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GUEST EDITORIAL

How can we manage intimate partner violence better?

On 27 May 2016, the 69th World Health Assembly endorsed the global plan of action to strengthen the role of health systems within a national multisectoral response to address interpersonal violence, especially against women and children.[1] This landmark plan was adopted with a resolution (EB 138.R3) co-sponsored by 44 member states. It will promote the achievement of the Sustainable Development Goals, including historic Goal 5 (achieve gender equality and empower all women and girls), Goal 16 (promote peace, justice and inclusive societies) and Goal 3 (ensure healthy lives and promote wellbeing for all at all ages).[1] These initiatives coalesce with, and will add to, attaining the objectives of the new Global Strategy for Women's, Children's, and Adolescents' Health.[1]

The era of making excuses for not addressing sexual, domestic and child abuse effectively in clinical practice is over. These issues point to an evidence base and provide clinicians with current contextual approaches to providing care for intimate partner violence (IPV). They also offer insight into key dynamics within IPV, and the vital interface between IPV, HIV and mental health.

Gordon[2] discusses practical steps for identifying and managing IPV against women. This is enhanced by her sensitive, insightful discussion of why women tend neither to report nor to leave their abusive partners and the multiple masked ways in which such patients present. Her extensive clinical experience guides the reader through dealing with IPV. This is complemented by Lopes's[3] in-depth guide to legal and support services. With a psychology background, and years of experience of non-governmental organisations, Lopes offers a vital understanding of the dynamics of IPV and provides a detailed account of how to secure a protection order within the vagaries of our current court system. Lopes also supplies helpful information regarding referral to shelters, complete with an updated contact list for shelters nationwide.

An established working relationship with a social worker is critical, but when they are overloaded, it is important to utilise alternative referral resources. Furthermore, there appears to be little emphasis on, or resources provided for, prevention and early intervention programmes. It became clear from work in the Witzenberg area, Cape Winelands, South Africa, that children are routinely removed in cases where domestic violence is reported, thereby further traumatising both mother and children.[4]

Woollett and Hatcher[5] explore key intersections between mental health, IPV and HIV and recommend that HIV care is recognised as an optimal entry point for identifying patients who are living with mental disorders and/or IPV. They introduce the concept of 'continuous trauma', which marks a vital evolution in our understanding of trauma beyond post-traumatic stress disorder, where the traumatic stress is no longer current or real. Continuous trauma offers a far more appropriate understanding of the ongoing psychological effect of living with IPV, where threat and danger are ever present. Woollett and Hatcher[5] also highlight recent national evidence that increased depressive symptoms among women were linked to a perceived frequency of neighbourhood domestic violence, thereby revealing the community level mental health effects of neighbourhood violence. They discuss clinical concepts and interventions for mental health and IPV, noting that recent studies suggest that mental health treatment may reduce IPV, symptoms of mental disorder and risk of future violent victimisation, even if the partners remain together.

The 'separation assumption' refers to the commonly held belief that partners experiencing IPV should end the relationship, and that it is our duty to encourage them to do so. A woman in a physically violent relationship is more at risk of being murdered when she leaves her partner, and for 2 years thereafter.[6] Is it not therefore highly unethical to urge her to leave? Only when she requests this, can we encourage and support her, including referral to a safe place. In this instance she is advised not to inform her partner, and to take her children with her.

Statistics indicating that 1 in 3 or 4 women has experienced IPV in their lifetime can be misleading, as it appears to be an isolated event. Typically, IPV escalates in severity over time, involving multiple violations. Similarly, while the term 'victim' is used by authors to align with national initiatives around victim empowerment, in my view the victims comprise our notorious intimate femicide statistics, while those who are still alive, are survivors.



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