RESEARCH BRIEF:
Identifying and Responding to Intimate Partner Violence Against Women

What We Know

- Intimate partner violence (IPV) against women is a serious social and health care issue and results in short- and long-term physical and psychological harm for women and their children.

Identification of exposure to IPV:

- Both universal screening and clinical case-finding can identify women exposed to violence, and a number of tools exist to support this process. Women generally support being asked about abuse.
- A recent randomized controlled trial (MacMillan et al., 2009) and related studies provided evidence to answer the question "is screening for woman abuse in health settings effective in preventing subsequent violence and improving quality of life?" The authors found that:
  - All women in the trial showed reductions in exposure to violence across time – these reductions were not, however, associated with screening.
  - Screening may have small benefits for abused women's life quality and depression. These may not be clinically important changes, and were not maintained when the analysis accounted for women lost to follow-up. There were no differences in other health outcomes, and there were no short-term harms of screening as implemented in this study.
  - Screened and control group women had no differences in the frequency of using violence-related health and social services.
  - Screening may over-identify women as experiencing IPV; and many women must be screened to identify one who discloses abuse.
- Many studies have identified clinical indicators of abuse that could be used by health care providers in a process of clinical case-finding or diagnostic assessment; these include:
  - being depressed or having symptoms of post-traumatic stress disorder (PTSD)
  - reporting somatic symptoms
  - having a male partner employed less than part-time, or who has a drug or alcohol problem

Interventions for IPV (health care and community-based services):

- A number of systematic evidence reviews (Wathen & MacMillan, 2003; Nelson et al., 2004; Ramsay et al., 2009) have concluded that the evidence supporting specific interventions for abused women is weak, especially interventions provided in health care settings, or those to which health care providers could refer women.
- A recent review (Feder et al., 2009) found some evidence that advocacy-based interventions can assist women on a number of important outcomes, especially those who decide to disclose abuse or who seek help from shelters. Success varies by the type and intensity of the intervention. Coordination of services ("one-stop-shopping") and taking into account women's help-seeking strategies and abuse experiences may improve service effectiveness.
- The evidence for batterer treatment is mixed, with the better-designed studies generally indicating no benefit, or potential harm (i.e., increased recidivism) (Babcock et al., 2004; Feder & Wilson, 2005).

- The evidence for couple therapy is mixed, with RCT level evidence indicating no benefit in a military sample (Dunford, 2000). Most authors caution that these types of approaches are not safe for many abused women, particularly those experiencing "intimate terrorism".
- Permanent, but not temporary, civil protection orders may be effective in reducing future violence (Holt et al., 2002).
- The effectiveness of shelter services in reducing violence and improving other outcomes for women remains understudied. The existing literature is characterized by methodological weaknesses (Tutty, 2006).
- While there is emerging evidence regarding specific types of personal counseling, including pre- and peri-natal counseling, to reduce IPV and improve other outcomes for women, replication in larger and more diverse samples using rigorous methods is required (Tiwari et al., 2005; McFarlane et al., 2006; Kiely et al., 2010)
- There is qualitative research evidence regarding the importance of culturally-appropriate and -specific interventions.

Practice & Policy Implications of Current Best Evidence

- Based on currently available evidence, health care providers and settings should:
  - Develop and implement protocols for referral of abused women, according to their needs, to local services.
  - Be alert to the signs and symptoms associated with intimate partner violence exposure and ask questions about abuse when these indicators are present (clinical case finding);
  - Ensure that women are asked about violence in sensitive and appropriate ways that lead to discussion to determine women's needs, safety concerns, etc.
- Education of health care providers and settings is urgently required in both key health and social service university and college-level programs as well as in continuing professional education modules for health care providers already in practice (Wathen et al., 2009).
- Those providing service to abused women should be aware of the significant mental health co-morbidities associated with current and past violence exposures.

What We Don't Know – Research Gaps

- Research evaluating the effectiveness of specific services and interventions for abused women remains a key priority. Development of, and research on, new and promising interventions, as well as evaluation of existing services (including shelter services), is urgently required.
- Promising interventions include those based on advocacy models, including coordinated service provision, case management and "system navigation".
- Further research is required regarding treatment for male abusers, as well as couples therapy for specific types of intimate relationship violence.
- Further research regarding identification of violence exposure in health care settings (including routine screening) should only be conducted when explicitly linked to a specific intervention or intervention(s), and this should form part of the evaluation.

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