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Intimate partner violence and witnessing domestic violence: medico-legal implications, standards of proof, and institutional duties

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Summary. This editorial accompanies the comprehensive review on Intimate Partner Violence (IPV) and Witnessing Domestic Violence (WDV) published in this issue, with a focus on their medico-legal implications. It highlights how clinical consequences – ranging from chronic pain syndromes to psychiatric sequelae – must be translated into legally cognizable injuries through rigorous forensic evaluation. Particular attention is given to the recognition of children as 'primary victims' of WDV, the evidentiary value of medical documentation, the duties of healthcare professionals under mandatory reporting frameworks, and the quantification of psychological harm in civil compensation. The discussion also considers institutional liability for omissions, the reciprocal expectations between clinicians and courts, and the research priorities necessary to align public health and justice. Ultimately, IPV and WDV must be understood as violations of fundamental rights that demand integration of clinical expertise, forensic rigor, and legal accountability.

Key words. Abuse, children, forensic medicine, forensic psychiatry, women.

Violenza del partner e testimonianza di violenza domestica: implicazioni medico-legali, standard di prova e doveri istituzionali.

Riassunto. Questo editoriale accompagna la review sull'intimate partner violence (IPV) e sul witnessing domestic violence (WDV) pubblicata in questo numero, con un focus sulle loro implicazioni medico-legali. Sulla base dei risultati della review, viene evidenziato come le conseguenze cliniche – che spaziano dalle sindromi dolorose croniche alle sequele psichiatriche – debbano essere tradotte in lesioni giuridicamente riconoscibili attraverso una rigorosa valutazione forense. Particolare attenzione è rivolta al riconoscimento dei bambini come vittime primarie del WDV, al valore probatorio della documentazione medica, agli obblighi dei professionisti sanitari nell'ambito delle normative sulla denuncia obbligatoria e alla quantificazione del danno psichico nei procedimenti di risarcimento civile. La discussione considera inoltre la responsabilità istituzionale per omissioni, le aspettative reciproche tra clinici e tribunali e le priorità di ricerca necessarie per allineare sanità pubblica e giustizia. In definitiva, l'IPV e il WDV devono essere intesi come violazioni di diritti fondamentali che richiedono l'integrazione di competenza clinica, rigore forense e responsabilità giuridica.

Parole chiave. Abuso, donne, medicina legale, minori, psichiatria forense.

Introduction

The article "Intimate partner violence and witnessing domestic violence: a comparison of Italian and international evidence" published in this issue synthesizes epidemiology, risk factors, clinical sequelae, and treatment options for intimate partner violence (IPV) and witnessing domestic violence (WDV), integrating Italian data with international evidence and mapping consequences across physical and mental health domains[1]. Building on its findings, this editorial examines the medico-legal ramifications: the translation of clinical harm into legally cognizable injury; evidentiary standards and forensic documentation; duties to report and the limits of confidentiality; civil compensation and disability; criminal liability (including state responsibility); and the status of children as primary victims when exposed to violence in the home.

From clinical categories to legally cognizable harms

The review confirms the scale and heterogeneity of IPV across settings, with lifetime prevalence varying widely by country and method[1]. The WHO multi-country study found lifetime physical or sexual IPV against women ranging from roughly 15% to over 70% across sites, highlighting cultural and measurement variability that courts should understand when assessing general causation[2]. Italian survey data (ISTAT) show that about 31.5% of women aged 16-70 report physical or sexual violence in their lifetime (≈6.8 million women), underscoring the systemic nature of the problem and the foreseeability of harm[3,4]. In England and Wales, the ONS estimated 2.1 million adults (1.4 million women, 0.75 million men) experiencing domestic abuse in the year ending March 2023, a context that judicial authorities increasingly frame as

an ongoing public health and justice emergency[5]. In medico-legal terms, these epidemiological data support recognition of psychological and psychiatric sequelae (depression, anxiety, PTSD, suicidality) as compensable injuries. The companion review details of how such sequelae, frequently detected in clinical settings, merit structured forensic assessment to satisfy legal standards for injury, causation, and prognosis[1]. Courts must also acknowledge that psychological violence and coercive control can be as disabling as overt physical harm, an insight critical for civil damage and for criminal aggravating circumstances.

WDV: children as primary victims

A pivotal contribution of the review is the focus on WDV, urging a categorical shift: children who witness IPV are not "secondary" but primary victims, with measurable developmental, cognitive, and mental health consequences[1]. A recent global proportional meta-analysis estimates that 16.5% of children worldwide have witnessed physical domestic or family violence, and 17.3% have been direct *victims*, with regional gradients that emphasize the need for context-specific safeguarding[6]. Earlier conceptual work on definitions and typologies of exposure (witnessing, overhearing, intervening, living with threats) anchors the forensic relevance of non-visible harm[7,8]. In family law, Italian jurisprudence has become increasingly explicit: the Supreme Court of Cassation recently stated that failure to consider allegations of domestic and assisted violence (WDV) is a serious error, as such facts – if proven – may justify suspending or limiting contact or imposing supervised visitation to protect the child's health and development (Ord. Cass., Sez. I, 21 Feb 2025, n. 4595). This child-centered approach aligns with the Istanbul Convention's protective framework and with Strasbourg case-law (e.g., Talpis v. Italy) that condemns state failures to protect mothers and children from domestic violence[9,10].

Causation and the forensic psychiatric mandate

The review catalogs high rates of depression, anxiety, and post-traumatic symptoms in IPV survivors and observes similar burdens among children exposed to WDV[1]. Forensic psychiatry's task is to convert these clinical findings into legally robust opinions on diagnosis (using standardized tools), specific causation (linking symptom onset/course to abuse exposure while ruling out credible alternatives), functional impairment and disability, and prognosis and treatment needs. Evidence shows that people with pre-existing severe mental illness (SMI) have markedly elevated odds of recent IPV, with stronger effects for sexual violence and higher odds of suicide attempt following IPV, findings that make routine inquiry and safety planning part of the standard of care in mental health settings[11,12]. Systematic reviews also document high IPV prevalence among psychiatric patients more broadly[7]. The companion review's emphasis on coercive control is jurisprudentially salient: in forensic evaluations, the pattern, context, and cumulative effect of coercion should be weighed at least as heavily as discrete episodes of physical harm[1]. Realist syntheses of psychosocial interventions indicate that trauma-informed, individualized care – rather than "one size fits all" – achieves the greatest mental-health impact for survivors, a point relevant to mitigation of damages and to court-ordered treatment planning[12].

Documentation and evidentiary standards: the clinical chart as the 'first file'

The review underscores the centrality of healthcare settings as gateways for detection and support[1]. Legally, contemporaneous clinical documentation often constitutes the earliest and sometimes the only record of abuse. WHO guidance details principles of safe enquiry, informed consent, neutral verbatim recording, injury mapping, and (where permitted) photographic documentation[2]. Italian practice frameworks – national judicial guidance (CSM 2018), regional protocols (e.g., Campania's 2020 guidelines for ED psychological reporting), and professional guidance from medico-legal societies – converge on accuracy, neutrality, and clear chain-of-custody procedures[13,14]. Clinicians should avoid conclusory legal language, document what was observed/reported, and preserve materials in a manner consistent with future evidentiary use.

Duties to report and the limits of confidentiality

As the review notes, healthcare professionals often occupy the only safe interface where disclosure occurs[1]. In Italy, Law 69/2019 ('Codice Rosso') accelerated procedural protections for domestic and gender-based violence, reshaping investigative timelines and enhancing victim safeguards; this interacts with pre-existing duties (e.g., reporting of crimes prosecutable *ex officio*) and with professional secrecy[15]. The resulting tension – protecting life and integrity versus respecting autonomy and confidentiality – demands institutional protocols that define when reporting is mandatory, standardize risk assessment, and ensure secure and survivor-centered pathways. Judicial and prosecutorial guidance increasingly stresses early, structured identification of risk factors and documentation, with explicit toolkits for front-line operators[15].

Criminal liability, aggravating factors, and state responsibility

The review's depiction of multi-factor risk – alcohol, substance use, prior trauma, psychiatric comorbidity – maps onto criminal inquiries into capacity, intent, and aggravation[1]. Evidence suggests that several psychiatric disorders, particularly substance use disorders, are associated with increased risk of IPV perpetration; this supports proactive treatment routes and targeted prevention in justice-adjacent populations[16]. At the systemic level, *Talpis vs. Italy* reaffirmed positive obligations under Articles 2 and 3 ECHR: failures to assess and act upon known risks can engage state responsibility[10]. Recent domestic homicide monitoring in England and Wales further ties coercive control to lethality and victim suicides, bolstering the case for multi-agency risk assessment and for re-examining "non-suspicious" deaths where domestic abuse indicators exist[5].

Civil damages, disability, and biological damage

The review outlines long-term consequences – chronic pain syndromes, gastrointestinal symptoms, reproductive health complications, and persistent psychological injury – each with civil-law implications for damages and disability[1]. From a medico-legal perspective, these sequelae demand structured forensic evaluation.

The assessment must establish:

- *causation*: the link between the abusive events and the medical or psychiatric outcomes. This requires a rigorous reconstruction of the chronology of violence, the latency of symptom onset, and the exclusion of alternative explanations (e.g., pre-existing psychiatric conditions, somatic comorbidities);
- *nature and extent of damage*: physical outcomes such as musculoskeletal injuries or gynecological sequelae may be quantified through impairment rating scales, whereas psychiatric conditions (major depression, PTSD, complex trauma syndromes) require validated diagnostic instruments (e.g., SCID-5, CAPS-5) and structured assessment of functional impact;
- *functional impairment and disability*: medico-legal practice increasingly emphasizes the translation of psychiatric symptoms into functional domains – first – occupational capacity, interpersonal functioning, and self-care. Forensic psychiatrists must document how chronic hyperarousal, dissociation, or avoidance impair daily functioning, using standardized disability schedules when available;
- *permanence versus reversibility*: compensation depends not only on the severity of harm but also on prognosis. For example, chronic pelvic pain associated with sexual violence or enduring PTSD following repeated coercive control may be considered partially irreversible, supporting long-term disability ratings. Conversely, conditions amenable to therapy (e.g., moderate depression responding to treatment) may require differentiated compensation;
- *secondary victimization and iatrogenic consequences*: medico-legal evaluations should also acknowledge that victims of IPV/WDV may experience secondary harm from inadequate institutional response, retraumatization during legal proceedings, or stigma. These factors may aggravate psychiatric morbidity and thus influence both prognosis and quantification of damage. Finally, in civil proceedings, forensic experts are thus required not only to attest to diagnosis but to operationalize psychiatric suffering into legally recognized categories of injury. This process underscores the convergence of psychiatry and law: without standardized, methodologically sound evaluations, courts risk underestimating psychological harm or dismissing it as subjective. Proper medico-legal methodology transforms "invisible" injuries into quantifiable damages, ensuring equitable compensation and reinforcing the legal recognition of IPV and WDV as violations of fundamental health rights.

Prevention as a legal duty: from foreseeability to accountability

The review calls for integrated prevention across healthcare, social services, and justice[1]. In legal terms, foreseeability triggers duties: where structured risk is identifiable, omissions by institutions (e.g., failure to screen, document, or act) can be negligent. The Istanbul Convention embeds the '4 Ps' – prevention, protection, prosecution, and integrated policies – into a binding framework; national reforms (e.g., 'Codice Rosso') and judicial organization guidelines (CSM) operationalize those duties locally[9,13-15,17]. Monitoring shows that gaps in risk documentation and inter-agency coordination remain critical weak points; closing them is both a public-health necessity and a shield against institutional liability.

Practice standards: what courts should expect from clinicians and vice versa

As highlighted in the review, the interface between clinical practice and the judicial system is one of the most delicate aspects of IPV and WDV management[1]. Courts

increasingly expect clinicians to move beyond purely therapeutic roles and to provide documentation that is both clinically accurate and legally usable. From the medico-legal standpoint, this entails a set of minimum standards that should be internalized across healthcare systems. Clinicians must incorporate systematic, trauma-informed enquiry into relevant settings, ensuring that questions about IPV and WDV are asked with sensitivity and safety planning in mind. When disclosures occur, the ensuing documentation must be drafted with forensic rigor: records should contain objective descriptions of injuries, verbatim statements from the victim, a clear timeline of events, and, where permitted, photographic evidences. Such documentation, neutral and precise, allows the court to rely upon medical notes as primary evidence rather than ancillary testimony. Forensic psychiatrists and psychologists play a critical role in translating psychological suffering into legally cognizable categories of injury. Their task is not only to diagnose but also to establish causal links, to evaluate functional impairment, and to predict prognosis. Courts expect this level of methodological transparency, particularly in cases where psychiatric harm forms the core of the injury claim. Conversely, clinicians require that courts respect the complexity of trauma assessment, acknowledge the validity of psychological injury even in the absence of visible physical trauma, and provide procedural safeguards to minimize secondary victimization during testimony. In this sense, the expectations are reciprocal: clinicians must produce documentation that withstands adversarial scrutiny, while courts must interpret that documentation through the lens of contemporary psychiatric knowledge, giving equal weight to psychological and physical sequelae.

Research and policy agenda derived from the review

The review also provides an implicit agenda for future research and policy, which has direct medico-legal implications[1]. One of the most pressing needs is to develop outcome measures that extend beyond conviction rates. Too often, legal systems evaluate their effectiveness solely in terms of prosecution and sentencing. Yet, for victims, the relevant outcomes are the effectiveness of protective measures, the timeliness of intervention, and the prevention of further harm[18]. Research should therefore prioritize indicators such as adherence to protection orders, recurrence of violence, or the time elapsed between first disclosure and effective institutional response. Another area requiring attention is the systematic documentation of WDV in health, education, and social service records. The review demonstrates that children are frequently overlooked in legal proceedings, despite strong evidence of developmental and psychiatric harm[1]. By embedding standardized WDV indicators into routine practice, courts would be better equipped to adjudicate custody disputes, to evaluate parental fitness, and to prioritize the child's best interests. Similarly, further research is needed to refine risk assessment protocols for suicidality among IPV survivors. The evidence presented in the review suggests that suicide attempts are disproportionately common in women with psychiatric comorbidities who have suffered IPV[1]. Developing robust screening and prevention protocols could save lives, while also reducing medico-legal claims related to institutional omission. Finally, comparative evaluations of regional or national protocols are necessary. The Italian context, as noted in the review, is characterized by heterogeneous approaches across emergency departments and mental health services[1]. Assessing which practices provide the most effective documentation, the most protective interventions, and the best integration with judicial processes would allow scaling up of best practices. Such research would not only enhance clinical outcomes but would also strengthen the evidentiary basis of court proceedings, ensuring that forensic standards are consistently met. In sum, the research and policy agenda that emerges from the review is not merely an academic exercise. It is a roadmap toward bridging gaps between health systems and the judiciary, creating a unified framework where prevention, documentation, and protection are aligned. This integration is indispensable if we are to transform epidemiological evidence and clinical insights into actionable medico-legal strategies that deliver justice and safeguard health.

Conclusions

The review anchors what courts, clinicians, and institutions must internalize: IPV and WDV are rights violations with foreseeable health consequences; they demand forensic rigor, consistent documentation, and integrated prevention. Recognizing children as primary victims, treating coercive control as functionally disabling, and embedding trauma-informed, evidence-based care into legal processes will improve both justice and health outcomes. Ultimately, accountability – clinical, institutional, and state – rests on whether we can transform high-quality clinical evidence into effective protection and reparative remedies for victims.

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