Current Psychiatry Reports (2019) 21: 12
https://doi.org/10.1007/s11920-019-0991-6

PSYCHIATRY IN PRIMARY CARE (BN GAYNES, SECTION EDITOR)

Identification and Management of Domestic and Sexual Violence in Primary Care in the #MeToo Era: an Update

Kelsey Hegarty[1,2] · Laura Tarzia[1,2]

Published online: 8 February 2019
© Springer Science+Business Media, LLC, part of Springer Nature 2019

Abstract

Purpose of Review We discuss recent evidence around the identification and response to domestic and sexual violence in primary care for perpetrators and victims, in the context of feminist social media movements such as #MeToo.

Recent Findings There is no recent research on identification and response to perpetrators in health settings. There is some limited recent evidence for how health settings can address domestic and sexual violence for female victims and their children. Recent studies of mixed quality focus on advocacy and empowerment, integrated interventions (with alcohol and drug misuse) and couples counselling for domestic violence and cognitive behavioural or processing therapy for sexual violence.

Summary Further research on perpetrator interventions in primary care is urgent. Larger sample sizes and a focus on sexual violence are needed to develop the evidence base for female survivors. Clinicians need to ask about violence and provide a first-line response depending on the patient's needs.

Keywords Domestic violence · Partner abuse · Social media · Interventions · Health settings

Introduction

Domestic or intimate partner violence (DV) and sexual violence (SV) are hidden epidemics in health care settings. [1] While both men and women use violence in relationships, men use DV more frequently and severely resulting in female victims fearing for their lives [1]. SV against adults is also perpetrated by men in the vast majority. Both DV and SV are associated with serious negative health impacts, for the victim and the perpetrator. For men, using DV is associated with increased alcohol and substance abuse, rates of depression, suicidal thoughts, stress, anxiety, low self-esteem, and increased use of health services [2, 3]. For their female partners, the aftermath of injuries, fear, and stress from DV results in chronic health problems that interfere with daily functioning and quality of life. Victims experience increased rates of anxiety, depression, substance abuse, post-traumatic stress disorder, and suicidality [1]. Globally, 38% of all female homicides are DV-related, and for women of child-bearing age, DV is the leading contributor to death, disability, and illness, mainly as a result of mental ill health [4]. For their children, DV-related trauma left unrecognised is cumulative and associated with social, behavioural, emotional, and cognitive problems, persisting into adulthood [5]. Similarly, SV against women—even the more subtle forms [6]—is associated with a range of poor physical and mental health outcomes, which can persist long after the incident [6–8]. These include post-traumatic stress disorder, anxiety and depression [7, 8], gynaecological problems [9], sexually transmitted infections [10] and unwanted pregnancies [11].

Over the past few years, DV and SV against women have received increased attention and recognition as issues of global concern [12–14]. This has corresponded, perhaps not coincidentally, with an increase in survivors coming forward to tell their stories through social and traditional media. In Australia, for instance, the high-profile case of Rosie Batty, whose son Luke was murdered in 2014 by his father, was a catalyst for DV to be firmly placed on the

This article is part of the Topical Collection on *Psychiatry in Primary Care*

✉ Kelsey Hegarty
k.hegarty@unimelb.edu.au

[1] Department of General Practice, The University of Melbourne, 200 Berkeley Street, Carlton, Victoria 3058, Australia

[2] Centre for Family Violence Prevention, The Royal Women's Hospital, Parkville, Australia

policy agenda [15]. Batty's subsequent advocacy profile ensured that DV remained prominent in the community's consciousness. In many countries, high-profile cases paved the way for other survivors to come forward and tell their stories. In a similar way, global social media feminist movements such as #MeToo, #YesAllWomen and #BeenRapedNeverReported have highlighted the prevalence and impacts of sexual harassment and SV [16]. They have also provided a platform for survivors to be heard and validated. Critically, these movements advocate a shift from victim-blaming to perpetrator accountability, encouraging women to 'call out' the men who have assaulted them. Several high-profile cases of SV perpetrated by powerful, white men such as Harvey Weinstein have demonstrated this to great effect.

While this increased societal awareness has succeeded in making some inroads into changing the justice system, health services have lagged behind in responding to DV and SV [17]. This gap is problematic given that at least 80% of women experiencing DV seek help from health services [1], and women experiencing SV are more likely than other women to have more doctor visits in a year [18]. General practice, antenatal, mental health services and emergency departments are key places for early intervention, as health practitioners are the major professional group to whom women want to disclose [19–21]. International guidelines are available for health practitioners on how to identify and respond to women who have experienced DV and SV [22, 23]. However, only a minority of women and children exposed to violence are recognised in health care settings [24], and there is evidence that health practitioners often lack the essential skills and experience to respond appropriately [22]. Furthermore, addressing the victims of violence is only one part of the problem. A recent systematic review [25•] shows there is a paucity of evidence from health care settings to help men stop using DV and even less on perpetration of SV. We acknowledge that men can be victims and that DV occurs in same-sex relationships; however, the majority of evidence to date has concentrated on DV and SV against women, as they are the majority of victims.

The aim of this review is to discuss how primary care can identify and respond to DV and SV for both perpetrators and victims, placing this in the context of the #MeToo era. We begin by discussing the lack of evidence for intervening with perpetrators, particularly the lack of focus on SV. We then describe the evidence-based guidelines for female survivors, developed in 2014/15. We then briefly critique the randomised controlled trials over the last 3 years for female survivors attending health settings, including primary care, highlighting the lack of attention on SV. Finally, we make recommendations for research, practice and policy drawing on the learnings from social media movements.

The Evidence Gap Around Perpetrators

Although interventions to support female victims of DV and SV are critical, it has been increasingly acknowledged there needs to be a focus on male perpetrators [14]. In health settings, there is almost a complete lack of evidence around how to identify and respond effectively to men using violence. A recent systematic review [25•] of interventions for male perpetrators of DV in health settings found nine randomised controlled trials of low to moderate quality that were confined to specific clinical settings (alcohol treatment centres, veterans affairs). The authors concluded that there is currently insufficient evidence to support the effectiveness of any intervention, although the concurrent treatment of violence and alcohol abuse through psychological therapies showed some promise. Only one pre-post pilot study was undertaken in a primary care context [26], testing the effectiveness of a training intervention on the identification and referral of male perpetrators. Whilst the intervention did increase clinician confidence, it did not result in a significant number of referrals to specialist services. Similarly, a 2018 review [27] synthesising recommendations for how primary care should respond to perpetrators found only expert opinion pieces and guidelines to draw upon; no empirical studies were found. In the case of SV perpetration, to our knowledge, there are no studies that address identification and response in the primary care context or in any health setting, including qualitative or other non-randomised studies. The majority of SV perpetrator research focuses on prevention of SV through attitudinal change in the college context or bystander interventions.

Identification for DV and SV

Health practitioners are crucial to early intervention given their pivotal role in DV identification, safety assessment, response and referral [21]. A 2015 Cochrane review [28] suggests that screening and initial response by health practitioners increases identification with no marked increase in referrals or changes in women's experience of violence or wellbeing. A recommendation was made that only in antenatal care should screening occur. The vast majority of women find screening or identification if there are symptoms or signs (case finding) acceptable if the questions are asked in a non-judgemental way [29–31]. Several studies have explored face-to-face versus more distal ways (paper or online) of asking about DV [32–34]. A 2015 systematic review of six randomised controlled trials [35] showed screening face-to-face does not significantly increase disclosure compared to self-administered written screening. However, computer-assisted self-administered screening was found to increase the odds of DV disclosure by 37% compared to face-to-face screening and 23% higher than self-administered written screening. A 2016

systematic review [36] found three out of ten tools; Women Abuse Screen Tool (WAST, Canada), Abuse Assessment Screen (AAS, USA) and Humiliation, Afraid, Rape and Kick (HARK, UK) had stronger psychometric values than the other seven, having been validated against an appropriate reference standard. There is much less evidence on screening for SV, other than in the context of DV. Although sexual violence victimisation scales do exist [37], there is limited evidence as to their usefulness in health settings. Most of the data on the prevalence of SV screening is conflated with data on "violence" more broadly, making it difficult to ascertain how common it is for health practitioners to enquire specifically about sexual assaults by a stranger, friend or acquaintance [38].

There are many barriers as to why practitioners may not screen or ask patients about DV or SV. A 2016 review reported low rates of routine screening of 10 to 20% (range 2 to 50%) across 35 studies [39]. Evidence shows that only half of health practitioners find screening acceptable [29, 40]. Some health practitioners do not see it as their role, are fearful of offending the patient, or feel they do not have the skills or sufficient time to provide an adequate response. Health practitioners are often impeded by the presence of the partner or feel unsupported by lack of training or referral options.

Response to Disclosure of DV or SV

In 2013, the World Health Organization (WHO) recommended all health practitioners be trained in a first-line response for DV and SV: Listen, Inquire about needs, Validate patients' experiences, Enhance safety and offer ongoing Support (LIVES) [22]. The main skills that practitioners need to acquire often are to assess safety and risk and understand that not all patients are ready to take action [41]. Many may not wish to access formal support services as they do not identify as 'DV or SV victims' [42]. There is limited evidence as to what interventions assist with recovery from DV; however, they can be categorised into the following areas: first-line response and referral, safety planning and advocacy, psychological treatments, and mother-child interventions. The most promising interventions identified by this WHO work were nurse home visiting advocacy programs, mother-child psychotherapeutic interventions and specific psychological treatments (trauma-informed cognitive behaviour therapy (CBT)) [22]. There are very few studies drawn from primary care to support women with DV to recover [43]. One primary care study [44] found no effectiveness for an interpersonal therapy intervention to enhance social support and improve interpersonal functioning. In a larger study, general practitioners [42] were trained and supported to respond to women's needs and deliver motivational interviewing or non-directive problem-solving techniques depending on women's readiness to change. There was no difference in the quality of life between groups; however, there were some effects of the intervention with women reporting less depressive symptoms and increased discussion of safety with the doctor.

There is also limited evidence for effective responses to women experiencing SV, especially in primary care. In the immediate post-sexual violence crisis period, the use of Sexual Assault Nurse Examiners (SANEs) is becoming more common. SANEs primarily operate out of hospital emergency departments and provide first-line response and post-sexual assault crisis care, offering an alternative approach to the collection of forensic evidence that may be more woman-centred and trauma-focused [45]. To date, however, the evidence for their effectiveness has been lacking, with no randomised controlled trials being conducted in any setting. It has been suggested that this is because SANE programs tend to be responsive to the needs of communities and survivors, making 'success' difficult to measure [45]. One study found a significant increase in prosecution of SV cases post a SANE intervention compared to before implementation [46]; however, rates of reporting were incredibly low.

Beyond a crisis response, a 2015 Cochrane systematic review [47•] of controlled studies found some evidence for psychological therapies such as assertion training, clinician-assisted emotional disclosure, CBT, eye movement desensitisation and reprocessing, prolonged exposure therapy, stress inoculation therapy and supportive psychotherapy in reducing some of the mental health impacts of SV. However, with the exception of CBT and prolonged exposure therapy, the long-term benefits (beyond 12 months) of these therapies were not established. Furthermore, interventions were delivered in a variety of clinic and university settings, and it is unclear to what extent they could be successfully delivered in primary care. A systematic review in 2013 [48] found similar results, concluding that there was a paucity of rigorously evaluated psychotherapeutic interventions for SV. Trauma-informed approaches to treatment for SV survivors show some promise [49, 50], but are yet to be evaluated.

Reproductive coercion, another hidden issue, has received little attention in research and policy. Emerging only in 2010 as a topic of discussion [51], it refers to interference with a woman's reproductive choices (typically by a male partner) and includes forced abortion and contraceptive sabotage [52]. Reproductive coercion sits within the intersection of DV and SV [53]; primary care is thus well-placed to identify and respond to it, yet almost no evidence exists to support practitioners in doing this effectively [54].

Recent Evidence

Our search over the last 3 years revealed only one primary care randomised controlled trial—a screening and brief intervention

via a resource card for reproductive coercion and DV in the family planning context (ARCHES). The intervention was not superior to usual care in reducing reproductive coercion or DV [55]. Extending our search to DV or SV trials from other health settings showed mixed-quality studies that focussed on advocacy and empowerment, integrated interventions (with alcohol or drug misuse) and couples counselling for DV [56–63] and cognitive behavioural or processing therapy for SV.

Advocacy and empowerment interventions [64] have been shown to increase referrals to services and are the mainstay of response to DV. A 2015 Cochrane review concluded that there is some support for advocacy effectiveness. Intensive advocacy may improve quality of life and reduce physical abuse up to 2 years later and brief advocacy may have short-term mental health benefits and reduce abuse, particularly in pregnant women and for less severe abuse. However, in a large 2017 well-designed trial [65•], 950 women experiencing DV attending 42 public health clinics in Mexico were randomised to a nurse-delivered session (DV screening, supportive referrals, safety risk assessments) and a booster counselling session after 3 months, or to screening and a referral card. There were no significant effects observed at 6-month follow-up, although immediately after the booster session, there were significant improvements in mental quality of life and safety planning behaviours. Similarly, in a recent randomised controlled trial [66] of telephone-delivered nurse support (referrals and social support) versus enhanced usual care for 300 women who reported DV within the past year attending a paediatric emergency department showed no difference on outcome variables, including DV, depressive and post-traumatic stress symptoms. Overall, the evidence for advocacy, although the strongest, still needs to be qualified by the small number of trials of mixed quality.

In contrast to the above, a randomised controlled trial of empowerment of women ($n = 239$ women) in the context of perinatal home visiting in the USA showed some positive results [67]. The Domestic Violence Enhanced Home Visitation Program (DOVE) intervention group received a structured abuse assessment and six home visitor-delivered empowerment sessions integrated into home visits. Women in the DOVE treatment group reported a larger mean decrease in DV scores from baseline compared to women in the usual care group over a 24-month period. The average 5-point reduction in scores was statistically significant and a clinically meaningful difference.

Several recent trials have attempted to integrate interventions for DV and alcohol or drug misuse. A 2015 randomised clinical trial [68] at two US emergency departments assessed the effectiveness of a motivational intervention (30 min) by masters-level therapists for 600 female emergency department patients who exceeded safe drinking limits and were experiencing DV. At 12 weeks, there were no significant differences between groups for experiencing DV or heavy drinking [69]. In a small low-quality trial [70], a 10-session CBT group was piloted in Spain among 14 women receiving outpatient treatment for a drug use disorder who had DV in the previous month. The intervention did not significantly reduce the likelihood of any DV, depressive symptoms, quality of life or health status. These results do not support widespread implementation of brief interventions for addressing co-morbid DV or heavy drinking or drug misuse. Alternative settings or more intensive interventions may be needed or in the latter study larger sample sizes to detect any differences.

Although there are many recommendations for health practitioners not to deliver couples interventions [22], several researchers are testing them in specific settings with mixed results. In a low-quality trial [71] of 69 male service members or veterans and their female partners attending two hospitals, the Strength At Home Couples Program (SAH-C) was compared to "supportive prevention" couples therapy. Completion rates for both treatment arms were low, and consequently, no statistically significant between-group differences on measures of domestic violence could be considered. In a secondary analysis of a randomised clinical trial [72] comparing behavioural couples therapy plus individually based treatment versus individually based treatment, there is a suggestion that individual is better than couples.

In a previous WHO systematic review, mother-child interventions have had the strongest evidence for assisting women [22]. More recently, a community-based intervention [73], the Moms' Empowerment Program, was tested with 181 mothers exposed to DV during the past year. Participants were allocated to three conditions: mother-plus-child intervention, child-only intervention and a wait list comparison. Women in the mother-child condition showed the greatest improvement over time in positive parenting and depression.

Very few randomised controlled trials were found addressing SV identification or response in health settings over the last 3 years, and the results of these were mostly inconclusive. One 2017 study compared cognitive processing therapy (CPT) to usual care in 47 women experiencing sexual assault-related acute stress disorder [74]. Small between-group effect sizes were reported in favour of CPT for both PTSD and depression, although the authors were unable to conclude that CPT was meaningfully superior due to the small sample size and large confidence intervals. Another study [75] compared CBT plus imagery rehearsal therapy (IRT) to CBT alone for 42 sexual assault survivors experiencing PTSD. They found no statistically significant differences between the two groups on mental health outcomes or on night time distress.

Health Systems Change Is Needed

The WHO recommends a broad systems-based approach to enable sustained change in health practitioner behaviour [21].

Improving patient outcomes in the context of DV and SV requires patient-centred care, but also a 'whole of system' health service response. At a health provider level, changes could include promoting a culture of gender equity; having trauma-informed principles (respect, privacy, confidentiality, safety); allowing sufficient consultation time and promoting awareness of DV and SV protocols and referrals. At a systems level, change might involve provision of workforce support and mentoring, appointment of champions, allocation of finances to family violence services, and information systems for evaluation. A survey of health clinics across Europe found several factors encouraged best responses including the following: (1) committed leadership; (2) regular training with mandatory attendance that included front-desk workers to health care providers; (3) use of on-site trainers and (4) a clear referral pathway [76].

Conclusion

There is extremely limited evidence over the last 3 years to guide health practitioners in the areas of DV and SV. Consensus guidelines from the WHO remain that screening in antenatal care is warranted and that all practitioners should be trained to deliver a first-line response which includes a safety assessment. Advocacy and empowerment for DV appear to be most beneficial when delivered to women in the perinatal period and through home visiting. Some patients are unable to access health care or are reluctant to disclose face-to-face as they fear judgemental attitudes, and so, researchers testing online safety decision aids and healthy relationship tools are showing acceptability, feasibility and some efficacy [57, 58, 60, 62, 63, 77]. For SV, there is older evidence to support the use of CBT and prolonged exposure therapy as an effective response, although not specifically in the primary care setting. No randomised controlled trial evidence could be found for effective ways for health practitioners to identify or ask about SV in health settings.

There are a number of critical gaps in the literature that our review has identified. First, the almost complete lack of evidence to support effective ways for practitioners to identify and respond to male perpetrators of DV and SV. Second, the lack of robust evidence to guide practitioners in identifying and responding specifically to SV, in primary care or more broadly across health settings. Although there are overlaps between DV and SV, it is not enough to address SV simply as part of a DV response; this does not acknowledge the particular nuances of SV perpetrated by an intimate partner, nor does it account for SV perpetrated by strangers [78]. How interventions might work for different groups of SV survivors is unclear [48]. Third, there is a need for a tailored response to women, men and their children as DV experience is heterogeneous, with patients at different stages of readiness to take action [17, 79].

Considering the review findings in the context of #MeToo and other social media movements highlights some interesting contrasts. These movements have highlighted SV and DV and the need to listen to survivors and make men accountable for their actions. It has been suggested in the news media that this has resulted not only in increased awareness about violence against women but also galvanised support for survivors and led to repercussions for perpetrators. A recent New York Times analysis, for instance, reported that over 200 powerful men had lost their jobs as a result of perpetrating sexual harassment in the workplace, with many of them being replaced by women [80].

If we look specifically at the health sector, however, it appears clear that #MeToo has not impacted on how SV and DV are addressed. We are yet to see an emphasis on perpetrator accountability in the health sector, nor even attempts to promote identification and referral. Furthermore, despite the primary focus of the #MeToo movement being SV, there is a dearth of literature around how to address this issue in health settings. The majority of health settings research focuses on DV, whose corresponding social media movements #WhyILeft and #WhyIStayed have not taken off in the same way as #MeToo [81]. It appears, then, that social media movements may not be the most effective way to encourage health systems change; new and innovative ways of translating social activism into concrete action for the health sector is critical for the future.

Compliance with Ethical Standards

Conflict of Interest Kelsey Hegarty and Laura Tarzia declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

References

Papers of particular interest, published recently, have been highlighted as:
- Of importance

1. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO; 2013.
2. Oram S, Trevillion K, Khalifeh H, Feder G, Howard LM. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. Epidemiol Psychiatr Sci. 2014;23(4):361–76.

3. Coben J, Friedman D. Health care use by perpetrators of domestic violence. J Emerg Med. 2002;22(3):313–7.
4. Ayre J, Lum On M, Webster K, Gourley M, Moon L. Examination of the burden of disease of intimate partner violence against women. Sydney: ANROWS; 2016.
5. Felitti V, Anda R. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behaviour: implications for healthcare. In: Lanius R, Vermetten E, Pain C, editors. The impact of early life trauma on health and disease. Cambridge: Cambridge University Press; 2010. p. 77–87.
6. Tarzia L, Maxwell S, Valpied J, Novy K, Quake R, Hegarty K. Sexual violence associated with poor mental health in women attending Australian general practices. Aust N Z J Public Health. 2017;41(5):518–23.
7. Pico-Alfonso MA, Garcia-Linares MI, Celda-Navarro N, Blasco-Ros C, Echeburua E, Martinez M. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. J Women's Health. 2006;15(5):599–611.
8. Chen L, Murad M, Paras M, Colbenson K, Sattler A, Goranson E, et al. Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. Proc Mayo Clin. 2010;85(7): 618–29.
9. Mark H, Bitzker K, Klapp B, Rauchfuss M. Gynaecological symptoms associated with physical and sexual violence. J Psychosom Obstet Gynecol. 2007;29(3):167–75.
10. Eby K, Campbell J, Sullivan C, Davidson W. Health effects of experiences of sexual violence for women with abusive partners. Health Care Women Int. 1995;16(6):563–76.
11. Miller E, Decker M, McCauley H, Tancredi D, Levenson R, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2010;81(4):316–22.
12. World Health Organization. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: World Health Organization; 2016.
13. United Nations. UN sounds alarm to end 'global pandemic' of violence against women. UN News [Internet]. 2014 1/10/18. Available from: https://news.un.org/en/story/2014/11/484692#.We-gOa2ZOU0.
14. Council of Australian Governments. National plan to reduce violence against women and their children 2010-2022. Canberra: Australian Government; 2010.
15. Hawley E, Clifford K, Konkes C. The "Rosie Batty Effect" and the framing of family violence in Australian news media. Journal Stud. 2018;19(5):2304–23.
16. Mendes K, Ringrose J, Keller J. #MeToo and the promise and pitfalls of challenging rape culture through digital feminist activism. Eur J Women's Stud. 2018;25(2):236–46.
17. Garcia-Moreno C, Hegarty K, d'Oliveira A, Koziol-McLain J, Colombini M, Feder G. The health systems response to violence against women. Lancet. 2014;385(9977):1567–79.
18. Plichta SB, Falik M. Prevalence of violence and its implications for women's health. Womens Health Issues. 2001;11(3):244–58.
19. Cox P. Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey 2012. ANROWS Horizons: 01/2015. Sydney: Australia's National Research Organisation for Women's Safety Limited (ANROWS); 2015.
20. Feder G, Hutson M, Ramsay J, Taket A. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006;166(1):22–37.
21. Garcia-Moreno C, Hegarty K, d'Oliveira A, Koziol-McLain J, Colombini M, Feder G. The health-systems response to violence against women. Lancet. 2015;385:1567–79.
22. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO; 2013.
23. NICE. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. London: NICE; 2014.
24. Hegarty K, Feder G, Ramsay J. Identification of partner abuse in health care settings: should health professionals be screening? In: Roberts G, Hegarty K, Feder G, editors. Intimate partner abuse and health professionals. London: Elsevier; 2006. p. 79–92.
25.• Tarzia L, Forsdike K, Feder G, Hegarty K. Interventions in health settings for male perpetrators or victims of intimate partner violence. Trauma Violence Abuse. 2017. https://doi.org/10.1177/1524838017744772. **This systematic review highlights the paucity of robust evidence to support effective identification and response to male perpetrators of DV in health settings.**
26. Williamson E, Jones S, Ferrari G, Debbonaire T, Feder G, Hester M. Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. Prim Health Care Res Dev. 2015;16(3):281–8.
27. Penti B, Timmons J, Adams D. The role of the physician when a patient discloses intimate partner violence perpetration: a literature review. J Am Board Fam Med. 2018;31(4):635–44.
28. O'Doherty L1, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. Screening women for intimate partner violence in healthcare settings. Cochrane Database Syst Rev. 2015. https://doi.org/10.1002/14651858.CD007007.pub3.
29. Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. Health Technol Assess. 2009;13(16):iii–v, xi-xiii, 1-113, 37-347.
30. Zink T, Levin L, Putnam F, Beckstrom A. Accuracy of five domestic violence screening questions with nongraphic language. Clin Pediatr (Phila). 2007;46(2):127–34.
31. Zink T, Levin L, Wollan P, Putnam F. Mothers' comfort with screening questions about sensitive issues, including domestic violence. J Am Board Fam Med. 2006;19(4):358–67.
32. Ahmad F, Hogg-Johnson S, Stewart D, Skinner H, Glazier R, Levinson W. Computer-assisted screening for intimate partner violence and control: a randomized trial. Ann Intern Med. 2009;151(2):93–102.
33. Kataoka Y, Yaju Y, Eto H, Horiuchi S. Self-administered questionnaire versus interview as a screening method for intimate partner violence in the prenatal setting in Japan: a randomised controlled trial. BMC Pregnancy Childbirth. 2011;10:84.
34. Webster J, Holt V. Screening for partner violence: direct questioning or self-report? Obstet Gynecol. 2004;103(2):299–303.
35. Hussain N, Sprague S, Madden K, Hussain F, Pindiprolu B, Bhandari M. A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: a systematic review and meta-analysis. Trauma Violence Abuse. 2015;16(1):60–9.
36. Arkins B, Begley C, Higgins A. Measures for screening for intimate partner violence: a systematic review. J Psychiatr Ment Health Nurs. 2016;23(3/4):217–35.
37. Thompson M, Basile KC, Hertz M, Sitterle D. Measuring intimate partner violence victimization and perpetration: a compendium of assessment tools. Atlanta: Centers for Disease Control and

Prevention, National Center for Injury Prevention and Control; 2006.

38. Stevens L. Screening for sexual violence: gaps in research and recommendations for change 2007 1/10/18. Available from: https://vawnet.org/sites/default/files/materials/files/2016-09/AR_ScreeningforSV.pdf. Accessed 25 Oct 2018.
39. Alvarez C, Fedock G, Grace K, Campbell J. Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors. Trauma Violence Abuse. 2016: 1–17.
40. Stayton C, Duncan M. Mutable influences on intimate partner abuse screening in health care settings. Trauma Violence Abuse. 2005;6(4):271–85.
41. Hegarty K, O'Doherty L, Gunn J, Pierce D, Taft A. A brief counseling intervention by health professionals utilising the 'readiness to change' concept for women experiencing intimate partner abuse: the weave project. J Fam Stud. 2008;14(2–3):376–88.
42. Hegarty K, O'Doherty L, Taft A, Chondros P, Brown S, Valpied J, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. Lancet. 2013;382(9888):249–58.
43. Bair-Merritt M, Lewis-O'Connor A, Goel S, Amato P, Ismailji T, Jelley M, et al. Primary care-based interventions for intimate partner violence. Am J Prev Med. 2014;46(2):188–94.
44. Zlotnick C, Capezza N, Perker D. An interpersonally based intervention for low income pregnant women with intimate partner violence: a pilot study. Arch Womens Ment Health. 2011;14:5–65.
45. Campbell R, Patterson D, Lichty L. The effectiveness of sexual assault nurse examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes. Trauma Violence Abuse. 2005;6(4):313–29.
46. Campbell R, Bybee D, Townsend S, Shaw J, Karim N, Markowitz J. The impact of sexual assault nurse examiner programs on criminal justice case outcomes: a multisite replication study. Violence Against Women. 2014;20(5):607–25.
47.• Parcesepe A, Martin SL, Pollock M, Garcia-Moreno C. The effectiveness of mental health interventions for adult female survivors of sexual assault: a systematic review. Aggress Violent Behav. 2015;25:15–25 **This systematic review provides a useful summary and critique of the current evidence around responding to adult female survivors of SV.**
48. Regehr C, Alaggia R, Dennis J, Pitts A, Saini M. Interventions to reduce distress in adult victims of sexual violence and rape: a systematic review. Campbell Syst Rev. 2013;2013(3).
49. Warshaw C, Sullivan CM, Rivera EA. A systematic review of trauma-focused interventions for domestic violence survivors. Chicago: National Center on Domestic Violence, Trauma & Mental Health. 2013. Available from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf. Accessed 20 Oct 2018.
50. Quadara A. Implementing trauma-informed systems of care in health settings: the WITH study. State of knowledge paper. Alexandria: Australia's National Research Organization for Women's Safety; 2015.
51. Miller E, Jordan B, Levenson R, Silverman J. Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. Contraception. 2010;81(6):457–9.
52. Grace KT, Anderson JC. Reproductive coercion: a systematic review. Trauma Violence Abuse. 2016;16:16.
53. Tarzia L, Wellington M, Marino J, Hegarty K. 'A huge, hidden problem': Australian health practitioners' views and understandings of reproductive coercion. Qual Health Res. 2018. https://doi.org/10.1177/1049732318819839.
54. Grace KT. Caring for women experiencing reproductive coercion. J Midwifery Womens Health. 2016;61(1):112–5.
55. Miller E, Tancredi D, Decker MR, McCauley H, Jones K, Anderson H, et al. A family planning clinic-based intervention to address reproductive coercion: a cluster randomized controlled trial. Contraception. 2016;94(1):58–67.
56. Hegarty K, Tarzia L, Murray E, Valpied J, Humphreys C, Taft A, et al. Protocol for a randomised controlled trial of a web-based healthy relationship tool and safety decision aid for women experiencing domestic violence (I-DECIDE). BMC Public Health. 2015;15(736).
57. Ford-Gilboe M, Varcoe C, Scott-Storey K, Wuest J, Case J, Currie L, et al. A tailored online safety and health intervention for women experiencing intimate partner violence: the iCAN Plan 4 Safety randomized controlled trial protocol. BMC Public Health. 2017;17(273):1–12.
58. Koziol-McLain J, Vandal A, Wilson D, Nada-Raja S, Dobbs T, McLean C, et al. Efficacy of a web-based safety decision aid for women experiencing intimate partner violence: randomized controlled trial. J Med Internet Res. 2018;20(1).
59. Glass N, Eden KB, Bloom T, Perrin N. Computerized aid improves safety decision process for survivors of intimate partner violence. J Interpers Violence. 2010;25:1947–64.
60. Glass N, Perrin N, Hanson GC, Bloom T, Messing JT, Clough A, et al. The longitudinal impact of an internet safety decision aid for abused women. Am J Prev Med. 2017;52(5):606–15.
61. Zlotnick C, Tzilos Wernette G, Raker CA. A randomized controlled trial of a computer-based brief intervention for victimized perinatal women seeking mental health treatment. Arch Womens Ment Health. 2018. https://doi.org/10.1007/s00737-018-0895-1.
62. Tarzia L, Iyer D, Thrower E, Hegarty K. 'Technology doesn't judge you': Young Australian women's views on using the internet and smartphones to address intimate partner violence. J Technol Hum Serv. 2017;35(3):199–218.
63. Tarzia L, Cornelio R, Forsdike K, Hegarty K. Women's experiences receiving support online for intimate partner violence: how does it compare to face-to-face support from a health professional? Interact Comput. 2018;30(5):433–43.
64. Rivas C, Ramsay J, Sadowski L, Davidson L, Dunne D, Eldridge S, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. Cochrane Database Syst Rev. 2015;3(12):CD005043.
65.• Gupta J, Falb K, Ponta O, Xuan Z, Campos P, Gomez A, et al. A nurse-delivered, clinic-based intervention to address intimate partner violence among low-income women in Mexico City: findings from a cluster randomized controlled trial. BMC Med. 2017;15(128) **This study represents a robust trial of an advocacy intervention with a large sample size. It contradicts previous systematic review evidence (mostly small, low-quality trials) that suggests that advocacy interventions are effective for women experiencing DV.**
66. Stevens J, Scribano P, Marshall J, Nadkarni R, Hayes J, Kelleher K. A trial of telephone support services to prevent further intimate partner violence. Violence Against Women. 2015;21(12):1528–47.
67. Sharps P, Bullock L, Campbell J, Alhusen J, Ghazarian S, Bhandari S, et al. Domestic violence enhanced perinatal home visits: the DOVE randomized clinical trial. J Women's Health. 2016;25(11):1129–38.
68. Rhodes K, Rodgers M, Sommers M, Hanlon A, Chittams J, Doyle A, et al. Brief motivational intervention for intimate partner violence and heavy drinking in the emergency department: a randomized clinical trial. JAMA. 2015;314(5):466–77.
69. Rhodes K, Rodgers M, Sommers M, Hanlon A, Chittams J, Doyle A, et al., editors. Evaluating a motivational intervention for intimate partner violence & heavy drinking in emergency department: a randomized controlled trial. 38th Annual Scientific Meeting of the Research Society on Alcoholism; 2015; San Antonio Texas.

70. Tirado-Munoz J, Gilchrist G, Lligona E, Gilbert L, Torrens M. A group intervention to reduce intimate partner violence among female drug users. Results from a randomized controlled pilot trial in a community substance-abuse center. Adicciones. 2015;27(3):168–78.
71. Taft C, Creech S, Gallagher M, Macdonald A, Murphy C, Monson C. Strength at Home Couples program to prevent military partner violence: a randomized controlled trial. J Consult Clin Psychol. 2016;84(11):935–45.
72. Schumm J, O'Farrell T, Murphy M, Muchowski P. Partner violence among drug-abusing women receiving behavioral couples therapy versus individually-based therapy. J Subst Abus Treat. 2018;92:1–10.
73. Graham-Bermann S, Miller-Graff L. Community-based intervention for women exposed to intimate partner violence: a randomized control trial. J Fam Psychol. 2015;29(4):537–47.
74. Nixon R, Best T, Wilksch S, Angelakis S, Beatty L, Weber N. Cognitive processing therapy for the treatment of acute stress disorder following sexual assault: a randomised effectiveness study. Behav Chang. 2017;23(4):232–50.
75. Belleville G, Dube-Frenette M, Rousseau A. Efficacy of imagery rehearsal therapy and cognitive behavioral therapy in sexual assault victims with posttraumatic stress disorder: a randomized controlled trial. J Trauma Stress. 2018;31:591–601.
76. Bacchus L, Bewley S, Fernandez C, et al. Health sector responses to domestic violence in Europe: a comparison of promising intervention models in maternity and primary care settings. London: London School of Hygiene and Tropical Medicine; 2012.
77. Tarzia L, May C, Hegarty K. Assessing the feasibility of a web-based domestic violence intervention using chronic disease frameworks: reducing the burden of 'treatment' and promoting capacity for action in women abused by a partner. BMC Womens Health. 2016;16(73):1–9.
78. Hegarty K, Tarzia L, Hooker L, Taft A. Interventions to support recovery after domestic and sexual violence in primary care. Int Rev Psychiatry. 2016;28(5):519–32.
79. Reisenhofer S, Taft A. Women's journey to safety - the transtheoretical model in clinical practice when working with women experiencing intimate partner violence: a scientific review and clinical guidance. Patient Educ Couns. 2013;93(3):536–48.
80. Carlsen A, Salam M, Miller C, Lu D, Ngu A, Patel J, et al. #MeToo brought down 201 powerful men. Nearly half of their replacements are women. New York Times. 2018. Available from: https://www.nytimes.com/interactive/2018/10/23/us/metoo-replacements.html. Accessed 25 Oct 2018.
81. Mervosh S. Domestic violence awareness hasn't caught up with #MeToo. Here's why. New York Times. 2018. Available from: https://www.nytimes.com/2018/10/16/us/domestic-violence-hotline-me-too.html. Accessed 26 Oct 2018.