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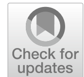

Practical Implications of Research on Intimate Partner Violence Experiences for the Mental Health Clinician

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Abstract

Purpose of review Individuals experiencing mental health difficulties are at heightened risk for experiencing past and recent intimate partner violence (IPV), including sexual, psychological, and physical violence and/or stalking, from an intimate partner. Yet, mental health clinicians often report limited knowledge about IPV, especially best clinical practices for identifying and addressing IPV experiences in routine mental health care.
Recent findings This paper reviews literature on IPV experiences, including prevalence, linkages with mental health problems, considerations for vulnerable populations, and evidence-based practices for screening, assessment, and intervention for IPV in the context of mental health care. These practices are rooted in trauma-informed and person-centered care principles and emphasize safety and empowerment.
Summary We conclude by commenting on common clinician challenges and considerations for case conceptualization for individuals experiencing IPV.

Introduction

Intimate partner violence (IPV) is a common social determinant of health and a cause of significant human suffering. IPV refers to any physical, sexual, or psychological violence and/or stalking from a past or current intimate partner [1]. Table 1 displays examples of different types of IPV. In the United States (US), 36.4% of women and 33.6% of men experience physical or sexual violence and/or stalking by an intimate partner in their lifetime [2]. More than one in five women (21.4%) and one in ten men (14.9%) experience severe physical violence (e.g., strangled or attacked with a weapon) [2]. Psychological IPV is also common (36.4% for women (36.4%) and men (34.2%) [2]. Further, the lifetime economic costs of IPV to US society is a staggering $3.6 trillion inclusive of IPV-related medical and mental health services, lost work productivity, and criminal justice costs [3].

IPV is not only prevalent and costly to individuals, families, and society at large, experiences of IPV frequently impact clients' mental health. To put this in perspective, median prevalence estimates from a meta-analysis suggest that 36% of women with depressive disorders and 28% of women with anxiety disorders experience past-year IPV [4]. Yet, IPV often goes undetected and unaddressed in mental health services [5, 6]. Common barriers to addressing IPV among mental health clinicians include limited knowledge of IPV, self-perceptions of inadequacy, inadequate familiarity with resources, and lack of training and knowledge regarding effective clinical practices for addressing IPV [7–9]. Education on IPV and best practices for identification and intervention have been identified as factors that would increase clinicians' willingness and self-efficacy incorporating IPV detection and intervention into routine practice [8, 10, 11]. Accordingly, this paper describes research and associated clinical implications for addressing IPV in mental health care.

Impacts of IPV experience on health and wellness

There are short- and long-term health consequences of IPV that should be considered when assessing and engaging in treatment planning for individuals experiencing IPV.

Physical health

Injury is a common impact of IPV. Approximately 34% of women and 11% of men who experience IPV suffer physical injuries from the abuse [12•]. Women's injuries tend to be more severe (including death) than those of men [2, 13]. For example, traumatic brain injuries from blows to the head and strangulation-induced anoxia from IPV are common among abused women and exacerbate mental health problems [14–16]. When physical injuries from IPV are repeated and/or severe, they may elicit chronic pain (e.g., headaches, back pain, and arthritis) [17, 18]. Beyond injuries and pain-related conditions, IPV is associated with many other physical health conditions, including neurological diseases, gastrointestinal disorders, hypertension, sexually transmitted infections including HIV, and poorer overall physical health functioning [19–23]. Among women, reproductive and adverse pregnancy-related outcomes have been found [20, 24].

Table 1 Intimate partner violence (IPV) definition and overview, subtypes, and examples

IPV refers to violence and aggression from a past or current intimate partner (e.g., spouse, boyfriend/girlfriend, dating and sexual partners). It can vary in how often it happens and how severe it is. IPV can occur in any intimate relationship, regardless of gender, age, race, ethnicity, or sexual orientation. IPV can include, but is not limited to, any of the following types of behavior:

Psychological IPV:	Physical IPV:	Sexual IPV:	Stalking:
The use of verbal and non-verbal communication with the intent to harm another partner mentally or emotionally and/or to exert control over another partner	When a person hurts or tries to hurt a partner by using physical force or threat of physical force	Forcing or attempting to force a partner to take part in a sex act (physical or non-physical) when the partner does not or cannot consent	A pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's own safety or the safety of others
• Humiliating and name calling • Chronic criticism and contempt • Controlling what partner is "allowed" to do/wear • Isolating partner from friends and family • Denying access to money or other resources without appropriate reason • Threats to harm self or others • Using LGBTQ+stereotypes • Exploitation of vulnerabilities (e.g., deportation) • Threatening to "out" the partner	• Scratching • Pushing and shoving • Hitting • Kicking • Shaking • Strangulation/choking • Burning • Beating-up • Throwing things • Breaking valuable items • Use of weapon (e.g., knife, gun, or other objects) • Use of restraints and strength to intimidate	• Coercion and manipulation • Threatening or forcing a partner to take part in a sex act when they do not consent • Intentional sexual touching • Refusing to wear protection or interfering with a partners birth control methods • Using gender roles to control sex • Coercing via LGBTQ+stereotypes • Forcing partner to not use protection (e.g., because LGBTQ+sex is "safer")	• Unwanted phone calls, text messages, and voice messages • Unwanted emails and instant messages • Social media messages and posts • Watching, following, or tracking • Approaching or showing up unwanted (e.g., home, work, school) • Leaving strange or threatening items for the partner to find

The Centers for Disease Control and Prevention published uniform intimate partner violence definitions and a common language for research that takes into account teen dating violence, lesbian, gay, bisexual, transgender, and queer+individuals 1

IPV intimate partner violence, *LGBTQ+*lesbian, gay, bisexual, transgender, and queer+

Mental health

Experiences of IPV, although not a mental health diagnosis or condition, can cause and exacerbate mental health problems. The most common mental health issues associated with IPV for all genders include posttraumatic stress disorder (PTSD) [25–27], depression [27–29], anxiety [27, 30, 31], and substance use disorders [26, 27, 30]. Additionally, IPV is associated with eating disorder pathology, sleep impairment, poorer overall mental health functioning, and suicidality [18, 32–34, 35•]. Some mental health difficulties, particularly PTSD, depression, and substance abuse, are also risk factors for experiencing IPV [36–38]. Effective mental health treatment may therefore help reduce clients' risk for future IPV [39, 40, 41•].

Although not as prominently discussed (or inquired about), when conceptualizing the effects of IPV on clients' mental health, it is imperative to attend to psychological IPV, which can be minimized by both clients and clinicians. Physical and sexual violence often occur alongside psychological abuse [42]. Some relationships include psychological IPV without physical or sexual violence, but the reverse is rare [30, 43]. Psychological IPV contributes to poorer mental health (i.e., PTSD, anxiety, and depressive symptoms) above and beyond the effects of physical and sexual IPV [27]. Clients often report that psychological IPV, including social isolation, belittling, intimidation, and gaslighting (e.g., "I'm not lying, you are imagining things") is the worst part of their IPV experience [42]. Such experiences can diminish self-efficacy and a sense of control, reduce internal and external resources, and fuel psychological distress [44–47]. The disempowering function of IPV and associated internalizing feelings (e.g., hopelessness, self-doubt, and fear) may contribute to individuals staying in or re-engaging in abusive relationships.

Vulnerable populations

Some groups are particularly vulnerable to IPV experiences and impacts, principally those that experience intersecting social determinants of health (e.g., housing insecurity, childhood abuse, low income, and educational access). Individuals already marginalized by economics, discrimination, racism, heterosexism, and increased adversity and trauma are more likely to experience IPV [48–52]. For example, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) and black, indigenous, and people of color (BIPOC) experience IPV at high rates while also experiencing oppression and discrimination [48, 49, 53, 54]. A recent review highlighted that the absence of models of healthy LGBTQ+relationships contributes to this vulnerability [49]. Further, believing stereotypes (e.g., violence is used only by men) may interfere with recognizing and labeling behaviors as unsafe. Factors impacting LGBTQ+persons' ability to access needed support include mistrust of the police and experiences of not being believed or being stereotyped based on appearance (e.g., police identifying the 'survivor' as the smaller, "more feminine" partner) [49].

BIPOC, especially black and Native American women, face unique risks and challenges, including higher risk for femicide and more barriers to help-seeking [55, 56•]. Black clients may be more reluctant to use services due to concerns about perceived betrayal to their community, fear about additional violence occurring to their partners if they access help, and invalidating responses from formal supports (e.g., police). Internalized stereotypes and the culturally held view of the "strong black woman" may factor into why black woman are more reluctant to seek help and may also prevent others from recognizing their needs [51, 56•, 57]. In terms of barriers for Native Americans, Giacci and colleagues [58] interviewed 56 women from tribal reservations who described little education about relationship health and challenges with privacy and obtaining confidential treatment, noting "…the experience of indifference by formal help seeking sources…feeling unsafe, not taken seriously, or even ridiculed" (p. 17).

Marginalized groups experiencing IPV face additional barriers to help-seeking [49, 50, 53]. Racism, transphobia, and homophobia negatively impact health and wellbeing [54, 59]. This discrimination creates structural inequities, particularly for individuals impacted by IPV, that reduce access to healthcare, legal services, safe housing, and employment [51, 56•, 57, 58]. In addition to reduced access, prejudice and racism can impact the quality of care received by marginalized groups across systems, including healthcare [60]. This may include a sense of alienation, belittlement, and being blamed by clinicians for their health disparities [61].

Other at-risk groups include rural residents and military Veterans. Research suggests higher prevalence and severity of IPV for persons residing in rural communities, including IPV-related homicides and reduced access to care [62, 63]. Additionally, Veterans are at particular risk for experiencing IPV and intersecting mental health and social determinants of health concerns (i.e., increased trauma exposure and PTSD) [52, 64]. This research highlights the importance of regular screening to identify IPV experiences and provision of trauma-informed care for individuals from culturally diverse backgrounds.

Overarching principles and conceptual considerations

Trauma-informed and person-centered care

The Substance Abuse and Mental Health Services Administration's [65] guide to trauma-informed care (TIC) enumerates principles that can inform best practices for addressing IPV in mental health care (Table 2). TIC recognizes the ubiquity of trauma and aims to facilitate, rather than direct, change in the service of empowering clients to have voice and choice in their care [65, 66•, 67]. TIC IPV care is important because individuals who experience IPV often have past traumas that contribute to their current mental health and clinical presentation [7, 56•, 68, 69]. Relatedly, when addressing IPV, it is important to recognize, understand, and effectively manage strong psychological reactions clients may have in response to trauma (e.g., shame, anger, emotion dysregulation, and avoidance). These experiences necessitate compassionate

Table 2 Trauma-informed care principles[a] and applications to addressing IPV experiences in the context of mental health care

Main tenants: the 4 R's of TIC	**Applications to experiences of IPV**
REALIZES the widespread impact of trauma and understands potential paths for recovery	• Understand and convey that many clients are impacted by IPV experiences and other forms of trauma • Be knowledgeable of and adopt strategies to ask about these experiences in a safe, non-judgmental manner • Believe people can recover from IPV and other traumatic experiences
RECOGNIZES the signs and symptoms of trauma	• Identify physical and mental health signs and symptoms related to IPV (see "Impacts of IPV on Health and Wellness") • Understand that clients can have diverse psychological responses to IPV and different treatment needs
RESPONDS by fully integrating knowledge about trauma into policies, procedures, and practices	• Scheduling practices, room setup, documentation practices, and all interactions should integrate strategies that work to engage others who have experienced violence or coercion in their relationships • Offer choices and be transparent in interactions, including eliciting informed consent prior to in-depth IPV assessment • Use reflective listening and non-judgmental language • Work to reduce power-differentials (e.g., do not stand over people but instead sit at the same level as them) • Prioritize physical and psychological safety
RESISTS re-traumatization	• Avoid being directive • Respect clients' boundaries and readiness for change • Be respectful in setting boundaries • Use person-first language (e.g., "individuals who experience IPV" in lieu of "victims")
Six guiding principles: fostering a trauma-informed therapeutic process	**Applications to experiences of IPV**
Promoting emotional, psychological, and physical safety; making available peer support opportunities	• Be non-judgmental • Offer documentation options to promote safety • Be mindful of telehealth safety (e.g., a partner could overhear) • Avoid discussing IPV in the presence of a child over the age of 2 and/or other adults • Develop and revisit safety plans • Be aware of community services and support group options for individuals with diverse backgrounds
Focusing on trustworthiness and transparency	• Informed consent should include discussion of relevant mandated reporting requirements related to IPV (e.g., child abuse and endangerment) • Transparency and shared decision-making for documenting IPV details in health records • Let people know what to expect in sessions and over time in treatment

Table 2 (continued)

Facilitating collaboration and mutuality	• Recognize that the client is the expert of his/her/their own experiences • Do not assume you know the best/safest path forward • Collaborative treatment planning
Targeting empowerment, voice, and choice	• Allow individuals to choose when and how they receive care • Give options about what to address in treatment • Elicit and honor client preferences
Maintaining sensitivity to cultural, historical, and gender issues	• Ask about values, experiences of discrimination, and barriers to change • Consider how the experience of IPV and associated contextual experiences are intersectional
Be recovery-oriented and person-centered	• Seek to understand clients' viewpoints on what recovery means to them • Understand and honor clients' treatment goals and priorities • Amplify clients' strengths

[a]Substance Abuse and Mental Health Services Administration's Concept of Trauma and Guidance for a Trauma-Informed Approach 67

and validating responses, such as reflective listening, normalization, psychoeducation, and tailored intervention. Similarly, clinicians may consider adopting person-centered language when discussing IPV, such as "individuals who experience IPV" (vs. "victims") and "partners who use IPV" (vs. "batterers"). This practice empowers clients to address IPV through increasing recognition that clients are not defined by their IPV experiences, fostering rapport building, and reducing stigma and re-traumatization.

A TIC and person-centered approach recognizes that clients impacted by IPV develop various coping strategies that are embedded within the multilayered context of their lives [70]. Clinicians can individualize and enhance treatment effectiveness by understanding important factors related to client's personal experience (e.g., culture, race, religious practices, sexual orientation, economic factors, trauma history, ongoing violence) [66•]. This facilitates conversations about what aspects of IPV are presently out of the client's control (e.g., partner behaviors) and within their control (e.g., self-care and safety planning). Because clients' IPV-related needs are diverse, treatments rarely include a single, scripted, step-by-step approach that will address the needs of all clients [71]. Interventions need to be responsive to the client's unique situation, preferences, and readiness for change.

Readiness for change

Clients experiencing IPV enter care at different stages of readiness for change [72–74]. Those in early stages of change may not fully recognize the risks or impacts of their relationship on their health or may be just considering what changes they want to make in their relationship, whereas individuals in later

stages may have already made decisions related to their relationship (and/or acted on those decisions). Evidence-based psychotherapies for individuals experiencing IPV that have been rigorously tested in randomized clinical trials typically focus on assisting clients with PTSD once they have left an unsafe relationship and/or after they have a safe living situation (i.e., shelter) [40, 41•, 75, 76]. Such treatments are critical and highly effective, but many individuals seeking mental health care in the context of IPV may not intend to leave their relationship or seek shelter. Therefore, clinicians should be prepared to support clients at various stages of readiness for change and empower clients to define the specific treatment goals that are most meaningful to them.

Intervention strategies, safety considerations, and treatment targets

Integrating advocacy into therapy

Given the broad psychosocial impacts of IPV, clinicians often need to dually serve as both therapists and case managers [10, 77]. For many therapists, this is a unique situation and may demand skills that include community partnering, awareness of local services, and integrating more advocacy than typical psychotherapies. Warshaw and Brashler [77] describe advocacy in mental health care as helping clients understand their options, effectively use community resources, and make individualized choices about reducing IPV exposure and ameliorating its impacts on their lives. This includes partnering with clients to represent their personalized needs, rights, and interests while assisting with safety planning and access to legal resources, housing, and employment resources [78]. Positive effects of advocacy includes increased choice making and access to resources and reduced psychological distress [79, 80]. Clinicians can contact state domestic violence coalitions to identify local, national, and culturally grounded resources for individuals experiencing IPV. Building relationships with community partners including advocacy organizations, shelters, and legal services that are affirming to clients of all ethnicities and sexual and gender orientations is critical to TIC and person-centered IPV care.

Prioritizing safety in all aspects of care

Individuals experiencing IPV face unique safety issues in comparison to treatments addressing historical trauma. Like the risk for suicide and/or homicide, individuals experiencing IPV may be in imminent risk due to ongoing violence and coercion. Clinicians must be attentive to safety and ongoing risks, which may include being more flexible in accommodating the scheduling needs of individuals in unpredictable and potentially

dangerous situations. Furthermore, controlling partners may interfere with scheduling and treatment engagement and attendance [67, 81, 82]. Safety should be discussed and prioritized in every aspect of care, including communication and scheduling practices (i.e., discussing the added risk of technology as one form of communication/scheduling), determining the safety of taking home treatment materials (e.g., IPV psychoeducation, safety plans and resources), and shared decision-making regarding documentation of IPV (i.e., concerns of retaliation violence if a controlling partner accessed their records). Transparent discussions about the pros and cons of detailed documentation and honoring client's preferences has been found to be a feasible TIC practice in the IPV screening literature [83].

Enhancing empowerment and general self-efficacy

Empowerment and self-efficacy are key factors that are associated with resilience and psychological well-being among individuals impacted by IPV [45, 84–89]. Although there are several definitions of empowerment in the IPV literature, Cattaneo and Goodman [90] describe empowerment as an iterative process in which "a person who lacks power sets a personally meaningful goal oriented towards increasing power, takes action and makes progress towards that goal, drawing on his or her evolving self-efficacy, knowledge, skills, and community resources and supports, and observes the impact of his or her action" [p. 88]. Several models for addressing IPV sequelae promote empowerment [66•, 73, 91]. For example, a motivational interviewing–based intervention [67] and an IPV-specific PTSD intervention [40, 41•, 75] have demonstrated large improvements in self-empowerment, along with improved mental health and reduced IPV [41•, 67, 75]. An empowerment lens may be particularly important when working with BIPOC and LGBTQ + clients who may experience less safety with more formal support services [56•, 66•].

General self-efficacy is closely aligned with empowerment and refers to clients' beliefs in their ability to cope with an array of stressors and challenges, and persevere in the face of difficulty [92]. Some scholars consider self-efficacy as central to recovery from trauma [73, 92]. Self-efficacy can be understood in the context of readiness for changes (described above), as readiness to change is related to one's confidence to make values-consistent changes and successfully improve their mental health [67, 93–96]. Relatedly, there is support for motivational interviewing-based interventions in increasing self-efficacy as primary treatment outcomes among individuals who experience IPV [67, 95, 96]. Working collaboratively with clients to enhance their empowerment and self-efficacy can additionally facilitate clients' readiness to engage in evidence-based treatments for corollary mental health conditions once critical components of IPV care have been addressed.

Critical components of trauma-informed mental health care for IPV

While the prior sections describe basic knowledge about IPV as well as theoretical and conceptual considerations for addressing IPV, this section briefly summarizes specific evidence-based practices for screening, assessment and intervention in mental health care.

Screening and case identification

Given the relevance of IPV for mental health, clinicians should consider incorporating routine screening and inquiry about IPV during intake and ongoing care for all mental health clients. Screening and discussion of IPV must occur individually in a private setting (e.g., private therapy room). Screening can occur via telehealth, but only after ensuring a partner, other adult, or child over the age of 2 is not within earshot. Additionally, clients should be informed of pertinent mandated reporting requirements prior to IPV inquiry to facilitate informed consent and transparency. It is important to review the limits of confidentiality and state and/or institution mandatory reporting requirements (e.g., child or elder abuse). Trauma-informed, person-centered, and transparent care that maximizes client physical and emotional safety includes offering clients opportunities to ask questions and eliciting informed consent to complete screening and assessment. If reporting is required, consideration of how reporting may differentially impact certain groups is important (e.g., LGBTQ + individuals; people of color; non-English speaking individuals) [97, 98]. Additionally, it is ideal to offer clients voice and choice in how the report is made (e.g., would the client prefer to make the report together or have the clinician report on their own). Finally, it is important to discuss with the client how an investigation (e.g., by the department of child services) may impact client and familial risk and therefore should inform safety planning.

Following informed consent regarding reporting requirements, clinicians should be mindful to frame and ask questions about IPV experiences with empathy and nonjudgement. Clients experiencing IPV may not disclose these experiences early in the intake/assessment process for various reasons, including shame, privacy and safety-related concerns (e.g., fear the partner will find out/retaliation violence, legal or immigration concerns), fear of family disruptions or social service involvement, not recognizing their experiences as abusive or sufficiently serious enough to report, and a desire to trust the clinician before sharing relationship details [6, 99, 100]. Therefore, clinicians should continue to provide opportunities for disclosure throughout assessment and treatment, as therapeutic rapport and trust is established. Clinician efforts to destigmatize IPV through education and inquiry may also increase client's readiness to acknowledge and address IPV [101•].

There are several brief and accurate screening tools to facilitate IPV inquiry [102]. For example, the Veterans Health Administration uses a comprehensive IPV screening protocol that includes 5-items assessing past-year IPV (VHA Directive 1198), which includes the Hurt, Insult, Threaten, Scream (HITS) [103] tool supplemented with a sexual IPV item. "Over the last 12 months, how often did a current or former intimate partner (e.g., boyfriend/girlfriend, husband/wife, dating or sexual partner): (1) physically hurt you?, (2) insult you or talk down to you?, (3) threaten you with harm?, (4) scream or curse at you?, and (5) force or pressure you to have sexual contact against your will or when you were unable to say no?" Strengths of this tool include that it is gender-neutral, behaviorally-specific, and assesses psychological IPV in addition to sexual and physical IPV. According to the National Center for PTSD, additional examples of gender-neutral questions for assessing psychological IPV include "Does your (ex)-partner keep you from seeing friends or family?" and "Are there times when you do not express your opinion because you are afraid your partner might punish you in some way?" [104]. Positive endorsements of any items should be met with supportive and validating statements and follow-up questions to enable a better understanding of the frequency and severity of IPV dynamics, including whether these experiences have caused physical and/or psychological harm (e.g., injury and fear), and perceived physical safety.

Risk assessment

Direct conversations about the types and severity of violence experienced can assist with treatment and safety planning. Validated tools, such as the Danger Assessment [105, 106], have the benefit of providing standardized assessment of clients' current risks, including risk for severe and life-threatening IPV. Risk assessment can be used to structure conversations about the client's situation and inform safety planning. Another aspect of IPV risk assessment is to ask about the risk for suicidal behavior [107]. This enables further discussion, as relevant, about how to work together to effectively prevent suicide throughout treatment [107, 108].

Safety planning

Safety planning is a harm-reduction strategy that increases client situational awareness of IPV-related risks and plans for associated actions to maximize safety in various situations (e.g., when planning to leave partner or while staying in the relationship) and can reduce future IPV [109]. A critical aspect of creating safety plans with clients in dangerous situations is being able to provide effective help in the moment, with confidence. Safety planning includes evaluating the client's current situation and risks; identifying the type of support, resources, and skills needed for enhanced safety; and developing a plan to prevent future IPV. Acknowledging intersectionality and incorporating affirming and culturally consistent resources into safety plans is essential

for BIPOC and LGBTQ + clients [59]. Safety planning can include various domains depending on the client's situation (e.g., child and pet, financial, and sexual health). Plans for each relevant situation are developed collaboratively (e.g., how to use technology safely; ideas for how to protect one's head from a brain injury; how and when to set boundaries in a safe manner) and situation (e.g., leaving or staying in the relationship; before and after a protection order). Online tools and resources exist to facilitate safety planning with clients, including the myPlan App (myplanapp.org) and the National Domestic Violence Hotline (thehotline.org).

Psychoeducation

Along with risk assessment and safety planning, clinician can ask permission to provide valuable verbal and written information (e.g., factsheets, brochures, online resources) about IPV to help clients better understand their situation, IPV dynamics, and the effects of IPV on their health. IPV psychoeducation topics may include IPV definitions, prevalence, health effects and warning signs, as well as other topics tailored to the client's personal circumstances and treatment goals. Table 3 provides examples of common psychoeducation topics for mental health treatment addressing IPV. Psychoeducation is desired by individuals who experience IPV and

Table 3 Potential psychoeducational topics to explore in mental health care with clients experiencing IPV

Topic areas	Content examples
IPV definitions and types	• Discuss definition of IPV and describe IPV subtypes • Client perceptions of IPV experiences in their past and current intimate relationships
Health effects of IPV	• How IPV (including psychological abuse) can impact physical, mental, and social health • Explore health impacts for children and families
Relationship health	• Qualities of a healthy relationship • "Red flags" to look out for in relationships • The cycle of abuse
Social support	• What is social support? • Exploring what social support is available • Identifying what support is still needed
Sexual violence and historical trauma	• What is consent? • What is coercion? • How are past experiences impacting present-day functioning?
Resources	• What resources are available? • What do specific resources help with?
Client's mental health conditions	• Educate clients about their mental health conditions (e.g., What is PTSD and depression? What is at-risk drinking?) • Describe evidence-based treatment options

may decrease isolation and shame, help clients gain perspective, aid in decreasing psychological entrapment, and offer a sense of hope and connection [73, 110].

Skills building

In addition to increased knowledge of IPV, enhancement of skills addressing self-mastery, building social support, and navigating community resources have been identified as important treatment targets by IPV clients and clinicians [66•]. Table 4 lists examples of specific skills that are relevant to mental health treatment for IPV. Moreover, when considering skill domains, it is important to remember clients and clinicians may prioritize treatment targets quite differently. Some clients may prefer to focus on developing social support and learning skills that enhance their identity over the more traditional safety planning, for example [66•, 67]. Skills training in affective and interpersonal regulation [111], dialectical behavior therapy [112], and helping overcome PTSD through empowerment [40, 41•, 44, 75] are just a few examples of relevant interventions that include specific IPV-related skills that are useful in the context of mental health treatment for clients experiencing IPV.

Table 4 Examples of skill-building topics for clients experiencing IPV

Domain	Skills-building topics
Safety	• Maximizing emotional safety • Maximizing physical and sexual safety
Emotion Regulation	• Teaching and practicing mindfulness • Teaching and practicing grounding • Teaching and practicing anger management • Teaching and practicing self-validation
Self-care	• Identifying and starting positive activities • Identifying and focusing on strengths • Building self-compassion and positive self-related cognitions
Stress management	• Education about stress and its impacts on the mind and body • Strategies for monitoring stress levels • Techniques such as diaphragmatic breathing, meditation, and grounding exercises
Communication	• Identifying and setting boundaries • Assertiveness training and planning for safety
Relationship building	• Improving current relationships • Creating new relationships
Life management	• Decision making • Identifying community resources and assistance, including potential barriers to accessing resources

Treat mental health symptoms

A number of mental health concerns are associated with experiencing IPV, particularly PTSD, anxiety, substance abuse, and depression. These concerns often require treatment [91], which can be implemented with ongoing attention to physical and psychological safety. Particularly relevant to IPV are front-line trauma-focused PTSD psychotherapies, include cognitive processing therapy, prolonged exposure, and eye movement desensitization and reprocessing [113], as PTSD is among the most common conditions associated with IPV. Additionally, two specialized psychotherapies have been developed specifically for IPV-related PTSD and have been evaluated in randomized clinical trials with women who have experienced IPV, including cognitive trauma therapy for battered women [76] and helping overcome PTSD through empowerment (HOPE) [40, 41•, 75]. Both of these trauma-informed cognitive-behavioral interventions result in significant and large reductions in PTSD and depressive symptoms (and corollary psychosocial concerns), while HOPE has the added benefit of increasing self-empowerment.

Effective treatment for clients experiencing IPV sometimes requires a stage-based approach [114], where clients develop skills in grounding, self-care, increased skills in maintaining safety where possible, and/or develop more social connections prior to depression or trauma-focused treatment. Consistent with a stage-based approach to treatment, Recovering from IPV through Strengths and Empowerment (RISE) [67] is a brief, motivational interviewing-based, transdiagnostic intervention that we developed, evaluated, and implemented in the VHA [10, 95, 115] that may be a useful intervention for some clients prior to mental health-focused psychotherapies for PTSD, depression, anxiety, etc., and addresses key areas for IPV care (e.g., psychoeducation, safety planning, skills enhancement). RISE fosters empowerment and self-efficacy using a collaborative MI approach focusing on value-driven changes that clients can control by themselves, even in the context of violent relationships (e.g., self-care and coping). At each RISE session, clinicians and clients address current safety concerns and update safety plans, assess and discuss the client's current self-efficacy, and focus on a skills-based module (e.g., IPV health effects, coping and self-care, and making difficult decisions). RISE is effective at improving women's psychosocial health, particularly empowerment and self-efficacy [67], and is being implemented in VHA with patients of all gender identities. Such interventions can serve as a bridge to evidence-based treatments for mental health conditions.

Common challenges for clinicians

Working with clients impacted by IPV can be demanding clinically and personally, even for highly trained and experienced clinicians. Clinicians may struggle with maintaining a person-centered approach, refraining from overtly directing the course of the treatment and maintaining a motivational stance.

When assisting clients in violent, volatile relationships clinicians may be understandably pulled to assume an action-oriented stance. Clinicians may jump to "solving the problem," not only to reduce the client's anxiety, but often to reduce their own. Well-meaning clinicians often desire to "help clients leave" unhealthy relationships, but this approach is not necessarily in line with the client's goals. Rather, clinicians can focus treatment on building self-efficacy and empowerment in the service of helping clients set value-driven goals and make decisions that are right for them. The trauma-informed clinician does not have the job of "fixing it." Attempting to "fix" client's problems can signal powerful messages that the client is not capable and may reinforce negative internalized self-schemas. Rather, employing a TIC, affirming, and empowerment framework may be more effective, albeit potentially more challenging for clinicians trained in more directive modalities.

Clinicians serving clients who experience IPV are most effective when they strive to understand the client's vision of "recovery," which may not reflect traditionally held perspectives. Recovery for clients may be less about leaving a situation and more about increasing their own sense of self-efficacy, empowerment, connection, and well-being.

Conclusions

Mental health clinicians commonly treat clients who experience past and recent IPV experiences. Thus, mental health clinicians need to be knowledgeable about the prevalence and health impacts of IPV, including the strong connections between IPV experiences and mental health concerns. Although there is not a universal approach to addressing IPV experiences, this article highlights trauma-informed and evidence-based principles and intervention strategies to inform the flexible integration of IPV screening, assessment, and intervention practices into routine mental health care. Future research is needed to identify specific implementation strategies and supports required for enhancing the uptake and maintenance of evidence-based IPV care in routine mental health care settings.

Author contributions

All authors contributed to the manuscript conception, drafting, and editing. All authors read and approved the final manuscript.

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Declarations

Conflict of interest
Drs. Doyle, Knetig, and Iverson are involved in VHA's IPV Assistance Program's dissemination and implementation of the RISE intervention, which is discussed in this article. The principles and theory underlying RISE influence some of the content of the article. Dr. Iverson developed and evaluated RISE in the context of a research grant from VHA's Office of Research and Development Services, Health Services Research and Development (HSR&D) Services (IIR 16–062; 2017–2021).

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