



Understanding Intimate Partner Violence as a Physical and Mental Health Issue

BY LEEANN RANIERI AND DIANE THOMPSON

“Domestic violence” is a term commonly used when referring to a woman who has experienced physical injury by a current or former intimate partner such as a boyfriend or spouse; the term has been used synonymously with other terms such as wife or spouse abuse over the past few decades. In recent years, the use of the term has expanded to include other forms of violence occurring within the home, including child, elder, and sibling abuse. For this reason, the Centers for Disease Control and Prevention (CDC) has recommended that the more specific term “intimate partner violence” (IPV) be used to refer to the intentional physical and/or serious emotional abuse by a current or former spouse, boyfriend/girlfriend, or date.¹ This term, which encompasses both physical and serious emotional abuse and does not overlook male victims or same-sex partners in its description, is used throughout this article.

The worldwide prevalence of IPV is difficult to measure because of the various definitions of abuse and societal stigma that may inhibit women from disclosing abuse to legal reporting agencies and healthcare providers. However, UNICEF reported in 1997 that 25-50 percent of women from all nations have experienced this type of abuse,² and the United Nations estimates

that up to 38 percent of all women have been physically assaulted by an intimate partner. This percentage climbs to as high as 60 percent in the developing world.³ In a recent US population-based study conducted in the context of women’s health, The Commonwealth Fund Survey reported that 31 percent of women experienced IPV by a spouse or boyfriend (see Fig. 1).⁴

Physical and Mental Health Impact

The impact of IPV on the physical and mental health of women has been well documented.⁵⁻⁷ Physical effects include serious injury such as broken bones, blunt trauma, burns, and stab wounds that result in hospital admission or major medical treatment, and even death. Other less recognized consequences are STDs including HIV, unplanned pregnancy, gastrointestinal disorders, chronic pain (perhaps from untreated injuries), and poor pregnancy outcomes such as low birthweight and pre-term labor. It is known that women experiencing abuse use the healthcare system more than women in the general population,⁸ and require more hospitalization, more clinic visits, and more mental health services. Depression is a primary reason a woman experiencing ongoing relationship violence seeks healthcare.⁹ And while depression may be an independent factor, symptoms of depression, anxiety, and post-traumatic stress disorder may all be causally linked to IPV.

In recent years, victims’ service and healthcare providers have begun to collaborate to meet the physical and emotional health needs of those experiencing violence. From the victims’ service or advocacy perspective, women must be empowered to make autonomous decisions without further coercion from a well-meaning healthcare provider. Behavioral healthcare needs have often been avoided or placed in the background due to the fear that a mental health diagnosis could possibly place a larger barrier in the path of a woman seeking refuge from a violent partner. In such a case, a mental health diagnosis could be held against a woman who is seeking custody of her children, especially if she finds herself in a judicial system that is neither sensitive to nor knowledgeable about the dynamics of IPV. From the medical perspective, women must have their physical and mental health needs addressed to have the strength to face the challenge of seeking alternatives to violence. The networking of these services provides a holistic approach to meet the needs of victims of abuse.

In their practices, healthcare professionals everywhere commonly see women experiencing IPV, although the women may not necessarily come in with clearly explained physical injuries or the ability to freely identify what is happening to them. And while healthcare professionals may not be sure of

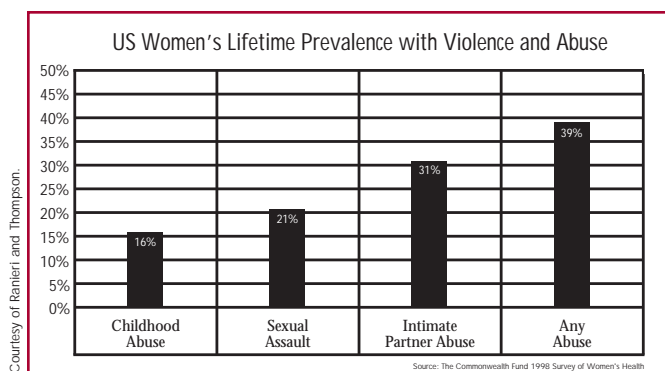


Figure 1. During the course of an American woman's life, she is likely to experience childhood abuse, sexual assault, and IPV according to the percentages indicated. The last column shows that patterns of abuse often follow a woman throughout her life.

how to respond to the needs of these woman, especially in areas where support services are not readily available for referral, universal screening is a standard that allows healthcare professionals the opportunity to identify abuse and violence that may impact their patients' health. A clinic also provides a safe and logical place for women to learn about options for increasing safety and ending the violence present in their lives.

How to Screen and Respond to IPV Patients: A Case Study

To better understand how IPV manifests itself both physically and mentally in a patient, as well as to explain how healthcare providers can interact with women facing this problem, a brief case study is provided below. It is important to remember when screening for IPV that victims are often reluctant to admit to any abuse and therefore providers should be aware of subtle indicators of potential abuse.

During an annual gynecological exam, Tanya complains to her provider that she lacks energy and suffers from extreme fatigue. She is 31 years old, lives with her husband and son in the city, and is employed as an accountant for a large manufacturing firm, which necessitates her traveling one hour to and from her job each day. Tanya appears frazzled as she states, "My house is a mess, I am exhausted, and I cannot seem to keep up with my home responsibilities." She further states that she is not sleeping well at night and feels she has gained excessive weight during the last year. She says that the reason for her visit is to have her annual PAP test and breast exam and to get a refill for her oral contraceptive prescription. She stresses that she does not desire to become pregnant in the near future. (Warning signals evident from Tanya's comments include vague complaints that have no obvious cause, difficulty in coping with daily activities, and a strong desire not to bring a child into a particular environment. Taken alone, none of these complaints indicates abuse; they do, however, indicate that Tanya may be feeling unsettled.)

The healthcare provider finds her vital signs and physical examination to be normal, and her family history does not reveal any significant health risks. Tanya is overweight for her height, but is not considered medically obese. She is not exercising regularly, has recently taken up smoking again (she quit when she was pregnant with her son), and occasionally uses alcohol to help her to relax and sleep. (Tanya's resumed use of cigarettes may indicate recent or intensified stress in her life.)

After completing her physical exam, Tanya's provider continues her health screening by asking her a question related to intimate partner abuse: "Tanya, do you feel emotionally and

The History of IPV as a Healthcare Issue

The development of more systematic screening for abuse began when battered women's shelters, which evolved out of the efforts of grass roots women's organizations, started to appear in the United States in the early 1970s. Recognizing the need to provide a safe haven for women and their children, shelters were established at secret locations in communities. At the same time, women began to send a message to the community that abuse is not acceptable.¹⁷

The birth of the shelter system attracted the attention of lawmakers and researchers, including those in medicine and nursing. The work of scholars in the late 1970s and early 1980s warned that the healthcare system was a place where a battered women was likely to experience "re-victimization"—through blaming, ignoring unexplained injury, by not providing validation of the abuse—when encountering professionals who lacked knowledge about the dynamics of abuse. These same researchers identified the healthcare system as an important potential resource where women could be empowered and helped.¹⁸

In 1985, US Surgeon General C. Everett Koop convened a workshop around violence and named IPV as a major public health threat in the United States. He called for the use of public health measures to combat the issue. Nurses attending the workshop held the first nursing conference on violence against women that same year, which is still held and known today as the Nursing Network on Violence Against Women International. In 1987, the American Nurses Association released recommendations for nurses for screening all women for potential abuse, while the American Medical Association made family violence their top priority in 1992, and published diagnostic and treatment guidelines on domestic violence for physicians.¹⁹ Education on this topic has only recently become a core area in nursing and graduate medical education, while community efforts to provide education to the public as a whole are gaining importance in most parts of the United States. Much progress has been made over the last few decades in recognition of IPV as a healthcare issue and the role of healthcare professionals in providing an appropriate healthcare response.

physically safe in your relationship with your husband?" Tanya seems surprised by the question and begins to cry. She quickly apologizes to her provider for her outburst of tears and says, "I am just so tired, I have not been a very good wife or mother lately." She continues to explain that her husband prefers that she does not work and has been pressuring her to quit her job. She feels that it is financially necessary to continue to work—"without my income we could not make ends meet." Tanya adds that her husband is not as well educated and has had an unstable work history. She provides the primary income for the couple. She expresses that if she could just lose some weight, and manage her home and child more efficiently, her husband might be more supportive of her career. (Tanya's self-criticism, the imbalance of power in her relationship—as the primary breadwinner she is occupying the position usually reserved for the



husband—and defense of her husband’s position by using self-blame, are additional red flags. The financial and educational imbalance of the relationship may cause Tanya’s husband to act out feelings of insecurity and low self-esteem.)

When the provider expands on the screening question, Tanya reveals that her husband frequently criticizes her for her appearance, the meals she prepares, her spending practices, and her son’s poor behavior and performance at school. Her sister is a good source of support, but her husband does not permit her to talk to her on the phone unless all of her household work is complete. (Abusers often try to control their partners by lowering their sense of self-worth and managing their access to people or resources, such as money or transportation.)

Tanya’s provider then asks directly about physical violence. Tanya admits to one incident about a month ago where she suffered a minor bruise on her shoulder when her husband pushed her into a wall during an argument. Tanya feels she provoked the incident by arguing with him over a recent clothing purchase and explains that the bruise was gone in a few days and her husband was very sorry and promised that it would never happen again. Victims of IPV often make excuses for the physical actions of their abusers, defining the incident as something they provoked or “asked for.” Tanya’s husband’s reaction is consistent with the typical cycle of violence as shown in Figure 2.

Identifying Patient Needs and Explaining the Cycle of Violence

The goals for screening in the healthcare setting are to identify abuse that impacts the physical and emotional well-being of a patient and to provide information and education regarding resource and referral services that will promote informed decision-making regarding safety options. In Tanya’s case, the provider will rule out organic causes for her fatigue and anxiety, treat her physical and emotional needs, but also assess her for her future safety needs and connect her with resources in the community that can provide further support and legal advocacy.

As in Tanya’s case, although a patient minimizes minor physical violence, she should be given information to alert her to expect future incidents. Rarely does this type of occurrence happen only once, and many women feel responsible for their

partner’s behavior as Tanya does. It is important therefore to name the behavior as abusive and reinforce to the woman that she is not to blame. Using a “Cycle of Violence” diagram can help explain to a woman why the abuse is not constant and help her recognize that violence is likely to recur (see Fig. 2).

The first phase of this cycle, the tension-building phase, happens over time. It consists of increasing friction such as

name-calling, mild physical abuse, and expression of dissatisfaction from the abusive partner. The woman attempts to please the partner by doing what she thinks might calm the situation. As the tension continues to escalate, the woman may feel exhausted and unable to perform routine tasks. The next phase, defined as the explosive stage, begins when acute abuse occurs. The discharge of verbal and physical abuse can leave the woman injured, ashamed, shaken, and further exhausted. During this time she will do her best to protect herself (and her children) from harm. The third phase, the honeymoon, follows with the abuser’s apologies and promises of no future abuse. These apologies may provide hope for the woman and positive reinforcement that she should remain in the relationship.

This cycle is repetitive and, over time, the tension-building phase may become more common, while the length of the honeymoon phase may grow shorter. Experiencing the continuous behaviors of an abusive partner begins to have an impact on a woman’s self-esteem, confidence, and behavior, which may become quite guarded. It is not uncommon for a woman to begin to engage in unhealthy behaviors such as smoking and substance abuse to cope with the violence.¹⁵

Providing Options for Safety

The cycle of violence model helps women begin to recognize that the behavior they are experiencing is abusive and to label what is happening to them in their relationship. The next step is for the healthcare provider to talk about options for her immediate and future safety. One way is to review a chart similar to the one shown in Figure 3, as well as to provide a patient with a card listing the phone numbers of community resources (see Fig. 4, page 38). A safety plan chart should include signs of increased danger, options for what choices exist, and tips for how to pro-



Figure 2. The cycle of violence model explains the cyclical nature of IPV and can be used to help a woman understand that it usually is not a one-time occurrence and does not end unless the cycle is broken.

Safety Planning

Increased Danger

Abuse of women is common.

Women who have experienced abuse need to know that any of the following means their situation is becoming more dangerous:

- Abuse happens more often.
- Abuse gets rougher.
- Abuser tries to choke.
- There is a gun in the house (or car).
- Abuser forces sex.
- Abuser uses drugs such as crack or speed.
- Abuser threatens to kill himself or others.
- Abuser is drunk often.
- Abuser hits when woman is pregnant.
- Abuser is extremely jealous, suspicious, or possessive.
- Abuser gets into fights with other people.
- Abuser hurts or kills pets.

Options

Every woman has choices.

Stay with the Abuser

- Make a safety plan.
- Call police if abused.
- Attend a battered women's support group.

Arrest

- Best way to stop future abuse.
- Temporarily removes abuser.
- Police can arrest and file charges.
- Filing a report is not the same as filing charges. Ask police what they are filing.

Remove the Abuser: Protective Orders

- Prohibits abuser from coming within a specified distance of work and home and from communicating with woman.
- If abuser violates the order, he can be arrested.
- After abuser is removed, change all door locks.
- Make safety plan.

Leave the Abuser*

- Battered women's shelter.
- Make a safety plan.

* Your risk of serious injury increases when you leave.

Safety Plan

Try to do the following:

- Hide money.
- Hide extra sets of house and car keys.
- Establish a code with family and friends.
- Ask a neighbor to call police if violence begins.
- Remove weapons.
- Hide a bag with extra clothes.

Have Available

- Social security numbers (his, yours, your children).
- Rent and utility receipts.
- Birth certificates (yours and your children).
- Driver's license (yours and your children's).
- Bank account numbers.
- Insurance policies and numbers.
- Marriage license.
- Valuable jewelry.
- Important phone numbers.

Figure 3. A safety planning chart lists behaviors that indicate increased danger, provides a list of options that a patient can follow, and lists tasks that should be accomplished as part of a personal safety plan.

Courtesy of Ranieri and Thompson.

protect oneself. One study of pregnant women experiencing violence found that an explanation of the cycle of violence followed by the discussion of a safety plan with a nurse resulted in a significant increase in safety behaviors almost immediately.¹⁶ If a woman feels safe taking these written materials with her, she can refer to them as needed. If not, she knows where to come for the information.

Mental Health Manifestations of IPV

As Tanya's case illustrates, the recognition and treatment of depression and anxiety in the IPV patient are important components of the diagnosis process. There has been an increasing awareness of gender differences in psychiatric disorders, and important recent findings can help us to better treat the IPV patient.

Depression is much more common in women than men. In fact, women are about two-thirds more likely to experience depression in both yearly and lifetime estimates.¹² The focus has shifted to research regarding genetic and hormonal etiology to better understand this predisposition for depression as well

as other mood and anxiety disorders including panic, phobias, and obsessive-compulsive disorder. However, it is important to remember that such disorders are affected not only by biology, but also by psychosocial factors. IPV and depression can form a vicious cycle that makes the treatment of either problem more challenging. Approximately 25 percent of women who seek psychiatric care and 25 percent of women who attempt suicide are involved in a violent relationship with their partner.¹³ Briefly discussed here are three common psychiatric disorders that an individual experiencing IPV may seek treatment for or that one may encounter as a co-morbid illness as one begins to address the IPV. They are depression, panic disorder, and post-traumatic stress disorder.

Depression

While it may not be important to determine which came first, both the safety of the patient with regard to IPV and her symptoms of depression should be thoroughly assessed and treatment options should be discussed. Depressive symptoms are likely to include feelings of guilt, low self-esteem, low energy, a



depressed mood, hopelessness, and changes in sleep patterns or appetite. Whenever depressive symptoms are apparent, it is crucial to ask about suicidal, as well as homicidal, ideation. These questions will not “put the idea in the patient’s head,” but rather offer her the opportunity to talk about these thoughts, if they exist, and assure the patient that if such thoughts occur in the future, it is safe to discuss them with the healthcare provider.

Anxiety

Anxiety disorders may often appear to exacerbate a violent relationship. Panic disorders include discrete episodes of attacks during which the patient feels short of breath, has chest pains or palpitations, or feels as if she or he is choking, dying, or going crazy. These symptoms can result in significant avoidance. Often this disorder will result in isolation due to a fear of having an attack outside of the home. The abusive partner may act as an enabler, “reminding” the patient what happens when he or she leaves the home alone, thereby increasing the level of his or her agoraphobic anxiety as well as the partner’s ability to maintain control.

Post-traumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD) can occur after any stressful event that causes the patient to fear for his or her own or another’s safety. It includes three main features:

- recurrent memories about the event;
- specific autonomic nervous system arousal; and
- withdrawal from usual activities and/or feeling numbness.¹⁴

As with depression or panic, PTSD can lead to further isolation, anxiety, and co-morbid depression. Concurrently, children who are exposed to IPV develop PTSD at higher rates than

children who have been physically maltreated nonsexually or who have experienced parental neglect.¹⁵ This exposure to physical abuse also correlates to a greater than 20 percent increase in unintended pregnancies in adult children who witnessed their mother’s abuse, as compared to those who did not report household dysfunction while growing up.¹⁶

In any of these cases, IPV and psychiatric disorders can result in a cycle of guilt,

avoidance, and low self-esteem that leaves the victim with the sense that he or she does not deserve treatment or support with regard to either mental health or violence/abuse issues. The isolation associated with anxiety and the low energy that accompanies depression make it even more difficult for the victim to initiate the appropriate measures to ensure safety and seek treatment for these mental health issues.

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An Opportunity Not to Be Missed

Tanya’s case demonstrates how a healthcare provider can address not only the obvious physical needs, but also the behavioral health needs of an individual experiencing abuse. The healthcare encounter can be used as an opportunity to give information to the individual about how the experience of violence can correlate with adverse health outcomes, not only for the individual but also for any children who may be witnessing abuse in the home. This gives the healthcare provider the opportunity to interrupt the cycle of violence, often empowering a patient looking for validation and guidance as to what his or her options might be.

The appropriate healthcare response to IPV will continue to be defined through clinical application of research and through listening to patients about what they want and need from their healthcare provider. All healthcare providers need to attend training on the dynamics of abuse to feel competent in addressing this issue within the healthcare setting and must work together to build support systems within their practice or clinic.

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Resources Available

Emergency Services:

Local Police _____

Ambulance _____

Shelter:

National Hotline: 1-800-799 (SAFE) _____

Shelter _____

Crisis Center _____

Counseling & Legal:

Figure 4. A card listing the phone numbers of community resources can be offered to IPV victims for future reference.

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Additional Resources

Family Violence Prevention Fund—www.fvpf.org

Nursing Network on Violence Against Women, International, PMB 165
1801 H Street, Suite B5, Modesto, CA 95354-1215; 1-888-909-9993

Physicians for a Violence-free Society—www.pvs.org

LeeAnn Ranieri (lranieri@mail.magee.edu), MSN, CRNP, is coordinator of the Domestic Violence Resource Center at Magee-Women's Hospital in Pittsburgh, Pennsylvania. Diane Thompson (thompsonds@msx.upmc.edu), MD, is the medical director for behavioral health at Magee-Women's Hospital, and assistant professor of psychiatry at the Western Psychiatric Institute and Clinics in Pittsburgh.