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Case Study

Did I Do Enough? Trauma-Informed Care & Intimate Partner Violence

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Abstract

In this case study we explore the application of trauma-informed concepts to a situation in which a woman is experiencing intimate partner abuse. While the woman's decisions may place her at risk of harm and the nurse is uncomfortable with the decision, it remains the woman's decision. This case includes a discussion of trauma-informed care, typologies of abuse, risks for lethality, and an application to a situation.

Keywords: trauma-informed care, intimate partner violence

Case Study Author Acknowledgement*: Authors in this section acknowledge that all cases that may be based on actual clients are anonymized with removal of any identifying and unique details, or are fictitious patients based on the collective of the author's client experiences.*

Did I Do Enough? Trauma-informed Care & Intimate Partner Violence

Beth was a 45-year-old woman who came into Emergency reporting a sexual assault that occurred that evening in a park near her low-income community housing complex. During the interview it was revealed that she was a victim of long-term intimate partner violence (IPV). For years, she stated, he physically and sexually assaulted her and had attempted strangulation on multiple occasions until she passed out. Her job involved working in the public with media, but she had to call in sick on multiple occasions as he had beaten her face. She eventually lost her job, giving him full financial control. Beth stayed with him until her children were safely out of the house, going to universities in another province. As he had full control of her finances, when she

left it was necessary to go on welfare while legal aid was helping her navigate a divorce. She was placed in a subsidized community housing complex. Even with the low rent she could barely pay her bills. The cost of a cell phone was out of her budget, so she relied on the phone at the corner store. Every few weeks, her husband would come to her townhouse and ask if she was returning. When she refused, he would physically assault her and throw a cheque for a few hundred dollars on her body, then leave.

After her husband's latest visit, in which she was again assaulted, she went to the store to use their phone. She called her legal representative to discuss options. On the way home, a man she believed lived in her housing complex started talking to her and convinced her to sit with him in the park to visit. He ended up taking her into the bushes and sexually assaulting her. She came into the nearest Emergency to have a sexual assault exam.

Management and Outcome

Beth was examined and treated for the effects of a sexual assault, including prophylactic treatment and anonymous evidence collection. She did not want police involved at that time. The main concern for Beth was helping her to return home safely. She described being fearful of returning to the community housing, since the assailant also lived in the neighbourhood. Beth stated not only was she fearful but was tired of being hungry, cold, and poor. When asked if she had any friends or family she could connect with, she stated that her husband had isolated her from everyone and he was the only one she now knew in the city. It was after midnight, and social work would not be in the department until 8 a.m. Beth agreed to stay in the Emergency and was given a pillow and blanket. When checking on her about 5 a.m., Beth was seen fully dressed and heading out toward the ambulance bay. When asked what was going on she indicated "my ride is here." When asked who she contacted she admitted she finally called her husband. Concern for her safety was expressed, and it was explained that with the sexual assault, increased physical assault frequency, and strangulation that her risk of death was high on return to her husband. Beth sadly stated, "At least I will have a warm house, food, and clothes before I die." Safety planning and other options were discussed along with other community resources if she chose to leave again, as well as the ability to return to Emergency. She waved and got in his car. This interaction left the nurse feeling like she, and the system, hadn't done enough for Beth.

Discussion

Some of the key considerations here included the dynamics of interpersonal violence, and the components of trauma-informed care.

Trauma-Informed Care

The core concepts of trauma-informed care (TIC) are focused on providing the client with sufficient information, as well as control and choice. The most comprehensive description of TIC was from the Substance Abuse and Mental Health Administration in the United States (SAMSHA-Substance Abuse and Mental Health Services Administration, 2014). This is the basis for many of the models used by agencies currently. There are four main assumptions—the four Rs—and six principles (Table 1). Understanding that trauma has significant impacts on clients and can result in certain trauma responses is important, as well as resisting actions that may result in retraumatization. How we respond, using the six principles, is aimed at empowering the client to choose what they wish to do provided they have enough information. Their choice may not be what the nurse would recommend but it is up to the client; they are the expert in their lives.

Facilitating client autonomy is a key ethical principle in nursing, consistent with TIC.

Table 1
Trauma-Informed Care

Assumptions	Principles
R – realizing the impact of trauma R – recognizing trauma responses R – resisting retraumatization R – responding appropriately	Safety Trustworthiness and Transparency Peer Support Empowerment, Voice, and Choice Mutuality and Collaboration Culture, Gender, and Historical Factors

Note: Adapted from SAMHSA (2014)

Interpersonal Care Dynamics

Johnson developed a typology of intimate partner violence (Johnson, 2009, 2024). He and his team described four main types of violent behavior (Table 2). While other typologies are available, this one has been consistently supported across populations and provides a useful tool for classification and intervention (Bates & Graham-Kevan, 2016; Bermea & van Eeden-Moorefield, 2023; Cares et al., 2024; Conroy & Crowley, 2022; Johnson, 2008). "Situational violence" is characterized by someone with poor communication skills and conflict resolution. They are often described as someone with a "hot temper," and stress can trigger the abusive behavior. In contrast, the person who uses "coercive control" may be described by others outside their relationship as calm—they only use power, coercion, and control against their partner, especially when that control is threatened (Conroy & Crowley, 2022). Anger management or communication courses are not typically effective. There are some situations where both partners use power and control against each other ("mutual violence and control"). The fourth type is in retaliation to being abused by a partner, perhaps with fear for their life.

Table 2
Johnson's Typology

Type of IPV	Characteristics
Situational violence	• Anger fueled by stress, unpredictability • Poor communications, conflict resolution skills
Coercive control	• Use of power, control and coercion against partner
Mutual violence and control	• Both partners use power, control, coercion
Retaliatory violence	• Abused partner uses violence in fear or to retaliate

Note: Adapted from Johnson (2009, 2024)

The coercive control type is the one most often seen in Emergency or in police reports. Injuries are typically more severe and more likely to be fatal compared to the situational form. Beth's husband was displaying hallmarks of coercive control and thus risks of death were more likely. Beth's case also illustrates several high-lethality indicators identified by Campbell's Danger Assessment (Campbell, 2004): strangulation, escalating frequency of physical assaults,

sexual violence within the relationship, and recent separation. The Danger Assessment is commonly used by forensic nurses and has established reliability and validity, but there are other tools available, each with different strengths (Department of Justice Canada, 2021). Regardless of the risk-assessment tool used, the escalation in abuse, sexual assault, and strangulation are all high-risk indicators of lethality.

It was concerning that Beth was returning to her husband, even knowing the risk of death. There are many reasons for this. Early in a relationship, the person experiencing abuse may be unaware that it is in fact abuse—it may have started as a romantic type of interaction but eventually may be followed by emotional abuse. Examples include subtle insults, gaslighting, blaming the partner, and isolating them from friends and family. According to Prochaska and Diclementi, this would be the precontemplation phase in which the victim believes they are at fault, not the abuser (Weiss, 2003; White et al., 2017). Screening for IPV may move them to the contemplation phase, helping them to realize this is not their fault or normal for a relationship. In Beth's instance, she had moved to the "action" phase of change, but it is not considered "maintenance" until they remain away for at least 6–12 months. It is well recognized that a victim of IPV typically returns to their partner at least five to seven times before reaching maintenance stage (staying away). There are many reasons for this: codependence, isolation, lack of support, and economic concerns are examples. For males experiencing IPV, they have described not even realizing it was IPV, just that they had an angry or controlling partner (Warthe et al., 2025). They didn't have the same exposure to information on healthy relationships or signs of abuse, and male gender stereotypes of what a "real man" should do impacted their disclosure to friends or seeking supports.

In Beth's decision to return, key factors included isolation, economic concerns, as well as safety. Economic concerns are recognized as a key predictor of returning (Swadley, 2017). It is difficult to exist safely and comfortably on the amount provided by welfare cheques. The coercive partner has strategically isolated their finances and perhaps affected the victim's employability. If the victim develops mental health issues such as posttraumatic stress disorder, anxiety, or depression, they may be unable to work. The development of a mental health disorder can be used as a control mechanism in relation to child custody (Domestic Abuse Intervention Programs (DAIP), 2017) or impact perceptions of truthfulness in investigations.

Peer supports are often a key in resilience and remaining out of toxic relationships, but coercive partners isolate them from friends and family. For male victims of IPV it may be even more difficult, as concepts of gender identity and toxic masculinity prevent them from disclosing their abuse or seeking assistance (Warthe et al., 2025).

Implications

Applying trauma-informed care relies upon what the patient wants, not what the nurse would prefer. Information, choice, and control are the key concepts. We must ask ourselves: Does Beth understand the implications of her choices? Did she truly understand her risk of homicide? Did she have enough information about alternative choices? Did she have information about support resources? In this case, the answer was "Yes"—safety planning was explained as well as potential options available that social work might offer for support. Although the significance and potential lethality of her choice was made clear, she did not appear to believe that there were other options for her. She was unwilling to wait for the social worker to see if there were other options. While it was not the outcome we would have liked to see, and it is sometimes distressing

for the nurse, this was Beth's choice. We also need to recognize, if she survives, that she may return. It is important to be as accepting of her the next time as the first time she sought help, or she will stop seeking help. One survivor described leaving as a process (Weiss, 2004).

We live in a broken system in which someone on welfare is not sufficiently safe or sufficiently supported to remain out of a relationship. The partner typically has control of their finances, their children, and their mental health. They have likely ensured the partner is dependent and isolated. Male victims have even fewer supports; there are very few male IPV shelters in North America. Nurses should empower clients to make their own choices. In addition, we must advocate to create a system that offers IPV survivors' choices for their well-being and thriving. We also have a role in community education of both men and women and particularly gender-diverse populations about IPV. Further research is needed on effective strategies for screening, risk assessment, and change-management strategies for clients while ensuring they retain choice and empowerment across genders. Legal change is also occurring—police and legislators are recognizing the lethality and consequences of coercive control, working to improve screening, charges, and convictions. We may have done "enough" for Beth at the time, using trauma-informed care, but we know there is more to do to support her and others experiencing IPV.

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