COCHRANE CORNER

Psychological therapies for women who experience intimate partner violence: a Cochrane Review†

Mohajer Hameed, Lorna O'Doherty, Gail Gilchrist, Judit Tirado-Muñoz, Angela Taft, Patty Chondros, Gene Feder, Melissa Tan & Kelsey Hegarty

†This review is the abstract of a Cochrane Review previously published in the *Cochrane Database of Systematic Reviews*, 2021, Issue 7: CD013017, doi: 10.1002/14651858.CD013017.pub2 (see www.cochranelibrary.com for information). Cochrane Reviews are regularly updated as new evidence emerges and in response to feedback, and the *Cochrane Database of Systematic Reviews* should be consulted for the most recent version of the review.

We thank the Cochrane Common Mental Disorders Group for their support in publishing this review.

See Round the Corner in this issue.

Background

Intimate partner violence (IPV) against women is prevalent and strongly associated with mental health problems. Women experiencing IPV attend health services frequently for mental health problems. The World Health Organization recommends that women who have experienced IPV and have a mental health diagnosis should receive evidence-based mental health treatments. However, it is not known if psychological therapies work for women in the context of IPV and whether they cause harm.

Objectives

To assess the effectiveness of psychological therapies for women who experience IPV on the primary outcomes of depression, self-efficacy and an indicator of harm (dropouts) at six- to 12-months' follow-up, and on secondary outcomes of other mental health symptoms, anxiety, quality of life, re-exposure to IPV, safety planning and behaviours, use of healthcare and IPV services, and social support.

Search methods

We searched the Cochrane Common Mental Disorders Controlled Trials Register (CCMDCTR), CENTRAL, MEDLINE, Embase, CINAHL, PsycINFO, and three other databases, to the end of October 2019. We also searched international trials registries to identify unpublished or ongoing trials and handsearched selected journals, reference lists of included trials and grey literature.

Selection criteria

We included randomised controlled trials (RCTs), quasi-RCTs, cluster-RCTs and cross-over trials of psychological therapies with women aged 16 years and older who self-reported recent or lifetime experience of IPV. We included trials if women also experienced co-existing mental health diagnoses or substance abuse issues, or both. Psychological therapies included a wide range of interventions that targeted cognition, motivation and behaviour compared with usual care, no treatment, delayed or minimal interventions. We classified psychological therapies according to Cochrane Common Mental Disorders's psychological therapies list.

Data collection and analysis

Two review authors extracted data and undertook 'Risk of Bias' assessment. Treatment effects were compared between experimental and comparator interventions at short-term (up to six months post-baseline), medium-term (six to under 12 months, primary outcome time point), and long-term follow-up (12 months and above). We used standardised mean difference (SMD) for continuous and odds ratio (OR) for dichotomous outcomes, and used random-effects meta-analysis, due to high heterogeneity across trials.

Main results

We included 33 psychological trials involving 5517 women randomly assigned to experimental (2798 women, 51%) and comparator interventions (2719 women, 49%). Psychological therapies included 11 integrative therapies, nine humanistic therapies, six cognitive behavioural therapy, four third-wave cognitive behavioural therapies and three other psychologically-orientated interventions. There were no trials classified as psychodynamic therapies. Most trials were from high-income countries (19 in USA, three in Iran, two each in Australia and Greece, and one trial each in China, India, Kenya, Nigeria, Pakistan, Spain and UK), among women recruited from healthcare, community, shelter or refuge settings, or a combination of any or all of these. Psychological therapies were mostly delivered face-to-face (28 trials), but varied by length of treatment (two to 50 sessions) and staff delivering therapies (social workers, nurses, psychologists, community health workers, family doctors, researchers). The average sample size was 82 women (14 to 479), aged 37 years on average, and 66% were unemployed. Half of the women were married or living with a partner and just over half of the participants had experienced IPV in the last 12 months (17 trials), 6% in the past two years (two trials) and 42% during their lifetime (14 trials).

Whilst 20 trials (61%) described reliable low-risk random-sampling strategies, only 12 trials (36%) described reliable procedures to conceal the allocation of participant status.

While 19 trials measured women's depression, only four trials measured depression as a continuous outcome at medium-term follow-up. These showed a probable beneficial effect of psychological therapies in reducing depression (SMD –0.24, 95% CI –0.47 to –0.01; four trials, 600 women; moderate-certainty evidence). However, for self-efficacy, there may be no evidence of a difference between groups (SMD –0.12, 95% CI –0.33 to 0.09; one trial with medium-term follow-up data, 346 women; low-certainty evidence). Further, there may be no difference between the number of women who dropped out from the experimental or comparator intervention groups, an indicator of no harm (OR 1.04, 95% CI 0.75 to 1.44; five trials with medium-term follow-up data, 840 women; low-certainty evidence). Although no trials reported adverse events from psychological therapies or participation in the trial, only one trial measured harm outcomes using a validated scale.

For secondary outcomes, trials measured anxiety only at short-term follow-up, showing that psychological therapies may reduce anxiety symptoms (SMD –0.96, 95% CI –1.29 to –0.63; four trials, 158 women; low-certainty evidence). However, within medium-term follow-up, low-certainty evidence revealed that there may be no evidence between groups for the outcomes safety planning (SMD 0.04, 95% CI –0.18 to 0.25; one trial, 337 women), post-traumatic stress disorder (SMD –0.24, 95% CI –0.54 to 0.06; four trials, 484 women) or re-exposure to any form of IPV (SMD 0.03, 95% CI –0.14 to 0.2; two trials, 547 women).

Authors' conclusions

There is evidence that for women who experience IPV, psychological therapies probably reduce depression and may reduce anxiety. However, we are uncertain whether psychological therapies improve other outcomes (self-efficacy, post-traumatic stress disorder, re-exposure to IPV, safety planning) and there are limited data on harm. Thus, while psychological therapies probably improve emotional health, it is unclear if women's ongoing needs for safety, support and holistic healing from complex trauma are addressed by this approach. There is a need for more interventions focused on trauma approaches and more rigorous trials (with consistent outcomes at similar follow-up time points), as we were unable to synthesise much of the research.

https://doi.org/10.1192/bja.2021.36 Published online by Cambridge University Press