Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POSITION PAPER

Recognizing and Responding to Intimate Partner Violence: An Update

Donna E Stewart, MD, FRCPC[1]; Harriet MacMillan, MD, MSc, FRCPC[2]; Melissa Kimber, PhD, MSW, RSW[3]

This position paper has been substantially revised by the Canadian Psychiatric Association's (CPA) Professional Standards and Practice Committee and approved for republication by the CPA's Board of Directors on January 30, 2020. The original position paper,[1] now an historical document, was first approved by the Board of Directors on December 13, 2012.

Intimate partner violence (IPV; also known as domestic violence) refers to behaviour by an intimate partner or ex-partner that can cause or causes physical, sexual or psychological harm. These behaviours include physical aggression, sexual coercion, psychological abuse and controlling behaviours.[2] Stalking and financial abuse have now been included in the list of IPV behaviours by some authorities.[3]

The Centers for Disease Control and Prevention has provided definitions and examples of four major types of IPV.[4] Physical IPV includes hitting, choking, shaking, biting, shoving, grabbing, slapping, burning, scratching, hair pulling and the threat of or the use of a weapon or restraints, as well as other aggressive physical acts. Sexual IPV includes forced sexual acts or attempts including acts committed when a partner is unable to give informed consent due to alcohol, drugs or mental incapacity. Sexual IPV may involve exploitation of economic or immigration vulnerability, intimidation or false promise (to marry), as well as sexually based degradation or threats. Psychological IPV includes the use of verbal and non-verbal communication to harm another person mentally or emotionally and/or exert control over their behaviours or decisions. Examples include expressive aggression (degradation, belittling, humiliation), mind games, exploitation of vulnerability, control of reproductive or sexual health, threats of

[1] University Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada; Head of Research and Academic Development, Centre for Mental Health, Senior Scientist, University Health Network, Toronto, Ontario, Canada; Ethics and Review Committee, World Psychiatric Association, Geneva, Switzerland
[2] Distinguished University Professor, Departments of Psychiatry and Behavioural Neurosciences, and Pediatrics, and Chedoke Health Chair in Child Psychiatry, Offord Centre for Child Studies, McMaster University, Hamilton, Ontario, Canada
[3] Assistant Professor, Department of Psychiatry and Behavioural Neurosciences and Core Member of the Offord Centre for Child Studies, McMaster University, Hamilton, Ontario, Canada

Suggested Citation: Stewart DE, MacMillan H, Kimber M. Recognizing and responding to intimate partner violence: An update. Can J Psychiatry. 2020,65 (ISS):000-000.

Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

violence to people or pets, as well as coercive control; the latter includes limiting access to money, friends or family, excessive monitoring, or threats of harm to self or others.[4,5] Stalking IPV consists of repeated unwanted attention that causes the person to fear for their personal safety or the safety of someone they know.[6] Examples include watching or following, repeated phone or electronic messages, spying, leaving gifts or threatening objects for the partner/ex-partner, or damaging a current or former partner's property.[5]

IPV can occur across genders and the term "intimate partner" does not require that individuals exposed to this form of violence have a history of sexual intimacy or a marital relationship.[2,7] Although IPV can occur in any intimate relationship, including dating relationships, it disproportionately affects women and gender/sexual minorities but can also be directed toward men. IPV has also been called family violence, domestic violence or spouse abuse, but these terms are less specific, and some include violence against children in the categories of family or domestic violence, which can be confusing. When IPV is directed toward women, the terms wife abuse, wife battering or wife assault are often used. All of these terms have in common an understanding of violence as an expression of power, control and domination enacted through a range of behaviours that often escalate, especially after the relationship has ended.[5] IPV is a violation of human rights that can result in serious mental and physical health impairment including death. IPV is an underrecognized problem that can have an enormous impact on the health and well-being of women, men and children. It is a major public health and social problem globally that results in significant personal, health, economic and social costs.[3,5,8] One study estimated that the costs arising as a result of IPV experienced by women aged 19 to 65 years who have left their partners are $7.2 billion annually for Canada.[9]

This paper discusses the epidemiology of IPV (including special populations and situations), risk indicators, health impacts, as well as approaches to identification, assessment, documentation, intervention, prognosis, prevention, education and research. We also provide recommendations for best practice in psychiatry. In general, this paper highlights key findings and common themes from the highest quality evidence available internationally, with a special focus on Canadian data. The Canadian Psychiatric Association (CPA) previously incorporated IPV in its 1992 Guidelines for the Evaluation and Management of Family Violence,[10] and they published a position paper on IPV in 2013,[1] but new information and resources require an update on this topic.[2,11-13]

As IPV is associated with a broad range of health problems experienced by patients seen by psychiatrists, including depression, anxiety disorders, posttraumatic stress disorder (PTSD), chronic pain, eating disorders, sleep disorders, psychosomatic disorders, alcohol and other substance use disorders, suicidal and self-harm behaviours, personality disorders (such as borderline and antisocial), nonaffective psychosis and health risk behaviours, the rationale for this position paper is clear.[14] IPV should be of vital interest to mental health professionals and, more specifically, psychiatrists.

Epidemiology

Self-report Data

IPV occurs in all countries, cultures, religions and socioeconomic groups in the world. Generally speaking, IPV is a gendered phenomenon as women are disproportionately affected by IPV. However, evidence indicates that IPV may be perpetrated by men toward women, women toward men, and in same-sex relationships. It may occur in marriage, common-law relationships, cohabitation or any intimate relationship including dating. In general, most data have focused on IPV perpetrated by men against women in heterosexual relationships as discussed in the following sections. The literature shows that the extent of IPV varies greatly across countries. Attempts to make comparison between Canada and other nations are difficult due to differences in IPV definitions, survey methods and measurement, including the reference period of IPV exposure (e.g., lifetime vs. previous 12 months, lifetime vs. current relationship). The best available cross-country comparison of IPV rates comes from the 2000–2003 World Health Organization's Multi-country Study on Women's Health and Domestic Violence against Women, though data from Canada were not collected. Prevalence data for 10 countries show significant variation in women's lifetime of exposure to physical and/or sexual violence by a current or former male intimate partner; estimates of prevalence ranged from 15 per cent to 71 per cent among ever-partnered women. In all sites but one, women were more at risk of violence from a partner or ex-partner than from violence by other people. There were also significant differences in IPV exposure across rural versus urban areas, with higher IPV rates usually reported by women residing in rural regions.[15]

In Canada, national data on IPV reported by men and women were first collected by Statistics Canada in its population-based 1999 General Social Survey (GSS), which is a quinquennial survey of the violence and victimization experiences of Canadians aged 15 and over.[16] In 1999, almost equal proportions of men (seven per cent) and women (eight per cent) reported being a victim of physical abuse in intimate relationships in the previous five years. [16] In 2009, 11.9 per cent of the GSS sample reported exposure to either physical/sexual IPV, emotional IPV or financial control/abuse. Data for 2014 showed reduced rates of exposure to physical or sexual IPV, with four per cent of Canadians aged 15 and over reporting one or both of these forms of IPV in the previous five years, with no difference between men and women.[17] Fourteen per cent of Canadians aged 15 or over said they had experienced emotional or financial abuse from a spouse or common-law partner sometime in the past.[18] Importantly, the most serious types of IPV, including sexual assault and being beaten, choked, threatened with a knife or gun, were reported by 25 per cent of abused Canadians, with women twice as likely as men.[18] Women victims were also more likely than men to have a physical injury (40 per cent vs. 24 per cent), to have experienced attempted murder or death (0.2 per cent of victims but 78 per cent were women) and are more likely to experience PTSD following IPV.[18]

Canadian Crime Data

Annual administrative data from the Canadian Homicide Survey and the Canadian Uniform Crime Reporting Survey (UCRS) provide compelling insights about the extent of IPV reported to Canadian police services. Generally speaking, police-reported IPV is much lower than self-reported IPV. In 2016, 79 per cent of IPV cases reported to police; women are the identified victims, and the majority of individuals charged in these cases are men (80 per cent).[19] Although majority of police-reported IPV (82 per cent) involves opposite-sex partnerships where females are victims and males are the perpetrators, approximately 55 per cent of police-reported same-sex IPV involves male partnerships.[20] In addition, violence within current or former spousal or dating relationships was the most common form of violence reported to police by females in 2017, with women and girls accounting for nearly 8 in 10 reports of IPV that year. With respect to youth, in 2010, approximately one per cent of policed-reported cases of dating victimization involved youth aged 12 to 14 years; approximately 93 per cent of these victimization reports were made by females, and 52 per cent of the reports involved sexual assault.[21] In 2017, 15,535 females aged 15 to 24 years reported dating victimization to Canadian police services: 19 per cent and 11 per cent of these reports were in reference to a current versus a former dating partner, respectively.[22] Notably, these gender-specific findings have remained consistent across iterations of the UCRS.[19] Threats, name calling, limiting contact with family or friends were reported by eight per cent of women and six per cent of men.[6] It is important to note that many incidents of IPV are not reported to police out of shame, embarrassment, denial, fear of not being believed, fear of rejection or retaliation, or believing the abuse to be their fault. Risk factors for dating violence include past abuse, beliefs and attitudes, lower relationship skills, drinking and drug use, peer influences and pornography.[23]

Bilateral (i.e., Common Couple) Violence

Historically, there has been the stereotype of the abusive male who uses severe and unilateral violence against a nonviolent female victim. It is now recognized that bilateral violence is more common than previously recognized, although women experience the overwhelming burden of morbidity and mortality associated with violence in intimate relationships.[24] Bilateral violence, otherwise referred to as common couple violence, is considered less serious than the pattern of violence known as battering or intimate terrorism—which is a severe and often escalating form of IPV characterized by threats and multiple forms of violence and controlling behaviour by the abusive partner. Research suggests that women are most often subjected to battering by male perpetrators.[24] Canadian women are more likely than men IPV victims to experience sexual offences (88 per cent), criminal harassment (76 per cent) and indecent and harassing communications (72 per cent).[6] In the 2014 GSS, stalking (one form of criminal harassment) was self-reported by six per cent of Canadians; 21 per cent of these reports involved a current or former intimate partner. Among those who reported stalking, women were the disproportionate victims. Compared to men, women's exposure to stalking is more likely to occur in parallel with exposure to violence after a spousal relationship had ended. Threats or intimidation, repeated obscene or silent phone calls were common, but the greatest increase in reported IPV behaviour between 2004 and 2014 was in unwanted emails, texts or social media messages.[6,11] These ongoing forms of IPV continue to have significant health and economic impacts on women.[25-30] The 2018 report on Gender-Based Violence and Unwanted Sexual Behaviour in Canada, although not focused on intimate partner relationships, reported that 32 per cent of women and 13 per cent of men experienced unwanted sexual behaviour in public

including unwanted sexual attention, physical contact or comments about their sex or gender.[31]

Despite more severe exposure and impacts for women, physical abuse, as well as psychological abuse, is also experienced by men. However, the context in which these acts occur has not been assessed, and evidence indicates that within heterosexual relationships, both sexes are sometimes perpetrators. Men have reported bruises, abrasions, genital injuries, minor head trauma, lacerations and internal injuries, as well as that their exposure to IPV leaves them feeling emasculated, marginalized, shamed and embarrassed. According to male victims, their reports of abuse are often met with skepticism or disbelief by medical and legal professionals, as well as friends and neighbours.[32] This disbelief was most marked for sexual IPV, as many people were unaware that erection and ejaculation could sometimes be caused by fear, anger or pain and not only by consensual sexual arousal.[33]

Special Populations and Situations

Cultural factors. Deep-seated values about the relative priority of one's own goals and autonomy (individualism) and those of the society (collectivism) to which one belongs are thought to be related to IPV rates. Collectivist cultures that are also patriarchal have rigid gender roles, subscribe to men's control of women's behaviour, link masculinity to dominance, control, honour and aggression and are suggested to condone the use of violence as a way of resolving conflict in intimate relationships.[34-37] Similarly, qualitative research with women residing in communities with collectivist cultures report being urged to endure rather than reject IPV, as a way of preserving cultural values, the family and honour. A recent meta-analysis examining cultural or structural factors in the risk for IPV reports emerging longitudinal, quantitative evidence supporting these claims.[5,38]

New immigrants. Migrant populations in Canada—which include immigrants and refugees—face the same types of IPV as their non-migrant peers, but additional challenges related to their migration status—including a fear of deportation, loss of refugee status, social isolation, threats of forced marriage, inability to speak either of the official languages, economic exclusion or collectivist or religious values that support and privilege men's power and keeping the family together or not disclosing "private matters"—may prevent these individuals from reporting their abuse exposure in surveys or to the police. While community-based studies of IPV involving immigrants from certain countries indicate high rates of abuse, the extent to which these rates differ from non-migrants is inconclusive.[39] Methods, measurement issues, access and acceptance of some types of IPV among immigrant/refugee groups make prevalence comparison difficult.[40,41]

Indigenous peoples. First Nations, Metis and Inuit (collectively referred to as "Indigenous") people account for 4.9 per cent of the total Canadian population.[42] Evidence from the 2014 GSS as well as national crime data indicate that Indigenous individuals are more than twice as likely as their non-Indigenous counterparts to report exposure to physical IPV in the last five years (nine per cent vs. four per cent). In addition, Indigenous women were three times more likely to report IPV compared to non-Indigenous women (10 per cent vs. three per cent), but no difference was found between Indigenous and non-Indigenous men. Indigenous people who experience IPV are also more likely than non-Indigenous people to suffer the most serious forms of IPV, such as being beaten, choked, threatened with a weapon or sexually assaulted (52 per cent vs. 23 per cent). Indigenous people are also more likely to report childhood exposure to abuse or neglect by an adult caregiver (40 per cent), a factor known to be associated with later spousal abuse. Indigenous individuals were also more likely as a child to have been exposed to IPV committed by a parent, step-parent or guardian.[11,42] A seminal eight-wave longitudinal study including data from youth aged 15 to 19 years who were living on one of the seven reservations/reserves located in the United States and Canada reported that 31 per cent of youth had already experienced physical IPV in their lifetime.[43] The dynamics of IPV and dating violence in Indigenous communities has been linked to colonization, structural violence, poverty, racism, discrimination, residential schools, foster care, alcohol and substance use disorders, and loss of traditional ways and culture.[44]

Psychiatric patients. Higher rates of IPV have been found among women in out- and in-patient psychiatric services in several countries.[14,45-47] A systematic review and meta-analysis of 41 studies found increased odds ratios of lifetime IPV in women with depressive disorders (2.77), anxiety disorders (4.08) and PTSD (7.34), compared with women without mental disorders. Individual studies reported increased odds ratios for both women and men for all psychiatric diagnostic categories, including psychoses, with a higher prevalence reported for women. Few longitudinal studies were found; thus, the direction of causality could not be determined.[14]

Gender and sexual minorities. There has been a long-standing lack of data on Canadian IPV prevalence among lesbian, gay, bisexual, transgender, queer, questioning, intersex and two-spirited (LGBTQQI2S) individuals. While some of these gaps are beginning to be addressed, many remain. In 2016, Statistics Canada reported that about one per cent of all legally married and common-law couples in Canada had same-sex spouses, similar to data in the United Kingdom and Australia.[11] Individuals who self-reported as lesbian, gay or bisexual were twice as likely to report spousal violence as heterosexual couples (eight per cent vs. four per cent). In dating relationships, the double prevalence of IPV in same-sex partners compared to heterosexual partners has remained stable for the last five years (18 per cent vs. nine per cent), with an even higher prevalence among lesbian/bisexual women compared to male counterparts (23 per cent vs. 11 per cent).

Police-reported violence among same-sex intimate partners in Canada between 2009 and 2017 revealed that these incidents represented three per cent of all reported incidents of IPV.[20] Over 55 per cent of police-reported same-sex IPV involved male partners. Major assault and use of a weapon were also more common among men (18 per cent compared to 12 per cent in women). Homicides involving same-sex partners represented five per cent of all IPV homicides over this time period. Rural victims of same-sex IPV (35 per cent of all same-sex IPV cases) were more likely to request that no further action be taken against the accused. Gender stereotypes about violence and mutual violence as well as social stigma may be factors in these decisions.[20] Some unique risk factors, such as the threat of outing, disclosure of human immunodeficiency virus (HIV) status, social stigma and the lack of emergency shelters for sexual minority victims, have been identified.[48]

A Canadian survey on IPV of 7,918 respondents in the workplace found that 8.5 per cent reported gender/sexual minority status.[49] Gender/sexual minority participants were significantly more likely to report IPV and that it continued at or near their workplace, negatively impacted their work performance and their co-workers. They also reported poorer mental health and quality of life. Some labour unions and provincial governments have supported paid domestic violence leave policies. A U.S. study found 51.8 per cent of transgender individuals reported lifetime IPV compared to 34.2 per cent of cisgender individuals. LGBTQQI2S people generally experience higher rates of all forms of IPV. [50,51]

People living with disabilities. People living with disabilities are not a homogeneous group; Statistics Canada recognizes four categories of disability (sensory, physical, cognitive and mental health), all of which may vary in severity and interact with numerous other sociodemographic characteristics to impact an individual's risk for exposure to IPV.[52] Compared to men, women have a higher reported prevalence of disability that limits their daily activities (14.9 per cent vs. 12.5 per cent) and approximately 23 per cent of women and 22 per cent of men who live with a disability report IPV exposure in the last five years (a rate much higher than those living without a disability). Of those who experienced spousal abuse, 39 per cent of women living with a disability report the most severe forms of abuse compared to men (16 per cent). Unique experiences of people living with a disability related to IPV include the abusive partner restricting the individual's access to mobility aids, medication or medical technologies. Data from Statistics Canada indicate that emotional or financial abuse by a partner is reported by 22 per cent of women and 21 per cent of men living with disabilities. Women living with a cognitive disability reported some form of IPV exposure more often than their male counterparts (43 per cent vs. 27 per cent), and this was most evident for physical or sexual assault (16 per cent vs. 9 per cent), respectively.[52]

Perinatal period. IPV may begin, escalate or decrease during pregnancy or the postpartum year. Canadian studies report IPV rates between six per cent and 10.5 per cent during pregnancy. Risk factors for perinatal IPV exposure include prior abuse, age under 20 years, low income, single status, stressful life events, depression, substance and alcohol use.[53,54] IPV exposure was four times more likely to be reported by women if the pregnancy was unplanned or unwanted.[55] IPV exposure during pregnancy is associated with adverse neonatal and maternal health, including maternal depression.[56] Of particular note, evidence indicates that IPV exposure among women tends to increase after the baby is born.[57]

Alcohol use by IPV perpetrators and victims. Alcohol use increases the occurrence and the severity of IPV.[58-60] It directly affects cognitive and physical function, reduces self-control and leaves people less capable of negotiating a nonviolent resolution to conflicts within relationships.[61] Excessive drinking by one partner can exacerbate stress related to financial difficulties, childcare problems, infidelity[62] or other family stressors, creating relationship tensions and conflicts and increasing the risk of IPV.[63]Alcohol use may also reduce the abused partner's ability to perceive, resist or escape from IPV. Experiencing IPV can lead to alcohol consumption as a method of coping or self-medicating.[64] However,

individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking, and alcohol may be used as an excuse for violent behaviour.[65] It is likely that other types of substance use also lead to higher prevalence rates of IPV, but reliable data are lacking.

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

Senior age. Better data are now available for Canadians who are 65 years of age or over and who experience IPV, including neglect, physical, sexual, emotional and financial abuse.[68] It is estimated that only 20 per cent of incidents among this age group are reported to police due to language, culture, health, transportation and technology barriers. Police reports of violence against seniors reveal that victimization by a spouse was the most common type of abuse (33 per cent) for women, while victimization by a child was the most common abuse reported by men (34 per cent).[68] Family-related homicides against seniors have risen, with a spouse being the perpetrator for 50 per cent of women victims and eight per cent of men victims.[68] Abusers may be socially isolated, stressed or suffer from a mental illness or substance use disorder. Dementias or other brain dysfunction may be major factors, as cognitive dysfunction along with sensory impairment may lead to deterioration in reality testing and paranoid ideation. Frontal lobe disturbances may result in a lack of normal inhibition, with little apparent remorse or insight after IPV. It is important to remember that older people can be aggressive, violent or dangerous. However, IPV perpetrated in old age is often regarded less seriously. In addition, more sympathy tends to be extended to the perpetrators because of their perceived physical frailty or infirmity, which complicates the ability to estimate the true prevalence and consequences of IPV in older individuals.[69]

Risk Indicators

Many Canadian studies, including national, population-based surveys, have shown a fairly consistent pattern in demographic, relationship- and partner-specific indicators for exposure to IPV, including a young partner, being in a common-law (rather than legally married) relationship or separated; being in a relationship with an un- or underemployed partner, low economic status, high stress and abuse of alcohol or other substances.[5] International studies have identified personality disorders, psychosis, depression, marital conflict and poor family functioning as factors associated with a man's risk for abusing his partner.[5] Marked jealousy, hostile-dependency, low self-esteem, low assertiveness, emotional inexpressiveness, and social and sexual inadequacy have also all been described in perpetrators of IPV.[69] For male victims, younger men were four to five times at greater risk of IPV than men over 45 years in age. Ecologic risk factors for IPV include individual, partner, family and community/social factors.[5] Although IPV can occur in any intimate relationship, individual factors for victimization include (among others) past exposure to IPV (intergenerational cycle of abuse), exposure to child maltreatment, poverty, disability, Indigenous identity, gender/sexual minority status, substance use and unemployment. Perpetration factors at the individual level include substance use, need for over control, exposure to child maltreatment, exposure to IPV, negative attitudes toward women, unemployment, lower education and other partners. Family factors include male dominance, marital conflict, violence as a way of resolving disputes and poverty. There are numerous community and social factors; examples include gender inequality, cultural acceptance of IPV, lack of community cohesion, restricted access to divorce, property ownership, or inheritance, media portrayal of IPV, patriarchal laws or religious values and lack of policies or legal safeguards against IPV. Protective factors identified in some studies include gender equality, monitoring and enforcement of effective policies against IPV, services for victims, safe environments, formal marriage and higher social economic status and education.[5,38]

Health Impacts

Mental Health Impact

IPV is consistently associated with high rates of depression, anxiety disorders (especially phobias and panic disorder), PTSD, alcohol and other substance abuse, sleep disorders, psychosomatic disorders, and suicidal behaviour and self-harm after exposure to IPV.[5,12,70,71] Depression and PTSD are the most prevalent mental health disorders associated with IPV, with considerable comorbidity of the two disorders.[72] In a meta-analysis of studies of women exposed to IPV, the mean prevalence of depression was estimated at 47.6 per cent, and PTSD at 63.8 per cent (3.5 and 5.0 times the general female population rates, respectively).[73] Loss, feelings of shame

and guilt, humiliation, entrapment and lack of control contribute to the development of poor self-esteem and depression.[74,75] Other studies have also identified increased rates of eating disorders, antisocial and borderline personality disorders and non-affective psychosis in women exposed to IPV.[12,15,73,76-79] IPV is also associated with health risk behaviours including alcohol and drug abuse, sexual risk behaviours and smoking.[5] Because evidence is mounting that depression and PTSD are pathways by which abuse affects physical health,[27,80,81] addressing mental health effects may also be important for preventing physical health problems such as chronic pain or cardiac disease. It has also been found that when violence decreases or is eliminated, physical and mental health both improve.[82]

Physical Health Impact

According to the Statistics Canada 2017 Homicide Survey, women account for approximately eight in 10 victims of intimate partner homicide, with the rate of intimate partner homicide five times greater for females compared to males.[22] This maps onto previous estimates. Specifically, between 2003 and 2013, police services reported 960 domestic homicides in Canada; 78 per cent of victims were women. In homicides between spouses six in 10 (60 per cent) between 2008 and 2018 were preceded by a known history of family violence.[83]

Homicide rates for men and women are substantially lower than the early 1990s, which can be partly attributed to rising divorce rates and more equitable male–female employment rates, thereby offering women more options. Laws, law enforcement, shelters and advocacy may also contribute to declining spousal homicides. In the 1990s, men were more likely than women to commit suicide following domestic homicide. In addition, women were more likely to kill their partner if violence was prolonged or they feared for themselves or their children. Men were more likely to kill their partner from rage or despair over actual or impeding estrangement.[84]

A range of acute injuries including bruises, factures, lacerations, bites, dental injuries, burns and other injuries may follow IPV. A recent systematic review found that certain injury patterns can differentiate people exposed to IPV, compared with other kinds of injurious events. Specifically, head, neck, dental or facial injuries that were not witnessed (i.e., as would likely occur with a motor vehicle injury) are indicators. In addition, multiple injuries are associated with IPV exposure, whereas thoracic or abdominal extremity injuries alone, tend to not differentiate between abused and non-abused women.[76,85]

IPV has been linked to many other physical health outcomes including those related to chronic conditions and infectious diseases. An international systematic review and meta-analysis by the World Health Organization and other studies have found IPV to be associated with, in addition to the injuries above, chronic pain syndromes, fibromyalgia, gastrointestinal disorders, including irritable bowel syndrome, sleep disorders, physical inactivity, disability and general reductions in physical functioning and (or) health-related quality of life.[5,12,76,86] IPV is also associated with gynecological disorders, infertility, pelvic inflammatory disease, pregnancy complications and (or) miscarriage, sexual/reproductive dysfunction, unsafe sexual behaviour, sexually transmitted diseases (including HIV/AIDS), as well as unsafe or forced abortion and unwanted pregnancy.[5,12,76] In addition to maternal health, IPV during pregnancy can threaten the health of the fetus. Abuse directed to the abdomen can result in poor pregnancy outcomes, preterm birth and perinatal death.[12,76,87-90]

Children's Exposure to IPV

Exposure of a child to any psychological, physical, sexual, financial or emotional abuse between adults who are, or have been, intimate partners or family members is considered a form of child maltreatment in many jurisdictions within Canada[2,91] and may have short- or long-term mental and physical health impacts. Adverse outcomes include an increased risk of physical, psychological, social, emotional and behavioural problems, including mood and anxiety disorders, and substance use disorders and school-related problems in children and adolescents.[2,91-95] These negative effects may continue into adulthood and become part of an intergenerational cycle of violence.[91,95,96] Children who are exposed to IPV in the home are more likely to maltreat their own children[96,97] and are more likely to have violent dating and intimate relationships as adults (either as victims or perpetrators).[98-101] Children exposed to IPV are at increased risk of experiencing other forms of abuse by caregivers (e.g., physical and sexual abuse).[102,103]

Identification, Assessment and Documentation

Victims of IPV

There is no evidence for universal screening for IPV, based on three randomized controlled trials (RCTs), conducted in Canada,[104] New Zealand[105] and the United States.[106,107] Across these trials, IPV screening did not reduce IPV or improve health outcomes,[106] a fact

highlighted in most major evidence-based systematic reviews[108-110] though not necessarily reflected in some specific practice guidelines.[111,112] The discrepancy can contribute to confusion among policy makers and health professionals. While screening is not recommended, it is especially important for mental health clinicians to be alert to the signs and symptoms of IPV exposure and to practice case finding for IPV in the assessment of patients who present with a wide range of psychological signs or symptoms as discussed above. Consequently, inquiring about current and past IPV victimization or perpetration should be part of the clinical assessment of all patients, both men and women, in mental health, addiction and perinatal care settings. Such inquiry is referred to as case finding because it involves including questions about exposure to and perpetration of violence within the diagnostic assessment; it does not involve screening—the use of standardized questions administered in the same way to all patients.[2] Being aware of a history of IPV is necessary to inform diagnostic formulation and treatment approaches; without this information, a key contributing factor to the onset and persistence of mental illness, as well as any opportunity for interventions, may be missed.[69] Many IPV victims seeking health care present with vague signs and symptoms or chronic somatic complaints, including chronic pain, rather than signs of obvious physical, sexual or emotional trauma. Other behaviours that may suggest IPV exposure or perpetration are delays in seeking care or multiple missed appointments.[113] Lack of knowledge about or interest in IPV, time constraints, fear of retribution or of legal involvement are not acceptable reasons for mental health professionals to avoid inquiring about IPV. It should be noted that some individuals and organizations prefer the term "survivor" of IPV and the preferred term should be used if it is known.

New online educational resources from the Violence Evidence Guidance Action (VEGA) Project, funded by the Public Health Agency of Canada, have been developed to assist healthcare and social service providers to recognize and respond safely to family violence including IPV, children's exposure to IPV and child maltreatment.[2] VEGA resources include a handbook, "how to" videos and interactive educational scenarios to enhance knowledge and skills. It includes some examples of questions and responses for clinicians which may be helpful to provide guidance (available at https://vegaproject.mcmaster.ca/). The World Psychiatric Association International Competency-Based Curriculum for Mental Health Care Providers on Intimate Partner Violence/Sexual Violence Against Women, which has been translated into 10 languages, also contains teaching PowerPoints, case vignettes, video-based vignettes and helpful references (available at http://www.wpanet.org).

A private, safe, supportive, confidential environment is essential to conduct a full diagnostic assessment that includes inquiry about IPV. There are many barriers to patients disclosing IPV, including the fear of potential retaliation from the abusive partner, family or community censure, embarrassment, shame, economic dependency, or apprehension about child custody, immigration status or the legal system. It is important to ask about exposure to IPV privately (with no one else present including the partner or a child beyond infancy); if the inquiry and (or) response is overheard, it could put the patient at risk for further IPV.[2] Special arrangements may be needed for immigrants or refugees whose primary language is not English or for whom a request to speak privately from other family members or partners may be perceived as an unusual or culturally insensitive request. The patient should be seen alone or by a same-sex interviewer if culturally indicated, and family and friends should not be involved as translators. Cultural competence should allow a person to not only reject violence but also maintain their cultural identity. Patients may also lack knowledge that IPV is a crime in Canada or that support services exist. Some patients may not see IPV or what happens within their intimate relationship or partner-conflict as a health issue that is appropriate to disclose to a healthcare provider.

It may be helpful to preface direct questions about IPV by asking about the patient's relationships more generally. An introduction such as "How are things at home?" or "How do you and your partner get along?" could be used. Possible follow-up questions to ask include the following, when appropriate:

- How does your partner respond when there is disagreement in the family? With these arguments, do you ever feel frightened by them?
- Sometimes partners or ex-partners use physical force. Is this happening to you?
- Have you felt humiliated or emotionally harmed by your partner or ex-partner?
- Do you feel safe in your current or previous relationships?
- Have you ever been physically threatened or hurt by your partner or ex-partner?
- Have you been forced to have any kind of sexual activity by your partner or ex-partner?

When IPV is first disclosed by an abused partner, the initial clinical response should include validation of the experience (e.g., "Violence is, unfortunately, a common problem in our society" [or, "in many families"]); affirmation that violence is unacceptable (e.g., "Everyone deserves to feel safe at home"); and expression of support (e.g., "There are things we can discuss that can help"). It is crucial that insensitive (e.g., "Why don't you just leave?") or critical remarks ("Well, did you do something to make them angry? Just don't do that.") are not made by mental health professionals as these may reinforce existing feelings of helplessness, inadequacy or self-blame in victims.[69] The clinician needs to acknowledge the complexity of IPV and respect the patient's individual concerns and decisions. All discussions in which IPV is disclosed must include an inquiry about current safety. If the patient denies IPV, but injuries, signs or symptoms suggest that it may be occurring, inquiries should be repeated at later visits when an atmosphere of greater trust may facilitate further discussion.[2]

IPV among adults is not reportable to the police unless a practitioner is concerned about a serious imminent risk to the patient or someone else. Although the decision to involve legal authorities usually belongs to the abused patient alone, a disclosure that indicates that a child is also being abused, or at risk of harm related to IPV exposure among caregivers, requires mandatory reporting to provincial or territorial child protection services (CPS). The legislation varies somewhat across provinces and territories; thus, it is important to understand the specific legislation in one's region of practice. Given the limits of confidentiality, owing to mandatory reporting to CPS, it is important that patients be advised about these limits to confidentiality before any inquiry about IPV exposure.[2] A practitioner's workplace (including hospitals) may have specific guidance about inquiring about or acting on disclosures of IPV as part of workplace safety, and psychiatrists should be familiar with their workplace requirements.

Decisions to leave an abusive relationship may require time and may follow six stages of change outlined by Prochaska (i.e., precontemplation, contemplation, preparation, action, maintenance and termination).[114,115] Women planning to leave a relationship involving IPV should be cautioned that the risk of more serious violence (at times, even homicide) is increased during and following leaving the partner.[11] Safety should be a consideration whenever a person discloses IPV, and simple questions can be useful, such as "Do you feel safe to return home today?" "Do you have a safety plan?" and "Does your partner have a weapon?"

Assessment. Following disclosure of IPV, the abused patient should receive a full psychiatric assessment to ascertain any mood, anxiety, personality, psychotic, substance use disorder or organic brain syndrome that may predate or follow IPV. Psychological sequelae of IPV should be noted and the patient reassured that these are common and may spontaneously resolve or can be treated.

In general, studies exploring women's preferred responses after disclosing IPV suggest that women want physicians to ask questions about the abuse, to listen and believe them, express concern, be nonjudgmental and supportive, and to make appropriate referrals to a shelter, and to social and legal services.[116] Women do not want to be pressured to disclose IPV (or to leave their partner); they prefer to be asked about it in a way that is confident and comfortable, with assurance of confidentiality (with the potential exceptions regarding child welfare, outlined above). It is important to state to the patient that all people have a right to live without abuse.

Perpetrators of IPV

Perpetrators of IPV may present with personality disorders, substance use disorders, depression, fear of losing control, obsessional jealousy, paranoid ideas, psychosis or brain dysfunction. Questions that may uncover IPV, such as "What happens when you lose your temper?" or "Have you ever become violent or threatened someone?" or "Has this person ever been your partner?" can initiate the inquiry about IPV perpetration. More specific questions about the types of abuse being perpetrated should follow. A Canadian study found that male and female psychiatric patient perpetrators of IPV fell into one of the following groupings: generally violent and antisocial; borderline and dysphoric; or low psychopathology.[117] Personality disorders were most common. Disclosures by perpetrators should not be dismissed, minimized, met with indifference or dealt with in a way that seems to collude with the perpetrator's justification of the use of violence.[69] The assessment of the abusive partner should ideally be conducted by a professional who is not treating the victim to avoid a conflict of interest and/or an accidental or inadvertent disclosure of confidential information that may place the victim at greater risk. Collateral information about the abuser from other individuals in their life (e.g., other providers, family members independent from the abuser) should be sought to increase accuracy. A structured clinical evaluation should include any acute or chronic psychiatric disorders or personality disorders, the pattern, frequency, severity of abuse, any criminal convictions, as

well as their insight and judgment about their behaviour. Various tools can serve as memory aids in the assessment of risk of IPV recurrence including the Spousal Assault Risk Assessment Guide,[118] based on the 20-item Historical, Clinical and Risk management tool.[119]

Documentation

Careful, accurate documentation in the medical chart for victims or perpetrators is vital for monitoring, diagnosis, formulation and treatment planning. It may also be needed for legal proceedings.[120] The reported history and chronology of IPV and its relation to perpetrator or victim psychiatric symptoms, and its effects on a victim, should be recorded. It is important to differentiate facts from opinions.[69] Factual information, such as documenting visible injuries in a victim (a body diagram or photograph may be useful), a personal description of the IPV and its context by the patient in quotation marks, and noting the patient's mental status, is useful. Patient records (as always) should only be released by written patient consent or by subpoena (unless reporting to child welfare authorities is mandated).

Management, Treatment and Prognosis

Victims of IPV

Following a full psychiatric assessment of an adult exposed to IPV, treatment for any specific symptoms or conditions should be in accordance with national practice guidelines delivered by professionals with a good understanding of IPV and its consequences.[2] Treatment approaches will depend on the psychiatric diagnosis and be informed by issues specific to the patient, the relationship, the trajectory of abuse, the patient's readiness for change, culture and the IPV characteristics.

Advocacy interventions for people exposed to IPV aim to empower victims and link them to community resources such as shelters, housing, safety planning advice, informal counselling and legal services. A systematic review of all controlled studies of IPV advocacy interventions, including some in healthcare settings, found a reduction in abuse, increased social support, improved quality of life, increased safety behaviours and use of community resources.[108,121] Shelters provide safety for women at moderate risk of IPV and their children.[2]

In a systematic review of controlled studies of psychological interventions for IPV, victims reported improvements in psychological outcomes, including depression, PTSD and self-esteem, with a wide range of psychological interventions, including individual or group cognitive trauma therapy.[122,123] For victims of IPV and living with related PTSD, there appear to be a number of possible interventions. Specifically, a systematic review update by the Agency for Healthcare Research and Quality on psychological and pharmacological treatments found high strength of efficacy (SOE) for cognitive behaviour therapy, exposure and CBT-mixed treatments and moderate SOE for cognitive processing therapy, cognitive therapy, eye movement desensitization and reprocessing therapy and narrative exposure therapy to improve symptoms related to PTSD. Among pharmacotherapies, moderate SOE was found for fluoxetine, paroxetine and venlafaxine and low SOE for sertraline, olanzapine, risperidone, topiramate and prazosin.[123] Although no studies were found that identified resilience as the primary outcome, components of resilience, such as self-esteem, self-efficacy and improved quality of life, were assessed among some of the intervention studies included in the review.[124] Importantly, most studies included in the systematic review were conducted with women who were no longer in abusive relationships; their relevance for male victims of IPV and with PTSD or in people with PTSD symptoms and who are still experiencing abuse is unknown.[113] Couples' interventions may take various forms including multi-couple or individual couple sessions which may offer separate sessions for the victim and abuser. In general, couple-based interventions are thought to pose safety risks to the victim and effectiveness is uncertain. Thus, couples' therapy is not recommended, especially for those experiencing intimate partner terrorism (VEGA Systematic Review). The evidence for working with the whole family is inconclusive.[2]

Studies of children exposed to IPV have shown positive outcomes for specific interventions, such as child–parent psychotherapy,[125,126] teaching child management skills combined with providing support to mothers,[127] advocacy for mothers and their children, combined with a support and education group for children,[128] and trauma-focused cognitive-behavioural therapy, involving individual sessions for mothers and children as well as joint sessions.[129] These interventions, focused on the mother–child dyad, have been shown to improve behaviour problems[125-127] and (or) PTSD symptoms in children,[125,126,129] as well as children's competence and self-worth.[128] They are promising in their level of evidence but require replication.

The prognosis for victims of IPV is uncertain, as intervention studies usually have small samples, short follow-up and high attrition. Cohort studies of the natural history of IPV are rare. There are numerous descriptive reports of women successfully leaving abusive partners

and establishing healthy relationships with subsequent partners. However, one follow-up study of women who received an advocacy-based intervention after leaving a shelter found that 44 per cent had been assaulted by their original or a new partner 3.5 years after leaving the shelter. In addition, despite significantly lower recurrence rates in the intervention group at two-year follow-up, this difference was not sustained at the three-year follow-up period. However, importantly, there was a significant improvement in quality of life and social support among women who participated in the advocacy-based intervention, compared with those who did not.[130] We were unable to find prognostic data about men or members of special population groups who were abused.

Perpetrators of IPV

Various programs have been developed for abusive partners, some of which are voluntary and others court-mandated. Nearly all of these are for men abusers, and adherence is often low. The evidence of effectiveness is mixed,[131] although motivational interviewing may be promising and requires further research. No studies were found for women perpetrators or perpetrators identifying as gender/sexual minorities. Thus, the focus of intervention, in addition to treating any mental illness that may be present, is to encourage the abuser to take responsibility for IPV perpetration, to recognize internal and external triggers for IPV and to understand and take responsibility for the consequences of their perpetration. Specific behavioural strategies that can reduce the risk of violence perpetration, offering advice on reducing alcohol or drug intake, as well as referral to appropriate perpetrator services may be helpful for specific people.[69] There is some evidence to suggest that permanent (not temporary) civil protection orders for men abusers may reduce future IPV.[132]

Prevention

Primary prevention of IPV consists of educational programs that focus on respectful relationships, conflict resolution strategies, changes in attitudes, and knowledge. However, a Cochrane systematic review of interventions to prevent relationship and dating violence in adolescents and young people found no convincing evidence that these programs decrease relationship/dating violence, attitudes, behaviours or skills. The only positive effect noted in the review related to improving knowledge about relationship violence.[133]

Although scientific evidence is lacking, many authorities recommend intersectoral collaboration between health, social, education and legal services, as well as between health specialties and disciplines to advocate for IPV prevention and policy.[134,135] The media can also be helpful in raising public awareness of IPV as a critical mental health determinant and in censuring public statements that sensationalize or normalize IPV as an acceptable or cultural norm.[135] However, it is important to evaluate the effectiveness of such approaches in reducing IPV.

Secondary prevention interventions for IPV have been described for pregnant women, consisting of advocacy and empowerment programs that reduced psychological and minor physical violence and improved pregnancy outcomes.[136,137] One trial of intensive advocacy (12 hours or more) reduced physical abuse after 12 to 24 months in women leaving shelters, but this was not the case for shorter or longer follow-up periods.[130] Other treatment interventions are discussed earlier in this paper.

Education and Research

Some psychiatric associations (e.g., the World Psychiatric Association[138] and the Royal College of Psychiatrists[69]) and a few Canadian medical specialty associations in addition to the CPA (e.g., the Society of Obstetricians and Gynaecologists of Canada[87] and the Canadian Orthopaedic Association[139]) have issued policy statements and educational objectives on the topic of IPV.

Trainees in psychiatry at the undergraduate and postgraduate level, including international medical graduates, and all mental health professionals should receive education about IPV from faculty who are familiar with this issue. Currently, rates of inclusion of IPV content in the Canadian curriculum of medical and allied health professionals, including mental health professionals, are very low.[140] This training should be included in the curriculum and be composed of both a didactic and a clinical component. The didactic component should include the prevalence (including special populations), etiology, health effects (especially mental health), how to inquire about IPV and safety using a case-finding approach, the range of interventions for IPV-related impairment, as well as risk assessment and management of victims and perpetrators of IPV. Continuing professional education programs should also include sessions on IPV. All psychiatrists should become familiar with, and implement, the guidance outlined in this CPA position paper, Recognizing and Responding to Intimate Partner Violence: An Update (informed by the CPA's position paper on cultural competence[141]).

In terms of research, there is now considerable descriptive information about IPV, especially in women, but it is also

important to examine IPV against men perpetrated by women and IPV in special populations. Studies of effective interventions for the prevention and treatment of victims and perpetrators are still in their infancy and there are important knowledge gaps. Specifically, there is a need for rigorously designed studies comparing different psychological interventions, and which focus on people at different stages of the abuse trajectory, as well as studies testing the impact of interventions of differing durations and follow-up periods. Both patient- and system-centred interventions should use standardized or comparable outcome measures.

Summary

- IPV is an under-recognized problem that impacts all genders and which occurs in all countries, cultures and socioeconomic groups.
- IPV has an enormous impact on personal health, and economic and social well-being.
- IPV may occur in heterosexual and gender/sexual minority relationships and may be perpetrated by individuals identifying with either sex, gender and by non-binary individuals.
- Canadian data from 2014 show equal proportions of men and women (four per cent) have been victims of physical IPV in the previous five years.
- Women are more likely than men to report severe IPV, to report chronic violence or to be killed. They are also more likely to be criminally harassed or killed after the relationship ends.
- Exposure to IPV has deleterious effects on children and other family members.
- Some populations are at greater risk for IPV. These include Indigenous women, gender/sexual minorities, people with disabilities, those in dating relationships, those with alcohol and other substance use disorders, those with low-income and those who have a previous partner that was abusive.
- Mental health problems associated with IPV include depression, anxiety disorders, PTSD, chronic pain syndromes, eating disorders, sleep disorders, psychosomatic disorders, alcohol and other substance use problems, suicidal and self-harm behaviours, psychosis, some personality disorders and harmful health behaviours, such as risk taking and smoking. As IPV is a major determinant of mental health, it is of vital importance to mental health professionals.
- Physical health problems associated with IPV include death, a broad range of injuries, reproductive disorders, gastrointestinal disorders, chronic pain syndromes, fibromyalgia, poor physical functioning and lower health-related quality of life. Sexually transmitted diseases, unwanted pregnancies and physical inactivity are also increased.
- Children's exposure to IPV may have short- and long-term health impacts on the child, especially mental health effects.
- Perpetrators of IPV most frequently have personality disorders, but substance use disorders and other types of mental illness or brain dysfunction may also occur.

Recommendations for Best Practice

- Psychiatrists and other mental health professionals should inquire about IPV victimization and perpetration using a case-finding approach as part of the clinical assessment of all patients. A person does not need to be in a current relationship to be experiencing IPV.
- Case-finding in patients with symptoms associated with IPV should be a priority and inquiries made about possible IPV in a private, safe, confidential, empathic setting. These questions may need to be repeated at subsequent sessions when the therapeutic relationship is better established.
- Particular attention to case-finding should be given to special populations and situations known to be at higher risk of IPV.
- If a patient discloses IPV, inquiries should be made about current safety (risk assessment) and referrals offered to appropriate services for people experiencing violence (e.g., shelters, local resource centres, social and/or legal resources and/or police if indicated).
- Safety should be an ongoing concern, especially if the abused partner plans to leave the abusive situation.
- Careful documentation of IPV in the patient's chart is essential. It should be released only with patient consent or by subpoena.
- CPS must be notified in accordance with provincial or territorial legislation if a child is exposed to IPV or is in danger. Victims of abuse should be informed of this duty to report, and that not all types of disclosures will be strictly confidential.
- Mental health professionals should ask about children in the family and determine the need for any children to be referred for assessment of emotional and behavioural problems.

- Treatment approaches will depend on the psychiatric diagnosis and national treatment guidelines and be informed by special issues particular to the person, the relationship, the trajectory of abuse, the patient's readiness for change, culture and the IPV characteristics. Mental health professionals should consider referral of patients to advocacy services and the need for specific psychological interventions as outlined above. They should be aware of the moderate strength of evidence for only a few psychotropic medications for treating PTSD following IPV as outlined above.
- Psychiatrists should be familiar with the principles of risk assessment and management for perpetrators of IPV. In addition to treating any mental illness or substance use disorder that may be present, the main focus of treatment should be on assisting the perpetrator to take responsibility for IPV and its consequences, to recognize its triggers and to develop behavioural strategies to stop IPV.
- Specific education on IPV should be part of the curriculum and provided to all psychiatric trainees and mental health professionals by faculty knowledgeable about IPV. Education should include the IPV prevalence, etiology, how to ask about and respond to disclosures and the range of interventions for IPV. Continuing professional education programs should include IPV. Psychiatrists should be familiar with and implement the guidelines outlined in this CPA position paper, Recognizing and Responding to IPV: An Update.
- Further research is needed in the Canadian context regarding special populations and situations, and, especially, on effective interventions for prevention and treatment of IPV and its mental health sequelae.
- The CPA should seek opportunities to confer with other professional health organizations (e.g., family medicine, emergency medicine, pediatrics, obstetrics and gynecology, orthopedics, dentistry, nursing and social work) and other sectors (e.g., social services, education, legal and media) so that psychiatrists contribute to and learn from wider advocacy for IPV prevention, policy and clinical practice. This could include, among others, increased public awareness of IPV as a critical mental health determinant and censuring public statements that normalize IPV as an acceptable or cultural norm.

Acknowledgements

Dr. Stewart, Dr. MacMillan, were co-principal investigators for PreVAiL funded by Canadian Institutes of Health Research, Institute of Gender and Health and Institute of Neurosciences Mental Health and Addictions (INMHA) grant (#: RDG99326).

Dr. MacMillan is the Project Lead of the Violence, Evidence, Guidance, Action (VEGA) Project funded by the Public Health Agency of Canada. She is supported by the Chedoke Health Chair in Child Psychiatry.

Dr. Kimber is the Lead, Dr. Stewart a co-Lead and Dr. MacMillan is VEGA Advisor of Preparing Providers to Recognize and Respond to Family Violence (Préparer les praticiens à reconnaître et à réagir à la violence familiale) funded by the Public Health Agency of Canada (Agence de la santé publique du Canada). The views expressed in this position paper do not necessarily represent the views of the Public Health Agency of Canada.

References

1. Stewart DE, MacMillan H, Wathen N. Intimate partner violence. Can J Psychiatry. 2013;58(6):1-15.
2. VEGA Family Violence Education Resources. VEGA education. VEGA Education. 2019; [accessed 2019 Sep 12]. https://vegaeducation.mcmaster.ca/
3. Centers for Disease Control. Intimate partner violence. Violence Prevention Injury Center CDC; 2018; [accessed 2019 Sep 12]. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html.
4. Breiding M, Basile K, Smith S, et al. Intimate partner violence surveillance: uniform definitions and recommended data elements version 2.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2015; [accessed 2019 Sep 17]. https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf.
5. Krug EG, Mercy JA, Dahlberg LL, et al. The world report on violence and health. 2002; [accessed 2020 July 20]. https://www.who.int/violence_injury_prevention/violence/world_report/en/introduction.pdf.
6. Burczycka M. Stalking in Canada. 2014. Section 1. [accessed 2019 Sep 23]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54893/01-eng.htm.
7. World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, Switzerland: World Health Organization. 2010; [accessed 2016 Oct 20). http://apps.who.int/iris/bitstream/10665/44350/1/9789241564007_eng.pdf.
8. Garcia-Moreno C, Watts C. Violence against women: an urgent public health priority. Bull World Health Organ. 2011;89(1):2.
9. Zhang T, Hoddenbagh J, McDonald S, et al. An estimation of the economic impact of spousal violence in Canada. 2009; [accessed 2019 Sep 12]. https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr12_7/rr12_7.pdf.
10. Bishop J, Patterson PG. Guidelines for the evaluation and management of family violence. Can J Psychiatry. 1992;37(7):458-481.
11. Burczycka M, Conroy S, Savage L. Family violence in Canada: a statistical profile. 2016; [accessed 2019 Oct 8]. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2018001/article/54978-eng.pdf?st=rNlYwyTF.
12. Stewart DE, Vigod SN. Update on mental health aspects of intimate partner violence. Med Clin North Am. 2019;103(4):735-749.

13. Public Health. The Chief Public Health Officer's Report on the state of public health in Canada 2016—a focus on family violence in Canada. 2016; [accessed 2019 Sep 12]. https://www.canada.ca/en/public-health/services/publications/chief-public-health-officer-reports-state-public-health-canada/2016-focus-family-violence-canada.html.
14. Trevillion K, Oram S, Feder G, et al. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PLoS One. 2012;7(12):e51740.
15. Ellsberg M, Jansen HAFM, Heise L, et al. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. Lancet. 2008;371(9619):1165-1172.
16. Bunge VP, Locke D. Family violence in Canada: a statistical profile. Statistics Canada; 2000 [accessed 2020 July 20]. https://www150.statcan.gc.ca/n1/en/pub/85-224-x/85-224-x2000000-eng.pdf?st=IXge_QGB
17. Burczycka M. Section 1: Trends in self-reported spousal violence in Canada, 2014. Statistics Canada. Family violence in Canada: a statistical profile. 2014. [accessed 2019 Dec 12]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2016001/article/14303/01-eng.htm.
18. Canadian Centre for Justice Statistics. Family violence in Canada: a statistical profile. 2014; [accessed 2019 Dec 12]. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2016001/article/14303-eng.pdf?st=aGoQ_JzQ.
19. Burczycka M. Section 3: Police-reported intimate partner violence. Statistics Canada: Juristat; 2018; [accessed 2020 july 20]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54893/03-eng.htm.
20. Ibrahim D. Police-reported violence among same-sex intimate partners in Canada, 2009 to 2017. Statistics Canada. 2019; [accessed 2019 Sep 11]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00005-eng.htm.
21. Sinha M. Section 2: Violence against intimate partners. Family violence in Canada: a statistical profile, 2010. Ottawa (ON): Statistics Canada; 2012; [accessed 2020 Jul 20]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2012001/article/11643/11643-2-eng.htm.
22. Burczycka M. Section 2: Police-reported intimate partner violence in Canada, 2017. Family violence in Canada: a statistical profile. Ottawa (ON): Statistics Canada. 2017; [accessed 2019 December 12]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54978/02-eng.htm.
23. Hébert M, Daspe M-È, Lapierre A, et al. A meta-analysis of risk and protective factors for dating violence victimization: the role of family and peer interpersonal context. Trauma Violence Abuse. 2019;20(4):574-590.
24. Johnson MP. Conflict and control: gender symmetry and asymmetry in domestic violence. Violence Against Women. 2006;12(11):1003-1018.
25. Varcoe C, Hankivsky O, Ford-Gilboe M, et al. Attributing selected costs to intimate partner violence in a sample of women who have left abusive partners: a social determinants of health approach. Can Public Policy. 2011;37(3):359-380.
26. Wuest J, Ford-Gilboe M, Merritt-Gray M, et al. Pathways of chronic pain in survivors of intimate partner violence. J Womens Health (Larchmt). 2010;19(9):1665-1674.
27. Wuest J, Ford-Gilboe M, Merritt-Gray M, et al. Abuse-related injury and symptoms of posttraumatic stress disorder as mechanisms of chronic pain in survivors of intimate partner violence. Pain Med. 2009;10(4):739-747.
28. Ford-Gilboe M, Wuest J, Varcoe C, et al. Modelling the effects of intimate partner violence and access to resources on women's health in the early years after leaving an abusive partner. Soc Sci Med. 2009;68(6):1021-1029.
29. Ansara DL, Hindin MJ. Psychosocial consequences of intimate partner violence for women and men in Canada. J Interpers Violence. 2011;26(8):1628-1645.
30. Ansara DL, Hindin MJ. Exploring gender differences in the patterns of intimate partner violence in Canada: a latent class approach. J Epidemiol Community Health. 2010;64(10):849-854.
31. Cotter A, Savage L. Gender-based violence and unwanted sexual behaviour in Canada, 2018: initial findings from the survey of safety in public and private spaces. Juristat: Statistics Canada. 2019; [accessed 2019 Dec 9]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00017-eng.htm.
32. Public Health Agency of Canada. Stop family violence. 2019; [accessed 2019 Oct 18]. https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence.html.
33. Coxell AW, King MB. Male victims of rape and sexual abuse. Sex Relat Ther. 2010:25380-25391.
34. Uthman OA, Lawoko S, Moradi T. Factors associated with attitudes towards intimate partner violence against women: a comparative analysis of 17 sub-Saharan countries. BMC Int Health Hum Rights. 2009;9(1):14.
35. Uthman OA, Lawoko S, Moradi T. Sex disparities in attitudes towards intimate partner violence against women in sub-Saharan Africa: a socio-ecological analysis. BMC Public Health. 2010;10(1):223.
36. Do KN, Weiss B, Pollack A. Cultural beliefs, intimate partner violence and mental health functioning among Vietnamese women. Int Perspect Psychol Res Pract Consult. 2013;2(3):149-163.
37. Hajian S, Vakilian K, Mirzaii Najm-abadi K, Parastoo H, Mehrdad J. Violence against women by their intimate partners in Shahroud in northeastern region of Iran. Glob J Health Sci. 2014;6(3):117-130.
38. Yakubovich AR, Stöckl H, Murray J, et al. Risk and protective factors for intimate partner violence against women: systematic review and meta-analyses of prospective-longitudinal studies. Am J Public Health. 2018;108(7):e1-e11.
39. Kimber MS, Boyle MH, Lipman EL, et al. The associations between sex, immigrant status, immigrant concentration and intimate partner violence: evidence from the Canadian General Social Survey. Glob Public Health. 2013;8(7):796-821.
40. Okeke-Ihejirika P, Yohani S, Muster J, Alphonse N, Thane C, Virginia P. A scoping review on intimate partner violence in Canada's immigrant communities. Trauma Violence Abuse. 2018 Sep 3. [Epub ahead of print]. doi: 10.1177/1524838018789156.
41. Tabibi J, Ahmad S, Baker L, et al. Intimate partner violence against immigrant and refugee women.2018; [accessed 2019 Sep 24]. http://www.vawlearningnetwork.ca/our-work/issuebased_newsletters/issue-26/Plain-Text-Issue-26.pdf.
42. Statistics Canada. Aboriginal peoples in Canada: key results from the 2016 census. 2017; [accessed 2019 Sep 12]. https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm.
43. Hautala DS, Sittner Hartshorn KJ, Armenta B, et al. Prevalence and correlates of physical dating violence among North American Indigenous adolescents. Youth Soc. 2017;49(3):295-317.

44. Varcoe C, Ford-Gilboe M, Browne AJ, et al. The efficacy of a health promotion intervention for Indigenous women: reclaiming our spirits. J Interpers Violence. 2019:1-31.
45. Khalifeh H, Oram S, Osborn D, Louise MH, Sonia J. Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis. Int Rev Psychiatry. 2016;28(5):433-451.
46. Dienemann J, Boyle E, Baker D, Resnick W, Wiederhorn N, Campbell J. Intimate partner abuse among women diagnosed with depression. Issues Ment Health Nurs. 2000;21(5):499-513.
47. Heru AM, Stuart GL, Rainey S, et al. Prevalence and severity of intimate partner violence and associations with family functioning and alcohol abuse in psychiatric inpatients with suicidal intent. J Clin Psychiatry. 2006;67(1):23-29.
48. Ard KL, Makadon HJ. Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. J Gen Intern Med. 2011;26(8):930-933.
49. Wathen CN, MacGregor JCD, Tanaka M, et al. The impact of intimate partner violence on the health and work of gender and sexual minorities in Canada. Int J Public Health. 2018;63(8): 945-955.
50. National Coalition of Anti-Violence Programs. Lesbian, gay, bisexual, transgender, queer, and HIV-affected intimate partner violence in 2015: a report from the National Coalition of Anti-Violence Programs 2016 Release Edition. NCAVP. New York: Emily Waters. 2016; [accessed 2019 Sep 11]. https://avp.org/wp-content/uploads/2017/04/2015_ncavp_lgbtqipvreport.pdf.
51. Bucik A. Canada: discrimination and violence against lesbian, bisexual, and transgender women and gender diverse and two spirit people on the basis of sexual orientation, gender identity, and gender expression. Toronto (ON): Eagle Canada Human Rights Trust. 2016; [accessed 2020 Jul 20]. https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/CAN/INT_CEDAW_NGO_CAN_25380_E.pdf.
52. Cotter A. Violent victimization of women with disabilities, 2014. Statistics Canada. 2018; [accessed 2019 Sep 26]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54910-eng.htm.
53. Stewart D, Cecutti A. Physical abuse in pregnancy. CMAJ. 1993; 149(9):1257-1263.
54. Kingston D, Heaman M, Urquia M, et al. Correlates of abuse around the time of pregnancy: results from a national survey of Canadian women. Matern Child Health J. 2016:20778-20789.
55. Wichman CL, Moore KM, Lang TR, St Sauver JS, Robert HH Jr, William JW. Congenital heart disease associated with selective serotonin reuptake inhibitor use during pregnancy. Mayo Clin Proc. 2009;84(1):23-27.
56. Alhusen JL, Ray E, Sharps P, Linda B. Intimate partner violence during pregnancy: maternal and neonatal outcomes. J Womens Health (Larchmt). 2015;24(1):100-106.
57. Stewart DE. Incidence of postpartum abuse in women with a history of abuse during pregnancy. CMAJ. 1994;151(11):1601-1604.
58. Leonard KE, Quigley BM. Drinking and marital aggression in newlyweds: an event-based analysis of drinking and the occurrence of husband marital aggression. J Stud Alcohol. 1999; 60(4):537-545.
59. Testa M, Quigley BM, Leonard KE. Does alcohol make a difference? J Interpers Violence. 2003;18(7):735-743.
60. Brecklin LR. The role of perpetrator alcohol use in the injury outcomes of intimate assaults. J Fam Violence. 2002;17(3):185-197.
61. Room R, Babor T, Rehm J. Alcohol and public health. Lancet. 2005;365(9458):519-530.
62. Shillington AM, Cottler LB, Compton WM, Spitznagel EL. Is there a relationship between “heavy drinking” and HIV high risk sexual behaviors among general population subjects? Int J Addict. 1995; 30(11):1453-1478.
63. Loi VM, Huy VT, Minh NH, et al. Gender-based violence: the case of Vietnam. Washington (DC): World Bank; 1999; [accessed 2019 Oct 18]. https://siteresources.worldbank.org/INTVIETNAM/Resources/Gender-Based-Violence.pdf.
64. Wingood GM, DiClemente RJ, Raj A. Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. Am J Prev Med. 2000;19(4):270-275.
65. Field CA, Caetano R, Nelson S. Alcohol and violence related cognitive risk factors associated with the perpetration of intimate partner violence. J Fam Violence. 2004;19(4):249-253.
66. Cohen MM, Maclean H. Violence against Canadian women. JOGC 2003(25):499-504.
67. Leone JM, Johnson MP, Cohan CL, et al. Consequences of male partner violence for low-income minority women. J Marriage Fam. 2004:66472-66490.
68. Conroy S. Section 5: Police-reported family violence against seniors. Statistics Canada. 2018; [accessed 2019 Sep 26]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54893/05-eng.htm.
69. Royal College of Psychiatrists. Policy statement on domestic violence. London, UK 2002.
70. Campbell JC. Health consequences of intimate partner violence. Lancet. 2002;359(9314):1331-1336.
71. Jordan CE. Violence and women’s mental health: the pain unequalled. Trauma Violence Abuse. 2009;10(3):195-197.
72. Basile KC, Arias I, Desai S, Martie PT. The differential association of intimate partner physical, sexual, psychological, and stalking violence and posttraumatic stress symptoms in a nationally representative sample of women. J Trauma Stress. 2004;17(5):413-421.
73. Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. J Fam Violence. 1999;14(2):99-132.
74. Pallitto CC, García-Moreno C, Jansen HAFM, et al. Intimate partner violence, abortion, and unintended pregnancy: results from the WHO multi-country study on women’s health and domestic violence. Int J Gynaecol Obstet. 2013;120(1):3-9.
75. Astbury J, Cabral M. Women’s mental health: an evidence-based review. 2000; [accessed 2020 Jul 20]. https://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf.
76. World Health Organization. WHO multi-country study on women’s health and domestic violence against women. 2005; [accessed 2019 Oct 18]. https://www.who.int/reproductivehealth/publications/violence/24159358X/en/.
77. Jordan CE, Campbell R, Follingstad D. Violence and women’s mental health: the impact of physical, sexual, and psychological aggression. Annu Rev Clin Psychol. 2010;6(1):607-628.
78. Afifi TO, MacMillan H, Cox BJ, et al. Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. J Interpers Violence. 2009;24(8):1398-1417.
79. Ehrensaft MK, Moffitt TE, Caspi A. Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? a longitudinal cohort study. Am J Psychiatry. 2006; 163(5):885-892.

80. Sutherland CA, Bybee DI, Sullivan CM. Beyond bruises and broken bones: the joint effects of stress and injuries on battered women's health. Am J Community Psychol. 2002;30(5):609-736.
81. Weaver TL, Resnick H. Toward developing complex multivariate models for examining the intimate partner violence-physical health relationship: commentary on Plichta. J Interpers Violence. 2004; 19(11):1342-1359.
82. Bybee DI, Sullivan CM. The process through which an advocacy intervention resulted in positive change for battered women over time. Am J Community Psychol. 2002;30(1):103-132.
83. Burczycka M. Section 2. Police - reported intimate partner violence in Canada. Statistics Canada, 2018; [accessed 2020 July 23]. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00018/02-en.htm.
84. Dawson M, Bunge VP, Balde T. National trends in intimate partner homicides: explaining declines in Canada, 1976 to 2001. Violence Against Women. 2009;15(3):15276-15306.
85. Wu V, Huff H, Bhandari M. Pattern of physical injury associated with intimate partner violence in women presenting to the emergency department: a systematic review and meta-analysis. Trauma Violence Abuse. 2010;11(2):71-82.
86. AuCoin K, Beauchamp D. Impacts and consequences of victimization, GSS 2004. 2007; [accessed 2019 Oct 18]. http://publications.gc.ca/collections/Collection-R/Statcan/85-002-XIE/85-002-XIE2007001.pdf.
87. Cherniak D, Grant L, Mason R, et al. Intimate partner violence consensus statement. J Obstet Gynaecol Can 2005;27(4): 365-418.
88. Shah PS, Shah J, Knowledge Synthesis Group on Determinants of Preterm/LBW Births. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. J Womens Heal. 2010;19(11): 2017-2031.
89. Campbell J, Torres S, Ryan J, et al. Physical and nonphysical partner abuse and other risk factors for low birth weight among full term and preterm babies: a multiethnic case-control study. Am J Epidemiol. 1999;150(7):714-726.
90. Murphy CC, Schei B, Myhr TL, et al. Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. CMAJ 2001; 164(11):1567-1572.
91. Gilbert R, Widom CS, Browne K, David F, Elspeth W, Staffan J. Burden and consequences of child maltreatment in high-income countries. Lancet. 2009;373(9657):68-81.
92. Gilbert R, Fluke J, O'Donnell M, et al. Child maltreatment: variation in trends and policies in six developed countries. Lancet 2012;379(9817):758-772.
93. Kitzmann KM, Gaylord NK, Holt AR, et al. Child witnesses to domestic violence: a meta-analytic review. J Consult Clin Psychol. 2003;71(2):339-352.
94. Evans SE, Davies C, DiLillo D. Exposure to domestic violence: a meta-analysis of child and adolescent outcomes. Aggress Violent Behav. 2008;13(2):131-140.
95. Dube SR, Anda RF, Felitti VJ, et al. Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: implications for health and social services. Violence Vict. 2002;17(1):3-17.
96. Doumas D, Margolin G, John RS. The intergenerational transmission of aggression across three generations. J Fam Violence. 1994;9(2):157-175.
97. Schwartz JP, Hage SM, Bush I, Lauren KB. Unhealthy parenting and potential mediators as contributing factors to future intimate violence: a review of the literature. Trauma Violence Abuse. 2006; 7(3):206-221.
98. Stith SM, Rosen KH, Middleton KA, et al. The intergenerational transmission of spouse abuse: A meta-analysis. J Marriage Fam. 2000;62(3):640-654.
99. Ehrensaft MK, Cohen P, Brown J, et al. Intergenerational transmission of partner violence: a 20-year prospective study. J Consult Clin Psychol. 2003;71(4):741-753.
100. Carr JL, VanDeusen KM. The relationship between family of origin violence and dating violence in college men. J Interpers Violence. 2002:17630-17646.
101. Kimber M, Adham S, Gill S, et al. The association between child exposure to intimate partner violence (IPV) and perpetration of IPV in adulthood: a systematic review. Child Abuse Negl. 2018: 76273-76286.
102. Margolin G. Effects of domestic violence on children. In: Trickett PK, Schellenbach CJ, editors. Violence against children in the family and the community. Washington (DC): American Psychological Association; 1998.p. 57-101.
103. McCloskey LA, Figueredo AJ, Koss MP. The effects of systemic family violence on children's mental health. Child Dev. 1995; 66(5):1239-1261.
104. MacMillan HL, Wathen CN, Jamieson E, et al. Screening for intimate partner violence in health care settings: a randomized trial. JAMA. 2009;302(5):493.
105. Koziol-McLain J, Garrett N, Fanslow J, et al. A randomized controlled trial of a brief emergency department intimate partner violence screening intervention. Ann Emerg Med. 2010;56(4): 413-423.e1.
106. Wathen CN, MacMillan HL. Health care's response to women exposed to partner violence. JAMA. 2012;308(7):712.
107. Klevens J, Kee R, Trick W, et al. Effect of screening for partner violence on women's quality of life. JAMA. 2012; 308(7):681.
108. Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet the UK National Screening Committee criteria for a screening programme? systematic reviews of nine UK national screening committee criteria. Health Technol Assess (Rockv). 2009;13(16):iii–iv, xi–xiii, 1–113, 137-347.
109. Institute of Medicine. Clinical preventive services for women: closing the gaps. Washington (DC): Institute of Medicine; 2011.
110. Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. preventive services task force recommendation. Ann Intern Med. 2012; 156(11):796-808.
111. Registered Nurses' Association of Ontario. Woman abuse: screening, identification and initial response. Guideline Supplement. 2012;[accessed 2019 Oct 25]. https://rnao.ca/bpg/guidelines/woman-abuse-screening-identification-and-initial-response.
112. American College of Obstetricians and Gynecologists. The American college of obstetricians and gynecologists committee opinion no. 518: intimate partner violence. Obs Gynecol. 2012; 119(2 Pt 1):412-417.
113. Feder G, MacMillan HL. Intimate partner violence. In: Goldman L, Schaaefer AL, editors. Goldman's Cecil medicine. New York: Elsevier Saunders; 2016. p. 1629-1635.

114. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. Am J Health Promot. 1997;12(1):38-48.
115. Burke JG, Denison JA, Gielen AC, et al. Ending intimate partner violence: an application of the transtheoretical model. Am J Health Behav. 2004;28(2):122-133.
116. Feder GS, Hutson M, Ramsay J, et al. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006;166(1):22-37.
117. Walsh Z, Swogger MT, O'Connor BP, et al. Subtypes of partner violence perpetrators among male and female psychiatric patients. J Abnorm Psychol. 2010;119(3):563-574.
118. Kropp PR, Hart SD. The spousal assault risk assessment (SARA) guide: reliability and validity in adult male offenders. Law Hum Behav. 2000;24(1):101-118.
119. Webster C, Douglas K, Eaves D, et al. HCR-20: assessing risk for violence—Version 2. Burnaby (BC); 1997.
120. Ferris LE, McMain-Klein M, Silver L. Documenting wife abuse: a guide for physicians. CMAJ. 1997;156(7):1015-1022.
121. Ramsay J, Carter Y, Davidson L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. Cochrane Database Syst Rev. 2009;6(3):CD005043.
122. Kubany ES, Hill EE, Owens JA, et al. Cognitive trauma therapy for battered women with PTSD (CTT-BW). J Consult Clin Psychol. 2004;72(1):3-18.
123. Hoffman V, Middleton JC, Feltner C, et al. Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update. Comparative Effectiveness Review No. 207. AHRQ Publication No. 18-EHC011-EF. PCORI Publication No. 2018-SR-01. Rockville (MD): Agency for Healthcare Research and Quality; 2018; [accessed 2019 Oct 2]. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-207-ptsd-update-2018-rev_0.pdf.
124. Herrman H, Stewart DE, Diaz-Granados N, et al. What is resilience? Can J Psychiatry. 2011;56(5):258-265.
125. Lieberman AF, Van Horn P, Ippen CG. Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. J Am Acad Child Adolesc Psychiatry. 2005; 44(12):1241-1248.
126. Lieberman AF, Ghosh Ippen C, VAN Horn P. Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2006;45(8):913-918.
127. Jouriles EN, McDonald R, Rosenfield D, et al. Reducing conduct problems among children exposed to intimate partner violence: a randomized clinical trial examining effects of Project Support. J Consult Clin Psychol. 2009;77(4):705-717.
128. Sullivan CM, Bybee DI, Allen NE. Findings from a community-based program for battered women and their children. J Interpers Violence. 2002;17915-17936.
129. Cohen JA, Mannarino AP, Iyengar S. Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. Arch Pediatr Adolesc Med. 2011;165(1):16-21.
130. Bybee D, Sullivan CM. Predicting re-victimization of battered women 3 years after exiting a shelter program. Am J Community Psychol. 2005;36(1–2):85-96.
131. World Health Organization. Violence and injury prevention: intervening with perpetrators of intimate partner violence: a global perspective. WHO. 2003; [accessed 2019 Oct 18]. https://www.who.int/violence_injury_prevention/publications/violence/intervening/en/.
132. Holt VL, Kernic MA, Lumley T, Marsha EW, Frederick PR. Civil protection orders and risk of subsequent police-reported violence. JAMA. 2002;288(5):589.
133. Fellmeth GLT, Heffernan C, Nurse J, Shakiba H, Dinesh S. Educational and skills-based interventions for preventing relationship and dating violence in adolescents and young adults. Cochrane Database Syst Rev. 2013;19(6):CD004534.
134. Robinson AL. Reducing repeat victimization among high-risk victims of domestic violence: the benefits of a coordinated community response in Cardiff, Wales. Violence Against Women. 2006;12(8):761-788.
135. Robinson AL, Tregidga J. The perceptions of high-risk victims of domestic violence to a coordinated community response in Cardiff, Wales. Violence Against Women. 2007;13(11): 1130-1148.
136. Tiwari A, Leung WC, Leung TW, Humphreys J, Parker B, Ho PC. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. BJOG. 2005; 112(9):1249-1256.
137. Kiely M, El-Mohandes AAE, El-Khorazaty MN, Susan MB, Marie GG. An integrated intervention to reduce intimate partner violence in pregnancy. Obs Gynecol. 2010;115(2, Part 1):273-283.
138. Stewart DE. The international consensus statement on women's mental health and the WPA consensus statement on interpersonal violence against women. World Psychiatry. 2006;5(1):61-64.
139. Canadian Orthopaedic Association. Intimate partner violence position statement and best practice recommendations. 2019; [accessed 2019 Oct 18]. https://coa-aco.org/wp-content/uploads/2017/01/COA-Intimate-Partner-Violence-Position-Statement-and-Best-Practice-Recommendations-APRIL2019-ENG.pdf.
140. Wathen CN, Tanaka M, Catallo C, et al. Are clinicians being prepared to care for abused women? A survey of health professional education in Ontario, Canada. BMC Med Educ. 2009; 9(1):34.
141. Kirmayer LJ, Fung K, Rousseau C, et al. Guidelines for training in cultural psychiatry. Canadian Psychiatric Association position paper. Can J Psychiatry. 2011;57(3):1-17.