Interventions for Violence Against Women

C. Nadine Wathen, MA
Harriet L. MacMillan, MD, MSc

Since the 1970s, intimate partner violence increasingly has been recognized as associated with significant morbidity and mortality, particularly among women. While some surveys suggest that similar proportions of men and women report intimate partner violence (IPV), abused women experience more physical and emotional impairment than men. It is not surprising, therefore, that the great majority of interventions aimed at prevention and treatment of IPV focus on violence by men against women. Although violence against men by women and between same-sex partners are important issues, presently there are too few original research articles with this focus to warrant a systematic review of these topics.

Violence surveys generally place lifetime prevalence of IPV against women at between 25% and 30% and annual prevalence at between approximately 2% and 12%. A recent Canadian population-based survey found 5-year rates of 8%, a decrease from 12% found in an earlier survey. In Canada, 1-year rates in 1999 were reported at 3%. The variability in these estimates has been attributed to a variety of factors, such as the definition of abuse used in the survey (ie, whether emotional and verbal abuse, stalking, and rape are considered); whether the samples are drawn from community or health care settings; and whether the respondents are asked to restrict their responses to abuse in the current relationship.

Context Intimate partner violence is prevalent and is associated with significant impairment, yet it remains unclear which interventions, if any, reduce rates of abuse and reabuse.

Objective To systematically review, from the perspective of primary health care, the available evidence on interventions aimed at preventing abuse or reabuse of women.

Data Sources MEDLINE, PsycINFO, CINAHL, HealthStar, and Sociological Abstracts were searched from the database start dates to March 2001 using database-specific key words such as domestic violence, spouse abuse, partner abuse, shelters, and battered women. References of key articles were hand searched. The search was updated in December 2002.

Study Selection Both authors reviewed all titles and abstracts using established inclusion/exclusion criteria. Twenty-two articles met the inclusion criteria for critical appraisal.

Data Extraction Following the evidence-based methods of the Canadian Task Force on Preventive Health Care, both authors independently reviewed the 22 included studies using an established hierarchy of study designs and criteria for rating internal validity. Quality ratings of individual studies—good, fair, or poor—were determined based on a set of operational parameters specific to each design category developed with the US Preventive Services Task Force.

Data Synthesis Screening instruments exist that can identify women who are experiencing intimate partner violence. No study has examined, in a comparative design, the effectiveness of screening when the end point is improved outcomes for women (as opposed to identification of abuse). No high-quality evidence exists to evaluate the effectiveness of shelter stays to reduce violence. Among women who have spent at least 1 night in a shelter, there is fair evidence that those who received a specific program of advocacy and counseling services reported a decreased rate of reabuse and an improved quality of life. The benefits of several other intervention strategies in treating both women and men are unclear, primarily because of a lack of suitably designed research measuring appropriate outcomes. In most cases, the potential harms of interventions are not assessed within the studies reviewed.

Conclusions Much has been learned in recent years about the epidemiology of violence against women, yet information about evidence-based approaches in the primary care setting for preventing intimate partner violence is seriously lacking. The evaluation of interventions to improve the health and well-being of abused women remains a key research priority.

JAMA. 2003;289:589-600

©2003 American Medical Association. All rights reserved.
Abuse during pregnancy is associated with impairment in both the mother and child. For the mother, the outcomes described above are all relevant, as well as the additional psychological and physical implications of experiencing abuse while pregnant. For the child, abuse can cause direct harm, such as preterm birth or injury caused by a blow to the mother's abdomen, or indirect harm caused by psychological distress, and/or a woman's reluctance or inability to obtain prenatal care. A recent meta-analysis and systematic review found that women abused during pregnancy are significantly more likely to give birth to low-birth-weight infants.

Given the recent emphasis on development of primary care screening approaches for IPV, this article systematically reviews the available evidence for strategies applicable in the primary care setting to identify and treat women who experience IPV. In a companion article, Rhodes and Levinson discuss the clinical applications of the evidence in the context of options available to primary care clinicians.

METHODS

Data Sources

MEDLINE, PsycINFO, CINAHL, HealthStar, and Sociological Abstracts were searched from the respective database start dates to March 2001 using appropriate database-specific keywords such as domestic violence, spouse abuse, sexual abuse, partner abuse, shelters, and battered women, among others. The reference lists of key articles were hand searched. Both primary authors reviewed all titles and abstracts according to the study selection criteria (see “Study Selection” below) to arrive at a final pool of articles for review. Also included were relevant articles from after the search end date and those articles identified by external reviewers.

A total of 2185 citations were retrieved during the first search. Twenty-two citations were identified via hand searching and a focused search update. One reviewer (C.N.W.) reviewed all titles and abstracts and created keep and reject databases in Reference Manager 9.0 (ISI Research Soft Inc, Berkeley, Calif). The second reviewer (H.L.M.) examined both databases and made necessary adjustments according to the study selection criteria. A total of 237 articles appeared from titles and abstracts to match the selection criteria; these articles were then retrieved in full length for further review. The final pool of articles was 97, 22 of which described interventions meeting the criteria for critical appraisal. An additional 18 articles, suggested by external expert reviewers and/or those published between the search end date and an updated focused search in December 2002, were added, none of which met the selection criteria for critical appraisal.

Both authors independently reviewed each study using the evidence-based methods of the Canadian Task Force on Preventive Health Care (Box). Quality ratings of individual studies—good, fair, and poor—were determined based on a set of operational parameters specific to each design category (eg, systematic review, case-series, and randomized controlled trials). The Canadian Task Force methodology is described in Woolf et al24 or available from the Canadian Task Force Web site: http://www.ctfphc.org, under History and Methods. General design-specific criteria by study type are outlined in Harris et al.25

<table>
<thead>
<tr>
<th>Levels of Evidence</th>
<th>A. Research design rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence from at least 1 randomized controlled trial.</td>
</tr>
<tr>
<td>II-1</td>
<td>Evidence from controlled trial(s) without randomization.</td>
</tr>
<tr>
<td>II-2</td>
<td>Evidence from cohort or case-control analytic studies, preferably from more than 1 center or research group.</td>
</tr>
<tr>
<td>II-3</td>
<td>Evidence from comparisons between times or places with or without the intervention; dramatic results from uncontrolled studies could be included.</td>
</tr>
<tr>
<td>III</td>
<td>Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees.</td>
</tr>
</tbody>
</table>

Similarly, prevalence estimates for abuse during pregnancy have significant variability. In their review of pregnant women from the United States and other developed countries, Gazmararian and colleagues 10 found rates of abuse ranging from 0.9% to 20.1%, with the majority in the range of 3.9% to 8.3%, which is consistent with US state-wide surveys.11,12 There is a relationship between abuse before, during, and after pregnancy, with abuse during an earlier period in the relationship strongly predicting abuse during a later period.13-15

Women who experience IPV are at increased risk of injury and death, as well as a range of physical, emotional, and social problems.16 Physical health consequences include a 50% to 70% increase in gynecological, central nervous system, and stress-related problems.6,13 Impairment in mental and emotional health is associated with exposure to IPV, including depression, anxiety, suicidality, posttraumatic stress disorder, mood and eating disorders, substance dependence, antisocial personality disorders, and nonaffective psychosis.16-19

In a companion article, Rhodes and Levinson discuss the clinical applications of the evidence in the context of options available to primary care clinicians.
control studies, randomized controlled trials [RCTs], and cohort studies) developed with the US Preventive Services Task Force.25

Study Selection
For this review, IPV was defined as physical and psychological abuse of women by their male partners, including sexual abuse and abuse during pregnancy. The systematic review focused on the effectiveness of interventions to prevent IPV, including all comparative studies evaluating interventions to which a primary care clinician could refer a patient. These studies included interventions for women, battered women, and/or couples. The type of comparison group could be a no intervention control, a usual care control, or a group receiving an alternate intervention for study purposes.

In the case of physical, sexual, and emotional violence, the primary health outcomes (ie, changes in disease morbidity or mortality) are those related to physical and psychological morbidity of abuse; however, these data often are not available. Thus, self-reported incidence of abuse is often used as the primary outcome in these studies; however, there is evidence that women underreport abuse.3

Furthermore, debate exists regarding whether incidence of reabuse is the appropriate measure for evaluating treatment interventions. For example, many authors argue that reabuse is an inappropriate measure because women have no control over whether they are abused again, and they are often forced to return to an abusive relationship for economic or other reasons. Some authors claim that the significant outcomes should be determined by the women themselves.26,27 Other types of outcomes suggested in the literature include the impact of clinically based interventions on the patient-physician interaction and subsequent physician action if women are identified as abused,28 whether women revisit emergency departments (EDs),29 and whether women’s mental health improves,30 among others. However, these were not considered primary outcomes for the present review, largely because of a lack of analytic studies.

Thus some studies, especially those describing interventions for women, do not provide outcomes for abuse per se, and the main outcome measures are those such as the amount of social support the women have access to, their use of safety behaviors or safety planning, or their use of community resources. While the link between these types of outcomes and subsequent abuse has not been empirically established, studies that meet other inclusion criteria and report only these types of outcomes are included in the analysis, with a caveat that they can inform effectiveness of interventions only with these outcomes. Potential harms of interventions also are reviewed. In their companion article, Rhodes and Levinson23 elaborate on the issue of relevant clinical outcomes to consider in primary care decision making.

RESULTS
Interventions to Prevent Abuse: Systematic Review
From the primary care perspective, there are 2 main intervention options to detect and to prevent violence against women. Primary care clinicians can screen women to determine if they are being abused or are at risk of abuse, and they can refer abused women or their partners to various intervention programs.

A number of screening tools exist, many of which have shown reasonable accuracy in detecting abuse,35-41 including tools designed for primary care settings,42,43 to screen pregnant women,44-47 and even a tool designed to screen men.48 However, no study to date has examined, in a comparative design, the effectiveness of screening where the end point was improved outcomes for women (as opposed to identification of abuse status). Therefore, this systematic review focuses on the effectiveness of treatment interventions for women identified as at risk of or experiencing IPV. From the perspective of the primary care clinician, this effectiveness of screening generally means a referral to either a safe place, such as a women’s shelter, to counseling, or to other community-based resources.

Another set of intervention options is referral of men to batterer treatment programs. Compared with interventions for women, more empirical data exist evaluating the effectiveness of different treatments for men. The link between detecting IPV in men and then treating the men is not clear, especially for the primary care clinician. However, given the potential for the reduction in IPV through treatment of perpetrators,49-51 it is important to understand the effectiveness of these approaches.

A few studies have examined the effectiveness of information and education interventions targeted at young people as primary prevention strategies for later domestic violence.52-54 Also, some authors have proposed that societal-level interventions, such as policing and legislative policies, can affect the incidence of violence against women.55-59 These latter interventions are considered to be outside the scope of the primary care setting, but a brief section outlining the key issues surrounding these types of policies is provided.

Interventions for Women
No interventions for use in the primary care setting, to our knowledge, have been evaluated in studies meeting the inclusion criteria for this systematic review. Eleven studies that met the inclusion criteria were classified as interventions to which primary care clinicians could refer abused women. These 11 articles described 4 interventions, with advocacy counseling following at least 1 night’s stay in a shelter as the subject of 6 articles.60-65 The other interventions included an assessment of the effectiveness of staying at a shelter,66 a program of personal and vocational counseling for abused women,67 and prenatal counseling designed to reduce further abuse.68-70

TABLE 1 (truncated version; the full table is published online at http://www.jama.com) shows studies with a quality rating of fair. Strict adherence to

©2003 American Medical Association. All rights reserved.
the a priori criteria established for this review resulted in no studies receiving a quality rating of good. Often, a main limitation was the use of self-report data as the primary outcome (incidence of violence) using a measure(s) that had not undergone adequate testing of its validity. Thus the highest level of evidence available would have been outcomes, including self-report data, that had been validated, for example, by medical or police records.

No studies meeting the criteria for a quality rating of good or fair exist that test the effectiveness of shelters for battered women. Using a cohort design, Berk et al interviewed battered women (identified either by their referral to a shelter or to the county prosecutor), comparing those women who had elected to enter a shelter during the interval between interviews (mean of 54 days) with those who had not. Of 155 women, 37% (n = 57) reported 1 shelter stay between interviews. Most of the sample (81%, n = 125), regardless of shelter status, reported no new violence in the time between interviews (for details of this study see the online Table 1 at http://jama.com). Of the 30 women (19%) experiencing violence, 22 (14%) reported a single incident, and 8 (5%) reported multiple incidents. Rates of reported violence did not differ between those who stayed at a shelter and those who did not. This study had several methodological weaknesses, including selection bias. The relatively short interval between interviews made it difficult to interpret whether the lack of reported violence in the majority of the sample was due to the intervention, the women’s participation in the study, or the relatively short time between intervals.

Table 1. Summary of Domestic Violence Intervention Studies: Primary Care Referral of Women

<table>
<thead>
<tr>
<th>Source and Design</th>
<th>Study Description and Participants</th>
<th>Study Interventions</th>
<th>Outcomes Assessment</th>
<th>Results</th>
<th>Strengths and Weaknesses</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sullivan et al, 62 1991; Sullivan et al, 63 1992</td>
<td>Women leaving shelter after at least 1 night’s stay</td>
<td>6-8 h/wk for 10 weeks postshelter of one-on-one advocacy counseling</td>
<td>Incidence and severity of abuse (MCTS), independence from assailants, and ability to obtain community resources</td>
<td>Abuse outcomes: unable to adequately compare due to very small number of women involved with assailant</td>
<td>Small sample size disproportionately weighted to intervention group</td>
<td>Fair</td>
</tr>
<tr>
<td>Sullivan et al, 64 1994</td>
<td>Women leaving shelter after at least 1 night’s stay</td>
<td>4-6 h/wk for 10 weeks postshelter of one-on-one advocacy counseling</td>
<td>Physical violence: incidence of abuse (MCTS), risk for being reabused, social support, quality of life, and ability to obtain community resources</td>
<td>Abuse outcomes: no differences between groups</td>
<td>No blinding</td>
<td>Fair</td>
</tr>
<tr>
<td>Sullivan et al, 65 1995</td>
<td>Women leaving shelter after at least 1 night’s stay</td>
<td>6-month follow-up results of Sullivan et al. 64</td>
<td>Same as above</td>
<td>Same as above</td>
<td>No blinding</td>
<td>Fair</td>
</tr>
<tr>
<td>Tan et al, 66 1996</td>
<td>Secondary analysis of data from Sullivan et al. 64, to explore link between social support and abuse</td>
<td>Same as above</td>
<td>Same as above</td>
<td>Same as above</td>
<td>No blinding</td>
<td>Fair</td>
</tr>
</tbody>
</table>

(Continued)
Advocacy counseling following shelter stay was evaluated using an RCT design, in a pilot study, and in a larger trial. The study reported by Sullivan and Bybee included the largest sample and reported the longest follow-up period (2 years) (Table 1). Overall, this study was assessed as having fair internal validity, mainly because of reliance on self-report measures for all of the outcomes. Women who had spent at least 1 night in a shelter were randomly assigned either to receive advocacy services 4 to 6 hours a week for 10 weeks following leaving the shelter or to have no contact other than for interviews. The focus of the intervention was on assisting women with devising safety plans (if needed) and accessing community resources, such as housing, employment, and social support. Of the 284 initial study participants, 278 women remained in the trial, and complete longitudinal data were available for 242 of them. Women in the intervention group reported less reabuse at the 2-year follow-up compared with those in the control group (76% and 89%, respectively). In addition, physical violence decreased for the intervention group across time and there was a group by time interaction. Quality of life also was better for women in the intervention group and improved across time. No differences were observed in reports of psychological abuse or depression. There was an increase in self-reported intermediate outcomes for the intervention group, including social support and effectiveness in obtaining resources. The secondary outcome did show improvement at earlier points in the follow-up—ability to obtain resources was improved immediately postintervention and at 6 months follow-up; satisfaction with social support was evident at the immediate postintervention period (at 10 weeks) as well as at 2 years.

A personal and vocational counseling program for abused women who had remained in a women’s protective

---

**Table 1. Summary of Domestic Violence Intervention Studies: Primary Care Referral of Women**

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Study Description and Participants</th>
<th>Study Interventions</th>
<th>Outcomes Assessment</th>
<th>Results</th>
<th>Strengths and Weaknesses</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sullivan and Bybee, 1999; RCT (the completed longitudinal study of the studies reported above)</td>
<td>Women leaving shelter after at least 1 night’s stay</td>
<td>4-6 h/wk for 10 weeks postshelter</td>
<td>Same as above</td>
<td>Abuse outcomes: Physical violence at postintervention and 2-year follow-up</td>
<td>Acceptable loss to follow-up: 95% retention rate at 2 years and no differences in attrition between groups</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Initial participants, N = 284</td>
<td>postshelter of one-on-one advocacy counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Analyzed, n = 278</td>
<td>Interviews conducted at preintervention, shelter exit, at 10 weeks postintervention, and at 6, 12, 18, and 24 months of follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed study, n = 265</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intervention group, n = 135</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control group, n = 130</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lost to follow-up, n = 13 (groups not specified)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: MCTS, Modified Conflict Tactics Scale; RCT, randomized controlled trial.

*Table 1 is truncated, showing only those studies with a quality rating of fair. The full version of Table 1 can be found online at http://www.jama.com.

†Quality ratings are made according to established criteria described in the Box.

©2003 American Medical Association. All rights reserved.
service for at least 2 weeks was evaluated (for details of studies not shown in Table 1, see the online Table at http://www.jama.com). However, this study had a small initial sample (N = 50) and high drop-out rates. Although there was some improvement in measures such as self-esteem, the limits in the design and analysis did not allow for conclusions to be drawn from this study.

Prenatal counseling for pregnant women with a history of abuse was evaluated using 1 or more comparison groups. McFarlane et al's 1997 study focused on the relationship between resource use and reports of abuse, rather than on the effectiveness of the intervention. In a cohort study, 3 sessions of individual counseling by a nurse trained for abuse prevention were provided to 132 women. A comparison group of 67 postpartum women were given an information card containing telephone numbers of local agencies that assist with domestic violence. While women who received the counseling intervention reported less violence, flaws in study design, such as difference in parity status between the 2 groups, precluded determining the effectiveness of the intervention. In a recent quasi-randomized trial by McFarlane and colleagues, 3 levels of intervention—brief (information card), counseling (professional), and outreach (professional plus “mentor mother”)—were compared in a sample of predominantly Hispanic women who were pregnant and had experienced physical abuse. Although severity of abuse decreased significantly across all intervention groups, there were no statistically significant differences among the groups at 18 months. Furthermore, the methodological shortcomings of the trial, including a flawed randomization procedure, have limited the conclusions that can be drawn from this study.

Interventions for Batterers and/or Couples

Ten studies and 1 systematic review of batterer and/or couple programs are summarized in Table 2 (truncated version showing only those studies with quality ratings of good and fair; the full table is published online at http://www.jama.com). Some of these intervention programs are aimed exclusively at men while others include their partners. Within individual studies, more than 1 treatment approach often was evaluated. More than half of the studies compared treatments without a control group; only 2 studies used an RCT design. The systematic review included 2 RCTs, one of which overlapped with the individual studies.

The systematic review was given a quality rating of fair. While the methodological quality of the individual studies was assessed in detail within the review, it was unclear whether 2 authors independently assessed the studies, and

### Table 2. Summary of Domestic Violence Intervention Studies: Batterer and Couple Interventions

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Study Description and Participants</th>
<th>Interventions</th>
<th>Outcome Measures</th>
<th>Results</th>
<th>Strengths/Weaknesses</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couples were randomly assigned to 1 of 4 groups: (1) men’s group—weekly sessions (1.5 hours) for 6 months followed by monthly sessions for 6 months; based on cognitive-behavioral model and included review and process activities (2) conjoint group—as above but included women (3) rigorous monitoring (RM) group—men were seen for 1 year of monthly individual counseling sessions (1 h) by case manager with FAC, included 6-week record search and information provided to commanding officer (4) control group—no FAC treatment</td>
<td>Outcomes at 1-year follow-up after first 6 months of treatment: (1) self-report episodic measure of violence (2) MCTS (3) official police and court records for all respondents (4) date of recidivism of violence</td>
<td>Abuse outcomes: No statistically significant differences were found across 4 groups for prevalence of new or continued abuse for either men’s or women’s reports No statistically significant differences were found across groups for new arrests based on official records Rates of arrest recidivism were low across all 4 groups (range, 3%-6%). Time to recidivism across groups did not show statistically significant differences Women’s self-reports of spousal abuse on 1 or more of 3 measures ranged from 18% (physically injured) to 37% (felt endangered) Cumulative completion rate of third and fourth interviews across groups was 78% and 75%, respectively</td>
<td>Large sample size Rigorous design High follow-up rate Outcomes validated by police and court records No blinding</td>
<td>Good</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(continued)*
Table 2. Summary of Domestic Violence Intervention Studies: Batterer and Couple Interventions* (cont)

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Study Description and Participants</th>
<th>Interventions</th>
<th>Outcome Measures</th>
<th>Results</th>
<th>Strengths/Weaknesses*</th>
<th>Quality Rating†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saunders,78 1996; quasi-randomized noncontrolled trial</td>
<td>Men accepted for treatment at a family counseling agency who had been referred by deferred prosecution program (17%), probation department following prosecution (59%) or other including agencies, friends, family, and self, N = 218</td>
<td>Groups attended 20 weekly sessions of 2.5 hours using 1 of the following approaches: (1) feminist-cognitive-behavioral treatment (FCBT) approach—combined skills-training, gender role resocialization in structured format that included lectures, role-play, and homework; or (2) process-psychoanalytic treatment (PPT) approach—supportive, nondidactic group relationships. Focus was on building trust, sense of safety, and exploring childhood trauma</td>
<td>Recidivism rates primarily based on women’s reports supplemented by batterer’s reports and arrest records. Reports based on expanded version of CTS. Women also assessed on self-report measures of fear, conflict resolution, and general changes, while men were assessed on personality characteristics, relationship satisfaction, self-esteem, adjustment, and other related measures. Data were collected pre- and posttreatment and at least once during the 54 months following treatment</td>
<td>Of men who completed treatment (n = 136), defined as attending 16 of 20 sessions, 79% (n = 107) of their partners were found and agreed to participate in follow-up assessment. Attrition rate of 38% for FCBT group and 24% for PPT. Average length of follow-up was 25 months (range, 18-54 months); 20 (15%) of the 136 were lost to follow-up. Did not report within-groups pre- and postresults. No differences between groups on recidivism rates based on women’s reports, arrests, and those based on 1 or more of women’s reports, arrests, and men’s reports. No differences between groups in general changes, fear, or result of disagreement. Personality characteristics and disorders interacted with type of treatment; men with antisocial traits had decreased recidivism if they participated in group with FCBT approach. Men with dependent traits had better outcomes if in group with PPT approach</td>
<td>Audiotape recordings were made to ensure integrity of treatments. No nontreatment control group, although FCBT was similar to usual care at the center. Attrition and loss to follow-up rates were moderate for this type of study. Randomization process not followed. Some of measures have unknown psychometric properties. No blinding. No intention-to-treat analysis. Post-hoc analysis for some tests of interaction.</td>
<td>Fair</td>
</tr>
</tbody>
</table>

Systematic Reviews of Treatment Interventions That Include Batterers

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Study Description and Participants</th>
<th>Interventions</th>
<th>Outcome Measures</th>
<th>Results</th>
<th>Strengths/Weaknesses*</th>
<th>Quality Rating†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis and Taylor,86 1999; review</td>
<td>Synthesis of 6 studies included 4 quasi-experimental and 2 randomized trials; effect sizes determined for 5 studies (1 quasi-experimental was omitted)</td>
<td>See specific studies; quasi-experimental,86,71 and RCTs49,86</td>
<td>Reviews effectiveness of batterer programs that examined reduction of violence. Synthesis of findings includes only studies with a comparison group. Used effect size on proportion of repeat violence based on police records as indicator of treatment effect</td>
<td>The effect sizes for 5 studies included in final analysis were as follows: Quasi-experimental studies: Dutton,74 1986, 0.046; Chen et al.,73 1989, 0.193; and Dobash et al.,77 1996, 0.108 (average, 0.416). Randomized trials: Palmer et al.,49 1992, 0.537; and Davis and Taylor,86 1997, 0.287 (average, 0.412)</td>
<td>Search strategies not described. Examined methodologic quality of studies comprehensively.</td>
<td>Fair</td>
</tr>
</tbody>
</table>

Abbreviations: CTS, Conflict Tactics Scale56; FAC, Family Advocacy Center; MCTS, Modified CTS31; RCT, randomized controlled trial. *Table 2 is truncated, showing only those studies with quality ratings of good and fair. The full version can be found online at http://www.jama.com. †Quality ratings are made according to established criteria as described in the Box.

search strategies were not described. Of the 10 individual studies, only 1 was given a quality rating of good.51 While several of the studies rated poor or fair reported some evidence of effectiveness for interventions aimed at batterers and/or couples,49,74 the study of good quality concluded that 3 types of interventions were not effective in reducing subsequent violence against women.51

This RCT study51 of good quality, the San Diego Navy Experiment, tested 12-month interventions, which included group sessions for men, group sessions with men and their female part-

©2003 American Medical Association. All rights reserved.
nners (conjint), and rigorous monitor-
ing with monthly individual counseling
sessions, compared with a control
group. Men assigned to the control
group received no Family Advocacy
Center treatment, although their part-
ners received stabilization and safety
planning assistance like all partners in
the treatment groups. This study in-
volved a large sample of couples
(N=861), had a low attrition rate, and
measures included both self-reports of
abused women and perpetrators as well
as police arrest records. Since the
sample consisted entirely of US Navy
couples, it is not clear how these re-
results can be generalized to other popu-
lations. As Dunford emphasized, how-
ever, this military setting provided
certain advantages in that all men in
the intervention groups were required to
attend treatment. Also, Dunford high-
lights the fact that many of the bat-
terer treatment programs described in
the literature that reported success did
not use an experimental research de-
sign. In the trial by Dunford, the low
recidivism rate among those men who
received 1 of the 3 treatments did not
differ from the rate among control sub-
jects. It is possible that employment in
a military setting acts as a deterrent
among men who commit violence
against their wives. This trial was not
able to control for this variable, since
all participants were US Navy couples
where the husband was on active duty.
It is important to note recidivism rates
were low in all treatment groups (range,
3% to 6%) and the control group (4%) as
compared with the rates reported in
other studies.

Other Interventions
The studies in the following sections evaluate interventions in settings out-
side the scope of primary care and did
not meet the inclusion criteria for criti-
cal appraisal. These studies are in-
cluded to provide a complete picture of
the research conducted to date to pre-
vent IPV.

Emergency Department Interven-
tions. Approximately 37% of women
presenting in EDs report having expe-
rienced emotional or physical abuse at
some point during their lives; 2.2% re-
port acute physical trauma resulting
from partner abuse, and 14.4% report
having been abused in the past year. In
response to these significant pro-
portions and also to the accreditation
standards implemented in 1992, inter-
ventions designed for ED settings have
been designed and evaluated. Fanslow et al developed and exam-
ned a protocol of care for individuals
abused by their partner and provided
1-year follow-up data. This was a com-
parative study of the only 2 EDs in
Auckland, New Zealand. The proto-
col was based on the principles of care
outlined by the American Medical As-
sociation, including providing staff
training on recognizing signs and symp-
toms indicative of domestic violence,
asking appropriate screening/case-
finding questions, assessing immediate
risk and providing appropriate
intervention (including depression as-
essment, counseling about police and
legal options, and safety planning, in
addition to treatment of physical inju-
ries), and referral to community and so-
cial services. To determine the presence
or absence of assault and how it was
treated, baseline data were acquired in
both hospital EDs via random chart au-
dit of women older than 15 years. Fol-
lowing this, medical and reception staff
in the intervention ED were trained to
implement the protocol.

Results immediately postinterven-
tion (experimental group, n=2276;
comparison group, n=1768) indi-
cated that more cases of domestic vio-
ence were rated as confirmed (rather
than suspected) following the imple-
mentation of the intervention proto-
col at the ED experimental site, and a
trend toward improved documentation
of abuse was observed. These find-
ings were coupled with a significant
increase in use of treatment interven-
tions in the experimental ED, particu-
larly in safety assessment and plan-
cing, counseling regarding use of police
and law enforcement services, and refer-
ral to other treatment services. How-
ever, these positive changes were not
maintained at the 1-year follow-up. The
authors attributed the lack of sus-
tainability of use of intervention pro-
grams to a failure in ongoing mainte-
nance training of the ED staff, rather
than to problems with the interven-
tion protocol itself, thus limiting the
generalizability of this study. Of note,
the prevalence of domestic violence-
related presentation to the ED in this
New Zealand sample was low com-
pared with samples from North Ameri-
can populations (2.6% of all presenta-
tions and 7% of trauma presentations
to the ED were because of partner
abuse); and the intervention protocol
advocated a case-finding approach
based on presenting symptoms rather
than a routine screening approach.

Similarly, there is some evidence that
system-based training of ED profes-
sionals can improve the identifica-
tion of and response to violence against
women; however, more research is
required to determine if this kind of ap-
proach will improve identification of
abused women (especially those pre-
senting without trauma, who are a sig-
nificant proportion). Again, the
subsequent key link between identifi-
cation of abuse and treatment or out-
comes requires investigation and sub-
stantiation.

Social Interventions. In the sole study
using a comparison group and mea-
sure of appropriate outcomes, Davis and
Taylor conducted a unique RCT in
New York City testing 2 types of public
intervention programs addressing both
primary and secondary prevention of
violence. Their primary prevention ini-
tiative randomly assigned 64 housing
projects (approximately 93000 indi-
viduals) to receive or not to receive a
public education campaign against vio-
ence, consisting of tenant meetings, leaf-
lets, and posters. Their secondary pre-
vention intervention randomly assigned
households of 436 individuals (380
women [87%] and 56 men [13%]), who
experienced family violence (as identi-
fied by a police-reported complaint) and
who were drawn from public housing
households in 3 New York City pre-
cincts to receive or not to receive a 10-
have attempted to evaluate the effect of intervention of partner abuse, some studies reports to police, abused women’s knowledge and use of intervention services, and official police reports of violence. Measures for both interventions were collected during a 6-month follow-up. Results indicated that for abuse outcomes, neither public education nor home visits reduced the frequency of new violence or severity of violence reported by abused individuals. In the secondary prevention intervention, abused individuals who received public education and those who received home visits called the police more frequently compared with their respective controls. Neither of the interventions affected service-awareness or service-use scores of individuals abused. The study was generally well-conducted, although some misassignment of the home-visit intervention (16.6% of cases) was reported, and there was a lack of blinding. (The analysis did not show any pattern to the misassigned cases). Loss to follow-up was moderate (28%).

In other efforts aimed at primary prevention of partner abuse, some studies have attempted to evaluate the effect of educational campaigns directed at young people. A major limitation of these studies is that the main outcome is change in knowledge and attitudes either immediately postintervention or after a brief follow-up. No such study reviewed has attempted to follow the subjects for an extended period to determine the impact of education on later incidence of IPV. Use of rigorous designs is required to determine if educational approaches reduce the rates of IPV.

Legal and Policy Interventions. An important and well-publicized series of research studies was conducted in the 1980s to determine the effectiveness of various police responses to domestic violence. The original study, the Minneapolis Domestic Violence Experiment, had police officers respond to calls of misdemeanour domestic violence according to 1 of 3 randomly selected protocols: arrest the perpetrator, separate the couple, or provide advice. The study found that violence recidivism rates 6 months later were significantly lower for those arrested than for the other groups.

These results had a significant effect on public policy in the United States, with arrest becoming a main strategy for dealing with misdemeanor domestic violence and the perception of domestic violence changing from a personal family problem, to a crime. However, a series of 6 replication studies, the Spouse Abuse Replication Program, which were funded to confirm the original results, found variable levels of the effectiveness of arrest. In some sites, there was an escalation of subsequent violence among the arrested men, while other sites showed the predicted deterrent effect.

A key finding arising from these studies was the importance of intervention effects between individual characteristics and arrest. For example, arrest has a much stronger deterrent effect on employed men (ie, those who have more to lose) than unemployed men. The implications of these types of findings have not been studied. The arrest policies arising from this research led to many subsequent studies on the effectiveness of batterer treatment programs, since this type of treatment is often mandated as a probation requirement.

A recent retrospective cohort study evaluating the association between civil protection orders and subsequent police-reported violence found that permanent (12-month), but not temporary (2-week) protective orders, as compared with no orders, were associated with a significant (80%) decrease in reported incidence of physical violence in the year following the initial incident. Temporary, but not permanent, orders were associated with a significant increase in psychological abuse, but no change in physical abuse.

In a recent pilot study evaluating the role of legal advocates for women entering the court system to obtain civil protection orders, Bell and Goodman used a quasi-randomized design to compare women receiving advocacy services (including legal representation and support, as well as referral to community agencies, information about abuse, and other forms of social and instrumental support) with those not receiving these services. Results indicated significantly less psychological and physical abuse in the intervention group as compared with the comparison group. While this study was small and had some methodological weaknesses (nonstandard randomization procedure, high loss to follow-up in the comparison group, and restrictions on eligibility of women in the intervention group), its positive results are promising and additional research would seem warranted.

Few comparative studies have examined the influence of other legal or policy interventions on domestic violence outcomes.

Potential Harms of Interventions. No studies to date have evaluated either the benefits or harms associated with the use of screening tools, including the potential harms from failing to identify women who have experienced abuse. Similarly, none of the interventions developed to prevent or to reduce violence against women used measures to determine possible harms associated with the intervention. Several of the studies compared different treatment groups without comparison to a no treatment or usual care group, so the likelihood of identifying any harms associated with the interventions was reduced. The results of the study by Berk et al suggest that the use of shelters might increase the risk of further abuse for some women. This possible risk of reprisal violence, while not yet measured directly, is a potential concern, and indeed it was the main patient-related barrier to screening cited (by 82% of respondents) in a study that surveyed primary care physicians about their screening and intervention practices for IPV. Clinicians should consider this risk, as it underscores the need to conduct visits that include discussion of these issues.
in a private setting, with adequate safety and confidentiality measures taken in any referral process.

Summary of Key Evidence
Screening instruments are available to identify women who have been abused, but no studies to date have evaluated the effectiveness of screening to reduce violence or to improve women’s health. In addition, data about the potential harms associated with screening are lacking.

No current evidence of suitable quality exists in the literature reviewed to evaluate the effectiveness of shelter stay as a means of decreasing 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 specific program of advocacy counseling services reported a decreased rate of reabuse and an improved quality of life during the subsequent 2 years. With regard to other types of interventions for women, limitations in the available studies precluded drawing any conclusions about program effectiveness.

Programs that target male batterers alone or with their partners represent the largest group of interventions. Of 10 studies and 1 review, only the trial by Dunford was considered of good quality. This RCT showed that 3 intervention programs for batterers and/or their female partners did not reduce domestic violence in the intervention groups compared with the control group, which did not receive any treatment. Despite the excellent internal validity of this trial, it is unclear to what extent these findings are applicable to the general population since the sample consisted entirely of US Navy couples.

One study found that a protocol for treatment of abused women in the ED showed some initial positive changes (such as referral to other intervention services), but these were not sustained at 1 year. A study of 2 community-based interventions (public education and police and social worker home visits) showed that neither intervention affected service-awareness or service-use scores of individuals who experienced abuse. A second education intervention that targeted youth in schools focused on change in knowledge and attitude and did not include a control group. A series of US studies evaluating the effectiveness of arrest as a deterrent for recurrent domestic violence showed mixed results. Although the original study suggested that arrest was effective in reducing subsequent domestic violence compared with separating the couple or providing advice, replication studies found variable results including increases in violence. Finally, an initial study of the use of civil protection orders and an innovative pilot study of legal advocacy and counseling showed promising results that these legal interventions can reduce physical abuse.

COMMENT
Although much has been learned in recent years about the epidemiology of violence against women, information about evidence-based approaches in the primary care setting for preventing IPV is seriously lacking. Our findings are consistent with those of Ramsay et al, whose recent systematic review concluded that there is a lack of evidence regarding the effectiveness of interventions for women experiencing abuse and that potential harms of identifying and treating abused women are not well-evaluated. They conclude that it is premature to recommend universal screening programs in health care settings, a finding similar to that of the Canadian Task Force on Preventive Health Care. Specifically, the effectiveness of routine primary care screening remains unclear, since screening studies have not evaluated outcomes beyond the ability of the screening test to identify abused women. Similarly, specific treatment interventions for women exposed to violence, including women’s shelters, have not been adequately evaluated. The notable exception is the advocacy counseling program following a stay in a shelter of Sullivan and Bybee.

It is important to distinguish between asking about abuse during the diagnostic evaluation of a patient and routine screening for domestic violence in health care settings. Questions about experiencing IPV should be included in any medical or psychiatric assessment of a patient with symptoms or signs that could be associated with such experience, and it is important for clinicians to be alert to these signs. Some authors have suggested that asking female patients about experiencing violence during routine history taking may be justified on the basis of prevalence alone, or the potential value of this information in caring for the patient, and may influence assessment and treatment of other health problems. Furthermore, failing to detect that a patient is at risk for or has experienced IPV may lead to unnecessary investigations and interventions. Rhodes and Levinson, in their companion article to this review, further discuss these issues, their implications for clinical practice, and the role of existing practice guidelines.

Research Agenda
There is an urgent need for additional research using rigorous designs to test the effectiveness of IPV interventions on important clinical outcomes. While research in this area is challenging, a number of questions need to be answered, both to allow primary health care clinicians to respond appropriately to IPV and to inform a more proactive approach to prevention at the level of public policy. Chief among these questions is whether screening in health care settings, coupled with appropriate, effective treatments, reduces physical injury and psychological abuse. Research is also required to determine whether batterer interventions are effective with men not mandated to treatment and not monitored by courts or other authorities.

Ongoing studies funded by the National Center for Injury Prevention and Control, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Canadian Institutes for Health Research, may answer some of these questions.
INTERVENTIONS FOR VIOLENCE AGAINST WOMEN

Funding/Support: This work was supported by the Canadian Institute of Health Research (CIHR) Institutes of Gender and Health; Aging: Human Development, Child and Youth Health; Neuroscience, Mental Health and Addiction; and Population and Public Health. The work was supported by the Wyeth Canada CIHR Clinical Research Chair in Women’s Mental Health.

REFERENCES


©2003 American Medical Association. All rights reserved.
It is usually not recognized that for every injurious or parasitic microbe there are dozens of beneficial ones. Without the latter, there would be no bread to eat nor wine to drink, no fertile soil and no potable waters, no clothing and no sanitation. One can visualize no form of higher life without the existence of the microbes. They are the universal scavengers. They keep in constant circulation the chemical elements which are so essential to the continuation of plant and animal life.

—Selman A. Waksman (1888-1973)