

A Mental Health Professional's Guide to Supporting Survivors of Intimate Partner Violence and their Children

Project Align: Aligning systems and practices to prevent domestic violence and support survivors and their children (a Dartmouth Health initiative), in collaboration with WISE and the Center for Safer Communities.



This guide provides trauma-informed, safety-centered guidance for mental health professionals working with individuals experiencing intimate partner violence (IPV) and their children.

One of the best actions you can take to support survivors is to build collaborative relationships with your local IPV or domestic violence (DV) advocacy agency and seek consultation, which can be de-identified, when working with survivors.

A Universal Precautions Approach

Talking about IPV can be difficult and dangerous. Providers should assume that discussing relationships, safety, and trauma in the presence of an abuser may pose a risk to clients or their children. Trauma-informed approaches should be used universally, even when abuse has not been disclosed.

Be mindful in your communication:

- Use strengths-based, person-centered language.
- Emphasize resilience, coping, and survival rather than pathology and diagnoses.

Use the client's language:

- Many individuals may not identify with terms such as survivor, victim, abuse, or intimate partner violence.
- Use the client's own language (e.g., "swore at me" or "took my phone") to reflect what you are hearing back to them.

See Table 1 on the next page for examples of deficit-based, blaming, or inappropriate language to avoid, and strengths-based, person-centered language to use instead.

TABLE 1. Intimate Partner Violence and Strengths-based Language

Deficit-based, Blaming, or Inappropriate Language	Strengths-based, Person-Centered Language
Domestic dispute, crime of passion, anger issues, wife beating.	Intimate-Partner Violence (IPV): violence between intimate partners, regardless of whether they cohabitate, are married, or are still in a relationship, in an ongoing pattern of coercive control perpetrated by one partner over another.
Victim, Battered Woman	Survivor: Person who has experienced IPV, regardless of gender.
“It’s a personal matter.” “It’s private; it’s between the two of you.”	“It’s not your fault.” “That was a crime.”
“So, you’re here because you’ve been abused?”	Build a rapport. Name the abuse or the survivor’s experience. Take time to listen and validate before providing psychoeducation on abuse: “What you’re describing sounds like abuse. It’s not okay that he/she said/did those things to you. Have you connected with [local advocacy organization]? We can do that today.”
“perpetrator,” “batterer,” “abuser,” “wife beater,” “offender,” “He’s a bad guy/she is a bad woman.”	It is more helpful to refer to the behavior rather than characterizing a person. Use language such as “abusive behavior” or “abusive partner.”
“So, it was just a misunderstanding.”	Abusive partners can minimize and deny the abuse and blame survivors. Repeat back what the survivor described without judgement.
“Why did you allow him/her to do that to you?” “Why didn’t you fight back?” “Why didn’t you just leave?” “You chose to stay.”	Recognize and reinforce the survivor’s struggles and choices in leaving a relationship. Some survivors may not be able to leave their abusive partners. Do ask “What did he/she do to you?” “What were the reasons you felt you couldn’t leave?” “What made it possible for you to leave?”
“Really? Did that really happen that way?”	Believe survivors. Don’t question their narrative, especially the first time they share it.
“You are mentally ill” “You seem unstable”	Avoid pathologizing. Abusive partners may use such language to belittle survivors (e.g. mental health coercion). Use the survivor’s own words, e.g. “You said you have a lot of anxiety”

Above table is based on: [American Psychiatric Association. \(2019\). Treating Women Who Have Experienced Intimate Partner Violence.](#)

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Privacy & Confidentiality Part 1

Conduct screening, assessments, and interviews, including an assessment of social support, privately. Conjoint or family services may pose risks when an abusive partner is present. Be aware that partners may interfere with care by:

- Making transportation, child care, or payment difficult.
- Monitoring communication.
- Trying to manipulate providers.
- Undermining the client's engagement.
 - (e.g., "If you love me, you won't talk bad about me," "You made me act that way," "No one will understand you as I do"), frequently dropping in or calling, insisting on attending or controlling sessions, or canceling sessions on their behalf.

Informed Consent and Privacy

- Provide detailed information about how their information is protected, as well as any limits of confidentiality and mandated reporting requirements.
- Provide this information before asking about IPV/DV or other sensitive topics
- Provide information about rights to access, amend, and supplement records.
- Respect the client's communication preferences (e.g., specific phone number, email).

Clients may be concerned about:

- Child protection or law enforcement involvement.
- Retaliation from a partner.
- Use of their own or their child's mental health or substance use information in custody or legal proceedings. Be mindful that usually, both parents with legal parent rights have access to the child's mental health records.

Example Language Related to Informed Consent:

- "Usually, I include many of the things we talk about in your health record so other healthcare providers can best care for you in the future, or in case you need this information in the future. This includes sensitive information if it is relevant to your health. While the clinic/hospital does its best to keep records confidential, I cannot guarantee complete privacy. If there is something sensitive you'd like to tell me but you don't want it in your record, we can talk about it.
- "We can leave this information out of your medical record, but others on your care team will not have this background information when you see them next."

Translation & Interpretation Services

Use professional interpreters to protect confidentiality and accuracy. Avoid using friends or family members due to possible:

- Censorship due to cultural norms.
- Inaccurate translation.
- Connections to the abusive partner.
- Confidentiality breaches that increase danger.

Best Practices for Screening and Assessment

- Universal screening in behavioral health settings.
- When clients screen positive, assess the survivor's safety, including suicidal risk and danger (see resource section for screening tools). Make an immediate referral to your local advocacy organization.
- Conduct assessments in a private, confidential space.
- Explain why the assessment is occurring.
- Describe next steps to increase predictability and control.
- Collaboratively develop safety plans.
- Identify coping strategies for high-risk situations.
- Reinforce strengths, supports, and motivations.
- Conduct ongoing safety assessments over time.

Best Practices for Services

Use Integrated Treatment Approaches

Provide integrated care for trauma, substance use disorders (SUD), and other mental health needs. Do not require clients to address IPV before mental health or substance use treatment (or vice versa).

Power With, Not Power Over

- Use person-directed, collaborative, relational approaches that are rooted in providers' trustworthiness.
- Maximize client voice and choice, balancing predictability and flexibility.
- Avoid replicating control dynamics.
 - Undermining decision-making or restricting autonomy can mirror coercive control.

Acknowledge Contextual Factors

- **Don't** focus primarily or solely on the client's personal accountability.
- **Don't** attribute the client's trauma or the abusive dynamics exclusively to SUD or other conditions.
- **Don't** overemphasize the client's autonomy without recognizing structural barriers like difficult legal proceedings, concerns about their children or finances, or lack of support.
- **Do** consider factors that might get in the way of the client's engagement, such as lack of resources or fears of retaliation.

Problem Solve Around Missed Appointments

Terminating services due to missed appointments can unintentionally increase risk when:

- Clients miss appointments due to safety concerns, coercion, or control tactics.
- Financial abuse limits payment ability.

Strategies can include flexible scheduling, collaborative planning with advocacy organizations and other agencies, and help with connecting to alternative providers.

Privacy & Confidentiality Part 2

Telehealth Visits

Telehealth introduces additional privacy risks. Providers should:

- Assess whether the client is alone and safe to speak. Consider using a code word if the client is not in a private space.
- Encourage headphone use.
- Offer chat or alternative communication methods.
- Allow rescheduling if privacy is compromised.
- Reassess safety throughout the session.

Information Sharing

When considering the release of information:

- Prioritize the client's perspective.
- Evaluate and discuss with the client the necessity, risks, and benefits.
- Obtain their informed consent.
- Share only required information.

Potential benefits of information sharing could look like:

- Coordination with shelter services to support storage of and access to important documents needed for services or mental health medications.
- When a survivor experiences challenges with personal phone privacy and would like their mental health provider to notify an agency (DV agency) when a service becomes available.

Documentation

Expanded access to client records through electronic health record client portals and insurance client portals warrant safety considerations. Providers should treat IPV-related information as sensitive and avoid automatic portal release when possible.

Document strategically:

- Include only clinically necessary details.
- De-identify sensitive information when possible.
- Use neutral, objective language, language that holds perpetrators (not survivors) accountable for their behavior, and language of the client.
 - Patient *states*... **not** alleges, claims, denies, etc.
- Consider safety implications of documentation choices, particularly in child records, as often both parents have access to the child's records. In some cases, providers can withhold records when concerned about safety and harm.

Opting Out of Open Notes

- Opt out of open notes to keep sensitive information regarding abuse out of the patient-facing documentation and not accessible to potential abusers.

Documentation Examples:

- Documentation of universal education with disclosure of IPV: “Universal education offered, health promotion and harm reduction strategies shared, referrals offered, and follow-up discussed.”
- “Risk factors for exploitation discussed and resources offered; recommend f/u with further discussion and resources in the future.”
- “Administered HEADSS screen and discussed positive components (underlined), with resources provided.”

Example script for discussing documentation with the client:

- “Can you think of a way I can communicate your health needs in the record while still addressing your concerns?” Perhaps: ‘We discussed health issues; HEADSS screen was positive for D and S1. Resources were discussed; recommend f/u and monitoring.’ What do you think? Would that be okay?”
- “You mentioned that your partner sometimes keeps you from taking your insulin. Would it be okay if I note this in your medical record? It might be useful for others on your care team to know. I would notate it in an area of your medical record that does not show up on your patient portal or explanation of benefits.”

Requests to Release Information

Requests from the client

- Ensure the client understands the potential risks, including:
 - Mental health stigma affecting credibility
 - Information used in custody disputes
 - References to non-compliance without context
 - Disclosure of sensitive histories (e.g., substance use)
- Review records with the client when possible.
- Discuss how records could be used in legal contexts.
- Consider narrowing the scope or providing summaries instead of full records.
- Withhold information if disclosure could harm the client (e.g., address where the client resides).

Requests from third parties

- Write: Document details of the request; Cite: Do not confirm client status prematurely; reference legal requirements, and Notify: Inform supervisors or designated personnel immediately.
- Contact the Client: Discuss wishes, risks, and options.
- Encourage Legal Consultation: Coordinate with the client’s attorney when possible.
- Obtain a valid release if disclosure is authorized.
 - Note: Do not share progress notes unless court-ordered directly from a judge (which is different from an attorney’s subpoena)
- Assert privilege and consult an attorney if the client does not consent or cannot be safely contacted.

References & Additional Resources

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Screening Instruments for IPV:

- [Humiliation, Afraid, Rape, Kick \(HARK\)](#)
- [Hurt, Insult, Threaten, Scream \(HITS\)](#)
- [Extended–Hurt, Insult, Threaten, Scream \(E-HITS\)](#)
- [Partner Violence Screen \(PVS\)](#)
- [Women Abuse Screening Tool \(WAST\)](#)

Safety Assessment and Planning:

- [The Danger Assessment](#) is a validated tool used to evaluate the risk of an abused woman being killed by her intimate partner. Similar tools include:
 - [Danger Assessment-Revised](#)
 - [Lethality Screen for First Responders](#)
- [Domestic Violence Personalized Safety Plan](#)
- [Her Toolkit](#)
- [IPV Interview Guide](#)

Suicide Assessment Tool

- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

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