Research Open

Integrative Journal of Nursing and Medicine

Volume 7 Issue 1

Research Article

The Role of the Medical Sector in Victim Protection and Early Intervention in Intimate Partner Violence

Psarra ML[1]*, Tasios K[1], Tsaklakidou D[2] and Douzenis A[1]

2nd Department of Psychiatry, Medical School, National & Kapodistrian University of Athens, Greece / Hellenic Forensic Psychiatric Association
Psychiatric Department, Sismanoglio General Hospital of Athens / Hellenic Forensic Psychiatric Association

***Corresponding author:** Psarra Marie-Louise, 58 Taygetou str., 15234, Athens, Greece; **Phone:** +306994129100

Received: October 10, 2025; **Accepted:** October 15, 2025; **Published:** October 17, 2025

Abstract

Intimate partner violence (IPV) constitutes a major public health and human rights issue with profound physical, psychological, and social consequences for individuals and societies worldwide. Extensive research demonstrates that IPV contributes significantly to morbidity, mortality, and long-term health inequalities across populations. The medical sector occupies a critical frontline position in victim protection and early intervention, as healthcare professionals are often the first formal point of contact for individuals experiencing violence. This paper examines the role of the medical sector in victim protection and early intervention in cases of intimate partner violence, integrating empirical findings from the EU-funded VIPROM (Victim Protection in Medicine) project with established international research and policy frameworks. By analysing stakeholder needs, institutional challenges, and innovative training and capacity-building models, the paper highlights persistent gaps in medical responses to IPV as well as promising strategies for improvement. The findings underscore the importance of societal awareness, trauma-informed care, early identification in healthcare settings, interdisciplinary cooperation, and the sustainable integration of domestic violence training into medical education. Strengthening the capacity of the medical sector is essential for preventing further victimisation, improving long-term health outcomes, and advancing broader public health and human rights objectives.

Keywords: *Intimate partner violence, Victim protection, Healthcare professionals, Trauma-informed care, Early intervention, Clinical training*

Introduction

Intimate partner violence (IPV) is widely recognised as a pervasive and global public health issue affecting individuals across gender, age, socioeconomic status, and cultural contexts. International evidence indicates that a substantial proportion of women worldwide experience physical or sexual violence by an intimate partner during their lifetime, with similarly severe consequences observed among other victim groups [1]. Beyond immediate physical injuries, IPV is strongly associated with long-term mental health disorders, including depression, anxiety, post-traumatic stress disorder, and substance use disorders. It is also linked to chronic pain, gastrointestinal disorders, reproductive health complications, disability, and increased risk of premature mortality [2]. Consequently, IPV is increasingly conceptualised not solely as a criminal justice concern but as a critical public health and human rights issue requiring comprehensive and coordinated responses [3]. Healthcare systems occupy a unique and strategically important position within this response landscape. Individuals experiencing violence often seek medical care for injuries, chronic symptoms, or stress-related health problems long before disclosing abuse to law enforcement or specialised victim support organisations. Emergency departments, primary care practices, dental clinics, gynaecology and obstetrics units, paediatric services, and orthopaedic settings frequently serve as the first professional environments in which the consequences of violence become visible [4]. This situates healthcare professionals at the forefront of early detection, victim protection, documentation of injuries, and referral to appropriate support services. Despite this critical role, extensive research demonstrates that many healthcare professionals feel insufficiently prepared to identify and respond effectively to intimate partner violence. Commonly reported barriers include limited training, lack of clear institutional protocols, uncertainty regarding legal responsibilities, time pressure, and fear of causing further harm or offending patients [5,6]. These challenges highlight the need for structured, evidence-based approaches that support healthcare professionals in fulfilling their role in victim protection and early intervention. Addressing IPV within the medical sector therefore requires both individual competence and systemic organisational change.

Conceptual Framework: Victim Protection and Early Intervention

Victim protection in the context of intimate partner violence refers to a set of measures aimed at preventing further harm, safeguarding physical and psychological well-being, and facilitating access to specialised protection and support services. Early intervention involves the timely identification of violence and the initiation of appropriate responses at the earliest possible stage, ideally before violence escalates or becomes chronic. Within healthcare settings, victim protection and early intervention are closely interconnected and mutually reinforcing [7]. A central component of effective victim protection is societal

awareness and sensitivity to the prevalence and dynamics of intimate partner violence. Recognising that victims of IPV may be present in everyday clinical encounters challenges persistent stereotypes about who is affected by violence and under what circumstances. Increased awareness within healthcare settings can foster environments in which patients feel safe to disclose abuse and confident that their experiences will be taken seriously [7]. Equally important is the adoption of trauma-informed approaches to care. Trauma-informed practice acknowledges the widespread impact of trauma and emphasises safety, trust, choice, collaboration, and empowerment. In the context of IPV, trauma-informed care aims to avoid secondary victimisation by ensuring that medical examinations, questioning, and documentation are conducted sensitively and respectfully. Research consistently shows that negative or dismissive responses by healthcare professionals can retraumatise victims and deter future engagement with services, whereas supportive and validating interactions can facilitate disclosure and improve long-term outcomes [8].

The Medical Sector as a Frontline Actor in IPV Response

Healthcare professionals across medical disciplines are uniquely positioned to identify and respond to intimate partner violence. Victims may present with a wide range of indicators, including acute injuries, unexplained or recurrent trauma, chronic pain, gastrointestinal complaints, reproductive health issues, dental injuries, and psychosomatic symptoms. However, these indicators are often non-specific, making detection challenging without appropriate training and awareness [2]. Empirical evidence from international research demonstrates that healthcare professionals regularly encounter victims of IPV but frequently fail to recognise the underlying cause of health problems [4]. Findings from the VIPROM Stakeholder Needs Assessment confirm these patterns across multiple European countries, revealing substantial variation in awareness, confidence, and expertise among medical professionals. Detection of IPV often depends on individual experience rather than systematic institutional practices, resulting in inconsistent responses and unequal levels of victim protection [9]. When disclosure of violence occurs, healthcare professionals play a decisive role in shaping victims' subsequent pathways to safety and recovery. Compassionate listening, validation of experiences, and the provision of clear information about available resources are essential components of effective response. Even brief supportive interventions in healthcare settings have been shown to positively influence victims' willingness to seek further help [5]. Nevertheless, many healthcare professionals report uncertainty regarding legal obligations, documentation procedures, and referral pathways. This uncertainty can lead to hesitation or inaction, even when violence is suspected or disclosed. Furthermore, a narrow focus on women and children as the primary victims of IPV, while justified by prevalence data, risks overlooking other affected groups such as men, older adults, individuals with disabilities, and those in same-sex relationships. An inclusive and intersectional approach is therefore necessary to ensure equitable access to protection and care [1].

Training and Capacity Building in the Medical Sector

A robust body of evidence demonstrates that targeted training significantly improves healthcare professionals' ability to identify and respond to intimate partner violence. Effective training programmes increase confidence, enhance communication skills, improve documentation practices, and strengthen referral pathways [5,8]. However, research also indicates that training is most effective when it is practical, multidisciplinary, and embedded within institutional structures rather than offered as isolated or optional initiatives [6]. The VIPROM project provides a comprehensive example of how training and capacity building can be systematically addressed within the medical sector. Based on extensive stakeholder needs assessments conducted across several European countries, VIPROM developed tailored training curricula for various medical professionals, including physicians, nurses, midwives, dentists, and medical students. The curricula emphasise practical competencies such as recognising indicators of violence, trauma-informed communication, medical documentation, risk assessment, and interprofessional cooperation [10]. A key innovation of the VIPROM approach is the use of a modular European Training Platform on Domestic Violence, complemented by a Train-the-Trainer model. This structure supports sustainability by enabling trained professionals to disseminate knowledge within their institutions and national contexts. Importantly, the training materials are adapted to different professional roles and healthcare settings, enhancing relevance and uptake. By embedding IPV training within existing medical education and professional development structures, VIPROM addresses a critical gap in traditional medical curricula [10,11].

Discussion

The findings presented in this paper reaffirm the central role of the medical sector in victim protection and early intervention in intimate partner violence. Healthcare professionals often represent the first and sometimes only formal point of contact for individuals experiencing violence, placing them in a critical position to identify risk, initiate support, and prevent further harm [4]. Nevertheless, a substantial gap remains between this potential role and everyday clinical practice. Recognition of IPV indicators continues to rely heavily on individual awareness rather than standardised institutional procedures. Time pressure, high workloads, and competing clinical priorities further limit opportunities for proactive intervention. These challenges underscore the importance of organisational support, clear protocols, and leadership commitment in enabling effective medical responses to IPV [11]. The persistence of stereotypical assumptions about victim profiles also constrains effective intervention. Although women and children are disproportionately affected by IPV, other victim groups remain under-recognised and underserved. Adopting intersectional frameworks that acknowledge diverse experiences of violence is essential for inclusive and equitable care. Training initiatives such as VIPROM demonstrate how healthcare systems can move towards more comprehensive, prevention-oriented responses through structured education, multidisciplinary collaboration, and institutional change.

Conclusion

This paper has examined the role of the medical sector in victim protection and early intervention in intimate partner violence, integrating international research with empirical findings from the VIPROM project. The analysis confirms that healthcare professionals

are pivotal actors in identifying violence, responding to disclosures, and facilitating access to specialised support services, thereby influencing both immediate safety and long-term recovery [2,10]. At the same time, structural constraints including insufficient training, lack of institutional guidance, and organisational pressures continue to undermine effective responses. Strengthening the medical sector's role requires sustained integration of IPV training into medical education, the adoption of trauma-informed and inclusive frameworks of care, and robust interprofessional cooperation [7,11]. By embedding victim protection within healthcare systems, initiatives such as VIPROM contribute not only to improved clinical practice but also to broader public health and human rights objectives. Enhancing the medical response to intimate partner violence is therefore both an ethical obligation and a critical strategy for preventing further violence and promoting safer societies.

Acknowledgment

VIPROM (Victim Protection in Medicine) is a European Union's Citizens, Equality, Rights and Values Programme (CERV-2022-DAPHNE, No.101095828) project co-funded by the European Union Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or CERV. Neither the European Union nor the granting authority can be held responsible for them.

References

1. World Health Organization (2021) Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women. Geneva: World Health Organization.
2. Campbell JC (2002) Health consequences of intimate partner violence. *The Lancet* 359: 1331-1336. [crossref]
3. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, et al. (eds) (2002) World report on violence and health. Geneva: World Health Organization.
4. García-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-McLain J, et al. (2015) The health-systems response to violence against women. *The Lancet* 385: 1567-1579. [crossref]
5. Feder G, Davies R.A, Baird K, Dunne D, Sandra E, et al. (2011) Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme. *The Lancet* 378: 1788-1795. [crossref]
6. Taft A, O'Doherty L, Hegarty K, Ramsay J, Leslie LD, Gene F, et al. (2013) Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews* (4), CD007007.
7. World Health Organization (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization.
8. Hegarty K, O'Doherty L, Taft A, Chondros P, Stephanie B, et al. (2013) Screening and counselling in primary care for women who have experienced intimate partner violence (WEAVE): A cluster randomised controlled trial. *The Lancet* 382: 249-258. [crossref]
9. VIPROM Consortium (2023) Deliverable D2.1: *Stakeholder Needs Assessment.*
10. VIPROM Consortium (2024a) Deliverable D3.1: EU and international Training content tailored to the various first line responders in the medical sector.
11. VIPROM Consortium (2024b) Deliverable D3.2: Design of EU and national Train-the-Trainer curricula tailored to various frontline responders.

Citation:

Psarra Marie-Louise, Tasios K, Tsaklakidou D, Douzenis A (2026) The Role of the Medical Sector in Victim Protection and Early Intervention in Intimate Partner Violence. *Integr J Nurs Med* Volume 7(1): 1-3.