Intimate Partner Violence
Systematic Review Summary

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EDUCATION RESOURCES

Acknowledgements

The VEGA Project's guidance development for the topic of intimate partner violence used as its starting point the 2013 World Health Organization (WHO) Clinical and Policy Guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women.[1]

Following VEGA guidance development processes, the evidence was updated by an expert panel, comprised of Marilyn Ford-Gilboe, RN, PhD (Chair); Donna Stewart, MD, VEGA (Intimate Partner Violence Evidence Review Group Lead); Nadine Wathen, PhD (VEGA Co-Lead); Harriet MacMillan, CM, MD (VEGA Lead); Jen MacGregor, PhD (Research Associate); as well as the following VEGA Intimate Partner Violence Review Group Members: Paula Barata, PhD; Prabha Chandra, MD, MBBS; Siàn Oram, PhD; Claudia Garcia-Moreno, MD, MSc; Kelsey Hegarty, MBBS, PhD; Colleen Varcoe, RN, PhD; Simone Vigod, MD, MSc.

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Contents

Introduction

Intimate partner violence is a widespread problem with significant impacts on health and well-being.[2–5] According to the World Health Organization (WHO), intimate partner violence includes multiple forms of physical, emotional/psychological and sexual abuse, as well as controlling behaviours like financial manipulation.[1] Other behaviours, such as stalking, can also be considered forms of intimate partner violence.[6]

The VEGA (Violence, Evidence, Guidance Action) Project provides guidance on intimate partner violence, including sexual violence, in the context of intimate relationships but excluding dating violence. The causes and consequences (including health impacts) of intimate partner violence are highly gendered. Most research has been conducted on 1) interventions for women exposed to intimate partner violence by a male partner and 2) interventions aimed at men who use violence in their relationships (with couple therapy generally involving heterosexual couples where the woman is experiencing violence and the man is using violence in the relationship). There is relatively little evidence (and none that met design criteria for this review) on interventions for same-sex couples, for men who are abused and women who are abusive, and for gender-diverse people. In terms of sexual violence within intimate relationships, available evidence is for women who are abused. Therefore, the immediate responses we discuss below are specific to women.

The following guidance uses as its starting point the 2013 WHO Clinical and Policy Guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women.[1] In addition to considering the WHO Guidelines, VEGA reviewed more recently published intimate partner violence-specific interventions, to which abused adults can be referred.

Our review group systematically evaluated and synthesized the available evidence, including following a modified GRADE[7] process with the VEGA Intimate Partner Violence Evidence Review Group topic experts, to arrive at guidance statements for identification and intervention/referral. The group attempted to contextualize the guidance for Canada, having discussions that will continue with the National Guidance and Implementation Committee (NGIC).

Where evidence was lacking, we provided good practice statements.[8] Based on the best available evidence and expert clinical judgment, these statements aim to guide healthcare and social service providers in identifying and responding to abused adults, as well as in responding appropriately when presented with confirmed or suspected abusive partners. Given the interrelated nature of intimate partner violence and children's exposure to intimate partner violence, it is important to remember that the child and their non-offending parent both require care and support. Therefore, in some cases, we explicitly link care of the non-offending parent (usually the mother) and child in our guidance statements. Related to this, some interventions are designed for both women and children experiencing intimate partner violence—studies reporting women's outcomes are included in this set of guidance statements, while those reporting on child outcomes are reported in the Children's Exposure to Intimate Partner Violence guidance statements. When this happens (i.e., for the Advocacy and Shelters interventions), the guidance statements are explicitly linked.

Summary of Guidance for Intimate Partner Violence Identification and Respsonse

Identification and Initial Response	Recommendation	Comments
Recommended		
Identification of those experience of intimate partner violence	Identification through **case-finding** (defined below) is recommended. Healthcare and social service providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence. Particularly in the context of perinatal care, mental health, and addictions care, healthcare and social service providers should consider asking about intimate partner violence at assessment and subsequently as needed.	"Universal screening" or "routine inquiry" (i.e., asking adults in all healthcare or social service encounters) should not be implemented. [Based on 2013 WHO Guidelines and review of new evidence]
Identification of abusive partners	Caution is warranted when considering discussions with potential abusive partners. Guidance is provided below for healthcare and social service providers to implement in cases when use of violence in a relationship is suspected, confirmed or disclosed.	Good practice statements.
Intervention	**Recommendation**	**Comments**
Recommended		
Shelters and transition houses for abused women* and children *All existing interventions reviewed were for abused women.	Women's shelters provide safety for women at immediate risk, and their children.	Ideally, a process of safety planning with the woman will be undertaken to determine whether a shelter or other safe accommodation is best. See the Children's Exposure to Intimate Partner Violence Systematic Review Summary for parallel guidance on shelters.
Advocacy for women* and children exposed to intimate partner violence *All existing interventions reviewed were for abused women.	Offer referrals to advocacy services to women who disclose intimate partner violence, especially those experiencing intimate partner violence during the perinatal period.	Advocacy interventions for children exposed to intimate partner violence (along with their mothers) are recommended based on the benefits of advocacy for women exposed to intimate partner violence. See the Children's Exposure to Intimate Partner Violence Systematic Review Summary Document for parallel guidance on advocacy and safety planning.

Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR)	Psychological interventions for those with diagnosed mental health conditions, including specific CBT or EMDR interventions, can be considered for intimate partner violence-exposed adults with post-traumatic stress symptoms.	There are differing opinions as to whether EMDR should be considered a type of CBT.[11]
Other evidence-based interventions	Following assessment by a qualified provider, adults exposed to intimate partner violence may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer adults exposed to intimate partner violence to any other interventions simply on the basis of this exposure. Referrals to interventions should be based on assessment of individual needs.	Treatment should be in accordance with WHO mhGAP intervention guidelines[12] and/or national or profession-specific practice guidelines, delivered by professionals with a good understanding of intimate partner violence and its consequences.
Interventions Targeted at Specific Groups		
Recommended		
Pregnant women	Consider brief to medium-duration counselling and advocacy/support for pregnant women who disclose intimate partner violence.	The extent to which this may apply to settings outside of antenatal care is uncertain.
Cannot recommend for or against		
Peer support interventions	There is insufficient evidence to recommend either for or against peer support interventions for adults exposed to intimate partner violence.	
Interventions for men who use violence in relationships	There is insufficient evidence to recommend either for or against interventions for men who use violence in relationships (i.e., “perpetrators”).	
Not recommended		
Couples’ interventions	Couples’ interventions are not recommended.	Available evidence does not show benefits for couples’ interventions. There are concerns about potential harms, especially to women. The type of violence present in a relationship (conflict vs. coercive control) is crucial when considering therapeutic options involving both partners.

1. Identification of Intimate Partner Violence

The potential benefits of identifying those exposed to intimate partner violence are complex and may only be realized when this occurs by a trained healthcare or social service provider in a safe manner.

a) Identification of Those with Experiences of Intimate Partner Violence

Universal screening or routine inquiry for those who have experienced intimate partner violence is not recommended. (WHO Recommendation and subsequent supporting randomized controlled trial-level evidence).

Identification of intimate partner violence through **case-finding** is recommended. Healthcare and social service providers should ask about intimate partner violence when potential indicators are present, including:

1) signs and symptoms directly related to intimate partner violence exposure (injuries, depressive or post-traumatic stress symptoms, chronic pain);
2) behavioural indicators or cues from abused adults (e.g., repeatedly cancelling visits, increasing use of health services, deferring to a partner during a visit, offering an implausible explanation for a physical injury) and/or indicators that suggest an abusive partner (always present, answering for partner, other controlling behaviour); and
3) specific evidence-based risk indicators (e.g., alcohol/drug misuse, recent separation, financial strain, expressing traditional gender norms).

Particularly in the context of perinatal care, mental health, and addictions care, healthcare and social service providers should consider asking about intimate partner violence at assessment and subsequently as needed.

b) Identification of Adults Experiencing Sexual Violence in an Intimate Relationship

When women[ii] report sexual assault in the context of intimate partner violence, specific additional actions are recommended, as outlined below. Psychological debriefing should not be used, but responses should be respectful and supportive of women's informed choices.

Based on the 2013 WHO Guidelines, the following actions are recommended in healthcare settings (for others identifying intimate partner violence, this may require a referral to healthcare services):

1) Take a complete history, documenting events to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia). The history should include the time since assault and type of assault; risk of pregnancy; risk of HIV and other sexually transmitted infections (STIs); and a mental health assessment.
2) Offer emergency contraception to survivors of sexual assault presenting within five days of sexual assault, ideally as soon as possible after the exposure, to maximize effectiveness. If a woman presents after the time required for emergency contraception, emergency contraception fails or the woman is pregnant as a result of rape, she should be offered safe abortion.

[ii] Based on the 2013 WHO Guidelines, abused women are specified; however, other genders are likely to benefit from similar but tailored approaches.

3) Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the adult to determine whether HIV PEP is appropriate.
4) Women survivors of sexual assault should be offered prophylaxis/presumptive treatment for: chlamydia; gonorrhea; trichomonas; and syphilis, depending on the prevalence in the geographic area.
5) Vaccination with hepatitis B immune globulin should be offered up to 14 days post-exposure.[9]

Remarks:[iii]

It is important for providers to recognize that sexual violence can and does happen in the context of intimate relationships (Canadian data estimate the prevalence of women's self-reported sexual violence in their abusive relationships at ~44%). Providers may feel uncomfortable inquiring about sexual violence in relationships due to their own incorrect assumptions about violence (e.g., there's no such thing as forced sex in intimate relationships) or due to their concerns about sensitively inquiring about this experience of violence. This, however, results in a missed opportunity to provide appropriate and essential support and care.

Summary of the evidence—intimate partner violence identification

Although a number of tools exist to identify intimate partner violence, three randomized controlled trials have found no benefits of universal screening of women for intimate partner violence on any violence, health or life quality outcomes. However, when there is evidence of specific risks, clinical indicators and impacts, a case-finding approach is warranted, as is increased vigilance and inquiry in specific service settings.

c) Identification of Abusive Partners

Caution is warranted when considering discussions with potential abusive partners. Healthcare and social service providers may encounter cases where use of violence in the relationship is suspected, confirmed or disclosed. Based on existing best practice evidence (RACGP),10 when safe to do so, a provider may ask the abusive (ex-)partner about their use of violence, being sure not to indicate that the inquiry was prompted by anything the abused partner said. If disclosure occurs, providers should acknowledge it while reinforcing the unacceptability of violence and offer ongoing support (details regarding referrals for abusive partners are described below), assessing the abusive (ex-)partner's suicide risk and the family's safety. At any point, if providers feel conflicted or compromised, they should refer the (ex-)partner to another provider.

2. Intimate Partner Violence Interventions

a) Shelters and Transition Houses

Recommendation

To address immediate safety concerns (i.e., risk of injury or death to the woman, and any children present), women's shelters are strongly recommended. (Strong recommendation for intervention; the body of evidence was rated as very low certainty).

[iii] "Remarks" summarize key points related to scope, acceptability, equity and other considerations discussed by the Evidence Review Group.

Remarks

Shelters are residential facilities for women exposed to intimate partner violence and their children. Shelters generally provide: 1) safe refuge in a time of crisis; 2) material support (e.g., food and clothing, as needed); 3) informational and system navigation support/advocacy; and 4) education and counselling. They may also provide transitional or "second-stage" housing. Many of these services are also available for women not residing in the shelter, on an outreach basis.

Despite moderate system costs, the lack of direct user costs increases access for vulnerable groups, which likely increases equity. Challenges include less access in certain (particularly rural and remote) areas and for people whose needs might be more complex (by virtue of culture, religion, disability status, etc.).

Summary of the evidence

The evidence for shelters and transition houses is of very low certainty, primarily due to the lack of studies using comparative designs.

b) Advocacy Interventions

Recommendation

Offer referrals to advocacy services to women who disclose intimate partner violence, especially those experiencing intimate partner violence during the perinatal period.

Structured, brief advocacy interventions have been shown effective for women experiencing intimate partner violence, whether or not they are in a shelter at the time. The evidence for intensive advocacy interventions remains uncertain, therefore no recommendation for or against is made.

These recommendations were based on a combination of recommendations from the WHO and the VEGA expert review panel, specifically:

- Women who have spent at least one night in a shelter, refuge or safe house should be offered a structured program of advocacy, support and/or empowerment. [WHO Recommendation (conditional[IV]); the body of evidence was rated as low certainty].
- While the evidence regarding advocacy for women who do not access shelters remains uncertain, there is some evidence that brief advocacy interventions may improve specific important outcomes. Therefore, referral to advocacy as part of an initial response to intimate partner violence is recommended (Conditional recommendation for intervention; the body of evidence was rated as low certainty).
- Brief advocacy interventions for women experiencing intimate partner violence in the perinatal period are recommended. (WHO recommendation was conditional; the body of evidence was rated as being of low certainty.)
- The evidence for intensive advocacy intervention remains very uncertain (No recommendation for or against; there was very low certainty in the body of evidence).

[IV] Using the GRADE method, recommendations were considered "strong" if it was agreed that the recommendation "would be of near universal benefit." "Conditional" recommendations were made when there were "caveats in the benefits across different contexts."

Remarks

Advocacy interventions are defined as any intervention that seeks to provide those experiencing intimate partner violence (currently or in the past) with advice (safety planning, legal, housing or financial) and/or support/empowerment to facilitate access to community resources (e.g., shelters, emergency housing, intimate partner violence outreach services, psychological interventions, social or other appropriate services). Advocacy may be offered in community, healthcare or shelter settings and could be implemented by varied professionals with expertise about how community services work and how to help women connect to such services. Advocacy interventions can vary in intensity/duration—for example, from one brief session to multiple longer sessions. The availability and use of advocacy interventions in Canada are not known. However, the 2009 General Social Survey[13] reports that of those individuals who experienced intimate partner violence, they access intimate partner violence-related services at community/family centres (13%), women's centres (5%) and shelters/transition homes (4%).

Advocacy services vary by geography (rural/remote versus urban) and by who uses them. For example, while shelters are widely accessible, they are not being used, for a variety of reasons, by the majority of abused women. They are disproportionately accessed by low-income women. Thus, further work and consideration is needed around access to and effectiveness of advocacy interventions for those who come from more middle-/high-income homes, who live in rural or northern communities, who are non-English/French speaking and/or who belong to cultural and sexual minority groups.

Advocacy interventions are probably acceptable to most clients (women and children) and providers (those referring to and those providing service), as they generally involve understanding client needs and developing coordinated care and referral plans and pathways. The costs and cost-benefit considerations are unknown. Equity was deemed to probably be increased, especially by forms of advocacy delivered at no cost to women and children through shelters or other community-based services.

Summary of the evidence

Most of the evidence is from studies with major design limitations and there was great heterogeneity across them regarding setting, type and amount of advocacy given, outcome measures and length of follow-up.

Brief advocacy interventions: The current evidence suggests some benefit of brief advocacy interventions, as compared to those receiving usual care, for emotional or psychological abuse, safety planning or behaviours and depressive symptoms.[14–17] However, no benefit has been shown for physical abuse, sexual abuse, overall abuse, actual or intended service and resource use, quality of life (including sub-domains), post-traumatic stress disorder (PTSD) and risk assessment or perceptions of safety and fear. No evidence that met our inclusion criteria was found for the outcomes of suicidal behaviour or ideation and self-esteem.

Intensive advocacy interventions: The current evidence suggests some benefit of intensive advocacy interventions as compared to controls for the outcomes of physical abuse (12 to 24 months after intervention), quality of life and self-esteem.[18] However, there is no benefit for

emotional or psychological abuse, overall abuse, actual or intended service and resource use, depressive symptoms, PTSD, and suicidal behaviour or ideation. No evidence that met our inclusion criteria was found for the outcomes of sexual abuse, safety planning or behaviours, and risk assessment or perceptions of safety and fear.

Adverse events: The limited available evidence suggests no serious adverse events or death is associated with either brief or intensive advocacy interventions.

Emerging evidence: New trials are underway that use online, computer-assisted advocacy and safety planning; these should be monitored as results become available, as they may overcome some of the challenges specific to the lack of service access outlined above.

c) Psychological Interventions

Psychological interventions cover a spectrum of potential therapies delivered by different types of providers. Some are available through publicly funded healthcare or social services, others are not.

CBT and EMDR[v]

Recommendation

Consider CBT or EMDR[11] interventions for intimate partner violence-exposed adults with post-traumatic stress symptoms. These interventions, if available, should be delivered by specialized professionals who have a good understanding of intimate partner violence. (WHO recommendation is strong; the body of evidence was rated as low-moderate certainty).

Remarks/summary of the evidence

The above recommendation is based on an existing recommendation by the WHO.[1] It also draws upon evidence from treatment of those with diagnosed conditions and, for CBT and EMDR, from a number of studies specifically examining CBT as a treatment for women exposed to intimate partner violence; however, it is largely supported by a body of moderate-quality evidence on CBT and EMDR in adults with PTSD in general. VEGA's review update did not identify any new studies examining CBT or EMDR for adults exposed to intimate partner violence and therefore deviation from the existing recommendation was not warranted.

Other Evidence-Based Interventions

Recommendation

Following assessment by a qualified provider, adults exposed to intimate partner violence may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer adults exposed to intimate partner violence to any other interventions simply based on this exposure; referrals to interventions should be based on an individual needs assessment. Mental health care for the disorder, in accordance with WHO mhGAP[12] intervention guidelines and/or national or profession-specific evidence-based practice guidelines, should be delivered by professionals with a good understanding of intimate partner violence and its consequences. (WHO recommendation was strong; the body of evidence was rated as indirect evidence. Note that certainty varies by intervention).

[v] There are differing opinions as to whether EMDR should be considered a type of CBT.[11]

Remarks/summary of the evidence

The above recommendation is based on a previous recommendation by the WHO1 for those with existing conditions. VEGA undertook a new review of interventions for adults with substance abuse problems exposed to intimate partner violence that included four RCTs (none that met review criteria were identified as specific to intimate partner violence and mental health conditions).[19–22] Each study examined a different intervention. One intervention was extremely brief (< 1 hour)[20] and the rest were more intensive (24+ hours total) and involved multiple sessions. All interventions involved some content focused on avoiding/reducing substance use, whether alcohol or drugs. A single study examined adverse events and found none.[19] Although some interventions showed positive effects (e.g., for depression and psychological intimate partner violence), heterogeneity across studies (interventions, comparators, outcomes, measures, time of follow-up, etc.) and the generally unclear risk of bias prevents strong conclusions from being drawn. Overall, the intimate partner violence-specific evidence is insufficient to warrant any substantial change to the existing WHO recommendation.

Emerging Interventions

New categories of intervention for adults exposed to intimate partner violence are emerging; however, the available evidence for any of these is not yet definitive. While no specific recommendations are made, motivational techniques—appearing in both research evidence and also becoming more widely available—are briefly described so they can be considered in specific circumstances (when available, accessible, feasible, equity-enhancing, etc.). More research is required to assess the effectiveness of these and other new types of interventions, including stress reduction techniques such as mindfulness and yogic breathing, for adults experiencing intimate partner violence and/or its consequences.

Motivational interventions: These may be brief relative to other psychological interventions and generally focus on increasing an individual's motivation to change their behaviour. Such techniques (including "motivational interviewing" and "motivational enhancement") have been used to address various psychosocial concerns (e.g., substance abuse; adherence to prescribed asthma medication). Numerous systematic reviews[23,24] indicate that motivational interviewing interventions can be effective for health promotion. In the case of intimate partner violence victimization, motivational interventions generally focus on identifying personal goals related to reducing intimate partner violence (e.g., readiness to change), making improvements against the impacts of intimate partner violence (e.g., emotional health) or their own intimate partner violence-related behaviours (e.g., safety planning). VEGA's update to the WHO's review of psychological interventions identified two recent randomized controlled trials evaluating brief motivational interviewing interventions of less than 12 hours in duration for women exposed to intimate partner violence.[25,26] Although improvements were seen in two studies for depression, more research is needed into this approach for adults exposed to intimate partner violence.

d) Recommendations for Specific Groups

Interventions for Pregnant Women

Recommendation

Consider brief to medium-duration counselling and advocacy/support for pregnant women who disclose intimate partner violence. The extent to which this may apply to settings outside of antenatal care is uncertain. (WHO recommendation is conditional; the body of evidence was rated as low certainty.)

NOTE: Use of psychotropic medications in women who are either pregnant or breastfeeding requires specific knowledge; consult with a clinician trained in this area, where available. For details on management of mental health issues in these two groups, please see the mhGAP guidelines.[12]

Remarks/summary of the evidence

VEGA updated a recent Cochrane review on interventions for pregnant women. In total, eight RCTs[15,27–33] and one quasi-randomized trial[34] were included. Findings regarding the effectiveness of interventions for pregnant women exposed to intimate partner violence are mixed, as is the general quality of studies. Although some improvements were found (e.g., for safety behaviours and intimate partner violence), drawing strong conclusions regarding which intervention is best is difficult given that all studies examined a different intervention. Consistent with the WHO's recommendation, interventions including advocacy components appear to be the most promising and therefore no substantial change to the recommendation is warranted.

Peer Support Interventions

Recommendation

There is insufficient evidence to recommend either for or against peer support interventions for adults exposed to intimate partner violence. (No recommendation for or against; the body of evidence was rated as being of very low certainty.)

Remarks

Peer support includes interventions in which the individuals delivering the intervention are community residing mentors or peers who are not professionally trained as healthcare or social service providers, but who may have received intervention-specific training and supervision from program/study staff. These interventions may be implemented individually with those exposed to intimate partner violence or in groups. For VEGA's purposes, peer support interventions are distinguished from unstructured online peer support.

Although often assumed to be no cost, hidden costs associated with peer support may include staff training (initial and ongoing) and support, pay/travel costs and facility costs. Nevertheless, peer support interventions probably increase equity because there is usually no direct cost for participants and such interventions may be offered in areas where other resources are not available. Peer support is probably acceptable to individuals exposed to intimate partner violence, particularly those who have had negative experiences with professionals. Peer support is also probably acceptable to the peer/mentor facilitators, especially those with their own violence experiences who may have a desire to help other survivors. However, there is a risk

of vicarious trauma for peers/mentors and therefore safety protocols and support for those facilitating peer support need to be in place. Clinicians/providers also probably find peer support acceptable, although there may be resistance from those who do not approve of non-professional interventions. Peer support may be generally feasible to implement, but funding for such programs is generally low. Given there is some evidence that peer support can be effective, particularly for disadvantaged groups, more research is needed to determine the effectiveness of peer support for adults exposed to intimate partner violence. Programs already underway should be evaluated.

Summary of the evidence

A single randomized controlled trial examining a non-professional mentor support program for pregnant and recent mothers experiencing intimate partner violence (or who were psychosocially distressed; 79% exposed to intimate partner violence at baseline) was included in this review. Peer support may slightly reduce intimate partner violence and depression and slightly improve overall mental health and physical health, but the overall certainty in the evidence is very low. The included study did not report on harms.

Interventions for Men Who Use Violence in their Relationships

Recommendation

There is insufficient evidence to recommend either for or against interventions for men who use violence in relationships (i.e., "perpetrators"). (No recommendation for or against; the body of evidence was rated as being of low certainty.)

Remarks

The above recommendations apply only to men who use violence in their relationships and should not be generalized to other genders. Interventions for men who use violence in their relationships vary widely in their focus, intensity/duration and availability in Canada. Some men who use violence in their relationships are mandated (e.g., by courts) to attend what are sometimes referred to as "batterer intervention programs," whereas others come to treatment voluntarily.

While programs aimed at men who use violence in their relationships are often offered in group format, they are associated with moderate to high costs for society. Men who attend these programs usually do not pay out of pocket but may incur other costs related to travel or time off from work. In Canada, many programs aimed at men who use violence in their relationships are at risk of discontinuance, in part due to lack of demonstrated effectiveness. This may reduce feasibility and equity. Treatment adherence is also a concern, especially among those not mandated to programs, suggesting acceptability for men attending these programs may be low.

Interventions using motivational interviewing approaches may be a promising form of intervention for those who use violence in their relationships (see below) and access to these approaches may increase as they generally (i.e., not necessarily specific to intimate partner violence) become more available in Canada.

Summary of the evidence

The certainty of the evidence for "batterer intervention programs" is low. Although 17 RCTs[35–51] were reviewed, the studies vary greatly in quality and many different intervention approaches were examined. Interventions could be classified into three groups: 1) brief, pre-treatment or adjunct sessions; 2) longer duration intervention programs; and 3) interventions with substance abuse treatment. Specific approaches included the Duluth model, CBT, motivational interviewing, psychoeducational therapy, mind-body bridging, individual 12-step facilitation therapy and communication skills training. No studies reported specifically on adverse outcomes although increases in negative outcomes (e.g., recidivism) were not found to be associated with any of the interventions. Although a number of studies found significant improvements on some outcomes, overall, findings are inconsistent and prevent strong conclusions from being drawn. Evidence from five studies using a motivational interviewing approach (three offered as pre-treatment/ adjunct sessions, one intervention of longer duration and one intervention with substance abuse treatment)[35,36,38,45,47] suggests motivational interviewing may be effective, but certainty in the evidence is low and results are inconsistent. Taken with the broader literature suggesting that motivational interviewing can be effective for a variety of issues (e.g., health conditions and health-related behaviours such as substance abuse), as well as its increasing availability in Canada, this intervention for men who use violence in their relationships may be considered a promising approach requiring further research. No studies examined motivational interviewing for female or gender-diverse abusive adults, though; therefore, no recommendation regarding treatment for these groups can be made.

Couples' Interventions

Recommendation

Couples' interventions are not recommended (Conditional recommendation against intervention; the body of evidence was rated as very low certainty.)

Remarks

Couples' interventions may take various forms, including multi-couple or individual couple sessions and interventions where partners participate together in the same session(s) or separately, as is the case in "gender-specific group" interventions. These interventions are often referred to as "couples' therapy."

The cost of couples' interventions is likely moderate for society and moderate to high for couples, but this varies by interventions' intensity/duration. Multi-couple group interventions are likely less costly than individual couples' sessions, but are also generally less available in Canada. Couples' interventions conducted outside of hospital or primary healthcare settings are not covered by Canada's public healthcare system. Due to the moderate to high costs, this intervention would reduce equity. The acceptability of couples' interventions is unknown. Although it may be acceptable for some couples, adherence data indicate that many couples/individuals do not finish therapy. However, it is unclear whether attendance is related to the intervention itself or to the fact that couples' interventions can be lengthy and therefore difficult for people to complete over longer time periods. Some providers, particularly feminist-oriented therapists, may find the intervention highly objectionable. Although there is little to no research evidence that such interventions cause harm, clinical observations suggest couples' interventions can result in increased harm for women. Couples' interventions may be particularly dangerous in cases

where one partner is afraid of the other and/or when the relationship is characterized by coercive control (also called intimate partner terrorism) as opposed to the generally less severe form, situational couple violence or relationship conflict. Understanding the type of violence present in a relationship is crucial when considering potential therapeutic options that involve both partners.

Summary of the evidence

Seven studies (six randomized controlled trials[21,49,50,52–54] and one clinical controlled trial[55]) examining interventions for heterosexual couples were included in this review. All couples' interventions involved 12 sessions or more, but intervention format and content varied (e.g., multi-couple, individual couple and gender-specific groups). Three studies reported that participating couples were experiencing situational intimate partner violence, whereas the type of intimate partner violence in the other studies was unclear. All studies reported on some measure of recidivism/intimate partner violence, other outcomes examined in one or a few studies were treatment adherence, adverse outcomes, the abused partners' feelings of safety, the abused partners' injuries and mental health/anger or stress management. No studies examined the essential outcome of readiness to change. Overall, there is little to no evidence that couples' interventions improve intimate partner violence-related outcomes and little to no evidence that they cause harm. However, the certainty of this evidence is very low. Clinical observations/reports raise concern, as described above, regarding potential harm for women when the intimate partner violence features coercive control.

For further information

Please refer to VEGA's online education resources about intimate partner violence, including the Recognizing and Responding Safely to Intimate Partner Violence Module and the Handbook Section on intimate partner violence (https://vegaproject.mcmaster.ca/).

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