15. Intimate partner violence

Intimate partner violence, defined as physical, emotional, financial and/or sexual abuse perpetrated against the victim by his or her intimate partner,[472] is a significant public health problem worldwide.[440] In Canada, a 1999 study of a nationally representative sample of 26 000 participants reported 8% intimate partner violence against a female and 7% against a male by a previous or current partner in the past five years.[473] Women, however, are more likely than men to be the victims of serious violent acts such as sexual abuse, beatings (25% v. 10%), being choked (20% v. 4%) or being threatened or having a weapon used against them (13% v. 7%).[474] They are also more likely than men to be injured during the violent act (40% v. 13%) and to be fearful for their lives (40% v. < 10%).[474] In this review we aimed to determine whether existing screening tools and approaches for intimate partner violence are appropriate for immigrant and refugee women and to identify care barriers for these populations. The recommendations of the Canadian Collaboration for Immigrant and Refugee Health related to intimate partner violence are outlined in Box 15A.

Methods

We used the 14-step approach developed by the Canadian Collaboration for Immigrant and Refugee Health[16] (summarized in section 3 of this article, above). We considered the epidemiology of intimate partner violence in immigrant populations and defined clinical preventive actions (interventions), outcomes and key clinical questions. We searched MEDLINE, Embase, CINAHL, PsychLIT, the Cochrane Library and other sources from Jan. 1, 1995, to Dec. 31, 2010. Detailed methods, search terms, case studies and clinical considerations can be found in the complete evidence review for intimate partner violence (Appendix 13, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1).

Results

We found no systematic reviews or evidence-based guidelines on screening, prevention or treatment for intimate partner violence in immigrants or refugees. The general literature search identified 409 titles on intimate partner violence, and after appraisals, we retained two key reviews as evidence.[475,476] After the search update, we selected two additional key reviews and one randomized controlled trial.[477–479] Studies conducted with general population and ethnic minority samples informed our clinical recommendations.

What is the burden of intimate partner violence in immigrant populations?

Three studies provided secondary analyses of the 1999 Statistics Canada General Social Survey. Women born in developing countries reported the highest prevalence rates of intimate partner violence, followed by Canadian-born women and immigrant women from developed countries. However, when all other variables in the model were controlled for, the analysis showed that recently settled immigrant women (i.e., in Canada for less than 10 years) had significantly lower odds of intimate partner violence victimization than longer-term immigrants and Canadian-born women.[480] Single, divorced, separated or widowed immigrant women were 10 times more likely to report intimate partner violence than immigrant women married or in a common-law relationship.[481] Immigrant women reported higher rates of emotional abuse than Canadian-born women (14.7% v. 8.7%), with the strongest risk factor being their partner's low educational level.[482]

Regional surveys on intimate partner violence have yielded higher rates. MacMillan and colleagues[483] reported rates that ranged from 4.1% to 17.7% for Canadian-born women and 12.6% for foreign-born women. Ahmad and coauthors[484] reported a 22% rate of intimate partner violence following computer screening. Prevalence rates also vary in relation to the health care setting (highest prevalence in emergency departments). Finally, women in war zones, disaster zones, during flight or displaced in refugee camps in countries of asylum may be at higher risk for intimate partner violence.[485]

Does screening for intimate partner violence reduce morbidity or mortality?

Screening tools

Screening for intimate partner violence differs from tradi-

Box 15A: Recommendations from the Canadian Collaboration for Immigrant and Refugee Health: intimate partner violence

Do not conduct routine screening for intimate partner violence.

Be alert for potential signs and symptoms related to intimate partner violence, and assess further when reasonable doubt exists or after patient disclosure.

Basis of recommendation

Balance of benefits and harms

Current evidence does not demonstrate clear benefits from screening women for intimate partner violence, and harms have resulted from screening. Compared with the general population, there may be greater risk among immigrant and refugee women for harm directly related to screening (e.g., risk of loss of migration status and sponsorship agreements). Harm may occur indirectly through impaired patient–physician rapport and subsequent reduction in use of medical and mental health services.

Quality of evidence

Moderate

Values and preferences

The committee attributed more value to evidence of harms and lack of evidence of benefits and less value to recommending uncertain interventions, even in the face of significant concerns.

tional screening for medical disorders because the target of clinical concern is a behavioural event, which women usually recognize as a problem but which they may not view as appropriate for medical attention.[485,486] Four short self-report questionnaires have received the most study. The "Hurt, Insulted, Threatened, or Screamed at" questionnaire (four items) yields sensitivity ranging from 30% to 100% and specificity from 86% to 99%.[476] The Partner Violence Screen (three items) provides sensitivity from 35% to 71% and specificity from 80% to 94%.[477] The Women Abuse Screening Tool (eight items) yields 47% sensitivity and 96% specificity.[479] The Abuse Assessment Screen (five items) yields sensitivity ranging from 32% to 94% and specificity from 55% to 99%.[487]

A Canadian randomized controlled trial found women preferred self-completed approaches.[483] However, other studies comparing administration methods of screening instruments (e.g., face-to-face interviews, computer screening, written screening) have shown inconsistent results.[484,488,489] Furthermore, it is unknown whether these results apply to immigrant and refugee women.

Relative benefits and harms of screening

A Canadian trial on the effect of screening found no statistically significant differences between women screened or not screened at 6, 12 or 18 months follow-up for recurrence of intimate partner violence (Table 15A).[478] More than half of the women who disclosed being victims of intimate partner violence on screening did not discuss the violence with their practitioner during the health care visit. An important study limitation was that no specific intervention was provided to women who disclosed or screened positive.[478]

Other studies have found screening benefits such as decreasing isolation, increasing support, relief, breaking the silence and validating women's feelings.[485,490] However, these same studies identified several harms, including feeling that the practitioner is too busy or not interested, feeling judged and being disappointed by the practitioner's response, increased anxiety, concerns about privacy,[484] breaches of confidentiality and legal repercussions, fear of being reported to child protective services,[485] and concern about or actual increased risk of retaliation or further harm from the partner.[485]

Relative benefits and harms of treatment

The strongest evidence for treatment has come from studies of the Experimental Social Innovation and Dissemination program,[491,492] which reported decreased physical and emotional abuse at 12–24 months follow-up and improvement of women's quality of life at 12 months follow-up. Ramsay and coworkers[472] reported that, while promising, the results were inconclusive. In Table 15B, we report the efficacy of the Experimental Social Innovation and Dissemination advocacy and counselling intervention program in decreasing the incidence of intimate partner violence[475] in an ethnically

Table 15A: Summary of findings on screening for intimate partner violence to reduce morbidity due to such violence

Patient or population: English-speaking female patients
Settings: Health care settings in Ontario
Intervention: Screening for intimate partner violence
Comparison: No screening
Source: Macmillan HL, Wathen CN, Jamieson E, et al. Screening for intimate partner violence in health care settings: a randomized trial. *JAMA* 2009;302:493-501.[478]

	Absolute effect					
Outcome (18-mo follow-up)	Risk for control group	Difference with screening (95% CI)	Relative effect (95% CI)	No. of participants (studies)	GRADE quality of evidence	Comments (95% CI)
Intimate partner violence, by Composite Abuse Scale	530 per 1000	74 fewer per 1000 (159 fewer to 32 more per 1000)	RR 0.86 (0.70–1.06)*	379 (1)	Moderate†‡	NNT not statistically significant
Post-traumatic stress disorder screening, by SPAN (startle, physically upset by reminders, anger, numbness)	601 per 1000	162 fewer per 1000 (246 to 66 fewer per 1000)	RR 0.73 (0.59–0.89)*	379 (1)	Moderate†‡	NNT 7 (5–16)
Quality of life, by WHO Brief	Mean score 52.7	Mean score 5.8 higher (2.14 to 9.46 higher)	NA	379 (1)	Moderate†§	NA
Depression	Mean score 24.4	Mean score 3.4 lower (5.8 to 1.0 lower)	NA	379 (1)	Moderate†§	NA

Note: CI = confidence interval; GRADE = Grading of Recommendations Assessment, Development and Evaluation; NA = not applicable; NNT = number needed to treat; RR = relative risk; WHO = World Health Organization.
*Calculated using Review Manager on the basis of observed counts.
†Only one study.
‡Dichotomous outcome: total number of events was less than 300.
§Continuous outcome: total population size was less than 400.

diverse sample of women who had spent at least one night in a shelter.

Clinical considerations

What are potential implementation issues?

Signs and symptoms of intimate partner violence differ significantly among women. They may be absent in some women or be of a psychological (depression, anxiety, suicidal ideation, alcohol or drug abuse), social (social isolation) and/or physical (injuries, bruises and aches) nature in other women. Patient–physician rapport thus remains a key element in the detection of intimate partner violence.

Recently settled immigrant women in Canada are more likely to report intimate partner violence to the police than women in the general population but are less likely to use social services.[494] Barriers to help-seeking included fear of deportation or not accessing Canadian citizenship, lack of knowledge of services or language-specific services, experiences of racism or discrimination.[494] Culturally specific perceptions of spousal relationships, gender roles, negative experiences with authorities, aggression and abuse may affect reporting and disclosure.[485] Involvement with police or criminal proceedings may put immigrant women at risk of losing their sponsorship agreements.[485,494]

Intimate partner violence is now considered a form of child maltreatment. Women may delay disclosure of violence because of fear of losing custody of their children (child protection services often cite the mother's failure to protect her children).[485,494] In addition, some women feel coerced into staying in a shelter to keep custody of their children. Although this may protect them from further intimate partner violence, it may also isolate them from extended family and community networks that might otherwise be integrated effectively into the intervention plan.[458]

Services that can defuse conflict situations and reduce family stress include social welfare, reliable childcare, safe housing, language classes, and other educational and vocational training opportunities. Community grassroots organizations can provide information and support groups in appropriate languages and in a culturally competent manner.[495–498] Research is beginning to show benefits when screening and interventions target women with specific conditions, for example pregnancy, mental illness and substance abuse, but this work has yet to consider the immigrant context.

Recommendations of other groups

National clinical preventive screening committees, the Canadian Task Force on Preventive Health Care, the UK National Screening Committee and the US Preventive Services Task Force have not found sufficient evidence to recommend for or against screening all women for intimate partner violence.[476–478] The UK National Screening Committee concluded that "screening for domestic violence should not be introduced" in periodic health examinations. The American Medical Association, the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists have recommended routinely screening all women for intimate partner violence.[479] However, these organizations have not based their recommendations on systematic reviews of effectiveness. Our guidelines

Table 15B: Summary of findings for advocacy programs to prevent further intimate partner violence

Patient or population: Women in a Midwest shelter program for women with abusive partners who had (i) spent at least one night in the shelter and (ii) planned on staying in the general vicinity for the first three months after leaving the shelter
Setting: Community setting
Intervention: Advocacy programs
Comparison: No advocacy program
Sources: Wathen CN, Macmillan HL. Interventions for violence against women: scientific review. *JAMA* 2003;289:589-600.[475] Sullivan CM, Bybee DI. Reducing violence using community-based advocacy for women with abusive partners. *J Consult Clin Psychol* 1999;67:43-53.[491]

Outcome	Absolute effect, mean score: Risk for control group	Absolute effect, mean score: Difference with advocacy programs (95% CI)	No. of participants (studies)	GRADE quality of evidence
Self-reported severity or frequency of abuse (scale 0–3; follow-up 24 mo)	0.85	0.15 higher	265 (1)[493]	Low*†‡
Effectiveness in obtaining community resources (scale 1–4; follow-up 10 wk)	2.7	0.50 higher (0.34 higher to 0.66 higher)	265 (1)	Low*†‡
Quality of life (scale 1–7; follow-up 24 mo)	4.94§	0.25 higher (0.02 lower to 0.52 higher)	265 (1)	Low*†‡
Depression (scale 0–3; follow-up 24 mo)	2.00	0.08 lower (0.24 lower to 0.08 higher)	265 (1)	Low*†‡

Note: CI = confidence interval; GRADE = Grading of Recommendations Assessment, Development and Evaluation.
*Only one study.
†Concerns about directness and applicability only to women seen in primary care who have been in a shelter.
‡Fewer than 300 events.
§ Postintervention scores.

highlight the paucity of data on the effectiveness of screening programs and the concern for potential harms from routine screening.

Take-home messages

- The rate of reporting of intimate partner violence is lower among recently settled immigrant women than among longer-term immigrants and Canadian-born women.
- Linguistic barriers, financial dependencies, fear of losing custody of children and limited knowledge of laws and health services constitute significant barriers to both disclosure and adherence to interventions among immigrant and refugee women.
- To decrease the rate of abuse, practitioners should refer women who report spending at least one night in a shelter to a structured program of patient-centred (advocacy) support services.

For the complete evidence review for intimate partner violence in immigrant populations, see Appendix 13, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1.

More detailed information and resources on cultural aspects of intimate partner violence can be found at: www.mmhrc.ca.