

Source and contributors

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Recommended reading

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