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Review

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

Sonia Reisenhofer *, Angela Taft

Mother and Child Health Research, School of Nursing & Midwifery, Faculty of Health Sciences, La Trobe University, Australia

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ABSTRACT

Objective: Review the applicability of the Transtheoretical model and provide updated guidance for clinicians working with women experiencing intimate partner violence.
Methods: Critical review of related primary research conducted from 1990 to March 2013.
Results: Women's experiences of creating change within abusive relationships can be located within a stages of change continuum by identifying dominant behavioral clusters. The processes of change and constructs of decisional-balance and turning-points are evident in women's decision-making when they engage in change.
Conclusion: Clinicians can use the stages of change to provide a means of assessing women's movement toward their nominated outcomes, and the processes of change, decisional-balance and turning-points, to enhance understanding of, and promote women's movement across stages in their journey to safety.
Practice implications: Clinicians should assess women individually for immediate and ongoing safety and well-being, and identify their overarching stage of change. Clinicians can support women in identifying and implementing their personal objectives to enhance self-efficacy and create positive change movement across stages.

The three primary objectives identified for clinician support are: 1. Minimizing harm and promoting well-being within an abusive relationship, 2. Achieving safety and well-being within the relationship; halting the abuse, or 3. Achieving safety by ending/leaving intimate relationships.

Contents

* Corresponding author at: School of Nursing and Midwifery, La Trobe University, Victoria 3086, Australia. Tel.: +61 03 9479 5926; fax: +61 03 9479 5988.
E-mail address: s.reisenhofer@latrobe.edu.au (S. Reisenhofer).

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1. Introduction

As a form of violence against women, intimate partner violence (IPV) is any act by a current or past intimate partner, that does, or is likely to, result in 'physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of Liberty' [1], affecting 10–69% of women worldwide [2].

IPV puts women at greater likelihood of illness, injury and death compared with women in non-abusive intimate relationships [3,4]. Mental illness, experiencing suicidal thoughts/behaviors, depression, anxiety and post-traumatic stress are common outcomes [3–5]. Unwanted pregnancy, miscarriage, sexually transmitted infections and gynecological health concerns [4,6], risky drug and alcohol behaviors [5], and physical injuries are further risks [4]. The emotional, physical and financial burden for women, their families and communities are significant [3]. Women experiencing IPV are more likely to access healthcare across a variety of settings, particularly emergency departments, general practice clinics, mental health, and maternal and child health, centers [7].

In their early work, Stark and Flitcraft [8] researched women's experiences of attending emergency departments with IPV related injuries and highlighted the need for healthcare professionals (clinicians) to appropriately assess women and provide a supportive clinical response. Recently, obtaining disclosure (of IPV) through mandatory screening programs or case-finding of women experiencing abuse has been a primary clinical goal and focus of associated research [9]. The inherent assumption underlying programs to increase disclosure is that identifying IPV will 'lead to appropriate interventions and support [for affected women], and ultimately decrease exposure to violence and its detrimental health consequences, both physical and psychological' [7].

Once a woman has disclosed her experience of violence, healthcare often focuses on the use of referral to advocacy interventions [10]; however, women's uptake of referrals remains relatively low [9,11]. Advocacy interventions may involve counseling, providing information about IPV or safety planning, options for refuge and support, legal reporting, and police interventions [10]. While obtaining disclosure and promoting safety seems like an intuitive healthcare response, the realities women face in abusive relationships are complex and minimal evidence is available about long-term benefits of these interventions [10,11].

Women's decision-making around disclosing violence and implementing safety-behaviors or leaving abusive relationships may be exceptionally challenging. Women face significant risks from their abuser and often from family, friends and their community when making changes to, or even acknowledging, abusive relationships. The enablers of disclosure, clinician enhanced knowledge of IPV, privacy/confidentiality for women, and perceived respectful/non-judgmental/empathetic/caring attitude of staff have been well-documented [12]. However, the often unacknowledged, hidden or perceived shameful nature of abuse, the relationship between the abuser and woman (positive and negative components), isolation, and abused women's decreased self-efficacy, may make disclosing, changing, or leaving an abusive relationship, even more difficult [12]. Unsupportive or judgmental clinicians, a lack of privacy or clinician knowledge, may also prevent disclosure or the provision of appropriate support, and at worst, women may avoid future healthcare [12,13]. Furthermore, the risk of retaliatory harm or violence, financial hardship, loss of children, shame for a failed relationship, and loss of social status or family/community support are all real risks for women seeking to end abusive relationships [12,14].

Not always understanding this complexity, clinicians supporting women after disclosure of IPV have frequently encouraged them to leave violent relationships [15]. When this advice is not followed, clinicians may become disillusioned, losing empathy and providing only physical care to women who do not 'choose' to leave an abusive partner [15–18]. This response is reflective of current Australian community attitudes demonstrated by 81% of survey respondents ($n = 2800$) agreeing that 'it is hard to understand why women remain in abusive relationships' [19].

IPV-related healthcare research has increasingly recognized the complexity of women's experiences, using different models to highlight how abused women make decisions and create change [14,20–22]. Clinical scholars have also explored how clinicians can better support women in decision-making and achieving ongoing safety and well-being [14,20–22].

Prochaska and DiClemente's Transtheoretical Model of Change (TTM) – often referred to as the Stages of Change (SOC) Model, details five stages and ten processes of change and the constructs of decisional balance and self-efficacy [23–25]. It may provide a means of evaluating and supporting women's readiness and ability for change in the context of abusive relationships [21,22]. Nursing and health research using TTM, has explored women's journey to safety, and provided SOC-based Healthcare Guidelines [22,26–30].

Differences using TTM in change-making decisions for women experiencing IPV and those undertaking other behavior change, such as smoking cessation, lies in the individual's responsibility for the problem behavior and change process. Women experiencing IPV TRY TO stop or change a behavior not primarily within their control; namely another's abusive behavior [27]. We suggest that rather than blaming women, using TTM allows acknowledgment of the actions women take to prevent or minimize abuse and emphasizes women's agency in IPV relationships.

This paper critically reviews use of TTM within healthcare for women working to achieve safety from abuse, and considers how this knowledge can guide clinicians interventions and promote women's well-being. We acknowledge the complex challenges faced by women and provide guidelines for clinician support related to three primary objectives chosen by women:

1. Minimizing harm and promoting well-being within an abusive relationship,
2. Halting abuse and remaining in the relationship or
3. Achieving safety by ending an intimate relationship.

2. Methods

Primary research focusing on women's experience of IPV-related change utilizing TTM was included in this review when published in English from 1990 to March 2013. Five databases were searched using keywords

Intimate partner violence/abuse, battered women, domestic violence/abuse, family violence/abuse or spouse abuse/violence and stages of change or Transtheoretical model. A total of 883 abstracts were initially retrieved: Cinahl (84), Google Scholar (300), Medline (58), Proquest (414) and Psych Info (23).

Retrieved abstracts were reviewed to ensure they met primary inclusion criteria. Excluded articles researched change of IPV perpetrator's behavior, other primary behavior, such as smoking cessation, and non-primary research. After removal of ineligible papers and duplicates, 24 papers remained and were assessed for quality prior to inclusion in the review.

Quantitative studies were evaluated using the Effective Public Health Practice Project guidelines [31] and an overall rating of strong, moderate or weak was allocated. Studies with a weak rating were to be excluded from the review if they did not have similar findings to studies which had a ranking of strong or moderate. Qualitative studies were graded according to the hierarchy of evidence for assessing qualitative health research [32] as Level 1 generalizable studies, Level 2 conceptual studies, Level 3 descriptive studies or Level 4 single case studies. Studies with Level 4 ranking were to be excluded from the review if they did not have outcomes similar to studies with higher rankings. No studies met qualitative or quantitative exclusion criteria and 12 qualitative (Table 1) and 12 quantitative (Table 2) are included in the following discussion. Studies assessed as Level 1 (qualitative) or Strong (quantitative) allocation have been identified with an * in Tables 1 and 2.

3. Results

3.1. Qualitative TTM research

Qualitative studies explored the applicability of the SOC framework to women's experiences of IPV [26,28,33–36], the processes of change on women's change behaviors when living with IPV [26,30] and desired healthcare reflective of SOC [28,30]. Studies also explored the influence of turning-points [37–40] and decisional-balance[39]. The aims, participant demographics and primary outcomes of these studies are detailed in Table 1.

3.2. Quantitative TTM research

Studies that explored TTM from a quantitative perspective (shown in Table 2) focused on evaluating tools which allow assessment of women's SOC [22,27,29,42] and the typical behaviors/actions/emotions that are common in any given stage [27,43–46]. More recently one study evaluated the influence of a nominated intervention on women's SOC [47] while others explored the influence of cognitive-affective predictors [48], subjective norms and relationship commitment [49] and mental health [50] on women's positioning and movement within the SOC. The majority of studies were of cross-sectional design, a weak design for generalizability, with some using opportunistic sub-sets of women from larger studies. There is also a significant lack of longitudinal studies evaluating the applicability of TTM and women's movement across the SOC over time.

3.3. The findings

Participants were from a variety of socioeconomic and cultural backgrounds; many had children, and most involved women living in North America (USA and Canada). Studies tended to have larger populations of women in later SOC when recruiting from Domestic Violence shelters or support services. When participants were recruited from general community or healthcare environment samples (i.e. general practice, community outpatient centers or emergency departments) larger numbers of women were either located in the earlier SOCs or more evenly spread across the SOC. Precontemplation, by its very nature, usually involving unrecognized or un-named abuse is also potentially underrepresented due to difficulty in screening and identifying women in this stage.

Being older or having higher educational or financial status was sometimes related to later SOC [43,48], while higher levels of anger or other emotional states such as anxiety or PTSD, or perceiving relationships as abusive, increased women's likelihood of being ready to create change [44,48]. Women with children or low self-esteem [44], longer relationships, low anger levels and lower abuse scores [48], those with social networks supportive of their relationship [49] or who engaged in violence themselves [43], were more likely to be in early SOC. Some found no correlation between demographic data and SOC [49].

Only one study [36] explored the decision-making activities of college women in abusive dating relationships while all others explored experiences of women who have lived or are living within abusive relationships. Excluding Perrin et al. [46], who focused on an area outside healthcare–exploring desired workplace support for women reflective of their SOC–all other studies related to TTMs application in healthcare for women experiencing IPV.

With the exception of Cluss et al. [35], researchers generally agreed that women's experiences of change could broadly be defined across the SOC, although these findings were stronger in qualitative work. Quantitative researchers exploring how woman could be allocated different stages were challenged when determining which behaviors aligned with particular stages. Action in particular often difficult to classify [27], and viewing the SOC as a continuum rather than discrete stages was sometimes helpful [44]. Cluss et al. [35], found it difficult to locate women within a discrete SOC and consequently provided a model variation, the *Psychosocial Readiness Model*, which explored internal and external factors that influenced women's decision-making and ability to create change when experiencing IPV.

Women routinely 'leapfrogged' stages or 'regressed' through the SOC pathway when working to achieve safety [28,44]; usually accepted as a normal part of TTM for individuals making change. This was not generally identified as a problem of application [23]. Women also demonstrated behaviors that could be allocated to more than one SOC [28,39,44] and preparation was sometimes seen as being combined with or overlapping the action stage [50]. The primary areas of challenge when using TTM with women experiencing IPV lay in:

1. Determining the goal or measurable outcome of achievement, and (reflectively)
2. Identifying women's behaviors related to these outcomes across the SOC
3. Providing targeted evidence-based healthcare interventions that would assist women in each stage to make positive change and achieve their individually identified objectives.

4. Discussion and conclusion

4.1. Discussion: TTM, stages and processes of change, decisional-balance, self-efficacy and influence of turning-points

Within IPV research, SOC are foundational constructs of TTM consisting of five stages (precontemplation, contemplation, preparation, action or maintenance) identified as a pathway (not necessarily sequential) that women traverse as they work toward achieving safety. Additional to the SOC, TTM also uses ten processes of change which fall into cognitive and behavioral dimensions and, the constructs of decisional-balance and self-efficacy, when exploring how individuals undertake change [23,24].

4.1.1. The SOC and making changes related to IPV

Women in the precontemplative stage are those who do not acknowledge, or are unaware, they are being abused by their

Table 1
Qualitative TTM research.

Title/author(s)	Objective	Participants (demographics)	Findings
Evolving out of violence: an application of the Transtheoretical Model of Behavioral Change [33]	Identify if women's experiences of IPV matched SOC	Delphi Study: 4 women; advocates for women experiencing IPV and survivors of IPV themselves	TTM was applicable to women's experiences of leaving IPV relationships
*The process of ending abuse in intimate relationships: a qualitative exploration of the Transtheoretical model [34]	Explore TTM fit for women experiencing IPV	78 women; 1/2 HIV-positive, 91% African American; 67% completed high school; average age 36, recruited from Domestic Violence shelters, obstetrics & gynecology clinics, or HIV/Drug treatment community clinics	TTM consistent with how women experience (and survive) IPV
Ending intimate partner violence: an application of the Transtheoretical model [26]	Examine application of TTM to women's of ending IPV	23 women (in or having left) IPV relationships, recruited from obstetrics & gynecology clinics, or HIV/Drug treatment community clinics. 22 African American women, most with high school education; average age 38; 65% HIV-positive, most with children	7 of the 10 processes of change are used by women leaving IPV Self-efficacy and decisional balance are also related to ending IPV relationships
Identifying the Turning Point: using the Transtheoretical Model of Change to Map Intimate Partner Violence Disclosure in Emergency Department Settings [37]	Understand/interpret how women move toward IPV disclosure in Emergency Departments	19 Canadian women already enrolled in an RCT examining effectiveness of routine screening in an Emergency Department compared with 'usual care'; average age 30.7, all married.	Women distributed across all SOC Decision to disclose often followed a 'turning point' Movement across SOC non-linear Provide women's suggestions for care for each of the groups
Health care interventions for intimate partner violence: what women want [41]	Identify resources and assistance wanted from clinicians by women experiencing IPV	21 women with a current or recent past history of IPV; recruited from Domestic Violence shelters, hospitals, medical clinics and through direct referral. Mean age 44; 17 white; 19 completed high school; 11 employed; most divorced; 2 pregnant; 7 living with husband and 19 having children.	Women wished for Information (raising awareness), Counseling interventions & other interventions (such as police, shelter or legal involvement) Level of 'readiness to change' influences women's needs; women want to learn about IPV (often anonymously) and their options but may not be ready to disclose, discuss or act on this in the earlier SOC
Understanding behavior change for women experiencing intimate partner violence: mapping the ups and downs using the stages of change [28]	Map women's experiences of change on SOC/TTM as they move toward increased safety	Women recruited through direct referral from Domestic Violence shelter staff or flyer recruitment at outpatient clinics; Current or past history of IPV, 20 women; mean age 45; mostly white employed and finished high school; 1/2 divorced; 19 with children	Turning Points were noted to prevent a return to precontemplation Movement across SOC not linear and therefore question whether SOC is an appropriate model to explain women's movement toward safety. Given non-linear movement: clinician interventions can't focus purely on moving women from one stage to the next
Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change [38]	Understand factors/situations that lead to Turning points and change-seeking for women experiencing IPV	61 women recruited through direct referral from Domestic Violence shelter staff or flyer recruitment at outpatient clinics. Mean age 36.6; race 1/3 white/black/Latina; 2/3 employed and completed high school; 50% separated/divorced; 88% with children; 71% experienced IPV in last year.	Turning points fell into 5 themes: 1. Protecting others 2. Increased severity 3. Increased options or support 4. Fatigue (with abuse and awareness it won't change) 5. Betrayal (infidelity) Change occurred due to an external event or internal realization or both related to above 5 themes
The process of change for victims of intimate partner violence: support for a psychosocial readiness model [35]	Explore safety-seeking processes for women experiencing IPV & explore SOC fit for these processes	Women recruited through direct referral from DV shelter staff or flyer recruitment at outpatient clinics & major women's hospital; Current or past history of IPV, 20 women; mean age 45, mostly white employed and finished high school, 1/2 divorced, 19 with children and predominantly city living	SOC not adequate to explain change processes for women experiencing IPV (difficult to identify target behavior). Identified a new model: psychosocial readiness model to explain change process: Internal themes creating change: 1. Awareness 2. Perceived support 3. SE or perceived power External themes: 1. Interpersonal interactions (positive or negative validation blame on disclosure) 2. Situational events (employment/accommodation)

Table 1 (*Continued*)

Title/author(s)	Objective	Participants (demographics)	Findings
A qualitative analysis of college women's leaving processes in abusive relationships [36]	Assess the process of leaving an abusive dating relationship in college women	123 college women in abusive (physical, sexual, emotional) relationships; mean age 18.84; Caucasian 88%, average length of relationship 21 months	4 groups identified which match the SOC 1. Women who stayed with no ambivalence (precontemplation) 2. Women who stayed with ambivalence (contemplation) 3. Women who left for reasons unrelated to abuse 4. Women who left for reasons related to abuse (action or maintenance)
Theorizing the process of leaving: turning points and trajectories in the stages of change [39]	Theorize the processes of leaving for mothers who divorced abusive husbands	19 mothers purposively sampled from court-mandated parent education class for women divorcing men using IPV; white, married for mean 11 years and divorced. Mean age 34 with high school education or above	SOC fits with women's experiences and turning points were related to movement between stages
Women's use of resources in leaving abusive relationships: a naturalistic inquiry [40]	Explore emotional and psychological resiliency and inner resources in women leaving an abusive relationship	10 women from an out-reach center and local shelter in an Mid-Western American City who had left an abusive relationship >6/12 ago; ages 35–58 y; with 3–35 years of abuse; 9/10 women had experienced all types of abuse	Five major themes influenced women's change/leaving behaviors 1. Turning points 2. Realization (of abuse) 3. Reframing (understanding of abuse and responsibility) 4. Agency (ability to great change) 5. Self-efficacy
Medical management of intimate partner violence considering the stages of change: precontemplation and contemplation [30]	Explore how women want GPs to care for them when they experience IPV	32 women with a mean age of 32, 1/2 white and 1/2 African American, 75% lived below the national poverty level, all had children with an average length of abuse at 6.7 years and 28% were in an abusive relationship	SOC match women's decision-making activities Tools or processes of change helpful in precontemplation and contemplation stages are consciousness raising, dramatic relief and self-reevaluation

intimate partner [30,34]. The abuse may be seen as an expression of love (excessive jealousy) or as a normal part of an intimate relationship [28,30]. Precontemplation frequently involves a woman assuming responsibility for the (usually) un-named abuse in her relationship and attempting to fix it herself usually by modifying her behavior to prevent the problem. In this stage women also often engage in normalizing the problem (happens to everyone) OR minimizing the abuse (it's not that bad).

As women move into the contemplative stage, they acknowledge a problem within their relationship [28]. Women explore the benefits and costs (pros and cons) of their relationship, of making changes within or ending the relationship. Depending on this decisional-balance, women unable or too demoralized to engage in change may continue precontemplative behaviors. Having identified abuse, women may also undertake conscious actions to protect themselves from harm – suppressing their 'self' or not engaging in behaviours or actions which might 'trigger' violence. Women who have undertaken preparation or action activities may return to precontemplation or contemplation if the change behaviour they were attempting proves unachievable.

Depending on their objective for change, women in preparation will prepare for that change. This may include seeking information or resources; possibly involving others (family, friends, clinicians) as a means of seeking external support in their planned change. The preparation stage is often 'leap-frogged' by women creating change when responding to a turning-point (discussed below), with the lines between preparation and action often quite blurred. Women in the action stage enact their plan for change, while maintenance involves enacting the change behavior for a period of six months and longer.

Irrespective of women's change objectives, to aid women's movement across the SOC, clinicians also need to consider the constructs of processes of change, decisional-balance and the impact of self-efficacy and turning-points.

4.1.2. Processes of change

The processes of change provide examples of specific thought patterns or behaviors that individuals enact as they move between, or remain at, an SOC. Prochaska [24] identified ten processes of change as constructs of TTM (p. 99). Table 3 shows the 10 processes of change and example behaviors for women seeking safety in/FROM IPV.

The processes of change commence with cognitive constructs, shifting women's understanding, and labeling of abuse, aligning with an earlier SOC and moves toward behavioral constructs as women enter later SOC [21,26,30,39]. Using processes of change and moving between stages also reflects a woman's decisional-balance and her sense of self-efficacy for making and sustaining change [26].

4.1.3. Decisional-balance

Weighing the pros and cons of change is foundational in all change decisions [39]. A variety of decisional-balance factors have been identified for women seeking change related to IPV, including:

- The woman's degree of attachment to the abuser, where increased attachment = ⇓ lower ability for change [30]
- Having children (particularly risk of abuse to children = ⇑ ability for change or alternatively risk of losing children through separation from abuser = ⇓ ability for change)[39]
- Available or perceived external support (family and friends) and professional supports (medical, counseling, IPV services, legal, police), where ⇑ support = ⇑ ability for change [49]
- Finances/income/employment, where ⇑ availability = ⇑ ability for change [43]
- Previous experiences of seeking support, where negative experiences = ⇓ ability for change [34]
- Family and social norms (religious and cultural belief systems) and expectations; those supporting the relationship or marriage may = ⇓ ability for change [49]

Table 2
Quantitative TTM research.

Title author/year	Objective	Theoretical framework	Participants (demographics)	Findings
Predicting stages of change in battered women [43]	Analysis of psychometric properties of the Problems in relationship subscale of the Process of Change in Abused Women Scales (PROCWAS#) [21] and identifies the factors associated with battered women's SOC	Cross-sectional	754 women; already either seeking help from IPV agencies (37%) or their partners were receiving court ordered interventions; mean age 36.8 y	SOC fits women's experiences of making change related to IPV; particularly in the later stages of action & maintenance Later SOC related to older women who were more educated and had higher incomes Early stage women were more likely to report engaging in violence themselves Lower SOC related to an increased sense of dependence on abuser #PROCWAS based on unpublished data
African American women's readiness to change abusive relationships [44]	Explore AA women's readiness to change when experiencing IPV	Cross-sectional	178 African American women; mean age 34.5; 84% with children and 53% homeless; 58% in currently abusive relationships; sourced from hospital ED when presenting with attempted suicide or IPV or from hospital clinic waiting rooms	SOC along a continuum rather than discrete stages (non-exclusive i.e. may have some behaviors across various stages); most women around contemplation stage Women frequently shifted or had overlapping behaviors between action & maintenance Perceiving their relationship as abusive, anxiety, PTSD and spiritual well-being are positive predictors of readiness to change. Children in the home and self-esteem negatively correlated with readiness to change. Social support had no impact on readiness to change.
Defining appropriate stages of change for intimate partner violence survivors [27]	Distribution of IPV experiencing women across the SOC for a) staying safe and b) leaving	Cross-sectional	96 women; African American 83%; 58% completed high school; 81% had no paid employment; mean age 40 y; 27% HIV positive; and 97% severe abuse within the last year	All women, irrespective of stage undertake safety behaviors; early stages for both safety and leaving actually do more 'actions' in terms of hiding things and discussing the abuse with partners; Women in the Pre-action stages had a desire for information Women in Maintenance wanted peer support/ counseling
The Transtheoretical model in intimate partner violence victimization: stage changes over time [45]	Examine process of change over 3–4 months and identifies factors that may influence progression	Longitudinal cluster analysis conducted over 3–4 months	Recruited from an ED/Trauma center; 102 (out of 199) eligible participants commenced and 51% ($n = 53$) completed the follow up at 3–4 months Mean Age 31 y; 60% African American; 30% White; 10% Hispanic/unknown; Average length of relationship = 4 y	5 clusters reflective of SOC; most movement was in an upward direction Precontemplation (23%) women held onto beliefs that their partners would change Women who were uninvolved/ambivalent (contemplation) (27%) were apathetic or passive about their relationship Women in engagement (preparation) were ready to make changes but needed help Action cluster had biggest movement over time growing from 6–42% of women from at enrolment to upon completion Decisional balance: pros outweigh cons = positive movement across SOC
SOC as a correlate of mental health symptoms in abused, low-income African American women [50].	'Examine applicability of TTM to IPV with a focus on mental health symptoms' (p. 1531)	Cross-sectional	121 self-identified abused African American women completed the study at two time points (baseline and 1 week) (35% of the women who screened positive to IPV a the initial assessment and 9.4% of all women screened). Computer kiosk screening at an emergency department servicing a lower socio-economic inner city population. 18–55 y; 75% single; 58% with some high school and 41% some college education; 50% had moderate-severe depressive symptoms, 32% PTSD symptoms & 14% positive for suicidal ideation	Supports use of TTM for women seeking safety from IPV Majority of women in early SOC (69.4% in precontemplation, 25.6% in contemplation and 5% in Action). Study excluded preparation and no participants were in maintenance. Later SOC related to higher levels of mental health illness (PTSD & Depression) although results inconclusive due to lack of power related to low numbers in Action.

Table 2 (*Continued*)

Title author/year	Objective	Theoretical framework	Participants (demographics)	Findings
The domestic violence survivor assessment: a tool for counseling women in intimate partner violence relationships [22]	Develop a tool Domestic Violence Survivor Assessment (DVSA) which measures women's five 'states' when seeking safety from IPV (based on expert group and pilot testing of survey for acceptability and fit)	Cross-sectional	Pilot study done with 20 women receiving counseling for IPV from three agencies (inner city, suburban and rural) with primarily either African American or 'White European' ethnicity DVSA refined after pilot study and further testing then undertaken with 87 clients who disclosed IPV from 5 diversified settings (rural & urban hospitals and community agencies)	88.5% of women could be located into a state of change (reflective of SOC) DVSA can be used to identify areas of focus for counselors working with women experiencing IPV DVSA can be discussed with the woman to open the conversation and identify aims for intervention and support Interventions for women in early stages aiming to preserve relationship focus on education (i.e. circle of violence), expression of concern for safety and allowing the woman to return for further support as desired in the future For women in the mid-SOC–focus on safety planning and information pertaining to legal rights and available supports For women in the final states of change, peer support and individual counseling are recommended
The Domestic Violence Survivor Assessment (DVSA): a tool for individual counseling with women experiencing intimate partner violence [29]	Examined the validity and reliability of the DVSA to measure stages of change in women seeking safety from IPV	Cross-sectional, Longitudinal Study; 3 monthly assessments usually over 3–6 months to a maximum of 3 years	355 women undertaking individual counseling in an Abused Persons 'county' based Program. Demographic data not reported	Support the use of TTM for women seeking safety from IPV DVSA is a tool sensitive enough to detect SOC positioning change over time 57.7% of women receiving individual counseling had made positive SOC movement over three of more months Focus on empowerment & information about IPV found to be a less helpful intervention and treatment shifted to trauma recovery counseling
Psychometric properties of the DVSA [42]	Psychometric testing of a revised DVSA (added Control of Money); cross sectional descriptive statistics	Focus group to determine need for Control of Money and then testing to ensure fit	119 women (some women completed two surveys; total of 134 surveys as some women completed twice over time) & 129 clinicians completed surveys.	Revised tool found to effectively measure all five SOC; found to be reliable and valid Clinician completed forms clustered more behavior into one stage compared with women completed forms
Patterns of workplace supervisor support desired by abused women [46]	"Understand differences in patterns of supervisor support desired by female victims of IPV and to examine whether the pattern of support desired at work is reflective of a woman's SOC in the abusive relationship" (p. 2264)	Cross-sectional cluster analysis	133 subset of adult women from a larger American study exploring workplace interventions for low-income employed women with health disparities who had screened positive to IPV in the last year English or Spanish speaking only	Clusters of women's need were reflective of SOC positioning Women wanted different types of support depending on their allocated SOC Early SOC related to women not having disclosed IPV to their supervisor and wanting to be treated like everyone else Women in mid-SOC wanted concern, information and emotional support from their supervisors but no "active" help. Women in later SOC wished for interventional support such as security/police, legal and financial assistance in addition to emotional support
Does SOC predict improved IPV outcomes following an ED intervention? [47]	"Assess the effect of an ED based computer screening and referral intervention on the safety-seeking behaviors of female IPV victims at differing SOC"	Prospective cohort study	154 women were recruited from three large city hospital emergency departments, after screening positive to IPV; 92% had not presented to ED for IPV-related injuries; >50% had not completed high school; 92% were unmarried; nearly 63% had children and 85% self-identified as "black" Baseline: $n = 154$, 1-week: $n = 110$ and 3-months: $n = 63$)	>50% of participants undertook protective action at 1-week and nearly 75% at 3-months SOC at baseline and demographics did not influence use of protective action Most common protective actions were construction of a safety plan or ending the relationship
A preliminary investigation of the influence of subjective norms and relationship commitment on SOC in female IPV victims [49]	Explore the role of subjective norms (i.e. what other people think about the relationship) and relationship commitment on movement/position within the SOC	Cross-sectional (retrospective–last 6 months)	Community sample of 84 women who screened positive to having experienced physical aggression in the last 6 months; mean age 34 y; 64% Caucasian & 31% African American; 61% unemployed and 17% having a disability; 70% were separated at the time of the study	Demographic data and level of abuse did not significantly differ across the SOC positioning (largest clusters where in contemplation 61% and action 18%) Commitment to the relationship was positively associated with positioning in the precontemplation or contemplation stages and negatively associated with the later SOC Subjective norms (social support for the relationship) have positive correlation with precontemplation and negative with later SOC

Table 2 (*Continued*)

Title author/year	Objective	Theoretical framework	Participants (demographics)	Findings
Cognitive affective predictors of women's readiness to end DV relationships [48]	Explore cognitive and emotional factors which move women along the SOC	Cross-sectional	85 women recruited from DV shelters in US 18–55 y, predominantly Caucasian with low income and education levels	Women in longer relationships were more likely to be in the precontemplative stage Low anger or level of abuse scores predicted a higher chance of women being in precontemplation; higher anger or abuse levels were seen as being vital in the change process Older women score higher in Action and were more likely to blame their partner for the abuse Women in maintenance also more likely to be depressed; suggested to be coming to terms with the end of their relationship and realizing what lies ahead Self-blame was a the highest levels for women in precontemplation (blaming themselves for the violence) and maintenance (blaming themselves for leaving – or not leaving sooner)

- Mental health, particularly depression, anger and post-traumatic stress disorder (PTSD), which may have a variable effect [50]. Depression may impair a woman's ability to create change while anger may prompt change; PTSD is often associated with higher SOC where women have made change and are recovering from their experiences of trauma in the abusive relationship [44]
- Degree of violence/abuse/degradation where increasing levels may prompt and ⇑ need for change [30]
- Self-efficacy where enhanced self-efficacy strengthens a woman's belief in her ability to undertake and maintain successful change [44].

As individual women explore the benefits and costs of change, the balance of these particular factors related to her situation are forefront.

4.1.4. Self-efficacy

For women seeking change from IPV, their sense of self-efficacy influenced their 'perceptions of their ability to be successful if and when they decide to take steps to increase their safety' [35]. Enhanced perceptions of self-efficacy and an associated sense of self-worth encouraged women to see themselves as being deserving of a violence-free life and capable of achieving this (often within exceptionally challenging circumstances) and were a strong motivation to action within their decisional-balance decision-making [26,38].

4.1.5. Turning-points

Within the concept of decisional-balance the point at which the pros for change are considered stronger than the cons will often occur as a result of a turning-point, where an identifiable event or realization that influences positive movement along the SOC continuum occurs [40,42,43]. These turning-points 'permanently change how women view the violence, their relationship, and how they wish to respond' [38]. Within the SOC women may experience multiple turning-points often aligning with the processes of change, which prompt short- or long-term movement between and across stages [40].

Similar to other studies [37,39,40], using cognitive processes of change, particularly consciousness raising, 'The Realization' turning-point from Khaw and Hardesty [39] involved women labeling their experiences as abuse and shifting responsibility to the abuser. Doing this prompted women's movement from precontemplation to contemplation and often led to a rapid evaluation of possible options for change [34,39].

Reflective of the processes of self and environment re-evaluations, increasing abusive experiences (escalation of violence or levels of abuse/degradation/humiliation), abuse directed toward children or children mimicking the abuser's behavior toward the mother, often 'pushed [women] to react' [39]. Frequently, this facilitated movement of women from the contemplation to preparation or even action stages; moving women from cognitive to behavioral processes of change [39].

The shift to behavioral processes of change caused the most variation in women's SOC movement, leading to different trajectories [39]. While some women engaged in conscious decision-making, establishing an objective and preparing as necessary before moving into action, non-linear movement (moving from preparation/action back to contemplation) occurred when the decisional-balance cons held greater weight the than pros for change. Leap-frogging between stages (moving from precontemplation/contemplation directly to action) was often 'reactive and spontaneous' as women responded to a significant abusive event or realization that the abusers' behavior would not change [39].

Finally as women 'reclaim[ed] their identities' [39] and moved into the maintenance stage, they used the processes of change, Counter Conditioning, Reinforcement Management and Social Liberation, to find and consolidate a new way of being, separate from abuse [39].

4.2. Points of difference utilizing TTM

While descriptors of the TTM pathway are common in IPV literature; disagreement sometimes exists regarding the location of behaviors in the SOC pathway. This often reflective of the different goal or outcome measures for individual women. For example, Khaw and Hardesty [39] label a woman staying in an abusive relationship 'for the sake of the children' despite having prepared to leave for her own safety, as a move from preparation back to contemplation. In their work this is seen as being a child-focused decisional-balance issue where children losing their father take priority [39]. Conversely, Cluss et al. [35] use the same example to demonstrate their inability to nominate a woman's position of change; namely for her own safety behaviors she was allocated preparation/action staging but for her children she was in precontemplation stage, not recognizing potential danger to them from IPV. Highlighting further complexities, Chang et al. [28] identify information seeking as a form of action; however, if a woman's objective of change is 'leaving', information or knowledge seeking may be seen as preparation. If her goal is being safe within the relationship, seeking information may remain in preparation and enacting new knowledge (e.g. boundary setting) becomes action.

Table 3
The Processes of Change for women experiencing IPV.

Process of change	General descriptor [26].	IPV-related processes	Associated SOC movement
Consciousness Raising	Seeking new information and to gain understanding about the problem	'Increasing information about self and IPV' [30] and other options to enhance safety and well-being [26]; 'cognitive recognition that something was wrong in their relationship' [39]	1. Precontemplation ⇒ Contemplation; 2. Contemplation/Preparation ⇒ Action
Dramatic Relief	Experiencing and expressing feelings about the problem behavior	"Experiencing and expressing emotions about IPV" [30], disclosing abuse and feeling validated and supported by others [30]	Contemplation/Preparation ⇒ Action
Self-Reevaluation	Emotional and cognitive reappraising of values with respect to problem behavior	'Assessing how one feels and thinks about the abusive relationship' [28] and considering their own 'values, experiences and feelings' [30] particularly related to living with or without violence	Contemplation ⇒ Preparation ⇒ Action
Environmental Reevaluation	Considering and assessing how the problem behavior affects the individual's environment	Focused on considering how the IPV impacts on others, particularly children living within the home where IPV occurs [33]	Contemplation ⇒ Preparation ⇒ Action
Self-Liberations	Choosing and committing to changing the problem behavior – including belief in ability to change	Often focusing on acknowledging they do not need or want a relationship which comes at the cost of violence and abuse; choosing and committing to a life free from violence [26,38]	Contemplation ⇒ Preparation ⇒ Action
Stimulus Control	Controlling situations and other causes that trigger the problem behavior	Avoiding violence while within the relationship–focused on decreasing the abuser's 'triggers' to violence' or by attempting to maintain a safe environment after ending the relationship (avoiding the abuser/keeping him away from their new home) [26]	Contemplation/Preparation ⇒ Action
Helping Relationships	Trusting, accepting, and using the support of caring others during attempts to change the problem behavior.	Relationships that aided 1. Recognition and labeling of abuse 2. Knowledge about IPV and resources for support 3. Continuation of safety behaviors through support and validation from others [30,38].	1. Precontemplation ⇒ Contemplation 2. Contemplation/Preparation ⇒ Action 3. Action/Maintenance ⇒ Action
Counter Conditioning	Learning and practising alternative behaviors	Joining a support group or undertaking counseling to identify a new (non-abused) self and way of being [33]	Action ⇒ Maintenance
Reinforcement Management	Rewarding oneself or being rewarded by others for making changes	Congratulating self for achieving goals or undertaking activities which promote ongoing well-being; – i.e. doing well in a job that provides financial independence from the abuser [33]	Action ⇒ Maintenance
Social Liberation	Increasing awareness, availability and acceptance by the individual of alternative, problem-free lifestyles	Envisioning and enacting a new way of being in the world, often involved giving up behaviors that might increase risk of relapse such as drug or alcohol use [26]. Enhanced knowledge of the social supports available and how IPV may be viewed by the wider community [51] Desire to help other women escape abusive relationships [33]	Action ⇒ Maintenance

Disagreement arises from needing to acknowledge activities women undertake to remain safe in abusive relationships. Burke et al. [27] also demonstrate this dilemma for women. When assessing women for SOC location, over 90% of women who were located in the 'precontemplation or contemplation stages had undertaken potential safety behaviors which may be considered preparation or action, such as *hiding things*, *talked to the partner about the abuse* or *talked to family/friends*' [27]. Despite this, women denied having 'done anything to try to change [their] situation and keep [themselves] safe' [27].

Women are active in abusive relationships, irrespective of their stage, they work to enhance their relationships and minimize the risk and frequency of violence. When attempting to locate women within SOC an important component is exploring women's motivation in undertaking specific behavior or actions. A woman who compromises or makes herself submissive in the precontemplation stage may have a motivation for behavior that is focused on 'fixing' herself as the 'problem' to stop violence. Whereas a woman in the action stage, with a conscious awareness of the abuse, makes a decision to do this to manage the abuse at that time as she works toward achieving ongoing safety.

The primary goal of this discussion is for clinicians to empower affected women, assisting them to make their own judgments regarding objectives and providing information and support to help her achieve safety and well-being. As such, while a guide for behavior mapping follows, each woman needs to be assessed individually to determine her objective and desired change behaviors.

4.3. Practice implications

Women's behaviors rarely fall neatly into one SOC; the decisional-balance implies competing priorities for women seeking safety and women may demonstrate thoughts or behaviors

across two or more stages. As with much in healthcare, neat 'black or white' assessments are rarely available and clinical judgment must be used to determine the 'behavioral clusters' or dominant patterns within a woman's behaviors to establish an overarching stage.

Considering the stages as non-linear categories across a continuum [29] may make it easier for us to plot a woman's behaviors within the SOC and identify the densest positionings. Furthermore, these 'behavioral clusters' need to be evaluated in the context of specific and individual objectives identified with each woman. Thus we suggest that it is a woman's individual objective, her motivation or the intent behind a particular action that may aid in determining her overall SOC.

Individual factors that fall in stages earlier or later than the dominant stage may provide a focus area for clinicians to engage with women [22]. For example, a woman in the contemplative stage may identify a problem within her relationship and be considering change but still hold the precontemplative belief that IPV is normal. Her clinician could focus on providing ongoing education and reinforcing that IPV is not an acceptable or normal behavior. At the other end, factors that are seen as more advanced along SOC continuum (a woman with dominant contemplation behaviors seeking employment to enhance her financial resources) may be used by clinicians to provide positive reinforcement of a woman's self-efficacy for change.

The three objectives discussed: 1. Minimizing harm and promoting well-being within a continually abusive relationship, 2. Achieving safety and well-being within relationships; stopping the abuse, or 3. Ending abuse and leaving relationships, are similar in the early SOC but differ significantly in the way that women can be supported in later stages.

Irrespective of a woman's objective, we should conduct a comprehensive assessment with each woman to understand her current level of safety, objective(s) and individual decisional-balance factors, self-efficacy for change and potential turning-points. Sensitive questioning, active listening, validating experiences, immediate safety assessment, discussion of possible safety behaviors and referrals for ongoing support (particularly individual counseling [29]) are all possible interventions for women experiencing IPV [12,52].

While usually recommended for all women in abusive relationships (where possible), implementing safety behaviors may not end abuse. Safety behaviors are seen as those which promote safety for women in abusive relationships and include preparation for emergency situations such as:

- Hiding money, extra house or car keys, extra clothing or valuables (jewelry).
- Establishing a code for assistance with family/friends/neighbors.
- Asking neighbors to call police if they suspect violence.
- Removing weapons.

Having copies of documents available (social security details, birth certificates, marriage or driver's license, personal identification, and bank account/insurance/superannuation information) [53].

Concurrently, mindful of our professional obligations to the woman and her family, we also need to assess the safety of children and ensure objective documentation, and, where possible, photographic evidence of a woman's injuries for possible legal action.

4.3.1. Minimizing harm and promoting well-being within a continually abusive relationship

Within the context of IPV, minimizing harm and promoting women's well-being remains an overarching objective. However, for women who consciously acknowledge abuse and remain in the relationship expecting continued abuse, this may become the primary objective. Women from culturally and linguistically diverse backgrounds, with religious, family, legal or community restrictions that promote the sanctity of marriage, or those facing threats of escalation of violence toward themselves or others should they attempt to leave, may choose this objective for their best possible safety and well-being. It may be chosen as a short-term or long-term objective. For this objective we can focus on assisting women with their safety planning and implementation, provide an avenue for ongoing engagement, and encourage women to regularly assess their safety, personal and family well-being, and ongoing objectives. Table 4 provides example behaviors for women with this objective across the SOC and suggestions for clinicians.

It is worth noting that aiming to minimize harm and promote well-being within a continually abusive relationship may be seen to mirror the contemplation stage for women with the next two objectives; namely, choosing to remain in an abusive

Table 4
Minimizing harm and promoting well-being within an abusive relationship.

Precontemplation	Using the processes of consciousness-raising, the clinician empathetically asks questions about abuse, conducts safety assessments, and provides information to woman regarding IPV and safety behaviors; allows opportunity for discussion/clarification. Validates women's experiences of abuse and reinforces that IPV is unacceptable; that no one (including her) deserves to be abused.
Contemplation	Continuing the provision of care reflective of precontemplation, the clinician engages with women to identify and label the abuse in her relationship. In early contemplation focus is on empathetic and active listening, validating experiences and confirming IPV (Consciousness-raising, dramatic relief and self and environmental reevaluation). In later contemplation, clinician discusses and provides options and information/referral to support networks (social work, legal services, women's centers) (Helping relationships, social liberation) and supports women in setting individual, appropriate and realistic objectives. Continues to provide empathy and support; validating experiences and confirming criminality of IPV.
Preparation	Woman establishes objective of enhanced safety in an abusive relationship. For women entering preparation, the need for ongoing support related to their change objective often uses the processes of change self-liberation, stimulus control and helping relationships. Clinicians provide/reinforce information regarding types of helpful safety behaviors and assist women in planning their implementation. Opportunities for enhancing the woman's sense of self and self-efficacy are explored and implemented as appropriate.
Action	Implementation of safety behaviors for less than six months with an anticipated decrease in the severity and frequency of abuse, using the processes of helping relationships, stimulus control, reinforcement management and social liberation. Clinician and woman continue engagement with opportunity to review effectiveness of interventions and re-evaluate strategies and change as necessary. Women are also provided with opportunity to review the appropriateness of their current objective (self and environmental reevaluation) and reset goals as desired.
Maintenance	Implementation of safety behaviors and continuing use of the later processes of change, particularly counter conditioning, reinforcement management and social liberation for more than six months with an associated decrease in the severity and frequency of abuse. Clinician and woman continue engagement, with opportunity to review effectiveness of interventions and re-evaluate appropriateness of the current objective (self and environmental reevaluation).

Table 5
Achieving safety and well-being within relationships; stopping the abuse.

Precontemplation Contemplation	As per Table 4
Preparation	Woman establishes objective of ongoing safety and well-being by ending the abuse while remaining in the relationship. She considers how this can be achieved and plans/prepares. The need for ongoing support related to this change objective requires women to focus on self-liberation and stimulus control and clinicians can assist with enhancing helping relationships. This may include seeking counseling for herself, preparing her abuser to access counseling or batters programs, seeking legal assistance, finding external employment or undertaking self-defense classes. In this objective, this stage often involves women preparing themselves to safely set boundaries for their abuser and thus requires enhanced personal/financial/physical resources. While supporting these processes clinicians also need to provide/reinforce information regarding types of helpful safety behaviors to promote safety during the implementation of chosen actions.
Action	Using the processes of helping relationships, stimulus control, reinforcement management and social liberation the implementation of interventions takes place, abuser undertakes counseling or attends batters support program, abuser enacted triggers are decreased/eliminated (use of alcohol or recreational medications), woman sets strong boundaries of acceptable behavior for a period of less than six months with an anticipated decrease in the severity and frequency, leading to halting, of abuse. Clinician and woman continue engagement, with opportunity to review effectiveness of interventions and re-evaluate strategies and change as necessary. Women are also provided with opportunity to review appropriateness of their current objective (self and environmental reevaluation).
Maintenance	Continuing use of the later processes of change, particularly counter conditioning, reinforcement management and social liberation women maintain the implementation of changes for more than six months with an associated cessation of abusive behavior. Clinician and woman continue engagement with the opportunity to review effectiveness of interventions and re-evaluate the appropriateness of the current objective (self and environmental reevaluation).

situation can be seen as Women not having made a decision toward change. Thus it becomes important to acknowledge that it is at the point of conscious objective-setting that women may be seen to choose this particular aim and move into action/maintenance. It is also important we maintain engagement with women working toward this objective and encourage them to reassess their safety, objectives and actions regularly as this objective may inherently leave women at risk of ongoing or worsening abuse.

4.3.2. Achieving safety and well-being within the relationship; stopping the abuse

Within research to date, some women have achieved ongoing safety by aiding/enforcing a permanent change in the abuser's behavior [27]. To choose this option, women need a realistic belief that a long-term change in the abuser's behavior can be achieved and that working toward this change will not place her in greater danger. The pathway for this objective changes at preparation where women commence resource-strengthening behaviors in preparation for creating lasting change. Table 5 provides example behaviors for women with this objective across the SOC and associated targeted interventions.

Women may find this option unachievable as they are attempting primarily to create change in another's behavior. As such, we may need to provide them Opportunities to review the progress/sustainability/success of meeting this objective and assistance in re-evaluating their options and revising their objective(s).

Table 6
Ending abuse and leaving relationships.

Precontemplation Contemplation	As per Table 4
Preparation	Woman establishes objective of ending the intimate relationship. She considers how this can be achieved and plans/prepares. This may include seeking counseling for herself, seeking legal or police assistance, finding external employment or financing, accommodation or refuge options. The need for ongoing support related to this change objective requires women to focus not only on the early processes of change, but particularly, on self-liberation and stimulus control and clinicians can assist with enhancing helping relationships. In this objective, this stage often involves women preparing themselves to safely leave the relationship and they may require enhanced personal/financial/physical/social resources. Clinicians are cognizant of the increased risks women face during 'leaving or ending' an abusive relationship. While supporting these processes clinician s also provide/reinforce information regarding types of helpful safety behaviors to promote safety during implementation of chosen actions. Clinicians can also work with the women's support networks (with permission) to "promot[e] non-judgmental and emotionally supportive relationships" [49] as social support of abusive relationships is linked to women remaining in contemplation/precontemplation.
Action	Women end/leave the abusive relationship as planned with heightened emphasis on ensuring physical safety and well-being during this time of increased risk. Clinician and woman continue engagement using the processes of helping relationships, stimulus control, reinforcement management and social liberation. There is the opportunity to review effectiveness of interventions and re-evaluate the strategies and change as necessary. It is important for the clinician to highlight that women often 'leave' an abusive relationship a number of times prior to achieving a permanent separation and that returning should not be seen as a 'failure' but rather as an opportunity to enhance individual resources and coping mechanisms. Women are also provided with the opportunity to review the appropriateness of their current objective and reset as necessary (self and environmental reevaluation). Women may experience increased levels of stress during the action/maintenance stage of this objective as they become (often) solely responsible for housing, finances and child rearing. They may experience heightened levels of depression or PTSD and need more intensive psychological support.
Maintenance	Continuing use of the later processes of change, particularly counter conditioning, reinforcement management and social liberation women maintain the implementation of changes for more than six months without returning to the intimate relationship. Clinician and woman continue engagement, with opportunity to review effectiveness of interventions and re-evaluate appropriateness of the current objective (self and environmental reevaluation). Women may seek the opportunity for peer support to redefine their sense of self and understanding of their experiences. Women may also often seek to support other women in escaping abuse.

4.3.3. Ending abuse and leaving the relationship

Women may aim to end abuse by ending or leaving an abusive relationship. In this objective, women need support to achieve and maintain the separation and additional safety measures, such as legal restraints for the abuser, or accessing women's refuge centers. Table 6 provides example behaviors for women with this objective across the SOC and targeted interventions.

The period of ending an abusive intimate relationship may be the most dangerous for women, due to the risk of retaliatory abuse and violence [54]. Women's risk for PTSD, anxiety and depression may also rise due to fear created by leaving, ending of a relationship and awareness of potential future hardships (i.e. meeting financial responsibilities) [48]. Furthermore, some women have lower levels of satisfaction with perceived social support networks; often related to the loss of support from family/friends/communities that endorsed the relationship [48]. Clinicians are recommended to provide targeted support to promote safety (information regarding available safety resources, legal, police and domestic violence support services or shelters) and well-being (specialist counseling referrals or ongoing clinician engagement as appropriate) while women enact and maintain this change.

4.4. Conclusion and recommendations for future research

This article has provided a framework for clinicians to consider how the processes of change, turning-points and decisional-balance can be utilized effectively to improve outcomes for women experiencing abuse. Understanding how we can support a woman's positive movement along SOC toward a set objective may lead to her enhanced personal (and familial) well-being and safety. The SOC may provide a means of assessing a woman's movement toward a nominated outcome while the processes of change, decisional-balance and turning-points influence how women move between these stages.

In addition to assessing a woman's individual objective to guide goal-setting and helpful behaviors, it may be useful to view the SOC as linear rather than discrete entities when 'staging' women as it is apparent that behaviors may fall into more than one stage at any given time point. Thus, we can assess the meaning of women's actions to determine an overall or dominant stage at any given time. The earlier (factors inhibiting women's change) and later (areas of strength for change) outliers may provide us with areas for discussion and promotion to assist women in achieving their objectives. Using the SOC and objective setting with women may provide a useful starting point for clinicians to engage with women experiencing abuse and a framework which we can use to guide our practice.

While some decisional-balance factors related to pros and cons of change and their influence within women's decision-making are evident in research to date, this is an area worthy of further exploration. We need to confirm which particular factors best enable decision-making (and action) toward enhanced safety behaviors and explore how healthcare interventions can be targeted to facilitate those factors particularly over time. With an extended knowledgebase regarding clinical interventions that positively impact on women's safety decision-making behaviors we can hopefully work more effectively with women to achieve ongoing safety and well-being when they are living with or working to end IPV.

Conflicts of interest

There are no conflicts of interest to be declared nor was financial support received to undertake this review.

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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