Intimate partner violence towards women

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ABSTRACT

INTRODUCTION: Between 10% and 70% of women may have been physically or sexually assaulted by a partner at some stage, with assault rates against men reported at about one quarter of the rate against women. In at least half of people studied, the problem lasts for 5 years or more. Women reporting intimate partner violence (IPV) are more likely than other women to complain of poor physical or mental health, and of disability. METHODS AND OUTCOMES: We conducted a systematic review and aimed to answer the following clinical question: What are the effects of interventions initiated by healthcare professionals aimed at female victims of intimate partner violence? We searched: Medline, Embase, The Cochrane Library, and other relevant databases up to September 2009 (Clinical Evidence reviews are updated periodically, please check our website for the most up-to-date version of this review). RESULTS: We found 26 systematic reviews, RCTs, or observational studies that met our inclusion criteria. We performed a GRADE evaluation of the quality of evidence for interventions. CONCLUSIONS: In this systematic review we present information relating to the effectiveness and safety of the following interventions: advocacy; career counselling plus critical consciousness awareness; cognitive behavioural counselling; cognitive trauma therapy; counselling; nurse support and guidance; peer support groups; safety planning; and shelters.

QUESTIONS

What are the effects of interventions initiated by healthcare professionals aimed at women victims of intimate partner violence? . . . 3

INTERVENTIONS

TREATMENT AND SUPPORT

Likely to be beneficial

Advocacy . . . 3

Career counselling plus critical consciousness awareness (more effective than career counselling alone) . . 8

Cognitive behavioural counselling versus no counselling . . . 5

Cognitive trauma therapy versus no treatment . . . 4

Peer support groups . . . 8

Safety planning . . . 9

Unknown effectiveness

Counselling (various types) versus no counselling . . 5

Different types of counselling versus each other (relative benefits unclear) . . . 6

Shelters . . . 10

Unlikely to be beneficial

Nurse support and guidance . . . 9

Key points

- Between 10% and 70% of women may have been physically or sexually assaulted by a partner at some stage, with reported assault rates against men about one quarter of the rate against women. In at least half of people studied, the problem lasts for 5 years or more.

  Intimate partner violence (IPV) has been associated with socioeconomic and personality factors, marital discord, exposure to violence in family of origin, and partner's drug or alcohol abuse.

  Women reporting IPV are more likely than other women to complain of poor physical or mental health, and of disability.

- Advocacy may reduce revictimisation rates compared with no treatment, but it may have low levels of acceptability.
- Cognitive trauma therapy may reduce post-traumatic stress disorder and depression compared with no treatment.
- Cognitive behavioural counselling may reduce minor physical or sexual IPV, both minor and severe psychological IPV and depression compared with no counselling.
- Career counselling plus critical consciousness awareness may increase a woman's confidence and awareness of the impact of IPV on her life compared with career counselling alone.
- We don't know whether other types of counselling are effective compared with no counselling. Although empowerment counselling seems to reduce trait anxiety, it does not seem to reduce current anxiety or depression or to improve self-esteem.
- We don't know how different types of counselling compare with each other.
- Peer support groups may improve psychological distress and decrease use of healthcare services compared with no intervention.
- Nurse support and guidance is probably unlikely to be beneficial in IPV
- Safety planning may reduce the rate of subsequent abuse in the short term, but longer-term benefit is unknown.
- We don't know whether the use of shelters reduces revictimisation, as we found little research.

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DEFINITION

Intimate partner violence (IPV) is actual or threatened physical or sexual violence, or emotional or psychological abuse (including coercive tactics), by a current or former spouse or dating partner (including same-sex partners).[1] Other terms commonly used to describe IPV include domestic violence, domestic abuse, spouse abuse, marital violence, and battering. This review only covers interventions in women currently experiencing IPV.

INCIDENCE/ PREVALENCE

Between 10% and 70% of women participating in population-based surveys in 48 countries reported being physically assaulted by a partner during their lifetime.[2] Rates of reported assault by a partner are 4.3 times higher among women than men.[3] Nearly 25% of surveyed women in the USA reported being physically or sexually assaulted, or both, by a current or former partner at some time, and 2% reported having been victimised during the previous 12 months.[3] Rates of violence against pregnant women range from 1% to 20%.[4] Between 12% and 25% of women in antenatal clinics[5] [6] [7] [8] and 6% to 17% of women in primary or ambulatory care reported having been abused by a partner in the past year.[9] [10] [11] [12]

AETIOLOGY/ RISK FACTORS

Two systematic reviews found that physical IPV towards women is associated with: unemployment and lower levels of education; low family income; marital discord; partner's lower level of occupation; childhood experiences of abuse; witnessing interparental violence; higher levels of anger, depression, or stress; heavy or problem drinking; drug use; jealousy; and lack of assertiveness with spouse.[13] [14] A similar review of research on psychological aggression found that the few demographic and psychological variables assessed were either inconsistently associated with psychological IPV or were found to be associated with psychological IPV in studies with serious methodological limitations.[15]

PROGNOSIS

A large longitudinal study of couples suggests that IPV tends to disappear over time within most relationships. However, couples reporting frequent or severe IPV are more likely to remain violent.[16] For all ethnic groups, half of those reporting moderate IPV did not report occurrences of IPV at 5-year follow-up; although, for people of black or Hispanic origin reporting severe IPV, only one third did not report occurrences of domestic violence at 5-year follow-up. A case control study conducted in middle-class working women found that, compared with non-abused women, women abused by their partners during the previous 9 years were significantly more likely to have or report headaches (48% of abused women *v* 35% of non-abused women), back pain (40% of abused women *v* 25% of non-abused women), STDs (6% of abused women *v* 2% of non-abused women), vaginal bleeding (17% of abused women *v* 6% of non-abused women), vaginal infections (30% of abused women *v* 21% of non-abused women), pelvic pain (17% of abused women *v* 9% of non-abused women), painful intercourse (13% of abused women *v* 7% of non-abused women), UTIs (22% of abused women *v* 12% of non-abused women), appetite loss (9% of abused women *v* 3% of non-abused women), digestive problems (35% of abused women *v* 19% of non-abused women), abdominal pain (22% of abused women *v* 11% of non-abused women), and facial injuries (8% of abused women *v* 1% of non-abused women).[17] After adjusting for age, race, insurance status, and cigarette smoking, a cross-sectional survey found that women experiencing psychological abuse are also more likely to report poor physical and mental health, disability preventing work, arthritis, chronic pain, migraine and other frequent headaches, STDs, chronic pelvic pain, stomach ulcers, spastic colon, frequent indigestion, diarrhoea, and constipation (see table 1, p 14).[18]

AIMS OF INTERVENTION

To improve quality of life and psychological and physical wellbeing; to reduce risk of physical and mental illness, injury, or death, with minimal adverse effects of treatment.

OUTCOMES

Reported rates of IPV (as defined above), mortality, non-fatal injuries, gynaecological and reproductive/obstetrical complications (e.g., chronic pelvic pain, miscarriage, or recurrent vaginal infections). **Psychological wellbeing** including chronic disorders that may have a psychosomatic component (e.g., chronic pain, sleep or eating disorders, or hypertension), and psychological conditions (e.g., depression, suicide, substance abuse, anxiety, low self-esteem, low self-efficacy, or poor assertiveness) associated with IPV, victims' self-esteem, coping, personal control, empowerment, perceived safety or fear, anxiety, stress, social support/isolation. **Recurrence of IPV (revictimisation),** quality of life, physical and functional status, and adverse effects of treatment. **Knowledge and utilisation of IPV services** and help-seeking behaviour, work days lost, jobs lost, self-sufficiency, or economic independence. Scales frequently used were the Severity of Violence Against Women Scale, Spielberger's 20-item State-Trait Anxiety Inventory, Hudson's Index of Self-esteem, Self-efficacy Scale, Modified Conflict Tactics Scale, Beck Depression Inventory, Index of Spouse Abuse Scale, Career-Search Self-Efficacy Scale, and Critical Consciousness of Domestic Violence Measure.

METHODS

Clinical Evidence search and appraisal September 2009. The following databases were used to identify studies for this systematic review (SR): Medline 1966 to September 2009, Embase 1980

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to September 2009, and The Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Clinical Trials 2009, Issue 3 (1966 to date of issue). An additional search was carried out of the NHS Centre for Reviews and Dissemination (CRD) — for Database of Abstracts of Reviews of Effects (DARE) and Health Technology Assessment (HTA). We also searched for retractions of studies included in the review. Abstracts of the studies retrieved from the initial search were assessed by an information specialist. Selected studies were then sent to the contributor for additional assessment, using pre-determined criteria to identify relevant studies. Study design criteria for inclusion in this review were: published SRs of RCTs/non-randomised trials and RCTs, controlled clinical trials (CCTs), cohort and case control studies in English or Spanish languages, and containing more than 20 individuals. There was no minimum length of follow-up required to include studies. We included all studies described as “blinded”, “open”, “open label”, or not blinded. We included SRs of RCTs/CCTs and individual RCTs, CCTs, cohort studies, and case control studies where harms of an included intervention were studied applying the same study design criteria for inclusion as we did of benefits. Couple interventions were included only if women participated regularly in the intervention and recurrence of violence or other outcomes among women were measured. Given the paucity of studies, none were excluded because of limitations in methods; however, when high non-participation, attrition, or high rates of loss to follow-up were found, we mention these studies in the comment sections. We examined SRs of the effectiveness of screening for IPV conducted by the US Preventive Services Task Force, [19] of the effectiveness of screening in emergency-department settings, [20] and of the effectiveness of advocacy interventions to reduce IPV published in the Cochrane Database of Systemic Reviews. [21] The two intervention studies cited in the US Preventive Services Task Force [19] review did not have comparison groups. The emergency department-screening SR [20] found no studies that met inclusion criteria for this review as none assessed health outcomes. The Cochrane review found no new RCTs that met our inclusion criteria. [21] To aid readability of the numerical data in our reviews, we round many percentages to the nearest whole number. Readers should be aware of this when relating percentages to summary statistics such as relative risks (RRs) and odds ratios (ORs). We have performed a GRADE evaluation of the quality of evidence for interventions included in this review (see table, p 16). The categorisation of the quality of the evidence (high, moderate, low, or very low) reflects the quality of evidence available for our chosen outcomes in our defined populations of interest. These categorisations are not necessarily a reflection of the overall methodological quality of any individual study, because the *Clinical Evidence* population and outcome of choice may represent only a small subset of the total outcomes reported, and population included, in any individual trial. For further details of how we perform the GRADE evaluation and the scoring system we use, please see our website (www.clinicalevidence.com).

QUESTION	What are the effects of interventions initiated by healthcare professionals aimed at women victims of intimate partner violence?

OPTION	ADVOCACY

Rates of IPV

Compared with counselling alone Unlimited counselling plus mentoring (similar to advocacy) may be more effective at reducing threats or rates of physical violence at 2 months' postpartum (low-quality evidence).

Compared with resource cards Unlimited counselling plus mentoring (similar to advocacy) may be no more effective at reducing threats or rates of physical violence at 2 months' postpartum (low-quality evidence).

Revictimisation

Compared with no treatment Advocacy may be more effective at reducing rates of revictimisation at 6 to 24 months (very low-quality evidence).

Quality of life

Compared with no treatment Advocacy is more effective at 24 months at improving quality of life in women living in shelters (moderate-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: **Advocacy versus no treatment:**

We found one systematic review (search date 2002), [22] one RCT, [23] and one additional controlled clinical trial (CCT). [24] The RCT (278 women leaving shelters) included in the review compared work with an undergraduate psychology student trained as an advocate (6.4 hours/week for 10 weeks) versus control. [23] The RCT found that, compared with baseline, advocacy significantly reduced psychological abuse and increased quality of life at 6, 12, 18, and 24 months' follow-up, but it found no significant change from baseline for depression. The RCT found no significant differences between groups for psychological abuse or depression (Center for Epidemiologic Studies

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Depression Scale [CES-D]), but found that advocacy significantly improved quality of life (P = 0.01) and reduced revictimisation at 24 months compared with control (revictimisation rate: 76% with advocacy *v* 89% among controls; P less than 0.01). The additional non-randomised controlled trial (81 women seeking temporary restraining orders who were not already represented by an attorney) allocated 22 women to law school advocates and 59 to standard court services without an advocate (see comment below). [24] Women assisted by advocates reported less physical (5% with advocacy *v* 25% without advocacy; P = 0.05) and psychological revictimisation (10% with advocacy *v* 47% without advocacy; P = 0.002) at 6 months of follow-up compared with women receiving standard court services.

Adding advocacy to counselling versus counselling alone or versus a resource card:
We found one systematic review (search date 2001, 1 CCT, [25] 290 pregnant Hispanic women). [26] The CCT compared three interventions: unlimited counselling plus a mentor (who might be considered to have acted as an advocate), unlimited counselling only, and a resource card. [25] Participants in all three groups reported a reduction in levels of violence and threats of violence at follow-up 2 months postpartum. The controlled trial found that women receiving unlimited counselling plus mentoring reported less physical violence than women receiving unlimited counselling only (mean on the Severity of Violence Against Women Scale adjusted for entry scores: 34.7 with counselling plus mentoring *v* 39.5 with counselling alone; P less than 0.05). There were no significant differences in outcomes for either treatment compared with women receiving only a resource card at 6-, 12-, or 18-month follow-up assessments (see table 2, p 14).

Harms: A potential harm for any intervention targeting victims of domestic violence is escalation of violence as a result of reprisal.

Advocacy versus no treatment:
The RCT included in the review and the additional non-randomised control trial gave no information on adverse effects. [23] [24]

Adding advocacy to counselling versus counselling alone or versus a resource card:
The CCT included in the systematic review gave no information on adverse effects. [25]

Comment: **Advocacy versus no treatment:**
In the additional CCT (81 women seeking restraining orders), 41% of those approached did not consent to participate. [24] An additional 13% did not appear for their first appointment. Assignment to the intervention group was based on women's acceptance of free legal representation from a law student. The RCT [23] evaluating the effect of advocacy for women leaving shelters, and the controlled trial involving women seeking restraining orders, utilised law school advocates in a legal setting (interventions not available in a healthcare setting). [24] Although referral to an advocate (usually available at community-based IPV services) at any time was considered an intervention to which a healthcare professional could potentially refer a victim, we don't know how far the effectiveness of these interventions for women leaving shelters or women seeking restraining orders can be generalised to women in other conditions.

OPTION — COGNITIVE TRAUMA THERAPY VERSUS NO TREATMENT

Psychological wellbeing
Compared with no treatment Cognitive trauma therapy may be more effective at reducing symptoms of post-traumatic stress disorder and depression at 6 weeks in battered women (low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found no systematic review. We found one RCT (125 battered women with post-traumatic stress disorder [PTSD] in Hawaii) comparing 8 and 17 twice-weekly sessions of cognitive trauma therapy (CTT) versus no-treatment control. [27] Women in the treatment group received CTT immediately after an initial assessment, while those in the control group received CTT 6 weeks after the initial assessment. The RCT did not compare groups directly. However, it found that, at 6 weeks, immediate CTT significantly improved symptoms of PTSD and depression from baseline, while there was no significant change in PTSD symptoms or depression from baseline in women who had not received CTT (PTSD scale score after immediate CTT: 72.9 before treatment *v* 15.8 after treatment; P less than 0.001; Beck Depression Inventory score: 25.1 before treatment *v* 4.6 after treatment; P less than 0.001). [27]

Harms: The RCT gave no information on adverse events. [27]

Comment: In the RCT the authors also conducted an intention-to-treat analysis and found a similar, although lower, effect size. [27]

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OPTION COGNITIVE BEHAVIOURAL COUNSELLING VERSUS NO COUNSELLING

Rates of IPV

Compared with single information session Cognitive behavioural counselling and empowerment may be more effective at decreasing physical, sexual, or psychological IPV at 3 months in battered women (low-quality evidence).

Psychological wellbeing

Compared with non-structured support group Cognitive behaviour-orientated therapy may improve assertiveness and reduce exposure to abuse (very low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found no systematic review but found one RCT [28] and one controlled clinical trial (CCT). [29] The RCT (34 women aged 18 or older) was in women currently enrolled in an outpatient methadone maintenance treatment programme reporting illicit drug use and exposure to physical aggression, sexual coercion, injury-related abuse, or severe psychological abuse by an intimate partner in the past 90 days. [28] It compared 12 sessions lasting 2 hours each (11 group sessions and one individual session) based on social cognitive behavioural and empowerment theories and techniques versus a single 1-hour informational session. At 3 months' follow-up, women in the social cognitive behavioural counselling group were more likely than women in the single informational session group to report decreases in physical or sexual IPV, minor psychological IPV, and severe psychological IPV (decrease in reporting of minor physical or sexual IPV: OR 7.1, 95% CI 1.00 to 49.81, P = 0.05; decrease in reporting of minor psychological IPV: OR 5.3, 95% CI 1.30 to 21.63, P = 0.03; decrease in reporting of severe psychological IPV: OR 6.07, P = 0.03; no confidence interval or absolute numbers reported). The CCT (20 women in Colombia, aged 19–50 years) compared 20 twice-weekly 3-hour sessions of CBT versus a non-structured support group. [29] Two women in the CBT group and four in the non-structured support group reported new episodes of IPV after the intervention began. The trial found that CBT significantly improved levels of assertiveness compared with baseline; P less than 0.05), whereas the control group did not. [29] Differences between treatments were not reported.

Harms: The RCT monitored participants for and detected none of the following adverse effects: embarrassment by self-disclosed information, distress caused by topics of discussion, breaches in confidentiality, and partner abuse attributed to participating in the intervention. [28] The CCT gave no information on adverse effects. [29]

Comment: None.

OPTION COUNSELLING (VARIOUS TYPES) VERSUS NO COUNSELLING

Rates of IPV

Compared with resource cards Counselling on its own or plus mentoring (similar to advocacy) may be no more effective at reducing severity of physical violence at 2 months' postpartum (very low-quality evidence).

Compared with no counselling Motivational interviewing maybe no more effective at reducing the rate of IPV at 3, 6 or 9 months in women with a history of incarceration at risk of HIV (low quality evidence).

Psychological wellbeing

Compared with no counselling Problem solving or empowerment may be more effective at reducing proneness to anxiety, but may be no more effective at reducing depression or state anxiety, or at increasing self-esteem (very low-quality evidence).

Utilisation of services

Compared with no counselling Counselling and no counselling may have similar rates of utilisation of medical care by battered women at 5 years (very low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found three systematic reviews (search dates 1997 [30] and 2001), [26] [31] which between them identified one cohort study [32] and one controlled clinical trial (CCT). [25]

We found one additional CCT [33] and one subsequent RCT. [34]

The cohort study (117 women) identified by the reviews evaluated an intervention consisting of emergency-department counselling by a social worker and psychiatrist, overnight hospital stay even if not warranted by injuries, counselling after release, and referrals to social and legal services offered to women self-identified as battered. [32] Women receiving counselling had similar rates of

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utilisation of somatic and psychiatric care during the 5-year period after treatment compared with those who declined treatment or withdrew. No numbers or descriptions of types of services were reported.

The CCT identified by the systematic reviews (290 pregnant Hispanic women) compared three clinic-based interventions: unlimited counselling, unlimited counselling plus a mentor, or a wallet-sized resource card. [25] Women were allocated to interventions depending on which month they attended which clinic. Clinics were randomly assigned to rotate between delivery of interventions, and this may have increased the possibility of contamination across groups. [25] Women in all three groups reported a decrease in levels of violence and threats of violence at follow-up 2 months postpartum, which was sustained through follow-up at 6, 12, and 18 months. The trial found no significant difference in severity of violence between either type of counselling and resource-card intervention (mean on the Severity of Violence Against Women Scale: 34.7 for counselling plus mentor *v* 39.5 for unlimited counselling only *v* 38.2 for resource card). Physical-violence and threats-of-violence scores remained consistently, but not significantly, lower at each follow-up for the counselling-plus-mentor group, whereas scores for women in the counselling-only group were consistently higher than those in the resource-card group (see table 2, p 14).

The additional CCT (33 women in 2 shelters in South Korea) compared problem-solving/empowerment group counselling versus no counselling. [33] The trial found that counselling significantly reduced anxiety-proneness scores (measured using Spielberger's 20-item State Trait Anxiety Inventory) compared with no counselling (change from before test to after test: –11.81 with treatment *v* –0.35 with control; P less than 0.01). There were no significant differences between groups in current levels of anxiety, self-esteem, or depression (anxiety: –9.88 with treatment *v* –9.35 with control; P = 0.91; self-esteem; measured using Rosenberg's Self-esteem Scale: 1.56 with treatment *v* 1.29 with control; P = 0.84; depression; measured using the Centers for Epidemiological Studies Depression [CES-D]: –13.31 with treatment *v* –5.76 with control; P = 0.13). [33]

The subsequent RCT (530 women with a history of incarceration or currently on probation or parole, and engaged in risk behaviours for HIV infection) compared three interventions: motivational interviewing for women aimed at reducing the risk of HIV (177 women), motivational interviewing for women aimed at reducing both the risk of HIV and IPV (175 women), and control (undefined, 175 women) at 3, 6, and 9 months' follow-up. [34] We only report the comparison and outcome of interest here, namely the effects on rates of IPV of motivational interviewing for women to reduce both the risk of HIV and IPV versus control. Women were recruited from law enforcement and community sources, and were screened and enrolled when they presented to a health department for HIV testing. Community health specialists implemented 12 motivational interviewing sessions to the intervention group. The aim of motivational interviewing was to increase awareness, self-efficacy, and readiness to reduce risk of both HIV and IPV, with the hypothesis that there is a relationship between violence and an increased risk of HIV. Although both women in the intervention group and in the control group reported a decrease in IPV at all three follow-up assessments using a modified Conflict Tactics scale (CTS2), the RCT found no significant difference between motivational interviewing to reduce HIV and IPV and control in rates of IPV at 3, 6, or 9 months (at 3 months: OR 0.91, 95% CI 0.38 to 2.20; at 6 months: OR 0.89, 95% CI 0.34 to 2.30; at 9 months: 0.86, 95% CI 0.33 to 2.22; no absolute numbers reported). [34]

Harms: The cohort study, [32] CCTs, [25] [33] and RCT [34] gave no information on adverse effects.

Comment: The trial conducted in South Korea, comparing a group problem-solving/empowering intervention versus no intervention, had high withdrawal rates (47% with intervention *v* 43% with no intervention). [33]

OPTION DIFFERENT TYPES OF COUNSELLING VERSUS EACH OTHER

Rates of IPV

Compared with individual counselling Group counselling may be no more effective than individual couple counselling at reducing physical violence (very low-quality evidence).

Psychological wellbeing

Compared with group counselling Gender-specific counselling may be no more effective at reducing physical violence at 6 months (low-quality evidence).

Compared with feminist-orientated counselling We don’t know whether grief resolution-orientated counselling may be more effective at improving self-esteem or self-efficacy in battered women (very low-quality evidence).

Compared with individual counselling Group counselling may be no more effective than individual couples counselling at improving psychological wellbeing (very low-quality evidence).

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Compared with group counselling Gender-specific counselling may be no more effective than couples group counselling at reducing physical and psychological aggressive behaviour, and wives' depression (very low-quality evidence).

Revictimisation

Compared with individual counselling We don't know whether group counselling may be more effective than individual couples counselling at reducing rates of revictimisation (very low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits:

Grief resolution-orientated counselling versus feminist-orientated counselling:
We found one systematic review (search date 2001, one quasi-randomised trial, 20 women).[26] The trial included in the review[35] alternately allocated women requesting counselling at a battered women's programme to grief resolution- or feminist-orientated individual counselling for 8 weeks (see comment below). Women in both groups improved based on pre–post evaluation with Hudson's Index of Self-esteem and a Self-efficacy Scale. Pre–post score differences were statistically significant for self-esteem and self-efficacy only for women in the grief resolution-orientated group (self-esteem: 66.9 before treatment *v* 53.5 after treatment; P less than 0.01; self-efficacy: 63.3 before treatment *v* 74.7 after treatment; P less than 0.01). There were no significant changes in self-esteem and self-efficacy from baseline for women in the feminist-orientated group (self-esteem: 45.7 before treatment *v* 39.5 after treatment; self-efficacy: 68.4 before treatment *v* 77.7 after treatment; P values reported as not significant). Differences between treatments were not reported.

Group counselling versus individual couples counselling:
We found one systematic review (search date 1997, one controlled clinical trial [CCT], 68 couples)[30] and one subsequent CCT.[36] The CCT included in the review found similar rates of physical violence and similar psychological wellbeing between group and individual couple interventions. Withdrawal rates were higher in the group programme.[30]

The subsequent CCT (42 couples who had chosen to stay together after mild to moderate IPV) compared group or individual couple counselling (12 sessions) versus no counselling.[36] The trial found that group couple counselling significantly reduced rates of reported revictimisation after 6 months compared with no counselling, whereas individual couple counselling did not significantly reduce revictimisation (6-month revictimisation rate: 67% with no counselling *v* 43% with individual couple counselling *v* 25% with group couple counselling; P greater than 0.25 for individual couple counselling *v* no counselling; P less than 0.05 for group couple counselling *v* no counselling).[36] The trial did not provide a between-group analysis for group compared with individual couple counselling.

Gender-specific versus couples group counselling:
We found no systematic review. We found one RCT (49 couples)[37] and one CCT (124 couples)[38] comparing gender-specific group counselling versus group couple counselling. In the RCT, couples who indicated a desire to remain in their current relationship were randomly assigned to gender-specific counselling or couple counselling.[37] The RCT found no significant difference between type of counselling in victims' reports of subsequent physical violence at 6-month follow-up (reports: 7% with gender-specific therapy *v* 8% with couple therapy; P = 0.91).[37]

In the CCT, volunteer married and intact couples who reported at least two acts of husband-to-wife physical aggression (75 couples) — excluding couples with alcohol dependence, mental illness, and who reported severe injuries, or women who feared their partner — were alternately assigned to couple therapy or gender-specific therapy.[38] The trial found that both types of counselling reduced the prevalence of husband-to-wife physical aggression from baseline over 12 months (aggression on the Modified Conflict Tactics Scale: 100% before treatment *v* 74% after treatment; P less than 0.01). Both types of counselling significantly reduced scores of husband-to-wife psychological aggression, mild aggression, severe aggression, and wives' depression from baseline over 12 months (husband-to-wife psychological aggression: 93.37 before treatment *v* 44.79 after treatment; P less than 0.005; mild aggression: 19.31 before treatment *v* 8.63 after treatment; P less than 0.001; severe aggression: 3.34 before treatment *v* 1.71 after treatment; P less than 0.05; wives' depression; wives' depression on the Beck Depression Inventory score: 12.39 before treatment *v* 8.79 after treatment; P less than 0.005).[38] There was no significant difference between treatments in husband-to-wife physical or psychological aggression (see comment below).

Harms:

A potential harm of any intervention targeting victims of IPV is escalation of violence as a result of reprisal.

Grief resolution-orientated counselling versus feminist-orientated counselling:
The systematic review and the quasi-randomised trial gave no information on adverse events.[26][35]

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Group counselling versus individual couple counselling:
The systematic review [30] and subsequent controlled trial [36] gave no information on adverse effects.

Gender-specific versus couples group counselling:
The RCT reported that qualitative assessment of weekly reports did not support the belief that women who received couple counselling were placed in any further danger than those who attended individual therapy. [37] In the CCT comparing gender-specific counselling versus couple counselling, women reported that physical aggression resulted from content discussed in 2% of the sessions, with equivalent rates in both treatment groups. [38]

Comment: In the quasi-randomised trial comparing grief-orientated versus feminist-orientated counselling, the scoring range was unclear, and the authors did not indicate whether the original 14-point Likert scale was used. [35] In the first trial comparing gender-specific interventions versus couple intervention, 18% of people declined to participate and 38% were lost to follow-up. In the second trial comparing gender-specific interventions versus couple intervention, two-thirds of eligible couples declined to participate. [38] In addition, 67% of the participants withdrew before follow-up.

OPTION CAREER COUNSELLING PLUS CRITICAL CONSCIOUSNESS AWARENESS

Psychological wellbeing
Compared with career counselling alone Career counselling plus activities to facilitate awareness and understanding of the impact of IPV on career development and power dynamics may be more effective at increasing critical consciousness and confidence in performing career-search tasks in women who have experienced IPV, but may be no more effective at increasing progress towards career-search self-efficacy at 5 weeks (low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found no systematic review. We found one RCT (72 women who had experienced IPV, recruited from an urban community) comparing three interventions: five 2-hour group sessions of standard career counselling; standard career counselling plus activities to facilitate critical consciousness awareness and understanding of the impact of IPV on career development and power dynamics in their lives; and no treatment. [39] Standard career counselling was designed to facilitate exploration of career interests and goals, development of career skills, and knowledge and use of community resources. At 5 weeks' follow-up post-intervention, women receiving career counselling plus critical consciousness awareness had significantly higher critical consciousness of domestic violence (CCDV) scores compared with women receiving career counselling alone (CCDV score: 93.2 with standard plus counselling *v* 85.2 with standard counselling; P = 0.02). There was no significant difference between groups in progress towards career search self-efficacy (CSES) (CSES score: 222 with standard plus counselling *v* 226 with standard counselling; P = 0.57).

Harms: The RCT did not assess adverse effects of treatment. [39]

Comment: In the RCT, 45% of those recruited did not participate; only 46% of those recruited were assessed post-intervention, and 32% of those were assessed at the 5-week follow-up post-intervention. Only the two intervention groups were compared at the 5-week post-intervention follow-up. Participants were paid for completing the study. [39]

OPTION PEER SUPPORT GROUPS

Psychological wellbeing
Compared with no support We don't know whether peer support groups may be more effective at reducing psychological distress in women in domestic-violence shelters compared with no structured support groups (low-quality evidence).

Utilisation of services
Compared with no support We don't know whether peer support groups may be more effective at decreasing utilisation of healthcare services or perceived social support by women in domestic-violence shelters compared with no structured support groups (low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found one RCT (24 female first-time residents in a domestic-violence unit, 71% non-Hispanic white). [40] It compared a 90-minute peer support group session once a week for 8 weeks facilitated by a trained nurse and structured to promote a sense of belonging and provide affection, affirmation, and tangible aid, versus free-flowing chat sessions with no structure. Comparisons of change in pre–post assessments found significant differences in perceived availability of social support (difference in change from baseline mean on the Interpersonal Self Evaluation List (ISEL): 35.4;

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P = 0.013), psychological distress (difference in change from baseline mean on the Brief Symptom Inventory : –15.2; P = 0.016), and decreased utilisation of healthcare services (difference in change from baseline mean on the Health Screening Questionnaire (HSQ): –60.2; P = 0.032; see comment below).

Harms: The RCT gave no information on adverse effects. [40]

Comment: The *Clinical Evidence* contributors were unable to access the HSQ for further analysis of the reported score used in the trial.

OPTION NURSE SUPPORT AND GUIDANCE

Rate of IPV

Compared with no support Nurse support and guidance is no more effective at reducing threats of assaults, assaults, danger risks for homicide, work harassment, safety behaviour, and stress, in women subjected to IPV (moderate-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found no systematic review, but found two RCTs. The first RCT recruited women in two primary care public health clinics and two Women, Infants, and Children clinics in a large urban area (360 women, 50% Hispanic). [41] It compared four sessions (at 6-month intervals) of nurse support and guidance on safety behaviours and available resources versus a card listing a safety plan and resources for IPV services. At 2 years' follow-up, both treatment groups reported fewer threats of assault, assaults, danger risks for homicide, and events of work harassment, and reported increases in safety behaviours compared with baseline. However, the differences between groups were not significant (mean decrease in both groups on observed scale score from baseline: threats of abuse 14.5, 95% CI 12.6 to 16.4; assaults: 15.5, 95% CI 13.5 to 17.4; danger risks for homicide: 2.6, 95% CI 2.1 to 3; work harassment: 2.7, 95% CI 2.3 to 3.1; practised safety behaviours: 2, 95% CI 1.6 to 2.3; P less than 0.001 for all comparisons; absolute numbers not reported).

The second RCT (207 women attending antenatal clinics, 75% non-Hispanic white) compared nurse support with no support. [42] Women were categorised as high risk because of exposure to IPV or high stress score (116 women). Women in the nurse support group were contacted by nurses on average 22 times for 4 hours to provide emotional support and guidance on pregnancy, parenting, or other needs. Women in the control group received a card listing a safety plan and resources for IPV. At 11 weeks' follow-up, stress scores decreased for both groups compared with baseline; however, the differences were not significant between groups (total stress score: 19.67 with nurse support *v* 21.73 with control; P reported as not significant).

Harms: The first RCT reported no adverse effects due to the interventions. [41] The second RCT did not assess adverse effects. [42]

Comment: None.

OPTION SAFETY PLANNING

Rates of IPV

Compared with control Safety planning may be more effective at improving safety behaviour (decreasing role limitation, number of threats, actual violence, physical and psychological abuse) and in increasing positive effects of helping women develop a safety plan on health, and on revictimisation (moderate-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found one systematic review (search date 2002, 2 controlled clinical trials [CCTs]) [22] and one subsequent RCT. [43] The first CCT included in the review (150 English- and Spanish-speaking women recruited from a family-violence unit in an urban District Attorney's office, 2 publications) compared standard services offered by the District Attorney's office versus standard services plus six telephone sessions on safety behaviours. [44] [45] The CCT found that additional sessions on safety improved safety behaviour compared with usual care at 3, 6, 12, and 18 months (P less than 0.01; safety behaviours were assessed using the Safety Behaviour Checklist of 15 behaviours, adjusted for relevance [e.g., if no firearms were in the home, then using the safety behaviour of removing the firearm was not applicable]; mean increase of 2.0 safety behaviours for sessions *v* usual care at 3 months and 1.5 at 18 months; effect size 0.91 at 3 months and 0.56 at 18 months). [45]

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The second CCT included in the review (199 pregnant women attending public antenatal clinics who had been physically or sexually assaulted in the past year by their partner) compared standard antenatal care (67 women) versus safety planning (132 women). [46] Women in the standard-care group received a wallet-sized resource card with information on community resources. In the safety-planning group, trained nurses helped participants prepare a safety plan and provided them with information on applying for legal protection orders and filing for criminal charges, as well as community-resource telephone numbers. This information was provided during three evenly spaced sessions throughout pregnancy, and was reinforced with a brochure at the end of each session. After adjusting for entry levels of violence, women in the safety-planning group reported less ongoing physical and non-physical abuse on the Index of Spouse Abuse Scale at 12 months (score: 37.6 with safety planning intervention *v* 56.9 with usual care; P = 0.007). The trial also found that safety planning reduced the number of threats and instances of actual violence on the Severity of Violence Against Women Scale at 6 and 12 months (threats score at 6 months: 27.3 with safety planning *v* 33.4 with usual care; actual violence at 6 months: 33.1 with safety planning *v* 35.9 with usual care; threats score at 12 months: 27.0 with safety planning *v* 33.6 with usual care; actual violence at 12 months: 32.6 with safety planning *v* 37.1 with usual care) compared with women in the usual-care group (P = 0.052), although it is unclear to which comparison the statistical test refers. At 12 months, women in the safety-planning group had used significantly more relevant safety behaviours than women in the control group (P less than 0.001). [46]

The subsequent RCT (106 pregnant women screened for exposure to IPV in Hong Kong) compared a 30-minute session providing advice on safety planning, choice making, and problem solving, as well as empathic listening, versus a wallet-sized card with information on available resources. [43] It found that, compared with the wallet card, the safety-planning session significantly improved higher physical functioning (mean difference on the Short Form Health Survey-36 (SF-36): 10; P less than 0.05), and reduced role limitation (mean difference on the SF-36: 19; P less than 0.05), postnatal depression (OR: 0.36, 95% CI 0.15 to 0.88), psychological abuse (mean difference on the Modified Conflict Tactics Scale (CTS2): –1.1; P less than 0.05), and minor physical violence (mean difference on the CTS2: –1.0; P less than 0.05). However, there were no significant differences in severe physical abuse or sexual abuse, and the women in the safety-planning group reported significantly more bodily pain (mean difference on the SF-36: –13; P less than 0.05; see table 3, p 15).

Harms: The review did not report any harms. [22] A potential harm for any intervention targeting victims of IPV is escalation of violence as a result of reprisal. In the trial conducted in the District Attorney's office, one woman committed suicide after 3 weeks. The study did not report which treatment she was assigned and it is not clear whether the suicide was related to treatment. [44] [45] The subsequent RCT found no adverse events for any of the three interventions after questioning women at follow-up about whether the violence had increased since the baseline interview. [43]

Comment: The first CCT recruited people from a District Attorney's office — a setting to which healthcare providers may refer women who have experienced IPV. [44] Less than 3% of eligible women refused to participate (4/154). Nearly all women completed the study at 18 months (149/150). At baseline, women in the intervention group reported 0.8 more safety behaviours than women in the control group. The occurrence of IPV during the trial was not assessed. The intervention ceased at 8 weeks, and a subsequent assessment of effect size showed a decrease between 3 to 18 months. The authors noted that this may reflect a ceiling effect or a need for reinforcement with additional intervention services. In one of the CCTs, the intervention group was recruited during antenatal care, whereas the comparison group was recruited postpartum. [46] The influence of different periods of recruitment on recall of abuse was not explored.

OPTION SHELTERS

Rates of IPV

Compared with no shelters Staying in a shelter and engaging in a help-seeking behaviour may be more effective at reducing the risk of new violence compared with not choosing to stay in a shelter (very low-quality evidence).

For GRADE evaluation of interventions for intimate partner violence towards women, see table, p 16 .

Benefits: We found one systematic review (search date 1997), [30] which identified one cohort study (243 women in total, some voluntarily going to a shelter and others sent by the prosecutors' office) compared outcomes for those who chose to stay at the shelter (from 1 to 30 days) with those who chose not to stay. [47] The cohort study found that women who stayed at the shelter, and who engaged in at least one other type of help-seeking behaviour, were at lower risk of new violence compared with those not using the shelter (OR 0.6, CI not reported; P less than 0.05). Women who did not seek any other help were more likely (though not significantly) to experience new episodes of violence during the 6 weeks after leaving the shelter (OR 1.8, CI not reported; P = 0.13; after

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adjusting for initial risk of violence, days outside the shelter, and attrition). In the study, help-seeking behaviour was defined as the number of distinct kinds of help-seeking actions taken during the 6 months before the baseline interview, and included previous shelter stay, calling the police, seeking a restraining order, seeking criminal justice prosecution, seeking counselling, and trying to get help from legal aid or a private attorney. [47]

Harms: We found no RCTs.

Comment: None.

GLOSSARY

Advocacy involves providing information to a client on her legal, medical, and financial options; facilitating her access to and use of community resources such as shelters, counselling, and protection orders; accessing and mobilising her natural support networks; assisting in goal setting and making choices; validating her feelings of being victimised; and providing emotional support. [6]

Controlled clinical trial a study that compares experimental treatment(s) with a placebo/no treatment or other treatment, but is not randomised.

Counselling usually involves professional guidance in solving a client's problems. Counselling services tend to focus on providing information rather than the use of psychological techniques. However, counselling, as used in one of the controlled trials referred to above, [33] may also include referral to services and assistance in accessing these services (overlapping with advocacy).

Safety planning helps participants to identify behaviours that might signal increased danger and prepare, ahead of time, codes of communication with family or friends, as well as needed documents, keys, and clothing should a quick exit become necessary.

Shelters provide housing, food, and clothing, usually for 30–90 days, to victims and their children under 12 years of age who leave their abuser. Many shelters also offer individual or group therapy or counselling, advocacy, child care, job training, and assistance in finding transitional housing.

Beck Depression Inventory is a 21-item ordinal scale of symptoms of depression. Scores less than 10 are normal or minimal depression: 10–18 indicates mild to moderate depression, 19–29 indicates moderate to severe depression and greater than 30 indicates severe depression. A short version has 13 items; scores above 4 indicate increasing levels of depression.

Brief Symptom Inventory (BSI) is a 53-item 5-point rating scale with nine symptom constructs: somatisation, obsessive-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Scores vary from 0 to 212.

Career-Search Self-Efficacy Scale (CSES) is a 35-item 10-point Likert scale of an individual's confidence in performing career-search tasks. Scores range from 0 to 315, with higher scores indicating greater self-efficacy.

Centers for Epidemiological Studies Depression (CES-D) Scale 20-item 4-point Likert scale, with scores that range from 0 to 60. Higher scores indicate more symptoms of depression.

Critical Consciousness of Domestic Violence Measure (CCDV) is a 20-item 6-point Likert scale measuring the degree to which respondents are aware of the impact of intimate partner violence in their lives, and the skills and power they possess to exert control over their lives. Scores range from 0 to 100, with higher scores indicating higher critical consciousness.

Health Screening Questionnaire (HSQ) is a 21-item self-report of medical and surgical history, visits to health clinics, health providers, hospital emergency, and inpatient and outpatient departments.

Hudson's Index of Self-esteem scores vary from 0 to 100. Higher scores indicate lower self-esteem.

Index of Spouse Abuse Scale is a 30-item, self-report scale measuring the frequency with which respondents have experienced 11 types of physical abuse and 19 types of non-physical abuse inflicted by a male partner. In scoring the measure, items are weighted differentially based on severity. Scores range from 0 to 100 on each subscale, with high scores indicating high frequency of severe abuse and low scores indicating relative absence of abuse.

Interpersonal Self Evaluation List (ISEL) is a 16-item, 4-point rating scale measuring the perceived availability of the four functions of social support.

Low-quality evidence Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Moderate-quality evidence Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Modified Conflict Tactics Scale (CTS2) has 78 items measuring the frequency (on an 8-point scale ranging from never to more than 20 times) with which partners engage in psychological and physical attacks on each other.

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Peer support group Sometimes facilitated by a professional, peer support groups are hypothesised to help women exposed to domestic violence by reducing social isolation (risk factor for or effect of domestic violence) and providing affection, affirmation, a sense of belonging, and tangible aid.

Rosenberg's Self-esteem Scale A 10-item scale with a 4-point response format resulting in a score range of 10–40, with higher scores representing higher self-esteem.

Self-efficacy Scale scores on the original 23-item scale vary from 14 to 322, with a mean of 230 ± 39. Higher scores indicate higher self-efficacy. [29]

Severity of Violence Against Women Scale scores on the physical violence component range from 27 to 108, where 27 would equal never being exposed to any of the behaviours and 108 would equal being exposed many times to all of the behaviours in the inventory.

Short Form Health Survey (SF-36) is a 36-item scale measuring general health, mental health, physical function, social functioning, bodily pain, and role limitation owing to physical health problems or emotional health problems. Standardised scores range from 0 to 100.

Social Cognitive Behavioural Counselling utilises a combination of techniques to restructure an individual's thinking patterns and help them learn new behaviours through discussion, modelling, role-play, and reinforcement.

Spielberger's 20-item State-trait Anxiety Inventory scores range from 20 to 80, where 20 equals not feeling like that at all (state anxiety) or ever (trait anxiety) and 80 would equal feeling like that very much (state anxiety) or always (trait anxiety).

Very low-quality evidence Any estimate of effect is very uncertain.

SUBSTANTIVE CHANGES

Counselling (various types) versus no counselling: One RCT added comparing three interventions: motivational interviewing for women aimed at reducing the risk of HIV, motivational interviewing for women aimed at reducing both the risk of HIV and IPV, and control. [34] The RCT found no difference between motivational interviewing to reduce HIV and IPV in of rates of intimate partner violence at 3, 6, or 9 months compared with control. [34] Categorisation unchanged (Unknown effectiveness) as there remains insufficient good-quality evidence to assess the effect of counselling on rates of IPV.

REFERENCES

1. National Center for Injury Prevention and Control. *Injury fact book 2001–2002*. Atlanta, GA: Centers for Disease Control and Prevention, 2001.
2. Krug EG, Dahlberg LL, Mercy JA, et al. *World report on violence and health.* Geneva: World Health Organization, 2002.
3. Tjaden P, Thoennes N. *Full report of the prevalence, incidence, and consequences of violence against women.* Washington, DC: National Institute of Justice, 2000.
4. Gazmarian JA, Lazorick S, Spitz AM, et al. Prevalence of violence against pregnant women. *JAMA* 1996;275:1915–1920.[PubMed]
5. Savona-Ventura C, Savona-Ventura M, Dregsted-Nielsen S, et al. Domestic abuse in a central Mediterranean pregnant population. *Eur J Obstet Gynecol Reprod Biol* 2001;98:3–8.[PubMed]
6. Purwar MB, Jeyaseelan L, Varhadpande U, et al. Survey of physical abuse during pregnancy GMCH, Nagpur, India. *J Obstet Gynaecol Res* 1999;25:165–171.[PubMed]
7. Lueng WC, Lueng TW, Lam YY, et al. The prevalence of domestic violence against pregnant women in a Chinese community. *Int J Gynaecol Obstet* 1999;66:23–30.[PubMed]
8. Hedin LW, Grimstad H, Moller A, et al. Prevalence of physical and sexual abuse before and during pregnancy among Swedish couples. *Acta Obstet Gynecol Scand* 1999;78:310–315.[PubMed]
9. Bauer H, Rodriguez MA, Perez-Stable EJ. Prevalence and determinants of intimate partner abuse among public hospital primary care patients. *J Gen Intern Med* 2000;15:811–817.[PubMed]
10. Richardson J, Coid J, Petruckevitch A, et al. Identifying domestic violence: cross-sectional study in primary care. *BMJ* 2002;324:271–277.[PubMed]
11. McCauley J, Kern DE, Kolodner K, et al. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med* 1995;123:737–746.[PubMed]
12. Gin NE, Ruker L, Frayne S, et al. Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. *J Gen Intern Med* 1991;6:317–322.[PubMed]
13. Schumacher JA, Felbau-Kohn S, Smith-Slep AM, et al. Risk factors for male to female physical abuse. *Aggress Violent Behav* 2001;6:281–352.
14. Stith S, Tritt D, Smith B, et al. Intimate partner physical abuse perpetration and victimization risk factors: a meta-analytic review. *Aggress Violent Behav* 2004;10:65–98.
15. Schumacher JA, Smith-Slep AM, Heyman RE. Risk factors for male-to-female psychological abuse. *Aggress Violent Behav* 2001;6:255–268.
16. Caetano R, Schafer J, Fals-Stewart W. Stability and change in intimate partner violence and drinking among white, black, and Hispanic couples over a 5-year interval. *Alcohol Clin Exp Res* 2003;27:292–300.[PubMed]
17. Campbell J, Jones AS, Dienemann J, et al. Intimate partner violence and physical health consequences. *Arch Intern Med* 2002;162:1157–1163.[PubMed]
18. Coker AL, Smith PH, Bethea L, et al. Physical health consequences of physical and psychological intimate partner violence. *Arch Fam Med* 2000;9:451–457.[PubMed]
19. Nelson HD, Nygren P, McInerney Y, et al. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U. S. Preventive Services Task Force. *Ann Intern Med* 2004;140:387–396.[PubMed]
20. Anglin D, Sachs C. Preventive care in the emergency department: screening for domestic violence in the emergency department. *Acad Emerg Med* 2003;10:1118–1127. [PubMed]
21. Ramsay J, Carter Y, Davidson L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. In: The Cochrane Library, Issue 3, 2009. Chichester, UK: John Wiley & Sons, Ltd.[PubMed]
22. Wathen C, MacMillan H. Interventions for violence against women: scientific review. *JAMA* 2003;289:589–600. Search date 2002.[PubMed]
23. Sullivan CM, Bybee DI. Reducing violence using community based advocacy for women with abusive partners. *J Consult Clin Psychol* 1999;67:43–53.[PubMed]
24. Bell ME, Goodman LA. Supporting battered women involved with the court system: an evaluation of a law school-based advocacy intervention. *Violence Women* 2001;7:1377–1404.
25. McFarlane J, Soeken K, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nurs* 2000;17:443–451.[PubMed]
26. Centre for Clinical Effectiveness. Is therapy/counseling/group work more effective than no treatment for women who are victims of domestic violence? Melbourne: Southern Health/Monash Institute of Public Health, 2001. Search date 2001.
27. Kubany ES, Hill EE, Owens JA, et al. Cognitive trauma therapy for battered women with PTSD (CTT-BW). *J Consult Clin Psychol* 2004;72:3–18.[PubMed]
28. Gilbert L, El-Bassel N, Manuel J, et al. An integrated relapse prevention and relationship safety intervention for women on methadone: testing short-term effects on intimate partner violence and substance use. *Violence Vict* 2006;21:657–672.[PubMed]
29. Laverde DI. Effects of cognitive-behavioural therapy in controlling wife abuse. *Rev Anal Comp* 1987;3:193–200. [In Spanish]
30. Chalk R, King PA (eds). *Violence in families. Assessing prevention and treatment programs.* Washington, DC: National Academy Press, 1998. Search date 1997.
31. Ramsay J, Richardson J, Carter Y, et al. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002;325:314–327. Search date 2001.[PubMed]
32. Bergman B, Brismar B. A 5-year follow-up of 117 battered women. *Am J Public Health* 1991;81:1486–1489.[PubMed]
33. Kim S, Kim J. The effects of group intervention for battered women in Korea. *Arch Psychiatr Nurs* 2001;15:257–264.[PubMed]
34. Weir BW, O'Brien K, Bard RS, et al. Reducing hiv and partner violence risk among women with criminal justice system involvement: a randomized controlled trial

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of two motivational interviewing-based interventions. *AIDS Behav* 2009;13:509–522.[PubMed]

35. Mancoske RJ, Standifer D, Cauley C. The effectiveness of brief counseling services for battered women. *Res Soc Work Pract* 1994;4:53–63.
36. Stith SM, Rosen KH, McCollum EE, et al. Treating intimate partner violence within intact couple relationships: outcomes of multi-couple versus individual couple therapy. *J Marital Fam Ther* 2004;30:305–318.[PubMed]
37. Brannen SJ, Rubin A. Comparing the effectiveness of gender-specific and couples groups in court-mandated spouse abuse treatment program. *Res Soc Work Pract* 1996;6:405–424.
38. O'Leary KD, Heyman RE, Neidig PH. Treatment of wife abuse: a comparison of gender-specific and conjoint approaches. *Behav Ther* 1999;30:475–505.
39. Chronister KM, McWhirter EH. An experimental examination of two career interventions for battered women. *J Counseling Psychol* 2006;53:151–164.
40. Constantino R, Kim Y, Crane PA. Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: a pilot study. *Issues Ment Health Nurs* 2005;26:575–590.[PubMed]
41. McFarlane JM, Groff JY, O'Brien JA, et al. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nurs Res* 2006;55:52–61.
42. Curry MA, Durham L, Bullock L, et al. Nurse case management for pregnant women experiencing or at risk for abuse. *J Obstet Gynecol Neonat Nurs* 2006;3:35:181–192.[PubMed]
43. Tiwari A, Leung WC, Leung TW, et al. A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong King. *BJOG* 2005;112:1249–1256.[PubMed]
44. McFarlane J, Malecha A, Gist J, et al. An intervention to increase safety behaviours of abused women: results of a randomised clinical trial. *Nurs Res* 2002;51:347–354.[PubMed]
45. McFarlane J, Malecha A, Gist J, et al. Increasing the safety-promoting behaviours of abused women. *Am J Nurs* 2004;104:40–50.[PubMed]
46. Parker B, McFarlane J, Soeken K, et al. Testing an intervention to prevent further abuse to pregnant women. *Res Nurs Health* 1999;22:59–66.[PubMed]
47. Berk RD, Newton PJ, Berk SF. What a difference a day makes: an empirical study of the impact of shelters for battered women. *J Marriage Fam* 1986;48:481–490.

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TABLE 1 **Risks for reported conditions in women experiencing psychological abuse.** [18]

	Prevalence of intimate partner violence (%)		
Complaint	**Ever**	**Never**	**RR (95% CI)**
Poor physical health	28	17	1.69 (1.20 to 2.29)
Poor mental health	23	9	1.74 (1.07 to 2.73)
Disability preventing work	28	15	1.49 (1.06 to 2.14)
Arthritis	31	20	1.67 (0.20 to 2.22)
Chronic pain	38	22	1.91 (1.49 to 2.36)
Migraine	37	24	1.54 (1.16 to 1.93)
Other frequent headaches	29	22	1.41 (1.05 to 1.82)
STDs	30	10	1.82 (1.19 to 2.68)
Chronic pelvic pain	17	9	1.62 (1.03 to 2.48)
Stomach ulcers	15	8	1.72 (1.02 to 2.84)
Spastic colon	7	3	3.62 (1.63 to 7.50)
Frequent indigestion, diarrhoea, or constipation	45	28	1.30 (1.03 to 1.63)

TABLE 2 **Scores of threats of violence/physical violence for all interventions.** [25]

	Time of score				
Type of intervention	**Entry**	**2 months**	**6 months**	**12 months**	**18 months**
Counselling plus mentor	34.1 45.0	28.4 35.0	26.4 33.8	27.3 34.6	26.5 33.2
Counselling only	36.1 46.0	30.7 39.8	28.6 37.1	29.2 36.9	28.3 34.1
Resource card	35.6 45.4	28.1 36.1	26.7 35.4	27.0 36.2	27.3 36.1

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TABLE 3 CTS2 and SF-36 mean scores for both groups after the interventions. [43]

Scales	Safety planning group mean (SD)	Resource card group mean (SD)	Mean difference (95% CI)
CTS2			
Psychological abuse	0.79 (1.00)	1.6 (2.2)	–1.10 (–2.20 to –0.04)*
Minor physical violence	0.05 (0.40)	0.51 (1.30)	–1.00 (–1.80 to –0.17)*
Severe physical violence	0.25 (1.20)	0.17 (0.54)	+0.08 (–0.26 to +0.42)
Sexual abuse	0.03 (0.11)	0.12 (0.55)	–0.07 (–0.30 to +0.16)
SF-36			
Physical functioning	90 (15)	80 (20)	10.0 (2.5 to 18.0)*
Role — physical	73 (38)	45 (40)	19.0 (1.5 to 37.0)*
Bodily pain	14 (19)	27 (25)	–13.0 (–23.0 to –2.2)*
General health	50.0 (7.0)	50.0 (7.5)	–1.3 (–6.4 to +3.9)
Vitality	55 (11)	55 (13)	+0.45 (–5.40 to +6.30)
Social functioning	49 (12)	43 (15)	+3.1 (–4.3 to +11.0)
Role emotional	77 (370)	47 (43)	28 (9 to 47)*
Mental health	60.0 (2.4)	64 (10)	+0.28 (–4.40 to +5.00)

CTS2, Modified Conflict Tactics Scale; SD, standard deviation; SF-36, short form-36. *Significant at the 5% level.

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TABLE GRADE evaluation of interventions for intimate partner violence

Important outcomes	Rates of IPV. Revictimisation, Utilisation of services, Quality of life, Mortality, Adverse effects								
Number of studies (participants)	**Outcome**	**Comparison**	**Type of evidence**	**Quality**	**Consistency**	**Directness**	**Effect size**	**GRADE**	**Comment**
What are the effects of interventions initiated by healthcare professionals aimed at female victims of intimate partner violence?									
1 (290) [25]	Rates of IPV	Adding advocacy to counselling *v* counselling alone	2	0	0	0	0	Low	
1 (290) [25]	Rates of IPV	Adding advocacy to counselling *v* resource cards	2	0	0	0	0	Low	
2 (359) [24] [23]	Revictimisation	Advocacy *v* no treatment	4	–2	0	–1	0	Very low	Quality points deducted for inclusion of controlled clinical trial (CCT) and incomplete reporting of results. Directness point deducted for data only in specialised population and environment
1 (278) [23]	Quality of life	Advocacy *v* no treatment	4	0	0	–1	0	Moderate	Directness point deducted for data only in specialised population and environment
1 (125) [27]	Psychological wellbeing	Cognitive trauma therapy *v* no treatment	4	–1	0	–1	0	Low	Quality point deducted for sparse data. Directness point deducted for no comparison between groups
1 (34) [28]	Rates of IPV	Cognitive behavioural counselling *v* no counselling (single informational session)	4	–2	0	0	0	Low	Quality points deducted for sparse data and incomplete reporting of results
1 (20) [29]	Psychological wellbeing	Cognitive behavioural counselling *v* no counselling (non-structured support group)	2	–2	0	–1	0	Very low	Quality points deducted for sparse data and incomplete reporting of results. Directness point deducted for no direct comparison between groups
1 (353) [34]	Rates of IPV	Various types of counselling *v* no counselling	4	–1	0	–1	0	Low	Quality point deducted for incomplete reporting of results. Directness point deducted for generalisability of results to other populations
1 (117) [32]	Utilisation of services	Various types of counselling *v* no counselling	2	–2	0	–1	0	Very low	Quality points deducted for sparse data, incomplete reporting of results, and allocation flaws. Directness point deducted for not specifying type of medical care services
1 (33) [33]	Psychological wellbeing	Problem-solving/empowerment counselling *v* no counselling	2	–2	0	0	0	Very low	Quality points deducted for sparse data and poor follow-up
1 (98) [37]	Rates of IPV	Gender-specific counselling *v* couples group counselling	4	–2	0	0	0	Low	Quality points deducted for sparse data and poor follow-up
1 (20) [26]	Psychological wellbeing	Grief resolution-orientated counselling *v* feminist-orientated counselling	4	–3	0	–1	0	Very low	Quality points deducted for sparse data, weak randomisation method, incomplete reporting of results, and uncertainty about evaluation methods. Directness point deducted for no direct comparison between groups
1 (136) [30]	Psychological improvement	Group counselling *v* individual couple counselling	2	–2	0	0	0	Very low	Quality points deducted for sparse data and poor follow-up

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Important outcomes	Rates of IPV. Revictimisation, Utilisation of services, Quality of life, Mortality, Adverse effects								
Number of studies (participants)	**Outcome**	**Comparison**	**Type of evidence**	**Quality**	**Consistency**	**Directness**	**Effect size**	**GRADE**	**Comment**
1 (84) [36]	Revictimisation	Group counselling *v* individual couple counselling	2	–1	0	–1	0	Very low	Quality point deducted for sparse data. Directness point deducted for no between group comparison
1 (150) [38]	Psychological wellbeing	Gender-specific counselling *v* couples group counselling	2	–2	0	0	0	Very low	Quality points deducted for sparse data, and poor follow-up
1 (72) [39]	Psychological wellbeing	Career counselling plus critical consciousness awareness *v* no treatment	4	–2	0	0	0	Low	Quality points deducted for sparse data and poor follow-up
1 (24) [40]	Psychological wellbeing	Peer support groups *v* no control	4	–1	0	–1	0	Low	Quality point deducted for sparse data. Directness point deducted for no comparison between groups
2 (476) [41] [42]	Rates of IPV	Nurse support and guidance *v* no support	4	–1	0	0	0	Moderate	Quality point deducted for incomplete reporting of results
3 (455) [22] [43] [46]	Rates of IPV	Safety planning *v* control	4	–1	0	0	0	Moderate	Quality point deducted for inclusion of CCTs
1 study (243) [47]	Rates of IPV	Shelters *v* no shelters	2	–1	0	0	0	Very low	Quality point deducted for incomplete reporting of results

Type of evidence: 4 = RCT; 2 = Observational; 1 = Non-analytical/expert opinion. Consistency: similarity of results across studies.
Directness: generalisability of population or outcomes.
Effect size: based on relative risk or odds ratio.

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