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Review Article

Intimate Partner Violence Prevention: Moral, Legal and Healthcare Algorithms

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Abstract

"Gender inequality" and "gender-based violence" are paradigms that one hope would be extinct by the 21st Century, two cultural concepts that our society tries to disguise as dated, but that still exist in the form of intimate partner violence in developed countries. In this literature review, intimate partner violence is described as a serious public health issue with high occurrence rates across the world, which requires an urgent implementation of protection and prevention measures.

The extensive study of contents resulting from a search with the terms "intimate partner violence", "domestic violence", "prevention", "violence against women", "abuse", "IPV" and "crime" allowed to gather information on preventive measures and integrate updated statistics of the World Health Organization (WHO) and of the Portuguese Association for Victim Support (APAV).

The measures of protection and prevention of this type of crimes demand a change of moral and legal behaviours around the globe, as well as the implementation of algorithms of functional performance that can be applied by health professionals at patient-directed services. In this literature review, we will present the "RESPECT", "AVDR" and "HELP" algorithms.

Keywords: Intimate Partner Violence; Domestic Violence; Prevention; Violence Against Women; Abuse; Crime; IPV; AVDR; RESPECT; HELP

Research Methodology

This review article results from an extensive study of bibliographic contents available at the PubMed platform, which resulted from a search with the terms "intimate partner violence", "domestic violence", "prevention", "violence against women", "abuse", "IPV" and "crime". In a first phase, the articles were selected by reading their abstracts and, in a second phase, by reading them in full. In an attempt to obtain the largest amount of varied information about the topic, no time restrictions were applied to the conducted bibliographic search. However, only the most recent studies and those with a bigger probationary degree were used as reference in the results regarding occurrence and statistics presented in this article. The bibliographic references of the World Health Organization (WHO) and of the Portuguese Association for Victim Support (APAV) were searched specifically in the Google platform with the terms "WHO intimate partner violence" and "APAV domestic violence statistics".

After choosing the articles, the collected data was organized according to contents, in a way to allow a complete and clear approach to the topic. The gathered and organized data was then combined and contextualized in the form of a literature review, allowing the drawing of knowledge and conclusions about the studied topic.

Introduction

We are still faced with gender-based violence in the 21st century, and one of the proofs is violence against women, especially in the context of intimate partner violence.

The United Nations define violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Intimate partner violence, according to the World Health Organization, refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. Statistics show that the majority of victims are women [1-8].

Intimate partner violence is the most common form of violence, with 30% of women who have been in a relationship reporting that they have experienced some sort of physical or sexual abuse by their partner.

Globally, as many as 38% of murders of women are committed by an intimate partner. We should reinforce the limitations inherent to the statistics on this type of crimes, which are even more conditioned by the amount of reports and existing documentation. Therefore, despite the high statistical figures associated with this crime, they might not show its real occurrence.

Intimate partner violence is a vastly studied and debated topic nowadays; however, despite the efforts, the number of cases remains high. That is why it's crucial to prevent these acts by studying this type of violence and the abuse and victimization patterns, in order to prevent the existence and perpetuation of these conflicts. The objective is to reduce the occurrence of intimate partner violence and guarantee the safety of victims, survivors and children involved, as well as avoid the extension of these cultural patterns to future generations [7-16].

Consequences of intimate partner violence

Intimate partner violence is a continued and persistent crime that causes immediate and future consequences, both short-term and long-term, and it affects victims at a physical, psychological, emotional and social level. This type of violence can, in the most serious cases, lead to temporary or permanent disability in the victim or even to her death, whether through homicide or suicide.

The consequences and indicators of an intimate partner violence episode rely on factors related to the abuse situation, factors relating to the aggressor and also victim-related factors. In view of this, the consequences depend on the type of aggression, its duration and number of repetitions, and also on the attempt at self-defense from the victim. The factors inherent to the aggressor include the gender, age and physical constitution, which will influence the intensity of the applied violence. The consequences and signs of aggression in the victim vary according to factors such as gender, age, physical constitution and pre-existing pathologies that might influence the consequences of such abuse events [17-23].

Most physical injuries resulting from an aggression in an intimate partner violence context are traumatic, and the most frequent include jaw fracture, loss of teeth, ocular and visual injuries, hearing capacity disorders, rib fractures, abdominal injuries, infertility in the sequence of successive infections and/or vaginal and uterine injuries. According to the World Health Organization, female victims might also suffer consequences at a reproductive level, with the data pointing out that those who experience intimate partner violence are 1.5 times more likely to develop sexually transmitted diseases and, in some regions of the world, HIV, when compared to women who have never experienced this type of violence [7,24-26]. Recent studies show high rates of occurrence of brain injuries and traumatic brain injuries, as well as the possibility of spinal injuries [19,22,27-32]. The psychological damages usually occur in the form of post-concussive syndrome (PCL), depression, anxiety, dizziness, insomnia, nightmares, apathy, irritability, fatigue, headaches and memory loss. The post-traumatic stress disorder (PTSD) is also common in victims of intimate partner violence. These symptoms can lead the victim to attempt or consummate suicide, as a result of the abuse they were subjected [28,33,34].

The gravity of these consequences depends on the frequency, severity and type of abuse; they are often linked between themselves and are a consequence of each other. Since intimate partner violence is an on-going form of abuse, almost always multiple and often kept as a secret during years, it is common to observe a worsening of these factors throughout time and in the context of this kind of relationship. In this context, the idea that there is a

cycle of violence that tends to evolve through different phases that repeat themselves cyclically is particularly relevant. According to this model, there is, in an intimate partner violence context, a "cycle of violence" *per se*, which is characterized by the phases "tension increase", "violent attack" or "episode of violence", and "appeasement", "reconciliation" or "honeymoon". As time goes by, the acts of violence tend to be more frequent, more intense and more dangerous.

The gravity of the consequences associated with this public health issue demands an urgent implementation of cultural, legal and healthcare algorithms for protection and prevention of intimate partner violence [5,7,8,12,15,16,21,35,36].

Cultural and legal measures of prevention and protection

The measures of protection and prevention depend on the cooperation of all countries, on the revision of the legislation and on the development of policies and programmes aimed at fighting violence against women, supporting victims, promoting gender equality and a pacific social future [7,10,12,37,38].

The elaboration of new laws suggests that the legal system ought to be not only more efficient in the way how it deals with intimate partner violence, but it also needs to adopt strategies that prove its concern with the victims, with injustice and corresponding procedures, and with punishments and the rehabilitation of criminals. In this regard, the application of stronger measures to the perpetrators of this type of crimes may be beneficial as a form of preventive legal measure [7,17].

However, the application of preventive legal measures has proved insufficient to solve this issue, which demands an equal consideration and application of moral and cultural measures. That is to say, despite the implementation of new laws that promote gender equality, the traditional inferiority of female roles in the private sphere of society seems to influence legal systems, which, sometimes, promote the preservation of gender hierarchies in society. For this reason, the World Health Organization asks for a change on the world's moral standards regarding gender equality [7,12,13,38,39].

The evolution of the moral and cultural behaviours of society is conducted mostly by the media through selection and dissemination of information in different countries. For this reason, gender equality and the general notion of intimate partner violence depend on the position of the media towards the topic, as described by Sutherland, G., *et al.* [13]. Exposing and informing populations about this health problem through the media is vital to change the cultural concepts needed to prevent this type of crimes, making them an unacceptable practice in marital relationships [13].

This change of social paradigm would enable victims to identify themselves as such and to understand that if they are going through an unhealthy and violent relationship, they should report it to the authorities and to health professionals. The collaboration of health professionals and their interest on the victim might allow them to feel safe enough to expose their fears and seek professional help with no fear of being judged.

The World Health Organization suggests the application of a protocol called "RESPECT" to prevent violence against women. This protocol consists of seven strategies and was elaborated by the World Health Organization and by the United Nations Women in cooperation with ten United Nations and bilateral agencies in June 2019. Each letter represents a strategy:

- R - Relationship skills strengthened;
- E - Empowerment of women;
- S - Services ensured;
- P - Poverty reduction;
- E - Environments made safe;
- C - Child and adolescent abuse prevention;
- T - Transformed attitudes, beliefs and norms.

Preventing intimate partner violence is possible with the implementation of new laws and the change of moral and cultural attitudes; however, it requires the collaboration of the media and of all law and health professionals, so that these measures take effect and we are able to reduce the occurrence of this type of abuse [7-10].

Prevention measures addressed to health professionals

Preventing intimate partner violence involves more information on this topic and collaboration between health professionals, since they are sometimes the victim's only way to seek help, but it might be difficult for a health professional to recognize and approach an victim or survivor and know how to act before such situation [18,23,26,40,41]. One way to simplify this is to create effective performance algorithms that assist and limit the intervention of health professionals in these situations; the other is to amplify and implement education programmes about this topic [29,42-44].

Victims can be found in any health sector, but studies on the subject put more emphasis on emergency units and odontology offices. Studies show that the victims who appear before health professionals with visible abuse-related injuries are still not questioned about the same; as a result, they're not getting proper healthcare [43,45-47]. Wilbur, L., *et al.* [46], Gerbert, B., *et al*. [43] and Smith, D.J., *et al*. [45] reinforce the need of health professionals to examine and question patients about signs of choke that they may show and recommend medical treatment and follow-up to the victims. Glass, N. and his colleagues [17] wrote about the need of intervention and guidance of victims who survived strangling, in a way to prevent the worsening of intimate partner violence situations and the chance of death by murder. The authors appeal to the need of raising awareness between police officers and health professionals regarding strangling injuries and the urgency of documenting such injuries. According to Wilbur, L. [46], questioning patients seems to be an effective measure to identify intimate partner violence and prevent further abuse [42,46].

The implementation of performance algorithms addressed to health professionals is fundamental to prevent this public health problem. In this regard, we reinforce the need to define a functional algorithm and introduce it as mandatory in the health system. Besides creating a functional algorithm for global prevention, it might also be necessary to create specific algorithms for the serious pathological consequences of abuse, as suggested throughout this article, in view of the screening of brain injuries in victims and survivors [18,23,26,40,45,46].

In their article with the title "Simplifying physicians' response to domestic violence", Barbara Gerbert and her colleagues, suggest a new performance algorithm that consists of four steps and is based on the acronym AVDR:

- A- Ask patients about abuse;
- V- Validate the message that battering is wrong and confirm the patient's worth;
- D- Document the presenting signs, symptoms, and disclosures;
- R- Refer victims to domestic violence specialists [43].

The AVDR protocol might be of interest, since the authors suggest its implementation as part of the clinical or hospital routine of approaching patients, that is to say, it should be applied to all patients. By doing this, we overcome the health professional's need to identify whom he should or should not apply the algorithms to, reducing cultural barriers, physical discomfort and fear of offending patients. The AVDR algorithm has also the advantage of educating society, in the sense that it treats domestic violence as a health problem and makes victims more aware of their own situation [42,43,48].

Since most intimate partner violence injuries are located in the face, head and neck, dentists can take part directly in this type of crime [25,42,44,48]. The application of the AVDR algorithm by dentists is suggested by Nelms, A.P. and his colleagues [42] in their study published in 2009, whose results were obtained from a survey answered by victims and survivors who were living in shelters. Restricting his sample to women who presented injuries in the face, head or neck that were visible at the time of a dentist's appointment, the results show that 88.6% of the sample (N = 39) was not approached by the dentist in relation to the striking injuries, and 69.2% of the same (N = 27) wish their doctor would have asked about them. In the same study, neck injuries were observed in 14% of the sample (N = 30), possibly as a result of strangulation. According to Glass, N., *et al*. the fact that a woman was exposed to an aggression by choking increases her risk of being murdered in the same intimate partner violence context; this premise reinforces the need to document, guide and inform victims and the survivors in a way to prevent more tragic incidents in the future [17,20].

Women who survived this type of abuse are at high risk for brain injury caused by a hit to the head or strangulation. Healthcare and intimate partner violence advocates/clinicians need to be trauma responsive and routinely screen women for a possible brain injury [17,19,22, 24,27,29,31,32]. In view of this, Rajaram, S.S., *et al.* [29] presented the "HELP" algorithm, to screen brain injuries in survivors; this algorithm might be applied by all health professionals in a simple way and without an extensive knowledge on the topic. It results from a change to the "HELPS" algorithm suggested by Picard., *et al*. in 1991, and the acronym is the key to the screening:

- H - Hit in the head;
- E - Emergency room treatment;
- L - Loss of consciousness;
- P - Problem because of a hit to the head or due to strangulation.

A HELP screening is considered positive for a possible brain injury when the following three items are identified: (a) an event that could have caused a brain injury (yes to H [Hit in the head] or E [Emergency room treatment]); (b) a period of loss of consciousness or altered consciousness after the injury or another indication that the injury was severe (yes to the L [Loss of consciousness] or E [Emergency room treatment]); and (c) the presence of two or more chronic problems listed under P (problem because of a hit to the head or due to strangulation) that were not present before the injury [29].

The conjugation of these two algorithms could be a good option of intimate partner violence protection and prevention measures, ensuring that the victims and survivors would have access to appropriate healthcare. All organizations should implement and evaluate education and training programmes for their staff on the intersection between intimate partner violence and brain injury and develop referral protocols to support services for survivors who have experienced a brain injury. Future research should develop validated screening tools to detect a possible brain injury and screening guidelines to provide timely care for survivors [17,19,29,31].

Thus, literature suggests that the following aspects should have a positive impact in decreasing and preventing intimate partner violence's fatal outcomes: a) timely identify high-risk situations (such as those that involve strangulation), allowing protective measures to be timely implemented in order to avoid or reduce fatal outcomes; b) provide adequate support to victims and their children who report interparental violence; c) improve the intervention of mental health services on the problem and prevent alcohol and other substance abuse; d) promote the identification and assessment of this form of violence among criminal investigators and forensic technicians; e) inform and encourage health professionals to identify signs of intimate partner violence and apply performance algorithms that work; f) perform diagnostic tests of neurological injuries on victims [5,7,8,18, 22,25,27,41,42,44,47].

This revision emphasizes the need to conduct more studies aimed at a better understanding of how these different approaches work and in which situations their application is helpful. Understanding the reasons that prevent victims from seeking help and act directly upon them might allow a safer and more direct approach to the discussed topic and, consequently, an improvement of measures meant to prevent this type of crime.

Conclusions

The extinction of social paradigms, such as gender inequality and gender-based violence, requires the collaboration of worldwide cultural, legal and healthcare systems. The gravity of the consequences associated with this public health issue requires the urgent implementation of moral and legal measures of prevention and protection addressed to the health sector, with the objective of reducing intimate partner violence occurrence and guarantee the safety of victims, survivors and children involved, as well as avoid the perpetuation of these cultural patterns of gender inequality in future generations. For that effect, we suggest the "RESPECT" algorithm as a measure of cultural and moral prevention and the "AVDR" and "HELP" algorithms as measures of prevention addressed to health professionals.

Conflict of Interest

The authors have no conflicts of interest to declare.

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