REVIEW / DERLEME

DOI: 10.5455/JCBPR.247567
JCBPR 2017; 6(3):141–150

Safety Planning: A Vital Preliminary Step for Professionals Working with Intimate Partner Violence Victims

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Abstract

Intimate partner violence refers to coercive behaviors used by individuals against their intimate partners systematically. Intimate partner violence (IPV) victims can experience physical, sexual and psychological aggression, including economic coercion and stalking, perpetrated by their intimate partner. Approximately one third of women all over the world have experienced physical or sexual violence perpetrated by an intimate partner. Besides the physical harm that is frequently observed as a result of intimate partner violence, psychiatric conditions, including posttraumatic stress disorder and major depression, may also develop or worsen as a result of victimization.

Safety planning is a widely used intervention by mental health professionals to enhance the safety of intimate partner violence victims. The process includes the gathering of information, evaluation of the existing situation, decision-making for the type of advocacy and resources needed and the identification of future strategies on how to respond effectively to violence. Although it is seen as the first step of helping battered women and trauma informed care in the United States, the safety planning technique is being limitedly used in Turkey only by women shelters.

The current review will summarize the characteristics and theoretical rationale of safety planning, discuss the safety planning process, clarify therapists' responsibilities about safety planning, highlight research findings on the effectiveness of safety planning with intimate partner violence victims, and consider the integration of safety planning into existing cognitive and behavioral therapeutic practices.

Keywords: Domestic violence, intimate partner violence, safety planning, cognitive behavioral therapies, PTSD, depression

Öz

Güvenlik Planı Hazırlama: Eş Şiddeti Mağdurları ile Çalışan Profesyoneller için Hayati Nitelikteki İlk Aşama

Eş şiddeti (EŞ), eşe karşı sergilenen saldırgan ve zorlayıcı davranış kalıpları ile tanımlanmaktadır; fiziksel, cinsel ve psikolojik saldırıların yanı sıra ekonomik kontrolü ve ısrarlı takip kavramlarını da kapsamaktadır. Bütün dünyada, kadınların neredeyse üçte biri eşlerinden fiziksel ya da cinsel şiddet görmektedirler. EŞ sonucunda ortaya çıkan fiziksel zararın yanı sıra TSSB ve majör depresyon sıklıkla gözlenen psikiyatrik sonuçlar arasında yer almaktadır.

Güvenlik planı hazırlama, EŞ mağduru kadınlarla çalışan profesyoneller tarafından yaygın olarak kullanılan bir müdahale olup kadınların güvenliklerini sağlamayı amaçlayan yapılandırılmış bir süreçtir. Güvenlik planı hazırlama şu aşamaları içerir: bilgi toplama, var olan durumu değerlendirme, ihtiyaç duyulan kaynakların biçimi ve nasıl bir savunmaya ihtiyaç duyulacağı hakkında karar verme ve gelecekte şiddete etkin bir şekilde nasıl yanıt verilebileceği konusundaki stratejilerin belirlenmesi. Söz konusu müdahale her ne kadar Amerika'da şiddet gören kadınlara yardım ederken ve travma mağdurları ile çalışırken ilk basamak olarak görülse de, bu tekniğin kullanımı Türkiye'de kadın sığınma evleri ile sınırlıdır.

Bu gözden geçirme kapsamında güvenlik planı hazırlama ile ilgili teorik bilgiler verilecek, terapistlerin güvenlik planı hazırlama konusundaki sorumlulukları netleştirilecek, güvenlik planı hazırlama süreci tartışılacak, tekniğin etkililiği konusunda yapılan araştırmaların sonuçları vurgulanacaktır ve güvenlik planı hazırlamanın bilişsel davranışçı terapilerle bütünleştirilmesi için düzlem sunulacaktır.

Anahtar Kelimeler: Aile içi şiddet, eş şiddeti, güvenlik planı hazırlama, bilişsel davranışçı terapiler, PTSB, depresyon

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Received / *Geliş:* October 29, 2016
Accepted / *Kabul:* June 22, 2017

Bilişsel Davranışçı Psikoterapi ve Araştırmalar Dergisi 2017; 6(3):141-150

Intimate partner violence (IPV), a term that encompasses related terminology such as "Domestic Violence", "Violence Against Women", and "Dating Violence", refers to coercive behaviors that are used by individuals against their intimate partners systematically. These behaviors include physical, sexual and psychological assaultive behaviors, along with economic coercion (Ganley, 1995). Over the years, the definition of IPV has been expanded to include stalking (Bauman, Haaga, & Dutton, 2008), which refers to various forms of unwanted fearful or threatening behaviors intended to elicit fear in the targeted victim (Spitzberg & Cupoch, 2007) and may incorporate the use of technological methods (Black et al, 2011).

Worldwide estimates of IPV indicate that approximately 30% of women internationally have experienced physical or sexual violence perpetrated by an intimate partner (World Health Organization [WHO], 2013). Within Turkey, results on DV rates obtained by the Turkish Statistical Institution indicate that, of the 7500 women surveyed, 35.5% of women reported exposure to physical violence in their lifetime and 8.2% of women reported physical violence exposure within the past 12 months prior to the survey (Türkiye İstatistik Kurumu [TÜİK], 2014).

IPV victims can experience numerous medical problems as a result of the abuse such as injuries directly sustained during the assault (e.g., broken bones, burns etc.), as well as medical conditions exacerbated due to the stress experienced from living in an abusive environment (e.g., asthma, lupus, etc.) (Ganley, 1995). Psychiatric conditions, including posttraumatic stress disorder (PTSD) and major depression, may also develop or worsen as a result of IPV victimization (La Flair, Bradshaw, Mendelson, & Campbell, 2015; Mechanic, Weaver, & Resick, 2008; Coker et al., 2002; Coker, Weston, Creson, Justice, & Blakeney, 2005; Golding, 1999). Additional psychological effects of IPV experienced by women include fear and shame, sense of loss of control, stress, hopelessness, anxiety, lowered self-esteem, and substance abuse (Davies, Lyon & Monti-Catania, 1998).

One of the most widely recommended interventions that is frequently identified as a crucial step when working with battered women is called Safety Planning (SP) (Campbell & Glass, 2009; Eden et al., 2015; Glass, Eden, Bloom, & Perrin, 2010; Herman, 2015), and is referred to as a structured procedure for enhancing the safety of women in IPV situations that includes the gathering of information, evaluation of the current situation, decision-making for the type of advocacy and resources needed, and the identification of future strategies on how to respond effectively to violence (Campbell, 2001; Davies et al., 1998; Parker & Gielen, 2014). This review article aims to discuss the process and importance of generating safety plans with IPV victims, including those seeking trauma-related psychological care. Furthermore, this review intends to make a comparison between the United States and Turkey in systematic usage of SP.

THEORETICAL BACKGROUND

IPV against women is historically well-documented, and may have roots in patriarchal society structures. With the second wave women's movement in the 1970's, IPV and its consequences became visible in the United States and Britain, and since then substantial progress within these countries has been made in increasing awareness and responsiveness, including the formation of IPV crisis hotlines, shelters and other services (Davies et al., 1998). The idea that women are passive recipients of IPV and powerless to change their situations because of a pattern of repeated abuse (Parker-Corell & Marcus, 2004) was rejected within the United States in the 1980's after several studies showed that women are not passive recipients of abuse (Parker & Gielen, 2014; Goodman, Dutton, Weinfurt, & Cook, 2003). An alternative theory was proposed which suggested that women become increasingly active in their attempts to stop violence, and are more likely to engage in help-seeking behavior as the frequency and severity of violence intensifies (Gondolf & Fisher, 1988; Goodman et al., 2003; Davies, et al., 1998). Based on the findings from a focus group, Goodman and colleagues categorized the strategies used by women to keep themselves safe into six groupings labelled *placating, resistance, SP, legal, formal* and *informal*, which describe a range of private and public attempts to enhance women's safety in IPV situations (Goodman et al., 2003).

SP is a procedure to increase the safety of women and children in IPV situations (Lindhorst, Nurius, & Macy, 2005), and is often incorporated into trauma-informed care (Ferencik & Ramirez-Hammond, 2013) as traumatic events, including IPV victimization, can disrupt people's lives, creating a sense of powerlessness, lack of control, and disconnection (Herman, 2015). SP can enhance victims' sense of power and control through empowerment and facilitation of victim autonomy (Campbell, 2001), and

prepare them for other trauma-focused services. Before directly addressing the traumatic memories, emotions, and posttraumatic symptoms, therapy should begin by establishing an acceptable degree of safety (Herman, 2015; Rosenbloom & Williams, 2010); since posttraumatic reactions are prone to continue when either danger or threat of danger continues. However, when safety is enhanced, these posttraumatic reactions are expected to decrease over time (Hobfoll et al., 2007).

Within the United States, SP strategies are thought to be a vital part of interventions with abused women, and are utilized regularly by women shelters and crisis telephone lines (Miller, Howell, Hunter, & Graham-Bermann, 2012). SP has been included in protocols of crisis intervention services and advocacy services in health, social service and legal settings as well as in the delivery of support group and individual counseling services (Eden et al., 2015; Macy, Nuriosu, Kernic, & Holt, 2005). Directions about preparing safety plans and sample safety plans are also included in some self-help PTSD and IPV workbooks (Rosenbloom & Williams, 2010; Williams & Poijula, 2013) while its importance has been emphasized in various resources such as brochures and books targeting victims (Kubany, McCaig, & Laconsay, 2004; Williams & Poijula, 2013; Bancroft, 2015). However, the practice of SP with victims within Turkey appears to be inconsistently recommended, and utilized by social and legal services. It was not mentioned either in "The Protection of Family and Prevention Violence Against Women Law" (Law Number: 6284, published in the Official Gazette on March 8, 2012) that regulates procedures and principles with regard to the measures of preventing the violence or "Regulation on the Establishment and Operation of the Women's Shelter" (no: 28519, published in the Official Gazette on January 5, 2013) that regulates procedures and principles for the establishment and operation of shelters as well as the responsibilities of the staff working there. On the other hand, SP was recommended to IPV victims on the website of Mor Çatı Women's Shelter, an independent organization that fights against IPV in Turkey.

THE ROLES OF MENTAL HEALTH PROFESSIONALS ON THEIR CLIENTS' SAFETY

It is not only the victims' advocates but also the mental health professionals' (MHPs) responsibility to promote clients' safety, and assess the clients' situation. Hospital emergency departments serve frequently as the entry point for IPV victims (Bazargan-Hejazi et al., 2014); thus, it is vital for emergency department staff to be sensitive to IPV risk. Even if women do not want to take legal action against a batterer, the emergency department should discuss a safety plan with the victim.

As mentioned previously, IPV victims seen in outpatient and inpatient psychiatry departments are often diagnosed with depression and PTSD. Temiz and his colleagues assessed 102 women who were staying at Bakırköy Research and Training Hospital Inpatient Psychiatry, Neurology and Neurosurgery Units, and found that 90 out of 102 inpatient women were subjected to one type of violence, most commonly perpetrated by parents and husbands. The researchers concluded that IPV is frequently unidentified because it is overlooked by providers, despite high prevalence rates of IPV exposure among female psychiatric patient populations that is associated with higher rates of PTSD and suicide attempts (Temiz et al, 2014). Some have argued that violence risk assessment should be a "required professional ability" of MHP working in psychiatric settings (Elbogen, 2002).

When considering the high prevalence of IPV, it is very likely for MHPs to encounter IPV victims not only in emergency departments but also in child and adult psychiatry clinics, and in private practice settings providing individual and couples counseling. IPV and child abuse coexist frequently; thus, the presence of one of these might be an indicator of the other (Waugh & Bonner, 2002). Providers working with IPV victims should assess for child abuse and help establish children's safety. Likewise, therapists working with children and adolescents should assess for the occurrence of IPV within the home, and facilitate safety planning for DV-exposed children and family (Waugh & Bonner, 2002).

The essential role of MHPs in facilitating SP with their IPV-exposed clients was revealed in a review study on counseling literature by Kress and colleagues as well, which noted that it is crucial to develop a comprehensive safety plan with an IPV client before leaving the first session, especially if the client is still living with the abusive partner (Kress, Protivnak & Sadlak, 2008). Herman (2015) also addressed the premature engagement in therapeutic process before establishing safety as second most common therapeutic error; thus, establishing safety is agreed to be the first step of treatment for MHPs.

Couples and family therapists are likely to encounter IPV victims. Herman (2015) identified the commonality of victims and batterers to seek couples' treatment shortly after a violent episode following a batterer's assurances to change and discontinue the violence. However, identification of violent relationships is often missed (Bradford, 2010), and women's danger can be ignored (Davies et al., 1998). The victim may also be ignoring and underestimating the risk of ongoing danger (Herman, 2015); thus, couples should be screened for IPV using surveys or interviews. When IPV is identified, a safety plan should be conducted (Bradford, 2010). Furthermore, programs that work with batterers, including anger management and substance abuse programs, should communicate with the batterers' partners in order to help establish a safety plan, and inform victims about batterers' attendance and progress (Campbell, 2002).

No matter where the victim is seen, the MHP who is providing the service is responsible to consider safety as the primary concern. Due to high femicide rates, it is vital to incorporate SP in every system where victims are seen: health care, criminal justice, domestic and juvenile justice, and shelter systems (Campbell, 2004). Thus, MHPs are expected to be familiar with the legal regulations as well as the local resources such as IPV hotlines, shelters, and legal clinic programs that help IPV victims by educating them about and pursing legal action. A nationwide survey on IPV showed that the vast majority of women (92%) who experience physical violence do not contact legal and law enforcement authorities or NGO's after IPV incidents (KSGM, 2009).

HOW TO PREPARE SAFETY PLANS?

SP should identify practical strategies in the form of a personalized plan for reducing risk of future abuse, including ways of enhancing safety addressing a range of potentially violent circumstances in victims' lives, whether the victim is still in an abusive relationship, planning to leave, or has already left the relationship (Goodkind et al., 2004). The plans are developed in partnership between the victim and the professional (Campbell 2001); the victim is considered to be the best expert of her experience, given that many victims show a deep understanding of their abusers' behavioral patterns (Kress, Protivnak, & Sadlak, 2008). It is crucial to start from the victim's perspective about the violence, listening effectively, and considering her concerns and questions in the process, avoiding legal or medical jargon, and communicating simply and effectively (Davies et al., 1998).

Davies and her colleagues (1998) indicated that there are two main types of information which needs to be gathered when preparing safety plans: *identification of prior safety plans* (including the utilized strategies, their effectiveness, victims' likelihood of using them again with reasons, and abusers' reactions to those strategies), and *identification of current safety strategies* (including protection, staying and leaving strategies considering timeframe targeted, available resources for victim, and expected responses from abuser). Campbell remarked that the most important aspects of the victim's situation that need to be assessed by the professionals are: a) The abusive partner's potential for re-abusing and homicide; b) The victim's commitment to the abusive relationship –e.g. whether the victim plans to leave or stay. Whether the victim is in the process of leaving or has already left. c) The victim's emotional status; d) The available resources from the victim's family, employer, and public; and e) The victim's children (2009).

Assessing Lethailty or Dangerousness from the Batterer

Davies and colleagues (1998) stated that a thorough and accurate risk analysis, or an assessment of batterer dangerousness and lethality, is an essential component of SP. Campbell's research with 445 victims of attempted and actual femicide revealed that 14.1% women who were killed had visited health care units due to IPV injuries and a total of 47% of victims had been seen in the health care system for a IPV-related injury during the year before they were killed (Campbell, 2004). Unfortunately, the statistical estimates on femicide in Turkey are not sufficient because of the lack of comprehensive systematic data on the rates of femicide by intimate partners or on the family members (Güngör, 2012). According to The Monument Counter (Anıt Sayaç), an online (internet) monument to commemorate victims of femicide due to domestic violence in Turkey, the number of woman murdered rose from 226 to 289 from 2013 to 2015 and was determined to be 277 in 2016. "We Will Stop Femicide Platform" website states that there have been 328 femicides within Turkey in 2016 and 51% of them were perpetrated by current or ex-intimate partners ("Kadın Cinayetlerini Durduracağız Platformu, 2016 yılı raporu", 2016).

Femicide risk factors that should be considered during lethality assessment include homicide threats, use or threat

of using weapons, presence of a gun in the home, and pathological jealousy (Campbell, 2001). Escalating severity and frequency of physical violence might also be predictive of femicide (Kress et al., 2008). Other factors that have been found to heighten the risk of femicide and should be assessed include the batterer's drug and alcohol use, stalking behaviors, strangulation, batterer suicidality, forced sex and concomitant child abuse (Campbell, 2003; Kress et al., 2008). Victims' lethality risk may increase if their partners' drop out of a batterer program; thus, victims should be notified immediately if their partner discontinues treatment, in order to help victims take protective action, such as seeking shelter programming (Campbell, 2001). Homicide risk factors and updated lethality rates should be provided in order for victims to be fully informed during the SP, decision-making process (Campbell, 2001) while also ensuring that victims remain in charge of their own lives (Herman, 2015).

Notably, there is no one strategy that is effective universally to stop batterers' abusive patterns. Indeed, many batterers continue to engage in abusive behaviors despite having been arrested or placed on probation, left by their abused partners, or engaged in a specialized program for batterers (Goodkind et al., 2004). Notably, in the United States, 65% to 80% of femicide victims were killed by former intimate partners who were previously abusive (Campbell, 2004). Thus, it is crucial to enhance the safety of women who were previously abused by an intimate partner. Women are considered to be under risk of re-abuse until a rational, applicable contingency plan has been developed, and her ability to carry out this plan has been determined (Herman, 2015).

Leave or Stay Status

Assessing whether or not to remain in or leave the abusive relationship is a key component of the SP process. The MHP should clarify whether or not the victim is aware that she has been abused, the hazards that will stem from ongoing and/or escalating abuse, the potential consequences of staying in versus leaving the abusive relationship, and available options (Kress et al., 2008). The attitude of the MHP should be non-judgmental and the professional should refrain from carrying out their own personal agendas (Herman, 2015) by encouraging the victim to remain in or leave the relationship (Kress et al., 2008).

Stay-leave decision-making should be considered as a process, rather than a single event, and repeated attempts to return to or leave the abusive relationship should be viewed as part of the natural progression to ultimately leave the relationship (Dienemann, Glass, Hanson & Lunsford, 2007). The results of a nationwide survey conducted by Hacettepe University Institute of Population Studies (HÜNEE) in Turkey indicated that 39% of Turkish women who were married or were in an ongoing relationship experienced at least one IPV episode during their lifetime, and 26% of them left their home at least once because of IPV (2009). The number of leaving attempts that an average woman in the United States makes before ultimately ending the abusive relationship is estimated as five (Roberst et al., 2008; Okun, 1986).

Since IPV victims frequently apply MHP when they are still living with their abusive partners; MHP should be prepared to provide support through assisting victims in identifying their partners' use and level of force and assessing future risk. The main objective of the SP during this phase is to assist victim for determining some strategies that will help to enhance safety during arguments.

The victim may plan to leave in a few days, a few years or many years, so she may implement the safety strategies for leaving over short or long periods of time (Davies et al, 1998). The main objective of the SP with victims who are planning to leave is to address some strategies that will enhance a well-planned safe departure. IPV victims may decide to pursue a protection order to help facilitate the leaving process that will not only help to enhance a safe separation but also facilitate the victim's pursuit of legal action against the abusive partner (Roberts, Wolfer, & Mele, 2008). Thus, the MHP may inform and discuss the option of obtaining a protection order with the victim, and refer her to available services that provide legal support and guidance. According to Turkish legislation, to obtain a protection order, victims do not need to provide evidence of the violent incident. However, evidence of the event can make it easier for legal authorities to evaluate risk, and issue continuances of the protection orders. Moreover, since IPV is a cause of action according to Turkish Civil Code (Law Number 4721, accepted 22.11.2001), collecting evidence can be helpful for female IPV victims seeking divorce or custody. The MHP can play a role in helping guide victims about the possibilities of collecting such evidence.

It is important to consider that leaving is not always the safest strategy, as the batterer may escalate, becoming even more unpredictable and increasing the victim's risk of harm upon leaving (Ferencik & Ramirez-Hammond,

2013). Unfortunately, there is no systematic data available on how many Turkish women in IPV situations are killed by their ex-partners after leaving an abusive relationship. We Will Stop Femicide Platform remarked that 27 out of 303 women who were killed in 2015 were murdered despite having a protection order ("Kadın Cinayetlerini Durduracağız Platformu, 2015 yılı raporu", 2015).

Once the victim leaves, several issues need to be addressed concerning the victim's safety. SPs need to identify potentially dangerous locations and create a plan to increase safety in these locations. MHPs should work with victims to help them change routines and appointments that are known for the batterer, establish and maintain restraining/protection orders, and inform law enforcement with a picture of the offender ("*Path to Safety*", n.d., "*What can I do to stay safe?*", n.d., "Şiddete *uğradığınızda*", n.d.). IPV victims should also be informed about the risk of stalking after separating from an abusive relationship.

Emotional Status

When considering the high prevalence of PTSD and depression among IPV victims, MHPs should be aware of how PTSD related conditions, including symptoms of heightened arousal and reactivity, may interfere with the SP process (Ferencik & Ramirez-Hammond, 2013). Given the potential for emotional difficulties following DV exposure, professionals working with victims may want to consider developing emotional safety plans with DV/IPV victims (Ferencik & Ramirez-Hammond, 2013).

Although definitions of emotional SP vary, it is generally regarded as the development of a personalized plan that helps IPV victims accept and manage their emotions and decisions when dealing with abuse ("Emotional Safety Planning", 2015). Professionals' normalization of the traumatic events and reactions followed by supportive strategies offered to facilitate coping effectively with traumatic reactions is expected to provide trauma victims with a sense of mastery over their own feelings, reactions and stressors (Ferencik & Ramirez-Hammond, 2013). Then the professional can aid the victim in identifying triggers that may provoke traumatic symptoms, early cues of physiological and behavioral traumatic reactions, and calming/grounding techniques that may help the victim cope with acute traumatic reactions (Ferencik & Ramirez-Hammond, 2013). Wiliams and Poijula (2013) recommended several grounding techniques for victims experiencing flashbacks, including physical distractions (repeatedly blinking eyes, change the body position, moving vigorously around the environment, holding on to a safe object, clapping hands, washing face with cold water) and relaxation techniques (deep breathing, creating a safe place and getting to safe place through visualization to enhance emotional safety). As Kubany and colleagues (2004) noted, the utilization of these techniques can also help victims regulate tension level during exposure sessions in PTSD treatment.

Depression may also interfere with victims' abilities to actively problem solve and strategize ways to stay safe (Campbell, 2001), and MHPs should be aware of and assess for suicide risk. HÜNEE study revealed that 33% of women who reported IPV histories acknowledged having experienced suicidal ideation and 12% of women stated that they had attempted suicide (HÜNEE, 2009). Therefore, SPs may need to also address victims' suicidal ideation and identify steps to manage suicide risk.

Safety Planning and Cognitive Behavioral Therapies (CBT)

According to Emotional Processing Theory, any information associated with a trauma is expected to activate the fear structure, and this structure in PTSD groups is thought to include a particularly large number of stimulus elements, resulting in the fear structure being easily triggered (Foa et al., 2008). If the victim has PTSD symptoms, she is likely to experience hypervigilance and to have exaggerated perceptions of the batterer's ability to control her as well the system (Campbell, 2001). The hyperarousal symptoms of PTSD, such as heightened physiological arousal and emotion dysregulation, are also thought to place victims in a constant state of heightened alert, and thereby may hinder victims' ability to detect and/or respond to actual risk (Iversion et al., 2012). SP can enhance victims' experiences of safety during treatment facilitate coping with PTSD symptoms. Indeed, CBT-based treatment models developed for treating IPV-related PTSD have noted the importance of incorporating SP into the treatment regimen, especially in situations where partner violence may still be ongoing (Kubany, 2004).

SP may also play an important role in CBT approaches to treating depression within IPV victims. Depressed IPV victims may have difficulties actively problem solving difficulties and strategizing and applying ways to stay safe (Campbell 2001). Furthermore, IPV victims like other trauma victims might feel isolated (Herman, 2015), and behaviorally inhibited (Contractor, Elhai, Ractliffe &

Forbes, 2013). As such, SP may encourage IPV victims to become more behaviorally activated, and engage in active problem solving in order to identify and apply safety strategies.

Assessment of Victims' Resources

It is important that SPs identify the available resources from both informal and formal support systems (Campbell, 2001). Survivors might be hesitant to talk with their families about the abuse for several reasons; including concerns regarding victim blaming by family members, strong family reactions, increase risk of family harm due to knowledge of the abuse, and family members' likelihood to pressure victim to stay or leave the abusive relationship (Herman, 2015). Furthermore, victims may be isolated from their family members due to their controlling abusive partner limiting family contact or due to the victim self-isolating because of guilt or shame (Campbell, 2001). The evaluation process should include: an assessment of important relationships in the victim's life, categorization of these relationships into potential sources of protection, and help versus potentially harmful relationships (Herman, 2015). It is important that this evaluative process consider cultural norms, as these norms may affect the formal and informal support the victim receives, and may inform the identification of potential risk factors.

Children

IPV frequently co-occurs with child abuse (MacMillan, Wathen, & Varcoe, 2013; UNICEF, 2006; Waugh, 2002). Along with risk of physical abuse, children of IPV victims may also experience disruptions in their financial and emotional security (Davies et al, 1998). Thus, the safety of children is a paramount concern that should be considered by the MHP, and the main objective of SP regarding children is to assist victims in teaching their children how to stay safe during violence by not attempting to protect adults, and by seeking help (Campbell, 2001). Furthermore, the victim should be instructed to stay away from where the children are during violent episodes in order to reduce the children's risk of also being assaulted.

IPV victims may choose to stay or delay leaving an abusive relationship for several reasons related to their children's well-being. Campbell (2001) remarked that abused women may underestimate the undeniable long-reaching impacts of the abuse on their children, and thus, need to be encouraged to consider and recognize the effects of abuse on their children (Campbell, 2001).

Women who are pregnant also need to be careful about heightened risk during violent situations. A recent study in Turkey found that the incidence of IPV during pregnancy was 2.37% (Cengiz, Knawati, Yıldız, Süzen, Tombul, 2014). HÜNEE study indicated that one out of every ten women reported having been abused physically during pregnancy (HÜNEE, 2009). When conducting SP with pregnant women, the safety of the fetus should be considered as a priority.

THE EFFECTIVENESS OF SAFETY PLANS

Although little is known about the effectiveness of SP for IPV victims within Turkey, findings from other countries suggest the potential benefits of SP. Studies on the effectiveness of SP, however, are limited, and no known studies have investigated the effectiveness of incorporating SP into existing CBT approaches. One review study on safety strategies used by IPV victims identified only one study out of nine that examined SP techniques (Parker & Gielen, 2014). In that study conducted in the United States by Goodkind and her colleagues (2004), female participants were asked which safety strategies they used, and the consequence of each strategy. Study findings revealed that emergency escape plan strategies were found to be endorsed infrequently. Those who used these strategies were women likely to have a heightened lethality risk, and those who had experienced physical or psychological abuse. This study also indicated that women who had stayed in IPV shelters were more apt to make emergency escape plans (Goodkind et al., 2004). These findings emphasize the importance of putting emergency escape plans, or more comprehensively safety plans in practice.

It is important to note that providing SP information without conducting a comprehensive SP assessment is likely to reduce the effectiveness of the technique. Abused women should realize the situation she and her children are in, assess it, identify the risks, identify her priorities and resources, and then develop a SP. Research by Eden and colleagues (2015) examined the effectiveness of an internet safety decision aid called IRIS, which focused on making a personalized assessment of safety priorities, danger, characteristics of the relationship and previous actions taken for protection, and developing a personalized safety plan

that integrates personal information with proven safety techniques. Preliminary results indicated that women who used this personalized website had less decisional conflict when compared with women who used the conventional websites that include resources provided by domestic violence advocates or resources that they can reach through IPV hotlines and websites (Eden et al, 2015). Further evaluation of individualized SP tools, such as the one developed by Eden and colleagues, is necessary to determine if these tools are effective and efficient in directing SP.

CONCLUSION

SP is one of the vital techniques that professionals who work with IPV victims need to use. Usage of this technique promotes clients' safety and empowers treatment outcomes by promoting the sense of safety. Unfortunately, today, SP in Turkey appears to be solely provided by Morçatı, the non-profit shelter and program for abused women. Considering the high IPV prevalence and lethality rates, SP needs to be implemented by mental health care and health care professionals, therapists, forensic medicine professionals, family court social work field staff, probation division officers, law enforcement professionals, and programs for IPV victims. SP should go beyond providing victims with limited advice on how to stay safe, and it should be conducted in collaboration with victims, based on individual women's priorities, needs and concerns.

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