Interventions for intimate partner violence: review and implications for evidence-based practice
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CRD summary
The authors found that evidence for the most common treatments for perpetrators and victims of domestic violence was lacking. Emerging evidence supported the use of empirically validated substance abuse and trauma treatments. Given potential for bias in the review process, unclear quality of included studies and high rates of withdrawal and drop-outs, the authors’ conclusions should be treated with caution.

Authors’ objectives
To evaluate the effectiveness of treatment programmes for intimate partner violence aimed at perpetrators, victims or child witnesses.

Searching
MEDLINE and PsycINFO were searched from inception to June 2007. Search terms were reported. References of relevant articles were handsearched.

Study selection
Randomised controlled trials (RCTs) of interventions for intimate partner violence aimed at perpetrators, victims, couples or child witnesses and that measured recidivism rates were eligible for inclusion. Only studies with 20 or more participants were eligible for inclusion.

RCTs and non-randomised controlled trials of interventions for intimate partner violence aimed at perpetrators (Duluth treatment model, mandatory arrest, or group cognitive-behavioural therapy (CBT) with or without psychoeducation), victims (advocacy, counselling, or police and social services outreach), couples (CBT or behavioural couples therapy), or children (psychotherapy, CBT, or child-centered therapy) were included for review. In some studies the intervention was court ordered. For couples interventions, studies that compared couple therapy with another intimate partner violence intervention were also included. Recidivism rates were recorded through police or victim report. For child intervention studies the outcome inclusion criteria of recidivism rates was relaxed. The outcomes reported for these studies were mothers’ and children’s symptoms or behaviours. In the child intervention studies, most participants were no longer living with the perpetrator. Follow-up ranged from immediately post treatment to three years.

The authors stated neither how the studies were selected for the review nor how many reviewers performed the study selection.

Assessment of study quality
No formal validity assessment was conducted. However, the authors commented on some aspects of study validity (such as loss to follow-up and withdrawal rates and other possible sources of bias).

Data extraction
The authors did not state how the data were extracted for the review.

Methods of synthesis
The studies were combined in a narrative synthesis.

Results of the review
Twenty studies were included for the review (n approximately 9,900). Treatment dropout ranged from 14% to 50% where applicable and where reported. Loss to follow-up for victim report ranged from 15% to 89%. Statistical tests of significance were not reported for any of the outcomes.
Interventions for Perpetrators (seven studies, n=6,390): Results for the efficacy perpetrator interventions were mixed. Recidivism rates differed between police and victim reports. Mandatory arrest was associated with lower rates of recidivism compared to enforced separation and mediation (13% for mandatory arrest versus 26% for separation for eight hours and 19% for mandatory arrest versus 37% mediation conditions; one study, n=314), but not compared to non-arrest according to victim reports (36% for mandatory arrest versus 48% for control; one study, n=4,032).

Results on group CBT/psycho-education were mixed. One study reported a significant reduction in recidivism rates in the intervention group (10% versus 31%; n=56). One study reported no difference between intervention and control groups in recidivism rates (3% versus 6% for police report and 27% versus 35% for victim report; n=861). Pre-trial counselling was superior to probation counselling, but no different from mandatory sentencing in reducing recidivism rates (34% versus 45% versus 34%; one study, n=347). The Duluth treatment model did not significantly reduce recidivism rates compared to probation (one study, n=404) and community sentencing according to victim report (one study, n=376).

Interventions for Victims (five studies, n unclear): Advocacy for women who left a domestic violence shelter was associated with lower rates of violence experienced compared to shelter only at two years follow-up (31% versus 37%; one study, n=278), but these benefits were not evident at six months (one study, n=141) and were not maintained at three years (one study, n=124). Mentorship plus counselling for pregnant victims of intimate partner violence was associated with a significant reduction in violence at two months but not at 12 to 18 months compared to counselling alone (one study, n=329, data not reported). Police and social services outreach to victims did not significantly reduce recidivism rates (one study, n=434).

Interventions for couples (five studies, n unclear): Four studies found no differences in recidivism rates between couples therapy and individual or group perpetrator treatment, untreated controls or gender specific perpetrator and victim groups. One study of men with comorbid substance misuse and domestic violence found that behavioural couples therapy combined with individual substance misuse treatment was more effective than substance misuse treatment alone in reducing recidivism rates (18% versus 43%; n=86).

Interventions for Children (four studies, n unclear): Joint child and mother treatment was shown to be more effective than community case management (two studies, n=75 child-mother dyads), child-only treatment (one study, n=181) and waiting list control (one study, n=181) in reducing child and parent psychological symptoms. A study of children who experienced sexual abuse and domestic violence found that trauma-focused CBT was superior to child-centered therapy in decreasing post-traumatic stress disorder symptoms (19% versus 46%).

Authors' conclusions
The authors concluded that there was a lack of evidence for the most common treatments for perpetrators and victims of domestic violence. Emerging evidence supported the use of empirically validated substance abuse and trauma treatments.

CRD commentary
The review question was clearly stated. The inclusion criteria for study design and outcomes were clearly defined, but modified after study retrieval, which may have introduced a source of bias. Inclusion criteria for participants and interventions were broad. It was not always clear what types of study designs were included for review. Only two relevant databases were searched and so relevant studies may have been missed. It was unclear whether the search was restricted by language and so language bias could not be ruled out. Appropriate steps did not appear to have been taken to minimise publication bias. It was unclear whether necessary steps were taken in the review process to minimise reviewer error and bias.

No formal validity assessment was conducted, so it was not possible to ascertain the quality of the included studies. However, the high rate of drop-out and loss to follow-up in many studies undermines the reliability of these results. The decision to combine studies in a narrative synthesis was appropriate given the high degree of clinical heterogeneity between studies. That only one or two studies were found for each of the interventions made the strength of evidence weak. Further, the absence of statistical data made it difficult for the reader to determine the significance of the findings for themself.
Given the potential for bias in the review process, the unclear quality of the included studies and the high rates of withdrawal and dropouts, the authors' conclusions should be treated with caution.

Implications of the review for practice and research

**Practice:** The authors stated that behavioural couples therapy was an effective strategy for intimate partner violence cases where one or more partners also has a history of substance abuse problems. The authors also stated that including perpetrators in child therapy in their role as parents may be beneficial, but none of the studies included in the review evaluated this as an intervention. As families were often referred to a variety of interventions in a range of different settings, the authors recommended that a range of treatment approaches should be integrated into one location to promote access for families.

**Research:** The authors stated that further research was needed to investigate which treatment worked best for which type of perpetrator and to evaluate the effectiveness of behavioural couples therapy.

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