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POSITION PAPER

Intimate Partner Violence

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Introduction

The term intimate partner violence (IPV) describes physical, sexual, or psychological harm by a current or former partner or spouse.[1,2] IPV is essentially a violation of human rights and a preventable exposure associated with serious consequences that needs to be addressed through social, educational, and legal policies.[3,4]

This paper aims to discuss the epidemiology of IPV, including prevalence, risk factors, special populations, associated impairment in health (with a focus on mental health), exposure to IPV among children, identification, assessment, documentation, management, treatment, prognosis, prevention, education, and research. The scope also includes a summary of the current state of knowledge about IPV and provides recommendations for best practice in psychiatry. In general, this paper highlights key findings and common themes from the highest-quality evidence available internationally, with a special focus on Canadian data. The Canadian Psychiatric Association (CPA) previously incorporated IPV in its 1992 Guidelines for the Evaluation and Management of Family Violence,[5] but information about IPV has greatly increased during the last 20 years.

IPV is an underrecognized problem that can have an enormous impact on the physical and mental health and well-being of women, men, and children. It also has links to risky health behaviours, such as alcohol and other substance abuse. IPV is a major public health and social problem globally that results in significant personal, health, economic, and social costs.[6–8] One study estimated that IPV costs Canada over $6.9 billion annually for women aged 19 to 65 who have left abusive partners.[9]

As IPV is associated with a broad range of health problems, including depression, anxiety disorders such as posttraumatic stress disorder (PTSD), chronic pain, eating disorders, sleep disorders, psychosomatic

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disorders, alcohol and other substance abuse, suicidal and self-harm behaviours, personality disorders (such as borderline and antisocial), nonaffective psychosis, and health risk behaviours, the rationale for this position paper is clear.[10,11] IPV should be of vital interest to mental health professionals and requires urgent attention from policy, clinical, educational, and research perspectives.

Definition

As indicated above, the term IPV describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among hetero- or homosexual couples and does not require sexual intimacy.[1,2] Statistics Canada[12] uses the following definition: "[IPV] encompasses physical and sexual violence, as well as emotional and financial abuse, perpetrated by a current or former legal or common-law spouse."[p 8] Many authorities include any intimate relationship, such as dating.

IPV includes acts of physical aggression (such as slapping, hitting, kicking, biting, beating, and use or threatened use of a weapon), psychological abuse (such as intimidation, constant belittling or humiliation, and threats), forced sexual acts, or any other controlling behaviour (isolating a person from family or friends, monitoring their movement, and restricting access to information, financial support, or other assistance).[6]

IPV has also been called family violence, domestic violence, or spouse abuse but these terms are less specific, and some include violence against children in the categories of family or domestic violence, which can be confusing. When IPV is directed toward women, the terms wife abuse, wife battering, or wife assault are often used. As will be seen in the next section on epidemiology, IPV can also be directed toward men. IPV is not restricted to marital partners, heterosexual relationships, or by culture. All these terms have in common an understanding of violence as an expression of power, control, and domination enacted through a range of ongoing behaviours that often escalate.

Epidemiology

Prevalence

IPV occurs in all counties, cultures, religions, and socioeconomic groups in the world. It may be perpetrated by men toward women, women toward men, and in same-sex relationships. It may occur in marriage, common-law relationships, cohabitation, or any intimate relationship, including dating. In general, IPV rates are underreported, but especially in police statistics. Most data collected to date have focused on IPV perpetrated by men against women in heterosexual relationships, as the following sections will show.[7,8,13]

The extent of IPV varies greatly across countries, but such comparisons have often been difficult, owing to important differences in methods and definitions. However, the World Health Organization (WHO) Multi-country Study on Women's Health and Domestic Violence against Women[14] has comparable data for 10 countries that show vast differences; for example, 3.8 per cent of Japanese women, compared with 53 per cent of Ethiopian women, experienced IPV in the last 12 months. In all sites but one, women were more at risk of violence from a partner or ex-partner than from violence by other people. There were also significant differences in experiences reported by women residing in rural and urban areas, with higher rural rates usually found.[13]

In Canada, national data on IPV reported by men and women were first collected by Statistics Canada in its population-based 1999 General Social Survey (GSS).[15] Almost equal proportions of men and women reported being a victim of physical (seven and eight per cent respectively) and psychological (18 and 19 per cent respectively) abuse in intimate relationships in the previous five years.[15] Data for 2011 showed slightly reduced rates, with six to seven per cent of Canadian women reporting IPV in the last five years.[12] Higher rates of IPV have been found among women in out- and inpatient psychiatric services.[10,16–18] A systematic review and meta-analysis of 41 studies found increased odds ratios of adult lifetime IPV in women with depressive disorders (2.77), anxiety disorders (4.08), and PTSD (7.34), compared with women without mental disorders. Individual studies reported increased odds ratios for both women and men for all diagnostic categories, including psychoses, with a higher prevalence reported for women. Few longitudinal studies were found, thus the direction of causality could not be determined.[10]

Historically, there has been the stereotype of the abusive male who uses severe and unilateral violence against a nonviolent female victim. It is now recognized that bilateral violence is more common than previously recognized, although women experience the overwhelming burden of morbidity and mortality related to IPV.[19] Bilateral violence, otherwise referred to as common couple violence, is considered less serious than the pattern of violence known as battering or intimate terrorism—a severe and often escalating form of IPV characterized by threats and multiple forms of violence and controlling behaviour by the abusive partner. Current research suggests that women are most often subjected to battering by male perpetrators.[19]

As indicated above, there are marked differences in the patterns of IPV for women and men. Women reported more severe and chronic patterns of violence and control

involving high levels of fear and injury.[20] However, women and men were equally likely to experience less serious acts of physical aggression that were not embedded in a pattern of control (common couple violence). Researchers have also reported that women are more likely than men to report severe IPV, such as being beaten, choked, strangled, sexually assaulted, physically injured, or killed.[20] Canadian police statistics in 2009 also show that current or former spouses or other intimate partners committed more that 41 per cent of violent incidents involving female victims.[21] Most victims (83 per cent) of reported spousal violence were women, who were also more likely than men (42 and 18 per cent, respectively) to report a physical injury or fearing for their lives as a result of IPV (33 and five per cent, respectively), and were more likely to report chronic violence, defined as 11 or more incidents of violence, (20 and seven per cent, respectively). In 2007, women were four times more likely than men to be victims of IPV spousal homicide.[21] Accordingly, IPV has frequently been described as gendered.

IPV does not necessarily stop when a relationship ends. Canadian criminal harassment data from the Uniform Crime Reporting Survey and the Adult Criminal Court Survey[22] indicate that women accounted for three-quarters (76 per cent) of all victims of criminal harassment (including stalking) in 2009, with 45 per cent being harassed by a former partner and an additional six per cent harassed by a current partner.[22] This differs significantly from patterns of criminal harassment among men.[22] These ongoing forms of harassment and abuse continue to have health and economic impacts on women.[9,23–25]

As mentioned earlier, in the 1999 national sample of Canadian men, seven per cent reported exposure to physical violence and 18 per cent reported psychological abuse from an intimate partner.[15] Over one-half (54 per cent) of abused men reported more than one incident of IPV. Abused men were more likely than abused women to report having had something thrown at them, or been slapped, kicked, bitten, or hit, while abused women were more likely to report having been beaten, sexually assaulted, choked, threatened with a gun or knife, or having had such a weapon used against them. Common forms of psychological abuse reported by both men and women included controlling, shaming, demeaning, intimidating, or humiliating behaviours or remarks. The context in which these acts occurred is not reported, but psychological and physical abuse often co-occurred in both sexes, and both partners were sometimes perpetrators. Thirteen per cent of male victims of IPV reported physical injury and three per cent sought medical attention. Men reported bruises, abrasions, genital injuries, minor head trauma, lacerations, and internal injuries, and endorsed feeling emasculated, marginalized, shamed, and embarrassed. According to reports by male victims, their claims of abuse were often met with skepticism or disbelief by medical and legal professionals, as well as friends and neighbours.[26] This disbelief was most marked for sexual IPV, as many people were unaware that erection and ejaculation could sometimes be caused by fear, anger, or pain, and not only by consensual sexual arousal.[27] A small American study of adult suicidal patients in an acute inpatient unit found that over 90 per cent reported IPV perpetration and (or) victimization in the last year and that male and female patients did not differ significantly on the perpetration or victimization subscales.[18]

Risk Indicators

Many Canadian studies, including national, population-based surveys,[28] as well as other large-sample research studies in different settings,[29] have shown a fairly consistent pattern in demographic, relationship- and partner-specific indicators for exposure to IPV, including a young partner, being in a common-law (rather than legally married) relationship, or separated; being in a relationship with an un- or underemployed partner, low economic status, and abuse of alcohol or other substances. International studies have identified personality disorders, psychosis, depression, marital conflict, and poor family functioning as factors associated with a man's risk for abusing his partner.[6] Marked jealousy, hostile-dependency, low self-esteem, low assertiveness, emotional inexpressiveness, and social and sexual inadequacy have also all been described in perpetrators of IPV.[30] For male victims, younger men were four to five times at greater risk of IPV than older men (over 45 years in age). Men in common-law relationships were at increased risk, compared with those who were married (four and one per cent, respectively). Men who reported high stress or conflict in their relationship also were at greater risk.

The etiology of IPV includes exposure to violence in childhood, which raises the risk of both adult victimization and perpetration of child and partner violence (intergenerational cycle of abuse).[28] Community and societal factors for IPV also include weak social sanctions against IPV, poverty, low social capital, traditional gender norms, low status of women, and social norms that are supportive of violence.[6]

The assessment of a victim or a perpetrator of IPV for risk of future violence is difficult, with overall low predictive validity as a systematic review by Fazel et al[31] shows. However, the 20-item Historical, Clinical and Risk management tool (HCR-20) is a helpful memory aid.[32] The HCR-20 consists of 10 historical items: previous violence, young age at first violent incident, relationship instability, employment

problems, substance use problem, major mental illness, psychopathy, early maladjustment, personality disorder, and prior supervision failure. Five clinical items include the following: lack of insight, negative attitudes, active major mental illness, impulsivity, and lack of response to treatment. Five risk management items include the following: plans lack feasibility, exposure to destabilizers, lack of personal support, noncompliance with remediation attempts, and stress.[32] HCR-20 has been found to lead to significantly greater accuracy in violence prediction generally (in psychiatric patients) than the use of unstructured clinical judgment.[33] However, the predictive accuracy of all such tools varies depending on how they are used.

Special Populations and Situations

Cultural Factors

Cultural factors are prominent in IPV and often centre around deep-seated values about the relative priority of one's own goals and autonomy (that is, individualism) and those of the society (that is, collectivism) to which one belongs. Collectivist cultures that are also patriarchal have rigid gender roles, subscribe to men's control of women's behaviour, link masculinity to dominance, control, honour, and aggression, and accept violence as a way of resolving conflict. Women in collectivist cultures are often urged to endure rather than reject IPV, as a way of preserving cultural values, the family, and honour.

New Immigrants

New immigrants (including refugees and asylum seekers) to Canada from patriarchal cultures, who may not speak either of the official languages, may not be allowed to leave the home unaccompanied, and have no knowledge of Canadian laws or services available to them, have a higher risk of IPV.[34] Social norms, religion, and minority status in immigrants may also conspire to limit the options of women who experience IPV. Immigrant women from developing countries report a higher prevalence of IPV, compared with those from developed countries or Canadian-born women.[35] Single, separated, divorced, or widowed immigrant women were 10 times more likely to report IPV than those who were married or in a common-law relationship.[35] Based on the 1999 GSS findings, emotional IPV toward women was almost twice as high in immigrant groups to Canada, especially if the partner had less than a university-level education; however, the reported prevalence of physical spousal abuse was not statistically significantly different between the two groups.[36] There are reports from the United States, which may also pertain to Canada, of increased prevalence of IPV in people of colour and other visible minorities.

Aboriginal Women

Aboriginal women in Canada are two to four times more likely than non-Aboriginal women to experience violence by a male partner.[37–39] According to the 2009 GSS survey, Aboriginal women reported three times more spousal violence than non-Aboriginal women (15 and six per cent, respectively) in the five years prior to the survey and were more likely to report more severe forms of violence.[40] The dynamics of violence in Aboriginal communities has been partially attributed to colonization, racism, and discrimination.[38] Others have also discussed the impact of residential schools and the use of alcohol and drugs.[39]

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning

Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) relationships suffer from inadequate information about IPV prevalence in Canada, but it is thought that the dynamics of abuse are similar to those experienced in heterosexual relationships. It is suggested that IPV occurs at the same rate or at even higher rates than in heterosexual relationships. Some unique risk factors, such as the threat of outing, disclosure of human immunodeficiency virus (HIV) status, social stigma, and the lack of emergency shelter for homosexual victims, have been identified.[41,42] A literature review of IPV in gay men found that 15 to 51 per cent reported some form of IPV during their lifetime, and certain ethnicities may be at greater risk.[43] A random sample of 284 gay and bisexual men from British Columbia found that almost all respondents reported psychological abuse, more than one third reported physical abuse and 10 per cent reported unwanted sexual activity because of force or threats of force by a partner.[44] Population data from the the United States showed increased verbal, physical, and sexual IPV in same-sex and bisexual couples, compared with heterosexual couples.[45] We were unable to find representative Canadian data on IPV in lesbian or transsexual couples. A Toronto nonrandom, self-report survey of 189 lesbians found about 20 per cent reported IPV, with about 10 per cent reporting physical abuse.[46]

People With Activity Limitations

People with activity limitations (ALs) (previously called disabled) also report higher rates of exposure to IPV. In an analysis of the 1999 GSS, 1,483 women with current or former partners reported ALs that restricted them at home, school, or work. When compared with other women, women with ALs report more severe physical abuse, sexual abuse, emotional abuse, and any IPV. When adjusted for multiple variables, women who often had AL had a two-fold increase (odds ratio 2.12) for IPV.[47] An analysis of the 1993 Statistics Canada Violence Against Women Survey and the 1999 and 2004 GSS

found a significantly higher prevalence of IPV in women with ALs. Their partners engaged in more patriarchal domination, and possessive and jealous behaviours than other partners.[48] People with ALs are at special risk of IPV because of their disability and may have more difficulty in reporting IPV and accessing services. Note that ALs may be a result of IPV as well as a risk factor.

Pregnancy

Pregnancy is a time of change and IPV may begin, escalate, or stop during this period. Two Canadian clinical studies found prevalence rates of six to seven per cent during pregnancy.[49,50] Prior abuse is the strongest predictor of violence during pregnancy.[51,52] When the pregnancy was unplanned or unwanted, women were four times as likely to suffer increased rates of abuse as when the pregnancy was desired.[53]
In a Canadian clinical study, 95 per cent of the women who reported violence during pregnancy stated that the violence increased after the baby was born.[52] Earlier reports suggested that women who are pregnant are at increased risk of IPV; however, more recent (non-Canadian) studies suggest that IPV during pregnancy occurs at generally lower levels than lifetime and past-year IPV.[54,55] One of the few studies to examine longitudinal trends in IPV during the course of women's pregnancies[56] showed that early pregnancy seemed to trigger higher rates of physical violence for some women, but for others, it was protective.

Dating Violence

Dating violence is common and may be experienced by either sex throughout the adult years, although it is most common among youth. It may be a single episode or a pattern of abusive behaviour that may involve physical, sexual, or psychological abuse. The 1993 Canadian National Survey of University and College Students (see Department of Justice Canada[57]) reported that 35 per cent of women had experienced a physical assault by a male dating partner and 28 per cent reported a sexual assault in the previous 12 months. Eleven per cent of men reported sexual victimization by a dating partner in the past 12 months. Many of these incidents were not reported out of shame, embarrassment, denial, fear of not being believed, fear of rejection or retaliation, or believing the abuse to be their fault. Risk factors for dating violence include past abuse, beliefs and attitudes, lower relationship skills, drinking and drug use, peer influences, and pornography.[57]

Alcohol Use in IPV Perpetrators and Victims

Alcohol use in IPV perpetrators and victims has been reported in many countries. Alcohol use both increases the occurrence and the severity of IPV.[58–60] It directly affects cognitive and physical function, reduces self-control, and leaves people less capable of negotiating a nonviolent resolution to conflicts within relationships,[61] which is especially problematic in impulsive people. Excessive drinking by one partner can exacerbate financial difficulties, childcare problems, infidelity,[62] or other family stressors, creating relationship tensions and conflicts and increasing the risk of IPV.[63] Alcohol use may also reduce the abused partner's ability to perceive, resist, or escape from IPV. Experiencing IPV can lead to alcohol consumption as a method of coping or self-medicating.[64] However, individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking, and alcohol may be used as an excuse for violent behaviour.[65] It is likely that other types of substance abuse also lead to higher prevalence rates of IPV, but reliable data are lacking.

Poverty

Poverty is also associated with IPV, and although IPV can and does occur across all socioeconomic groups, it occurs most often among people living in poverty.[66,67] This may partly reflect the greater power, higher education, and more options available to escape violent relationships in higher-income people, as well as the general life stress caused by insufficient financial resources. Poverty may also coexist in combination with other risk factors for IPV.

Senior Age

Senior age does not confer protection from IPV, although there are less data available for this population. IPV experienced by older people may be a continuum from earlier years or occur in the context of new marital discord. Abusers may be socially isolated, stressed, or suffer from mental illness or substance abuse. However, dementias or other brain dysfunction may be major factors, as cognitive dysfunction along with sensory impairment may lead to deterioration in reality testing and paranoid ideation. Frontal lobe disturbances may result in a lack of normal inhibition, with little apparent remorse or insight after IPV. Couples who age at different rates may also provoke feelings of envy and narcissistic wounds of aging that may trigger aggression toward the more youthful-appearing partner. It is important to remember that older people may be aggressive, violent, or dangerous. However, IPV perpetrated in old age is often regarded less seriously and with more sympathy extended to the perpetrators because of their perceived physical frailty or infirmity.[30]

Other

A reanalysis of the 1999 GSS data found little difference in the 12-month or five-year IPV rates in women of visible minority status, different educational levels, living in either urban or rural settings, or with differing

numbers of children. However, as indicated above, higher IPV rates were found in immigrant women, Aboriginal women, women with ALs, or with low income or without a current partner (that is, IPV perpetrated by a former partner).[66]

Health Impacts

IPV has serious mental and physical health effects, including death.[6]

Mental Health Consequences

IPV is consistently associated with high rates of depression, anxiety disorders (especially PTSD, phobias, and panic disorder), alcohol and other substance abuse, severe sleep disorders, psychosomatic disorders, and suicidal behaviour and self-harm after exposure to IPV.[6,11,68] Depression and PTSD are the most prevalent mental health disorders associated with IPV, with considerable comorbidity of the two disorders.[69,70] In a meta-analysis of studies of women exposed to IPV, the mean prevalence of depression was estimated at 47.6 per cent, and PTSD at 63.8 per cent (3.5 and 5.0 times the general female population rates, respectively).[71] A systematic review and meta-analysis found major depressive disorder (nine to 28 per cent), elevated depressive symptoms, and postpartum depression could be attributed to lifetime exposure to IPV.[72] Loss, feelings of shame and guilt, humiliation, entrapment, and lack of control contribute to the development of poor self-esteem and depression,[14,73] findings also seen in the 2004 Canadian GSS.[74] As mentioned earlier, increased odds of adult lifetime IPV have been found in patients suffering from a wide variety of psychiatric disorders.[10]

Other studies have also identified increased rates of eating disorders, antisocial and borderline personality disorders, and nonaffective psychosis in women exposed to IPV.[13,14,69,71,75,76]

Aboriginal women with abuse histories have higher rates than non-Aboriginal women of mental health problems, such as depression and substance abuse.[77] A two-fold ratio of depression (18 per cent, compared with nine per cent) was found in Ontario First Nations women, compared with Ontario women, in the National Population Health Survey.[78] However, Canadian data from the 2009 GSS indicate that Aboriginal women's self-rated mental and physical health does not differ from that reported by non-Aboriginal women,[40] even though, as indicated previously, the frequency and severity of their violence exposures are significantly greater.

Because evidence is mounting that depression and PTSD are pathways by which abuse affects physical health,[24,79,80] addressing mental health effects may also be important for preventing physical health problems, such as chronic pain or cardiac disease. It has also been found that when violence decreases or is eliminated, physical and mental health both improve.[81] However, simply ending a relationship does not mean that the violence and harassment end, as indicated by the Canadian criminal harassment data.[22]

IPV is also associated with health risk behaviours, including alcohol and drug abuse and smoking.[6]

Physical Health

Between 2000 and 2009, there were 738 spousal homicides in Canada, representing 16 per cent of all solved homicides and nearly one-half (47 per cent) of all family-related homicides; women are about three times more likely than men to be victims of spousal homicide.[12,21] In 2010, there were 89 victims of homicide by an intimate partner (including a dating partner). However, trends in spousal and dating partner homicide are gradually declining.[12,82] Specifically, the rate of intimate partner homicide decreased by 32 per cent from 1980 to 2010.[82] This decline has been attributed to various factors, including improvements in women's socioeconomic status (SES) and the increased availability of resources for victims of violence.[83,84]

Few comparative studies have examined specific differences in injury patterns indicative of IPV, compared with other potential causes (that is, unintentional injuries). However, a systematic review and meta-analysis compared injury patterns of women presenting in emergency departments (EDs), with, and without, IPV exposures. They found that specific injury patterns can differentiate people exposed to IPV, compared with other kinds of injurious events; specifically, head, neck, dental, or facial injuries that were not witnessed (that is, as would likely occur with a motor vehicle injury); as well, multiple injuries were associated with IPV exposure, whereas thoracic, abdominal, or pelvic injuries, or extremity injuries alone, did not differentiate between abused and nonabused women.[85] This is consistent with individual, noncomparative studies, which also find that head, especially oral and (or) dental injuries, ocular injuries, strangulation wounds, concussion, internal and external contusions, fractures, and open wounds, are strongly associated with IPV assaults.[6,14,86]

IPV has been linked to many other physical health outcomes, including those related to reproductive health, and chronic conditions and infectious diseases. An international systematic review and meta-analysis by the WHO and other studies have found IPV to be associated with, in addition to the injuries above, chronic pain syndromes, fibromyalgia, gastrointestinal disorders, including irritable bowel syndrome, sleep disorders, physical inactivity, disability, and general reductions in physical functioning and (or) health-related quality of life.[6,14,74,87]

IPV is also associated with gynecological disorders, infertility, pelvic inflammatory disease, pregnancy complications and (or) miscarriage, sexual dysfunction, unsafe sexual behaviour, sexually transmitted diseases, including HIV/AIDS, unsafe abortion, and unwanted pregnancy.[6,14] In addition to maternal health, IPV during pregnancy can threaten the health of the fetus. Abuse directed to the abdomen can result in poor pregnancy outcomes and perinatal death.[88] The evidence regarding a direct association between IPV in pregnancy and low birth weight is conflicting, but there is an increased risk of preterm birth.[14,88–91]

In Canada, Aboriginal women exposed to IPV are more likely to report injuries than are non-Aboriginal women (59 and 41 per cent, respectively), and are also more likely to report fearing for their lives (52 and 31 per cent, respectively).[40]

We were unable to find Canadian data on health effects in other special populations.

Children's Exposure to IPV

Exposure by a child to any incident of psychological, physical, sexual, financial, or emotional abuse between adults who are, or have been, intimate partners or family members is defined as a form of child maltreatment,[92] and may have short- or long-term health impacts on the child, especially mental health effects. Adverse outcomes that result from IPV exposure in childhood include an increased risk of physical, psychological, social, emotional, and behavioural problems, including mood and anxiety disorders, and drug abuse and school-related problems in children and adolescents.[92–96]

These negative effects may continue into adulthood and become part of an intergenerational cycle of violence[92,96,97]; specifically, children who are exposed to IPV in the home are more likely to maltreat their own children[97,98] and are more likely to have violent dating and intimate relationships as adults (either as victims or perpetrators).[99–101] Children exposed to IPV are at increased risk of experiencing other forms of abuse by caregivers (for example, physical and sexual abuse).[102,103]

Identification, Assessment, Documentation

There has been ongoing debate about the clinical utility of routine IPV screening of women presenting to health care settings. In a Canadian randomized controlled trial (RCT), women screened for IPV in EDs, family practices, or obstetrics and gynecology clinics were compared with nonscreened patients. Although no harms were detected, the benefits were too few and too small to justify routine IPV screening in those health care settings.[104] A more recent RCT of screening in U.S. primary health care settings and among primarily women of colour receiving Medicaid found similar results.[105] Accordingly, these two trials, with complementary methodologies and samples, and conducted in two different health care systems, indicate that routine screening for IPV neither reduces violence exposures nor provides health or life quality benefits,[106] a fact highlighted in most major evidence-based systematic reviews (for example, see Feder et al,[107] Institute of Medicine,[108] and Nelson et al[109]), though not necessarily reflected in specific practice guidelines,[110,111] causing some confusion among policy makers and health care professionals. However, it is especially important for mental health clinicians to be alert to the signs and symptoms of IPV exposure, and to practice case finding for IPV in the assessment of patients who present with psychological signs or symptoms (such as depression, anxiety disorders, including PTSD, chronic pain, eating disorders, sleep disorders, psychosomatic disorders, self-harm, substance abuse, some personality disorders, and nonaffective psychosis) or physical signs or symptoms (see above), which are known to be associated with IPV exposure. Consequently, inquiring about current and past IPV victimization or perpetration should be part of the clinical assessment of all patients, both men and women, in mental health care settings. Such inquiry is referred to as case finding, because it involves including questions about exposure and perpetration of violence within the diagnostic assessment; it does not involve screening—the use of standardized questions administered in the same way to all patients. Being aware of a history of IPV is necessary to inform diagnostic formulation and treatment approaches; without this information, a key contributing factor to the onset and persistence of mental illness, as well as any opportunity for interventions, may be missed.[30] Most IPV victims seeking health care present with vague signs and symptoms or chronic somatic complaints, including chronic pain, rather than signs of obvious physical trauma. Other behaviours that may suggest IPV are delays in seeking care or multiple missed appointments.[4] Lack of knowledge or interest, time constraints, fear of retribution or of legal involvement are not acceptable reasons for mental health professionals to avoid inquiring about IPV.

A private, safe, supportive, confidential environment is essential to facilitate disclosure, as many patients will not spontaneously disclose IPV out of fear of retaliation, family or community censure, embarrassment, shame, economic dependency, or apprehension about child custody, immigration status, or the legal system. It is important to ask about exposure to IPV privately—with no one else present—including a child (beyond infancy) or partner; if the inquiry and (or) response is overheard, it could put the patient at risk for further IPV. Special arrangements may be needed for immigrants. The patient should be seen alone, or by a same-sex interviewer if culturally indicated, and family and family

friends should not be involved as translators. Cultural competence should allow a person to not only reject violence but also maintain their cultural identity. Patients may also lack knowledge that IPV is a crime in Canada, or that support services exist, or may not see this as a health care issue that is appropriate to disclose to a health care provider.

It may be helpful to preface direct questions about IPV by asking about the patient's relationships generally. An introduction, such as "I think it is important for me to understand my patients' safety in their close relationships" could be used. Possible questions to ask include the following:

1. Sometimes partners or ex-partners use physical force. Is this happening to you?
2. Have you felt humiliated or emotionally harmed by your partner or ex-partner?
3. Do you feel safe in your current or previous relationships?
4. Have you ever been physically threatened or hurt by your partner or ex-partner?
5. Have you been forced to have any kind of sexual activity by your partner or ex-partner?

When IPV is first disclosed by an abused partner, the initial clinical response should include the following: validation of the experience (for example, "Violence is, unfortunately, a common problem in our society" [or, "in many families"]); affirmation that violence is unacceptable (for example, "Everyone deserves to feel safe at home"); and expression of support (for example, "There are things we can discuss that can help"). It is crucial that insensitive (for example, "Why don't you just leave?") or critical remarks are not made by mental health care professionals as these may reinforce existing feelings of helplessness, inadequacy, or self-blame in victims.[30] The clinician needs to acknowledge the complexity of IPV and respect the patient's individual concerns and decisions. All discussions in which IPV is disclosed must include an inquiry about current safety. If the patient denies IPV but injuries, signs, or symptoms suggest that it is likely, inquiries should be repeated at later visits when an atmosphere of greater trust may facilitate disclosure.

Although the decision to make a formal complaint about IPV to legal authorities belongs to the abused patient alone, a disclosure that indicates that a child is also being abused, or is exposed to IPV, may require mandatory reporting to provincial or territorial child welfare authorities, depending on the legislation. The legislation varies somewhat across provinces and territories, thus it is important to understand the specific legislation in one's region of practice. Given the limits of confidentiality, owing to mandatory reporting to child welfare, it is important that patients be advised about these limits before being asked about IPV exposure.

Decisions to leave an abusive relationship may require time and may follow the stages of change outlined by Prochaska (that is, precontemplation, contemplation, preparation, action, and maintenance) (see Burke et al[112]). In fact, a clinical tool to assess abused women's readiness to address the violence in her life has been developed.[113] Women planning to leave a relationship involving IPV should be cautioned that the risk of more serious violence (at times, even homicide) is increased during and following leaving the partner.[12, p 33] Safety should be a consideration whenever a person discloses IPV, and simple questions can be useful, such as, "Do you feel safe to return home today?" "Do you have a safety plan?" and "Does your partner have a weapon?" Appropriate action (such as involving the police with the patient's permission) may be necessary if there is an imminent safety issue.

In general, studies exploring women's preferred responses after disclosing IPV suggest that women want physicians to ask questions about the abuse, to listen and believe them, express concern, be nonjudgemental and supportive, and to make appropriate referrals to shelter, and to social and legal services.[114] Women do not want to be pressured to disclose IPV (or to leave their partner); they prefer to be asked about it in a way that is confident and comfortable, with assurance of confidentiality (with the potential exceptions regarding child welfare, outlined above). It is important to state to the patient that all people have a right to live without abuse, and that physical abuse is a criminal offence in Canada.

Perpetrators of IPV may present with personality disorders, substance abuse, psychosis, depression, fear of losing control, obsessional jealousy, paranoid ideas, or brain dysfunction. Questions may uncover IPV, such as, "What happens when you lose your temper?" or "Have you ever become violent or threatened someone?" or "Has this person ever been your partner?" More specific questions about the abuse should follow. A Canadian study found that male and female psychiatric patient perpetrators of IPV similarly fell into one of three groupings of generally violent and antisocial, borderline and dysphoric, or family only and low psychopathology subtypes.[115] Disclosures by perpetrators should not be dismissed, minimized, or met with indifference or seeming collusion.[30]

Careful, accurate documentation in the medical chart is vital for monitoring, diagnosis, formulation, and treatment planning. It may also be needed for legal proceedings.[116] The reported history and chronology of IPV and its relation to perpetrator or victim psychiatric symptoms, and its effects on a victim, should be recorded. It is important to differentiate facts from opinions.[30] Factual information, such as documenting visible injuries in a victim (a body diagram may be

useful), a personal description of the IPV and its context by the patient in quotation marks, and noting the patient's mental status, is useful. Patient records (as always) should only be released by written patient consent or by subpoena (unless reporting to child welfare authorities is mandated).

Management, Treatment, and Prognosis

Treatment approaches will depend on the psychiatric diagnosis and be informed by issues specific to the patient, the relationship, the trajectory of abuse, the patient's readiness for change, culture, and the IPV characteristics. There are several reports of psychological interventions for IPV victims, and a systematic review of controlled studies identified seven individual and 10 group interventions. Improvements in psychological outcomes, including depression, PTSD, and self-esteem, were discussed in a wide range of psychological interventions, including cognitive trauma therapy provided to patients in individual or group formats.[117,118] Although no studies were found that identified resilience as the primary outcome, components of resilience, such as self-esteem, self-efficacy, and improved quality of life, were included among outcomes.[119] Most studies were conducted with women who were no longer in abusive relationships, and their effectiveness in men or in people still experiencing abuse is unknown.[4] The evidence for working with the whole family is mixed.[120] Couples therapy showed no benefit in a therapy trial in a military population, compared with other treatments or a control group.[121] All groups had a low rate of recidivism, thus it could be that employment in a military setting acts as a general deterrent for IPV recurrence, once it is identified. The current literature states that couples therapy is not safe for most women victims, especially those experiencing intimate terrorism.

Advocacy interventions for people exposed to IPV aim to empower victims and link them to community resources, such as shelters, housing, safety planning advice, informal counselling, and legal services. A Cochrane review of 10 RCTs of advocacy interventions found equivocal evidence of a beneficial effect on physical and psychological well-being among women recruited from IPV shelters, but were unable to draw conclusions for women recruited from health care sites.[117] However, a broader systematic review of all controlled studies of IPV advocacy interventions, including some in health care settings, found a reduction in abuse, increased social support, improved quality of life, increased safety behaviours, and use of community resources.[107]

Studies of children exposed to IPV have shown positive outcomes for specific interventions, such as:

1. Child–parent psychotherapy.[122,123]
2. Teaching child management skills and providing support to mothers.[124]
3. A program of advocacy for mothers and their children, combined with a support and education group for children.[125]
4. Trauma-focused cognitive-behavioural therapy, involving individual sessions for mothers and children as well as joint sessions.[126]

These interventions, focused on the mother–child dyad, have been shown to improve either children's behaviour problems[122–124] and (or) PTSD symptoms in children,[122,123,126] as well as children's competence and self-worth.[125] They are promising in their level of evidence and require replication.

The prognosis for victims of IPV is uncertain as interventions usually have small samples, short follow-ups, and high attrition. Cohort studies of the natural history of IPV are rare. There are numerous descriptive reports of women successfully leaving abusive partners and establishing healthy relationships with subsequent partners. However, a follow-up of women who received an advocacy intervention after leaving a shelter found 44 per cent had been assaulted by their original or a new partner 3.5 years after leaving the shelter. More encouragingly, there was a significant improvement in quality of life and social support among women who participated in the advocacy intervention, compared with those who did not,[127] even though, at three years' follow-up, there was no longer a difference in IPV recurrence as had been the case at two years' follow-up. We were unable to find prognostic data about men or members of special population groups who were abused.

Interventions for perpetrators of IPV show mixed results, with better designed studies showing no benefit or increased recidivism.[128] The main treatment, in addition to treating any mental illness that may be present, is to encourage the perpetrator to take responsibility for IPV, to recognize internal and external triggers for IPV, and to understand and take responsibility for the consequences. Specific behavioural strategies to reduce the risk of violence, advice on reducing alcohol or drug intake, and referral to appropriate services may be helpful for specific people.[30] The evidence of effectiveness for batterer intervention programs is mixed. There is some evidence to suggest that permanent (not temporary) civil protection orders may reduce future IPV.[129]

Prevention

Primary prevention of IPV consists of educational programs that focus on respectful relationships, conflict resolution strategies, changes in attitudes, and knowledge. An RCT in a Canadian school-based trial of Grade 9 students consisting of information about dating violence and healthy relationships reported a statistically

significant reduction in self-reported physical dating violence in the intervention, compared with the control groups (7.4 and 9.8 per cent, respectively),[130] although the effect was limited to boys.

Although scientific evidence is lacking, many authorities recommend intersectoral collaboration between health, social, education, and legal services, as well as between health specialties and disciplines to advocate for IPV prevention and policy.[131] The media can also be helpful in raising public awareness of IPV as a critical mental health determinant and in censuring public statements that normalize IPV as an acceptable or cultural norm.[132] However, it is important to evaluate the effectiveness of such approaches in reducing IPV.

Secondary prevention interventions for IPV have been described for pregnant women, consisting of advocacy and empowerment programs that reduced psychological and minor physical violence and improved pregnancy outcomes.[133,134] One trial of intensive advocacy (12 hours or more) reduced physical abuse after 12 to 24 months in women leaving shelters, but this was not the case for shorter or longer follow-up periods.[127] Other treatment interventions were discussed earlier in this paper.

Education and Research

Some psychiatric associations (for example, the World Psychiatric Association[3] and the Royal College of Psychiatrists[30]) and a few Canadian medical specialty associations (for example, the Society of Obstetricians and Gynaecologists of Canada[88] and the Canadian Orthopaedic Association[135]) have issued policy statements and educational objectives on the topic of IPV.

Trainees in psychiatry at the undergraduate and postgraduate level, especially international medical graduates, and all mental health professionals should receive education about IPV from faculty who are familiar with this issue. Currently, rates of inclusion of IPV content in the Canadian curriculum of medical and allied health professionals, including mental health professionals, are very low.[136] This training should be included in the curriculum and be composed of both a didactic and a clinical component. The didactic component should include the prevalence (including special populations), etiology, health effects (especially mental health), how to ask about IPV and safety, and the range of interventions for IPV, as well as risk assessment and management of victims and perpetrators of IPV. Continuing professional education (CPE) programs should also include IPV. All psychiatrists should become familiar with, and implement, the guidelines outlined in this CPA position paper on IPV (informed by the CPA's position paper on cultural competence[137]).

In terms of research, there is now considerable descriptive information about IPV, especially in women, but it is also important to look at IPV against men perpetrated by women and IPV in LGBTQ communities. Groups with special issues, such as Aboriginals, immigrants, people with low SES, ALs, alcohol and other substance abuse, pregnancy, youth in dating relationships, and the elderly, are poorly represented in the literature. Studies of effective interventions for prevention and treatment of victims and perpetrators are still in their infancy and there are important knowledge gaps. Specifically, there is a need for rigorously designed studies comparing different methods of psychological interventions, targeting people at different stages of the abuse trajectory, and studies testing different durations and follow-up periods. Both patient- and system-centred interventions should use standardized or comparable outcome measures.

Summary

- IPV is an underrecognized problem that occurs in all countries, cultures, and socioeconomic groups.
- IPV has an enormous impact on personal health, and economic and social well-being.
- IPV may occur in heterosexual and LGBTQ relationships and may be perpetrated by either sex.
- Canadian data from 1999 show about equal proportions of men and women had been victims of physical (seven and eight per cent respectively) and psychological (18 and 19 per cent respectively) IPV in the previous five years.
- Women are more likely than men to report severe IPV, to report chronic violence, or to be killed. They are also more likely to be criminally harassed after the relationship ends.
- Exposure to IPV has deleterious effects on children and other family members.
- Some populations are at greater risk or have special needs for IPV. These include immigrant women, Aboriginal women, LGBTQ communities, people with ALs, pregnant women, dating adolescents, older people, alcohol and other substance abusing people, low-income people, and those without a current partner (that is, IPV perpetrated by a former partner).
- Mental health problems associated with IPV include depression, anxiety disorders, chronic pain syndromes, eating disorders, sleep disorders, psychosomatic disorders, alcohol and other substance abuse, suicidal and self-harm behaviours, nonaffective psychosis, some personality disorders, and harmful health behaviours, such as risk taking and smoking. As IPV is a major determinant of mental health, it is of vital importance to mental health professionals.

- Physical health problems associated with IPV include death, a broad range of injuries, reproductive disorders, gastrointestinal disorders, chronic pain syndromes, fibromyalgia, poor physical functioning, and lower health-related quality of life. Sexually transmitted diseases, unwanted pregnancies and physical inactivity are also increased.
- Children's exposure to IPV may have short- and long-term health impacts on the child, especially mental health effects.
- Perpetrators of IPV most frequently have personality disorders, but substance abuse and other types of mental illness or brain dysfunction may also occur.

Recommendations for Best Practice

- Psychiatrists and other mental health professionals should inquire about IPV victimization and perpetration in current and past relationships as part of the clinical assessment of all patients. A patient does not need to be in a current relationship to be experiencing IPV.
- Case finding in patients with symptoms typical of IPV should be a priority and inquiries made about possible IPV in a private, safe, confidential, empathetic setting. These questions may need to be repeated at subsequent sessions when the therapeutic relationship is better established.
- Particular attention should be given to special populations and situations known to be at higher risk of IPV.
- If a patient discloses IPV, inquiries should be made about current safety (risk assessment) and referrals offered to appropriate services for people experiencing violence (for example, shelters or local resource centres, and social and legal resources).
- Safety should be an ongoing concern, especially if the abused partner plans to leave the abusive situation.
- Careful documentation of IPV in the patient's chart is essential. It should be released only with patient consent or by subpoena.
- Child welfare authorities must be notified in accordance with provincial or territorial legislation if a child is exposed to IPV or is in danger. Victims of abuse should be informed of this duty to report, and that not all types of disclosures will be strictly confidential.
- Mental health professionals should ask about children in the family and determine the need for any children to be referred for assessment of emotional and behavioural problems.
- Treatment approaches will depend on the psychiatric diagnosis, and informed by special issues particular to the person, the relationship, the trajectory of abuse, the patient's readiness for change, culture, and the IPV characteristics. Mental health professionals should consider referral of patients to advocacy services and the need for specific psychological interventions as outlined above.
- Psychiatrists should be familiar with the principles of risk assessment and management for perpetrators of IPV. In addition to treating any mental illness or substance abuse that may be present, the main focus of treatment should be on assisting the perpetrator to take responsibility for IPV and its consequences, to recognize its triggers, and to develop behavioural strategies to stop IPV.
- Specific education on IPV should be part of the curriculum and provided to all psychiatric trainees and mental health professionals by faculty knowledgeable about IPV. Education should include the prevalence, etiology, how to ask and respond to disclosures, and the range of interventions for IPV. CPE programs should include IPV. Psychiatrists should be familiar with and implement the guidelines outlined in this CPA position paper on IPV.
- Further research is needed in the Canadian context on special populations and situations, and, especially, on effective interventions for prevention and treatment of IPV.
- The CPA should seek opportunities to confer with other professional health organizations (for example, family physicians, emergency medicine, orthopedics, pediatrics, obstetrics and gynecology, dentistry, nursing, and social work) and other sectors (for example, social services, education, legal, and media) so that psychiatrists contribute to and learn from wider advocacy for IPV prevention, policy, and clinical practice. This could include, among others, increased public awareness of IPV as a critical mental health determinant and censuring public statements that normalize IPV as an acceptable or cultural norm.

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