Intimate Partner Violence: Effects on Health

Description/Etiology

Intimate partner violence (IPV), historically called domestic violence, is a pattern of coercive behaviors, including physical, sexual, and/or psychological aggression, used to establish or maintain control over a current or former intimate partner or spouse. IPV rarely consists of a single episode; rather, it usually occurs repeatedly and escalates in severity. IPV often involves behavior that functions to limit a victim’s access to the outside world and foster isolation in order to increase the victim’s dependence on the abuser. Victims may remain with the abusive partner for a number of reasons, including emotional investment in the relationship, sense of obligation to partner or children, economic dependence, fear of the repercussions of leaving, and feeling trapped. Although most frequently IPV is committed by a male against his female partner, IPV also encompasses violent acts toward a male by a female and abuse in same-sex relationships. IPV can consist of various kinds of violence:

- Physical violence: intentional use of force (e.g., hitting, slapping, punching, shoving, choking, kicking, shaking) with the potential to cause injury or death
- Sexual violence: forcing a partner to engage in a sex act when the partner does not consent, reproductive coercion (forcing partner to engage in intercourse without contraception)
- Psychological/emotional violence: verbal abuse, humiliation, name-calling; stalking; threats of physical or sexual violence; violence against pets; damaging/destroying possessions; denying access to basic resources; isolating partner from friends and family

Various models of IPV dynamics have been proposed. The “cycle of violence” theory describes a recurring pattern of escalating tension, explosive episode, and reconciliation. The Duluth (“power and control wheel”) model proposes that IPV is a continuous pattern of behavior that includes nonphysical control tactics such as coercion, intimidation, emotional abuse, and isolation along with physical aggression. Family systems theory proposes that IPV is an ongoing pattern that consists of repeating actions and reactions. Researchers have found evidence that there are several different patterns of IPV dynamics, with “random” IPV (frequent and unpredictable violence, corresponding with the Duluth model) being the most common (Burge et al., 2016).

IPV can affect the health of victims in many ways. The longer the period of time over which the abuse occurs, the more serious the effects can be. Many IPV victims suffer physical injuries that range from minor physical damage (e.g., cuts, scrapes, welts, bruises) to serious injury (e.g., broken bones, internal bleeding, traumatic brain injury), lifelong disability, and/or death. Victims of IPV often experience psychological impacts including trauma symptoms (e.g., flashbacks, panic attacks, and difficulty sleeping), post-traumatic stress disorder (PTSD), depression, anxiety, suicidal ideation, and substance misuse. IPV has also been linked with chronic physical health problems, including sexually transmitted infections such as HIV/AIDS, unintended pregnancy, gastrointestinal disorders (e.g., stomach ulcers, spastic colon, gastric reflux, indigestion, diarrhea), frequent headaches, asthma, diabetes, and chronic pain. IPV during pregnancy is associated with decreased or delayed prenatal care, higher prevalence of risky behaviors (e.g., poor nutrition, smoking, drug and alcohol use), and increased risk of miscarriage, low birth weight, and preterm birth and neonate morbidity. IPV can also limit a victim’s ability to manage other chronic illnesses such as diabetes and hypertension.
Facts and Figures

› Worldwide, of women who have had a romantic partner, nearly 30% have experienced physical and/or sexual violence from their intimate partner; the highest prevalence (37%) is in Africa and the Eastern Mediterranean and Southeast Asia regions, and the lowest (25%) is found in high-income regions, Europe, and the Western Pacific (WHO, 2013)
› Up to 38% of female murder victims are killed by their male partners (WHO, 2013)
› In the United States over 1 in 3 women and 1 in 4 men have experienced IPV involving physical assault, rape, and/or stalking; 1 in 4 women and 1 in 7 men have experienced IPV involving severe assault (Black et al., 2011)
• Among United States women, 31.5% have experienced IPV involving physical violence, 22.3% involving severe physical violence, 15.8% involving sexual violence, and 8.8% involving rape (Breidling et al., 2014)
• Among United States men, 27.5% have experienced IPV involving physical violence, 14% involving severe physical violence, 9.5% involving sexual violence, and 0.5% involving rape (Breidling et al., 2014)
• 13.4% of women and 3.5% of men report being physically injured as a result of IPV; 6.9% of women and 1.6% of men reported needing medical care as a result of IPV (Breidling et al., 2014)
• In a U.S. study almost 44% of women who had police contact for IPV also reported sexual violence (Messing et al., 2014)
• 250,000 hospital visits occur annually in the United States as a result of IPV (American College of Obstetricians and Gynecologists, 2012)
› In a study of almost 3,500 men and women in six European countries (Germany, Greece, Hungary, Portugal, Sweden, and the United Kingdom), researchers found that 5.6% of women and 5.4% of men reported experiencing physical victimization; an additional 15.9% of women and 18.4% of men reported bidirectional abuse (Costa et al., 2015)
› Data from a 2013 survey of 15- to 19-year-old women in five large world cities revealed that past-year physical IPV among women who had ever had a partner was 24.3% in Baltimore; 16.6% in New Delhi; 25.9% in Ibadan, Nigeria; 30.9% in Johannesburg; and 8.8% in Shanghai (Decker et al., 2014)
› Data from surveys of 39,000 ever-married women in 10 sub-Saharan African countries revealed that 40% had experienced some form of IPV in their lifetime; of those experiencing IPV, 29% reported physical violence, 12% reported sexual violence, and 14–16% reported HIV infection. Of ever-married women reporting no IPV, 10% reported HIV infection (Durevall & Lindskog, 2015)
› Researchers in a study in Bangladesh found that IPV was associated with a higher rate of termination of pregnancy (i.e., miscarriage, induced abortion, or stillbirth) (Rahman, 2015)

Risk Factors

Women ages 16–24 are the most vulnerable to IPV. Risk factors for IPV include poverty, poor living situations (e.g., unstable housing, overcrowding, homelessness, difficulty paying rent), unemployment, having been abused as a child, having witnessed IPV as a child, having previously been in an abusive relationship, substance abuse by the perpetrator of IPV, and being isolated socially from friends and family. Risk factors associated with severe and/or lethal IPV include extreme jealousy, estrangement from partner, escalating physical violence, previous strangulation, abuse during pregnancy, sexual violence, substance misuse (especially alcohol or “uppers” such as amphetamines, angel dust, cocaine), suicidal ideation, threats to life, threats to harm children, threats with a gun, access to firearms, and recent employment problems.

Signs and Symptoms/Clinical Presentation

› Psychological: feeling intimidated, emotional distress, depression, anxiety, suicidal ideation, panic attacks, low self-esteem
› Behavioral: drug and alcohol misuse, denial or minimization of violence, self-blame for partner’s violence, nonadherence to medical treatment, difficulty in getting to appointments to manage a chronic illness because of control by partner
› Sexual: unwanted pregnancy resulting from forced intercourse, sexually transmitted disease
› Physical: cuts, scratches, bruises, broken bones, welts, internal bleeding, face and head injuries, frequent headaches, chronic pain, difficulty sleeping, poor physical health (e.g., uncontrolled diabetes, hypertension)
› Social: isolation from friends and family, reluctance to seek medical care for fear that the IPV will be reported or fear that abuse will escalate if it is disclosed, difficulty trusting others (including healthcare providers) due to a history of isolation and feelings of helplessness

Social Work Assessment

› Client History
  • Conduct a biopsychosocial-spiritual assessment to include information on physical, psychological, spiritual, environmental, social, financial, and medical factors
• Ask about past or current IPV, including nature and level of violence, nonconsensual or aggressive sexual victimization, and reproductive coercion; family history; history of physical/sexual/emotional abuse; level of functioning; and history of substance abuse
• Assess for immediate safety (e.g., risk for severe assault and/or homicide by partner, child safety) and suicidal ideation
• Assess client’s readiness to address IPV, which can range from precontemplation (denying or minimizing IPV, blaming self for the abuse) to preparation (actively thinking about and/or making plans to leave) or action (taking steps to separate from abusive partner)
• Interview victims privately and separately from partner and/or verbal children; establish rapport and trust, be empathic and nonjudgmental

Relevant Diagnostic Assessments and Screening Tools
• Tools for screening for intimate partner violence may be administered (e.g., the Abuse Assessment Screen [AAS]; Domestic Violence Screening Instrument [DVSI-R]; DV-MOSAIC; HURT, Insult, Threaten, Scream [HITS]; Ongoing Violence Assessment Tool [OVAT]; Partner Violence Screen [PVS]; Revised Conflict Tactics Scale [CTS2]; Slapped, Threatened, and Throw [STaT]; Woman Abuse Screening Tool [WAST])
• Tools for assessing risk of recidivism may also be administered (Danger Assessment Scale [DA], Domestic Violence Risk Appraisal Guide [DVRAG], Ontario Domestic Assault Risk Assessment [ODARA], Spousal Assault Risk Assessment [SARA])
• Additional diagnostic assessment and screening tools can be used depending on the specific chronic health or mental health problem resulting from IPV, such as
  – depression (e.g., Beck Depression Inventory [BDI], Brief Patient Health Questionnaire)
  – substance abuse (e.g., AUDIT-C, CAGE Adapted to Include Drugs [CAGE-AID], Drug Abuse Screening Test)

Laboratory and Diagnostic Tests of Interest to the Social Worker
• Diagnostic tests, including X-rays and HIV/STD testing, can be performed to assess for medical conditions that may have resulted from IPV
• Toxicology screening may be helpful to determine drug and/or alcohol use

Social Work Treatment Summary
• A complete assessment of the client is helpful to understand the extent and nature of the IPV and its impact on other life areas (e.g., work, home, other relationships). This is essential for careful diagnosis, appropriate case management, and successful intervention
• Social workers should be knowledgeable of trauma-informed and strengths-based perspectives and utilize practices that foster recovery, such as respect, collaboration, transparency, and empowerment
• The highest priority often is addressing the individual’s immediate safety and basic needs. Core services include 24-hour crisis intervention, emergency shelters, housing assistance, financial assistance, medical care, child care, and legal advocacy (assistance with obtaining a protective order and navigating the legal system)
• Individualized safety planning is necessary whether the IPV survivor intends to remain in the relationship or separate from the abuser (http://www.ncdsv.org/publications_safetyplans.html, http://www.thehotline.org/help/path-to-safety/#tab-id-1); risk should be reevaluated on an ongoing basis
• Individualized, brief interventions can include psychoeducation on the dynamics and risk factors for IPV, impacts on mental and physical health, ongoing safety concerns, laws about IPV, and resources available to assist client, as well as psychosocial support
• Evidence-based treatment models should be used when possible. Trauma-focused therapy can help reduce mental health symptoms such as depression and PTSD. Complex trauma models utilize a treatment process that first establishes safety and stability, then addresses trauma recovery and assisting IPV survivors to find meaning and rebuild their lives. Cognitive behavioral therapy (CBT) techniques such as thought-stopping, automatic thought record, and role playing can be used to increase important skills and provide insight into the client’s core beliefs about himself or herself, dysfunctional thinking, and maladaptive coping strategies. Research has found that individual therapy coupled with group therapy is an effective treatment approach with individuals who have experienced IPV. Models such as cognitive trauma theory for battered women (CTT-BW) and helping overcome PTSD through empowerment (HOPE) have been adapted for IPV survivors. Integrative interventions (e.g., mindfulness-based stress reduction, creative arts) may be incorporated into treatment. Home visitation programs (e.g., DV enhanced home visitation program [DOVE] and nurse-led home visitation) can be beneficial for pregnant or postpartum women. Peer support groups and advocacy are also important supports for IPV survivors
Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Social workers should practice with awareness of, and adherence to, the social work principles of respect for human rights and dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the ethical standards and practices of the country in which they practice. Social workers should become knowledgeable of the IFSW ethical standards as they apply to IPV, and practice accordingly.

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<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<td>Client is unable to leave an abusive relationship despite increased risks to safety</td>
<td>Client will have a safety plan</td>
<td>Provide a crisis-oriented approach that focuses on the immediate safety of the client, including establishing a basic escape plan that specifies where to go and what to take. Address any health issues that may impede the client's ability to carry out a safety plan</td>
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<td>Client exhibits increased levels of emotional distress as a result of IPV</td>
<td>Provide for mental, physical, and emotional well-being; reduction of anxiety and depression (if present)</td>
<td>Provide interventions that aim to alleviate the feelings of hopelessness and helplessness. Determine how the client perceives his or her circumstances. Provide an empowerment-oriented approach that will enable the client to improve his or her safety, regardless of whether he or she chooses to stay or leave the relationship</td>
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<td>Client who has left an abusive relationship has flashbacks, panic attacks, difficulty sleeping, and fears of retaliation leading to increased physical health problems</td>
<td>Assist client in protecting herself from harm and decreasing stress and trauma symptoms</td>
<td>Behavioral therapy to reduce or eliminate objectionable, maladaptive behaviors/thoughts and replace them with healthier types of behavior/thoughts. Individual and group counseling for victims of IPV. Assist client in gaining and maintaining financial independence. Provide referrals for housing, legal, and financial assistance, job training, and substance abuse treatment (if present). Also educate and assist client in remaining safe by obtaining a protective order, keeping her new location secret, obtaining an unlisted telephone number, using a post office box, and canceling bank accounts and credit cards</td>
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**Applicable Laws and Regulations**

› The Violence Against Women Act of 1994 (VAWA) is a United States federal law that provides funds for investigation and prosecution of violent crimes against women, imposes automatic and mandatory restitution on those convicted, and allows civil redress for cases in which prosecutors choose not to prosecute. Its coverage extends to victims of domestic violence, dating violence, sexual assault, and stalking. The Violence Against Women Reauthorization Act of 2013 improved the nation’s response to violence for all victims (e.g., Native American women, immigrants, LGBT persons, college students, youth)

› The Victims of Trafficking and Violence Protection Act including the Battered Immigrant Women’s Protection Act, passed by the U.S. Congress in 2000, created the “U” nonimmigrant visa, which enables immigrant women and children in abusive marriages and family situations to leave their spouses without fear of change in their immigration status

› New Zealand’s Ministry of Women’s Affairs Act 24-97 guarantees that women in high-risk situations are provided with emotional and psychological support as well as ensuring that charges are pressed against those who assault women

› The majority of Latin American countries have fairly comprehensive national policies that address IPV, prevention, and care of victims and their children

› In Rwanda, women have made significant gains in political representation during the past two decades, and in 2008 the Prevention and Punishment of Gender-Based Violence law was passed

› In the United States, requirements concerning mandatory reporting of IPV by healthcare workers and social workers vary from state to state, ranging from no requirement to required reporting of any injury caused by a weapon. Detailed state-by-state reporting requirements can be found at the Website Health Cares About IPV, http://www.healthcaresaboutipv.org/getting-started/understanding-reporting-%20requirements/

› Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England), and practice accordingly

**Available Services and Resources**

› Abused Deaf Women’s Advocacy Services, http://www.adwas.org/

› Asian Pacific Institute on Gender-Based Violence, http://www.api-gbv.org/
Food for Thought

- IPV screening and counseling should be a component of women’s preventive health visits
- Disparities in IPV services have been noted among persons from racial/ethnic minorities, which can be the result of stereotyping, cultural issues, language, and/or immigration status
- LGBTQ clients also face barriers in accessing IPV services, in part as a consequence of provider perceptions of IPV involving male offenders and female victims
- In many less developed countries, violence against women is viewed as a family matter and not a criminal problem
- Access to financial resources is a key factor in a woman's ability to decide to end an abusive relationship
- Serious health issues such as chronic pain, depression, suicidality, and substance abuse impede the ability of IPV victims to work toward safety
- Mandatory reporting is important for early identification of victims, provision of safety planning and services, advocacy, documentation of the abuse, and planning and improving services for victims
- Clients may struggle with health problems for years after the end of a violent relationship and may not realize how their victimization relates to their current difficulties with gastrointestinal disorders, chronic pain, depression, or substance abuse

Red Flags

- Women who are highly committed to maintaining the relationship will often minimize and excuse the abuse and are more likely to blame themselves for their circumstances
- Factors that increase the risk of being harmed by a partner include previous violent or aggressive acts by the partner, the use of drugs or alcohol by either partner, seeing or being a victim of abuse as a child, and being unemployed
- Victims of IPV often do not volunteer that they have been sexually victimized by their partners due to shame and/or lack of understanding that sexual behaviors by a spouse or intimate partner could be considered abuse
- Victims of IPV are often in the most danger when they attempt to leave the relationship

Discharge Planning

- Educate client on the relationship between the stress resulting from a relationship that involves IPV and his or her physical health
- Assist client with access to prescription assistance programs or other medical assistance to reduce financial costs for any chronic condition
- Assist client with access to healthcare to screen for sexually transmitted disease, heart disease, hypertension, and diabetes; enroll in substance abuse treatment and/or smoking cessation services (if indicated); and increase positive coping strategies (e.g., healthy diet, stress management) to help improve well-being and overall health
- Educate the community, especially primary care physicians and emergency departments, on how to recognize IPV and treat victims
- Provide referrals for shelters, counseling, law enforcement agencies, legal assistance, support groups, substance abuse treatment, crisis lines, medical care, and personal empowerment programs
- Review safety plan and next step(s) of treatment and any obstacles caused by chronic health problems
- Offer printed take-home materials on safety procedures/plans and hotline numbers, being mindful that for women who reside with an abusive partner, it may not be safe for them to possess these materials
References


