Prevention of violence against women

Recommendation statement from the Canadian Task Force on Preventive Health Care

C. Nadine Wathen, Harriet L. MacMillan, with the Canadian Task Force on Preventive Health Care

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Recommendations

- There is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women (grade I recommendation); however, clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluation of these patients.
- There is insufficient evidence to recommend any of the following primary care interventions to prevent violence against pregnant or nonpregnant women, although decisions to do so may be made by the clinician and patient on other grounds:
  - primary care counselling (grade I recommendation)
  - referral to shelters (grade I recommendation)
  - referral to personal and vocational counselling (grade I recommendation).
- There is fair evidence (level 1) to refer women who have spent at least 1 night in a shelter to a structured program of advocacy services (grade B recommendation). A structured, multi-phased post-shelter advocacy service is described by Sullivan and Bybee;[1] to our knowledge, no such programs currently exist in Canada.
- There is insufficient evidence to recommend for or against screening men as potential perpetrators of violence against their intimate partner (grade I recommendation).
- There is conflicting evidence regarding the effectiveness of batterer interventions (with or without partner participation) in reducing the rate of further intimate partner violence (grade C recommendation).

In Canada, the annual prevalence of violence against women is about 8% among nonpregnant[2] and 6% to 8% among pregnant women.[3,4] For the purpose of our review[5] and recommendations, violence against women is defined as physical and psychological abuse of women by their male partners, including sexual abuse and abuse during pregnancy. Of women who are abused, 25% suffer episodes of beating, 20% of choking and 20% of sexual assault; 40% suffer injury, and 15% receive medical care as a result of partner violence. Separate from physical violence, 19% of women suffer emotional abuse and controlling behaviour, including financial abuse or control.[2] Emotional forms of abuse are highly correlated with physical violence: 5-year rates of violence are 10 times greater among those in emotionally abusive situations than among those who do not report emotional abuse.[2] Women exposed to partner violence are at increased risk of injury and death as well as a range of physical, emotional and social problems.[6] Abuse during pregnancy is associated with impairment in both the mother and child, including low birth weight.[7]

Manoeuvres

The following interventions were evaluated:

- Screening of all women, including pregnant women, in the primary care setting to detect intimate partner violence
- Interventions for women who are abused
- Treatment programs for men who abuse their partners

Potential benefits

- Decrease in the incidence of physical, sexual or emotional abuse by men against their female partners
- Increase in women's use of safety behaviours, social support, community resources, etc., following intervention

Potential harms

- Reprisal violence by men against women seeking intervention
- Failure to detect abuse (either by not screening or through false-negative results of screening)

[See "Evidence and clinical summary"[8–23] section on the next page.]

Recommendations by others

In 1996, the US Preventive Services Task Force concluded that there is insufficient evidence to recommend for or against the use of specific screening tools to detect domestic violence, although it suggested that clinicians be alert to signs of abuse and use selective screening questions if indicated.[24] The American Medical Association's Council on Scientific Affairs recommends routine screening in primary care settings and a structured approach to documentation and referral to appropriate community resources.[25] The Society of Obstetricians and Gynaecologists of Canada (SOGC) advocates a high degree of clinical suspicion and outlines

Evidence and clinical summary

- Several screening instruments with acceptable psychometric properties have been developed,[8–15] including brief forms[16–18] for primary[16] and emergency[17] care settings and forms for pregnant women.[19] However, at present there is insufficient evidence to evaluate whether screening is effective in reducing violence against women or associated negative outcomes. In addition, data about the potential harms of screening are lacking. This finding is similar to that of another recent systematic review.[20]
- Four types of interventions for abused women were evaluated within the category of potential referrals by primary care physicians: shelters, post-shelter advocacy counselling, personal and vocational counselling, and prenatal counselling. No evidence of suitable quality exists to assess the effectiveness of shelters to decrease the incidence of violence. Among women who had spent at least 1 night in a shelter, there was fair evidence that those who received a program of advocacy services reported less repeat abuse and better quality of life in the following 2 years than women who did not receive such services.[1]
- Programs that target male batterers — alone or with their partners — represent the largest group of interventions. Of 10 studies and 1 review of these programs, only 1 randomized controlled trial was considered of good quality.[21] This trial (the San Diego Navy Experiment) showed that 3 programs for batterers, their female partners or both (a weekly men's group, a conjoint group with men and their female partners and monitoring with individual counselling sessions) showed no reduction in abuse compared with a control group. Despite the excellent internal validity of this trial, the extent to which these findings are applicable to the general population is unclear, as the study group consisted of US Navy couples. The other studies in this category were all rated "poor" in terms of methodological quality.
- There is a clear and pressing need for additional research employing rigorous designs to test the effect of domestic violence interventions on important clinical outcomes.
- *A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians* is an excellent resource and provides an overview of the clinical manifestations of physical[22] and psychological[23] abuse.

key physical and psychological presenting symptoms.[26] Although not directly encouraging routine screening, the SOGC provides a brief set of screening questions to be used as part of history-taking. The American College of Obstetricians and Gynecologists takes a similar approach.[27] Both groups also provide guidance regarding counselling (including safety planning), referral and follow-up. A similar case-finding approach is also advocated by the American Academy of Pediatrics.[28]

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Correspondence to: *Canadian Task Force on Preventive Health Care, 117–100 Collip Circle, London ON N6G 4X8; fax 519 858-5112; ctf@ctfphc.org*

Members of the Canadian Task Force on Preventive Health Care
Chair: *Dr. John W. Feightner, Professor, Department of Family Medicine, University of Western Ontario, London, Ont.* ***Vice-chair:*** *Dr. Harriet MacMillan, Associate Professor, Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics, Canadian Centre for Studies of Children at Risk, McMaster University, Hamilton, Ont.*
Members: *Drs. Paul Bessette, Professeur titulaire, Département d'obstétrique-gynécologie, Université de Sherbrooke, Sherbrooke, Que.; R. Wayne Elford, Professor Emeritus, Department of Family Medicine, University of Calgary, Calgary, Alta.; Denice Feig, Assistant Professor, Department of Endocrinology, University of Toronto, Toronto, Ont.; Joanne Langley, Associate Professor, Department of Pediatrics, Dalhousie University, Halifax, NS; Valerie Palda, Assistant Professor, Department of General Internal Medicine, University of Toronto, Toronto, Ont.; Christopher Patterson, Professor, Division of Geriatric Medicine, Department of Medicine, McMaster University, Hamilton, Ont.; and Bruce A. Reeder, Professor, Department of Community Health and Epidemiology, University of Saskatchewan, Saskatoon, Sask.* ***Resource people:*** *Nadine Wathen, Coordinator; Ruth Walton, Research Associate; and Jana Fear, Research Assistant, Canadian Task Force on Preventive Health Care, Department of Family Medicine, University of Western Ontario, London, Ont.*