

Intimate partner violence

A whole-of-health responsibility

SUSAN REES PhD, MSocPol(Hons 1), BCW

NADA HAMAD BSc, MSc Forensic(Hons), MB BS(Hons), FRACP, FRCPA, FRCP, FRCPE, AFRACMA, GAICD, SpeCetClinRes (Onc)

AMANDA HENRY PhD, MPH, FRANZCOG, BMed(Hons), BMedSci(Hons)

SIMON ROSENBAUM PhD, BSc

KRISTEN BEEK PhD, MIPH, MA, BA

KIMBERLIE DEAN PhD, BMedSci(Hons), MB BS, MSc, FRCPsych, FRANZCP

Intimate partner violence has major health impacts, yet recognition and response remain inconsistent across disciplines. A whole-of-health approach, grounded in trauma-informed care and intersectionality, is needed to improve identification, referral and co-ordinated care.

Intimate partner violence is a leading public health issue, with profound physical, psychological and reproductive consequences across the life course.¹⁻³ Healthcare professionals are uniquely positioned to contribute to intimate partner violence prevention and response, yet awareness and preparedness remain inconsistent across health disciplines; this limits opportunities for mitigation, early identification and intervention.⁴ Australia's

MedicineToday 2026; 27(3): 48-50

Professor Rees is a Professor in Psychiatry and Mental Health in the School of Clinical Medicine, UNSW, Sydney. Professor Hamad is a Senior Haematologist and Clinician Researcher at St Vincent's Hospital, Sydney; and Conjoint Professor in the School of Clinical Medicine, UNSW, Sydney. Professor Henry is Program Head for Women's Health at The George Institute for Global Health, Sydney; Professor in Women's Health in the School of Clinical Medicine, UNSW, Sydney; and an Obstetrician at St George Public Hospital, Sydney. Professor Rosenbaum is a Professor in Psychiatry and Mental Health in the School of Clinical Medicine, UNSW, Sydney. Dr Beek is a Social Scientist and Public Health Researcher from the School of Population Health, UNSW, Sydney. Professor Dean is Head of Psychiatry and Mental Health in the School of Clinical Medicine, UNSW, Sydney; and Consultant Forensic Psychiatrist at Justice Health NSW, Sydney, NSW. SERIES EDITOR: Professor Phillip Mitchell AM, FASSA, MB BS, MD, FRANZCP, FRCPsych, Head, School of Psychiatry, Faculty of Medicine, UNSW Sydney; and Professorial Fellow, Black Dog Institute, Sydney, NSW.



KEY POINTS

- Intimate partner violence can affect any body system and present in any specialty, often indirectly or as chronic, nonspecific problems.
- Uneven training and limited system supports across disciplines lead to missed opportunities for early identification and safe intervention.
- Trauma-informed care supports sensitive enquiry, prioritises safety, builds trust and reduces retraumatisation in all clinical settings.
- An intersectional lens improves equity by recognising differing risks, barriers to disclosure and service needs across diverse groups.
- Cross-disciplinary education, clear referral pathways and collaboration can strengthen a co-ordinated health system response and prevention.

National Plan to End Violence against Women and Children 2022 to 2032 rightly notes that 'It is everyone's responsibility to end the perpetration of violence against women and children', and we argue that much more can be achieved by taking a whole-of-health approach.⁵ We call on all healthcare professionals to join us in building awareness and changing practices across medicine and health. We describe why this approach is crucial for the health system to play its most effective role in national prevention and impactful health interventions, and to mitigate the significant costs of intimate partner violence to the Australian health system.⁶

Engagement across disciplines

Between 2021 and 2022 in Australia, one in four women and one in fourteen men had experienced physical violence, sexual violence, or both, by an intimate partner since the age of 15 years, and between 2023 and 2024, nearly 90% of hospitalisations for assault by a partner were female.⁷ The health impacts of intimate partner violence are wide-ranging. Although this article focuses on victim-survivors, health risks for perpetrators must also be identified and responded to.

For victim-survivors, emergency practitioners, surgeons and orthopaedic specialists manage acute physical trauma, whereas psychiatrists, GPs and allied healthcare practitioners respond to the mental and physical health sequelae of intimate partner violence.⁷ Public health professionals undertake population- and community-based research to inform interventions for intimate partner violence prevention and response.

Pregnancy and the postpartum period are two of the highest-risk times for women to experience intimate partner violence, and obstetricians, gynaecologists and midwives are acutely aware of the risks to reproductive health, pregnancy and neonatal outcomes.⁷ In these fields, intimate partner violence tends to be well recognised as a clinical consideration, albeit one for which more professional training and practitioner confidence may be needed.

In contrast, in disciplines such as neurology, cardiology, haematology, oncology, endocrinology, general medicine or geriatrics, intimate partner violence may be less visible or not perceived as clinically relevant. Patients may present with chronic or nonspecific conditions such as cognitive changes from repeated brain trauma, excessive bruising, delayed cancer screening because of controlling partners, impaired immunity related to persistently inadequate nutrition and emotional distress, cardiac arrhythmia related to distress and anxiety, or poor treatment adherence for any disorder because of disempowerment, frailty, economic constraints or enforced isolation.⁸⁻¹² Regardless of its current level of disciplinary significance, without specific intimate partner violence training and system-level capacity to respond, all health disciplines risk missing clinical presentations and opportunities for intervention. For example, GPs are on the front line of intimate partner violence responses and are often the first clinicians who see, and continue to see, victim-survivors over time in consultations. However, they

report feeling underprepared to enquire about intimate partner violence, difficulty routinely recognising its many health impacts and a lack of time to navigate referral pathways.^{13,14}

Inconsistency across disciplines and the universal need for further practitioner training and support, reflect both a historical emphasis on acute presentations and 'frontline' settings, and systemic barriers, including viewing intimate partner violence as a social or private problem outside the scope of medicine. Specialties that directly encounter acute presentations have developed clearer protocols, whereas others lack formal training or awareness of the relevance of intimate partner violence to their practice. Medical and allied health training has not routinely included intimate partner violence, especially with a trauma-informed approach and intersectionality lens, across disciplines. Recognising intimate partner violence as a whole-of-health issue is therefore essential.

A trauma-informed approach

Intimate partner violence affects multiple organ systems and contributes to chronic physical disease, mental illness, reproductive harm and intergenerational trauma.⁷ No medical discipline is immune. Early recognition in any clinical setting can improve care, reduce morbidity, prevent escalation, support survivors in accessing safety and support perpetrators in accessing interventions. Conversely, inaction leads to fragmented care, repeated consultations, worsening health outcomes and premature death.³

A trauma-informed approach recognises how psychological trauma from intimate partner violence affects health and behaviour, and the need to deliver care that is mindful of social and structural factors that are inter-related with the risk and experience of the traumatic event.^{15,16} It shifts the question from 'What is wrong with this patient?' to 'What has happened to this person, and how can I respond appropriately and safely?'¹⁷

Trauma-informed practice considers cultural diversity and socioeconomic and geographic disadvantage, and emphasises empathy and careful exploration of what is needed to ensure safety. This approach strengthens healthcare responses and helps prevent further abuse and retraumatisation of survivors. Trauma-informed practice requires all healthcare professionals, not just those in mental health or emergency settings, to recognise signs of intimate partner violence, respond sensitively and empathically, build trust and have access to effective referral pathways.

Healthcare professionals are trusted figures. A supportive, trauma-informed response, even from a clinician outside traditional 'frontline' disciplines, can be pivotal in encouraging disclosure and may improve help seeking. This underscores the ethical responsibility of all practitioners to be aware, informed and prepared to respond.

Why intersectionality matters

Although exact definitions differ, intersectionality broadly refers to how interconnected social categorisations such as race, socioeconomic disadvantage and gender combine to create intersecting forms of privilege and oppression.¹⁸ Applying an intersectional lens ensures that trauma-informed approaches are truly inclusive and sensitive to the diverse realities of how intimate partner violence is experienced, manifests and should be addressed. An intersectional lens supports healthcare professionals understand why some groups of people are disproportionately affected, experience greater barriers to accessing support and face more significant health impacts.¹⁹

Groups at increased risk of intimate partner violence and its sequelae include women who are pregnant and caring for children; Aboriginal and Torres Strait Islander peoples; minoritised ethnicities; individuals who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and more; younger and older

people; people with disabilities; those with insecure migration status; people with neurodivergence; and those with mental health challenges are all at increased risk of intimate partner violence and its sequelae.^{20,21} Compounding forms of disadvantage and oppression related to these, and other factors, can influence help-seeking behaviours, clinical presentations, engagement with services and health outcomes.

Education as a driver of cross-disciplinary awareness

Health education is key to reducing knowledge and practice gaps between health specialties and disciplines. At the University of New South Wales, the Wattle Network has been established to encourage interdisciplinary health responses to intimate partner violence, and to promote and shape policy and practice that is informed by the diversity of its research.

The Wattle Network aims to ensure that teaching on intimate partner violence is embedded across curricula and made relevant to all disciplines. By taking an interdisciplinary health approach, the Wattle Network also promotes case-based learning and joint teaching sessions, to expose students to the diverse ways intimate partner violence can present in different specialties, including those less often considered relevant.²² Furthermore, the Wattle Network encourages an integrated approach, where the best response often requires diverse disciplines working together.

By equipping future healthcare practitioners with knowledge and skills tailored to their field and by modelling collaboration across disciplines, the Wattle Network hopes to build and strengthen awareness and preparedness across the health system to respond to intimate partner violence. Trauma-informed care and intersectionality provide the unifying frameworks for this education, ensuring that awareness translates into practice that is sensitive, respectful and safe.

From fragmentation to integration

Strengthening cross-disciplinary awareness in medicine and health does not mean expecting every practitioner to become an intimate partner violence specialist. Rather, it means ensuring all healthcare professionals can:

- recognise when intimate partner violence is contributing to a patient's presentation⁷
- respond with empathy and sensitivity, in line with principles of trauma-informed care and intersectionality
- know the appropriate referral pathways for specialist counselling, risk assessment and safety planning^{7,23}
- collaborate effectively with colleagues across disciplines, including in research and training. For example, GPs, who often work at the interface between services in diverse contexts, can support other disciplines by sharing their knowledge about the identification and management of intimate partner violence.²³

Such integration can improve diagnostic accuracy, shorten delays in care, provide more holistic support for victim-survivors, as well as deliver broader interventions for perpetrators. It also aligns with broader goals of health equity, patient safety and trauma-informed practice that should underpin modern health education and health care. This raises the question of whether a new national policy is needed to mandate discipline-specific clinical competencies, routine training and accountability standards for all health specialties to identify, respond to and continuously improve care for people experiencing intimate partner violence.

Conclusion

Intimate partner violence is a health issue that transcends disciplinary boundaries. Some specialties are more established in their awareness and protocols, whereas others are still developing their response. Strengthening awareness across all health

disciplines – anchored in the principles of trauma-informed care and intersectionality – requires targeted collaboration to ensure a co-ordinated and effective health system response. Initiatives such as the Wattle Network demonstrate how universities can lead and shape system-level change by embedding intimate partner violence into the core of medical and health research, teaching and practice.

By building awareness, fostering collaboration, and adopting trauma-informed care and intersectionality as shared responsibilities, the health profession can better support patients, prevent intimate partner violence and related harm, and contribute to a healthier, safer society. **MT**

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

COMPETING INTERESTS: Professor Hamad and Dr Beek: None. Professor Rees has received grants from the Australian Research Council, National Health and Medical Research Council, and Medical Research Future Fund. Professor Henry is a Board Director for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and had previously been a Board Director for the Society of Obstetric Medicine of Australia and New Zealand. Professor Rosenbaum has received funding from the National Health and Medical Research Council's EL2 Fellowship. Professor Dean has received grants or contracts from the National Health and Medical Research Council, Medical Research Future Fund and Justice Health NSW; has received support for attending meetings or travel from the National Health and Medical Research Council; and has held a leadership role in the Royal Australian and New Zealand College of Psychiatrists, Faculty of Forensic Psychiatry. All authors are members of the Wattle Network at UNSW, Sydney.



Studying medicine?

Or know someone who is? For our special subscription rates for medical students, contact:

Katrina on (02) 9908 8577 or email: subscriptions@medicinetoday.com.au

Intimate partner violence

A whole-of-health responsibility

SUSAN REES PhD, MSocPol(Hons 1), BCW

NADA HAMAD BSc, MSc Forensic(Hons), MB BS(Hons), FRACP, FRCPA, FRCP, FRCPE, AFRACMA, GAICD, SpeCetClinRes (Onc)

AMANDA HENRY PhD, MPH, FRANZCOG, BMed(Hons), BMedSci(Hons); **SIMON ROSENBAUM** PhD, BSc; **KRISTEN BEEK** PhD, MPH, MA, BA

KIMBERLIE DEAN PhD, BMedSci(Hons), MB BS, MSc, FRCPsych, FRANZCP

References

- Duncan A, Mavisakalyan A, Twomey C. Family and domestic violence in Australia: is enough progress being made? Perth: Bankwest Curtin Economics Centre; 2025. Available online at: <https://bcec.edu.au/publications/family-and-domestic-violence-in-australia-is-enough-progress-being-made/> (accessed February 2026).
- Mathews B, Hegarty KL, MacMillan HL, et al. The prevalence of intimate partner violence in Australia: a national survey. *Med J Aust* 2025; 222: 440-448.
- Leight J. Intimate partner violence against women: a persistent and urgent challenge. *Lancet* 2022; 399: 770-771.
- Greenfield P, Calcia M, McCree C, et al. Identifying, assessing and responding to perpetration of domestic abuse: practice guide for mental health professionals. *BJPsych Adv* 2025; 31: 8-19.
- Launch of national plan to end violence against women 2022-32. Adelaide: Embolden; 2022. Available online at: <https://embolden.org.au/2022/10/national-plan-2022-2032-launch> (accessed February 2026).
- Cadilhac DA, Sheppard L, Cumming TB, et al. The health and economic benefits of reducing intimate partner violence: an Australian example. *BMC Public Health* 2015; 15: 625.
- Australian Institute of Health and Welfare (AIHW). Intimate partner violence. Canberra: AIHW; 2026. Available online at: <https://www.aihw.gov.au/family-domestic-and-sexual-violence/types-of-violence/intimate-partner-violence#common> (accessed February 2026).
- Monahan K. Intimate partner violence (IPV) and neurological outcomes: a review for practitioners. *J Aggress Maltreat Trauma* 2019; 28: 807-825.
- Soler-Espejo E, Roldán V, Marín F. Stress, partner violence, and coagulopathy: unmasking new triggers for venous thromboembolism. *Thromb Haemost* 2025; 125: 657-659.
- Das S, Zhang Z. The immunological consequences of intimate partner violence. In: *Research Methodologies and Practical Applications in Psychoneuroimmunology*. Hershey: IGI Global Scientific Publishing; 2025. p. 537-556.
- Barsky AJ. Palpitations, arrhythmias, and awareness of cardiac activity. *Ann Intern Med* 2001; 134: 832-837.
- Bagherzadeh R, Sayad Nik A, Gharibi T, Vahedparast H. The predictive role of intimate partner violence in treatment adherence among women with chronic illness: a cross-sectional study. *Chronic Illn* 2024; 20: 76-85.
- Rees S, Fisher J. Gender-based violence and women's mental health: how should the GP respond? *Medicine Today* 2016; 17: 14-20.
- Reid SA, Glasser M. Primary care physicians' recognition of and attitudes toward domestic violence. *Acad Med* 1997; 72: 51-53.
- Brown T, Berman S, McDaniel K, et al. Trauma-Informed Medical Education (TIME): advancing curricular content and educational context. *Acad Med* 2021; 96: 661-667.
- Tremont JNP, Klausner B, Udekwu PO. Embracing a trauma-informed approach to patient care—in with the new. *JAMA Surg* 2021; 156: 1083-1084.
- Mollica RF. *Textbook of global mental health: trauma and recovery, a companion guide for field and clinical care of traumatized people worldwide*. Morrisville: Lulu.com; 2012.
- Crenshaw KW. Mapping the margins: intersectionality, identity politics, and violence against women of color. In: Fineman MA, Mykitiuk R, ed. *The public nature of private violence*. New York: Routledge; 1994. p. 93-118.
- Bastos JL, Harnois CE, Paradies YC. Health care barriers, racism, and intersectionality in Australia. *Soc Sci Med* 2018; 199: 209-218.
- Australian Institute of Health and Welfare (AIHW). Factors associated with family, domestic and sexual violence. Canberra: AIHW; 2026. Available online at: <https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv> (accessed February 2026).
- Australian Bureau of Statistics (ABS). Personal safety, Australia. Canberra: ABS; 2023. Available online at: <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release> (accessed February 2026).
- Wathen CN, MacGregor JCD, Burd C, Naeemzadah N, Ogunpitan YA, Canie J. A scoping review of intimate partner violence research in Canada. *Trauma Violence Abuse* 2025; 26: 73-85.
- Spangaro J. What is the role of health systems in responding to domestic violence? An evidence review. *Aust Health Rev* 2017; 41: 639-645.