**Counseling Interventions for Victims of Intimate Partner Violence: A Systematic Review**

**Abstract**

Intimate partner violence is a serious public health problem with significant implications for the mental health and well-being of victims. Therefore, we sought to critically review research on counseling interventions for victims to inform counselors’ work and identify areas of need for future research. We used the preferred reporting items for systematic reviews and meta-analyses protocols to identify articles from 2000-2022 which investigated the impact of counseling interventions on the mental health and safety of victims. Four themes emerged: (1) participant demographics, (2) treatment modality, (3) interventions and study outcomes, and (4) study limitations. Study findings are synthesized to help counselors identify effective interventions for victims based on mental health concerns and violence type. Many of the studies were limited by high attrition rates and few researchers implemented randomized control trials. Further research is needed on interventions for LGBTQ victims and victims who present with comorbid mental health concerns.

*Keywords:* intimate partner violence, victim, counseling, mental health, intervention

**Counseling Interventions for Victims of Intimate Partner Violence: A Systematic Review**

Intimate partner violence (IPV), defined as physical, verbal, or sexual acts intended to cause harm to a romantic partner (Heyman et al., 2015) impacts an estimated 27% of women globally (World Health Organization, 2021). In the United States, that number rises to 37% for women and 30% for men. (Smith et al., 2017). IPV has significant mental health consequences for victims, including low self-esteem, anxiety, depression, substance abuse and posttraumatic stress disorder (Coker et al., 2000; Lagdon et al., 2014; Smith et al., 2017). IPV victims may seek counseling to address their worsening mental health symptoms (Nichols et al., 2018) and to enhance functioning in other areas of their lives (Leone et al., 2007). Throughout this paper, we chose to use the term victim, rather than survivor, to highlight the immediate and ongoing victimization occurring in studies which were reviewed.

Despite the prevalence and significant social impact of IPV, research on evidence-based counseling interventions for IPV victims remains limited (Abel et al., 2000, Trabold et al., 2020). More research is needed to understand the most effective interventions for IPV victims (Trabold et al., 2020; Warshaw et al., 2013). Several literature reviews on IPV interventions have already been published; however, many of the previous reviews limited the number of articles they received by focusing only on IPV intervention studies with specific populations, outcomes, or research designs (Arroyo et al., 2015; Trabold et al., 2020; Warshaw et al., 2013).

Abel (2000) reviewed the efficacy of psychosocial interventions for IPV victims, but that article is now more than 20 years old. Warshaw et al. (2013) reviewed trauma-focused treatments for IPV victims. Lastly, Trabold et al. (2020) conducted a more general review on the effectiveness of interventions for IPV victims which excluded interventions for couples and qualitative studies. In the current systematic review, we expand on previous literature by focusing specifically on current literature about counseling interventions for all IPV victims.

In order to choose an appropriate intervention for clients experiencing IPV, clinicians must first understand the different IPV typologies: situational violence and power and control related violence. IPV typologies are characterized by the nature of the violence that occurs within the relationship (Johnson, 1995). For those presenting with situational violence, which consists of gender-mutual, less severe violence that does not escalate over time, couples’ interventions may be appropriate. Couples’ interventions would not be appropriate for victims of power and control related violence, in which one partner systematically utilizes abusive tactics to establish power and control over the other partner (Bograd & Mederos, 1999). This systematic review synthesizes findings on interventions for both situational and power and control related violence. Therefore, the goals this review are to (1) synthesize and critically examine the literature on current counseling interventions for IPV to inform clinicians’ work with victims and (2) identify areas of need for future research on interventions for IPV victims.

**Method**

We conducted a systematic review to identify and compare counseling interventions to support individuals who have experienced IPV. Specifically, our research team followed the preferred reporting items for systematic reviews and meta-analyses protocols (PRISMA-P; Moher et al., 2015). Through PRISMA-P, our research team: (a) determined eligibility criteria to answer the stated research questions; (b) identified informational sources (i.e., databases); (c) conducted a search of relevant literature based on the eligibility criteria and informational sources; (d) reviewed the included research studies and completed a quality assessment; (e) extracted data from the studies; and (g) created themes and implications based on the extracted data. Articles were identified through Academic Search Complete. Search terms included: ("intimate partner violence" OR "domestic violence") AND (counsel\* OR psychotherap\* OR therap\* OR "mental health services") AND (survivor\* OR victim\* Or "battered" Or couple\*). Lastly, articles were included if a full text in English was available from an academic journal published between 2001 and 2022.

**Eligibility Criteria**

Our systematic review identified current studies measuring the mental health outcomes of IPV victims who received counseling interventions. Using our search terms, the initial search produced 2046 articles and 1853 remained after removing duplicates. These articles were evenly distributed between the research team and each member reviewed the article’s title and abstract to determine appropriate fit with respect to eligibility criteria. Articles were excluded if they described a conceptual article, a preliminary or pilot study, did not have an English translation, or did not report the outcomes of a counseling intervention for IPV victims on mental health. After this review, 17 articles remained. A visual representation of the PRISMA-P (Moher et al., 2015) inclusion and exclusion process can be found in Figure 1.

**Quality Appraisal**

To assess the quality of each study that met inclusion criteria, we used the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). The MMAT outlines quality standards for various quantitative, qualitative, and mixed method designs. For each design, the MMAT poses seven quality standards in which the assessor can respond, “yes,” “no,” or “can’t tell.” Next, articles were distributed evenly between the research team and each article was independently assessed by at least two members. The research team compared the results of each independent assessment and came to consensus with respect to the MMAT quality standards. If the research team had a disagreement in one of the seven quality standards, a third research team member was asked to assess the study to achieve consensus. Quality appraisal results are represented in Table 1. Given the previously documented high attrition rates common to IPV intervention research (Abel, 2000; Leal et al., 2020), we chose to report the exact percentage of outcome data for each study in Table 1 rather than rating the quality standard questions concerning complete data with “yes” or “no.”

**Data Extraction**

After identifying the included articles through a consensus process and assuring each article met appropriate research standards through a quality appraisal, our research team organized key aspects of each study into tables. Articles were evenly distributed among research team members and each team member summarized pertinent aspects of the study, including study design, setting, participant information, sample size, attrition rate, intervention and study outcomes. This information can be found in Tables 2 and 3 and is further described in the Results sections.

**Theme Development**

We reviewed the interventions and results from each study and developed themes based on PRISMA-P (Mohen et al., 2015). Each member of the team proposed themes and we utilized a consensus process to come to agreement on the included themes. Themes were identified by their impact on participant outcomes and representation across multiples studies. Through the consensus process, we identified four themes as follows: (a) participant demographics, (b) treatment modality, (c) interventions and study outcomes, and (d) study limitations. The results section is organized in order according to the four identified themes.

**Results**

Table 2 shows the study design and setting of each article.Of the 17 identified studies, two were mixed-methods designs (Aktas Ozkafaci & Eren, 2020; Habigzang et al., 2018), six were randomized controlled trials (Bradley & Gottman, 2012; Bradley et al., 2014; Crespo & Arinero, 2010; Johnson et al., 2020; Miller et al., 2014; Tiwari et al., 2011), eight were non-randomized quantitative studies (Campbell-Kirk, 2015; Carlson et al., 2018; Choi at al., 2018; Davidson et al., 2012; Echeburua et al., 2014; Hernandez-Ruiz, 2005; Ikonomopoulos et al., 2017; Vela et al., 2016), and one was a qualitative design (Trabold et al., 2018). The settings where the services were provided varied as well. Six studies took place in agencies that provided IPV services – three in IPV shelters (Choi et al., 2018; Hernandez Ruiz, 2005; Johnson et al., 2020) and three in community IPV agencies (Crespo & Arinero, 2010; Echeburua et al., 2014; Trabold et al., 2018). Three studies took place in community mental health centers (Habigzang et al., 2018; Ikonomopoulos et al., 2017; Vela et al., 2016), two studies were in community settings (Carlson et al., 2018; Tiwari et al., 2011), and one was at a private counseling center (Aktas Ozkafaci & Eren, 2020). In one study, services were split between a domestic violence agency and a general practitioner office (Campbell Kirk, 2015). Four studies did not report the setting where the therapeutic services were provided (Bradley & Gottman, 2012; Bradley et al., 2014; Davidson et al., 2012; Miller et al., 2014).

**Participant Demographics**

As seen in Table 2, 14 of the 17 studies required participants to be women, with one of those requiring that the participant also be a mother (Miller et al., 2014). Two of the studies sought participants who were low-income couples with children who had both exhibited situational couple violence within the past year (Bradley et al., 2014; Bradley & Gottman, 2012). Finally, Carlson et al. (2018) studied a relationship education intervention for low-income individuals. Participants were not required to be in a relationship and this study represents the only one that did not require all participants to have experienced IPV, as the researchers studied the impact of the intervention based on differing levels of conflict experienced by the participants, which may or may not have included IPV.

Four studies excluded participants who presented with substance abuse (Bradley et al., 2014; Bradley & Gottman, 2012; Habigzang et al., 2018; Johnson et al., 2020). Five studies excluded participants based on comorbid mental health disorders (Bradley et al., 2014; Bradley & Gottman, 2012; Echeburua, et al., 2014; Johnson et al., 2020; Habigzang et al., 2018). Echeburua et al. (2014) and Habigzang et al. (2018) excluded participants who exhibited symptoms of severe mental disorders, Johnson et al. (2020) excluded participants who presented with bipolar disorder and high-risk suicidality, and Bradley et al. (2014) and Bradley and Gottman (2012) excluded participants with antisocial personality disorder.

Two studies excluded victims whose abusers were not men (Crespo & Arinero, 2010; Echeburua et al., 2014). Further, Echeburua et al. (2014) required the participant to no longer reside with their abusive partner. Johnson et al. (2020) required the participant to have experienced an abusive incident within one month of entering the shelter where the study was held, Davidson et al. (2012) required the participant to have experienced the abuse within the past five years, and Miller et al. (2014) required the participant to have experienced abuse within the past two years. Two studies excluded participants who were already receiving counseling services (Crespo & Arinero, 2010; Johnson et al., 2020). Lastly, at least eight of the studies limited the sample to victims who had sought services at a specific agency (Aktas Ozkafaci & Eren, 2012; Choi et al., 2018; Echeburua et al., 2014; Hernandez Ruiz, 2005; Ikonomopoulous et al., 2017; Johnson et al., 2020; Trabold et al., 2018; Vela et al., 2016), thereby limiting the ability to generalize the findings to non-service seeking victims.

None of the included studies specifically addressed the IPV experiences of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals and several required that participants be in differently gendered relationships (Bradley & Gottman, 2012; Bradley et al., 2014; Crespo & Arinero, 2010; Echeburua et al., 2014). LGBTQ+ individuals are just as likely to experience IPV as heterosexual individuals (Dank et al., 2014; Reuter et al., 2015; Reuter et al., 2017) and according to the minority stress framework, face additional stressors compared to heterosexual individuals which can contribute to increased stress (Meyer, 2003) and difficulties with emotion regulation (Hatzenbuehler, 2009), which can increase the potential for conflict within their relationships (Meyer, 2003).

***Couples***

Both Bradley et al. (2014) and Bradley and Gottman (2012) studied couples’ interventions. They focused on heterosexual couples who presented with low-level or gender mutual violence and excluded couples who presented with power and control related violence. The advantages of treating IPV within couples includes the ability to tailor the treatment to couples exhibiting situational or gender mutual violence and the inclusion of both partners in treatment. Tailoring the treatment to the specific type of relationship violence may improve treatment outcomes (Stith et al., 2003). All abusers do not require the same type of treatment. Couples’-based interventions are most likely to benefit couples exhibiting lower levels of violence (Stith et al., 2003). Further, couple-based treatments with heterosexual couples also target women who engage in aggressive or violent behavior, whereas many other treatments treat only abusers who are men. When the woman in a heterosexual relationship is also exhibiting violent behavior, treating the man alone is unlikely to be effective (Stith et al., 2003). Further, treatments for men abusers primarily focus on the man’s role in the violence, not any underlying relationship dynamics that may impact the violence and choices made within the relationship. Therefore, women choosing to remain in a relationship with the man would also benefit from services.

**Treatment Modality**

As seen in Table 3, seven studies tested a group intervention (Aktas Ozkafaci & Eren, 2020; Bradley & Gottman, 2012; Bradley et al., 2014; Choi et al., 2018; Crespo & Arinero, 2010; Davidson et al., 2012; Miller et al., 2014), nine tested an individual intervention (Campbell Kirk, 2015; Carlson et al., 2018; Habigzang et al., 2018; Hernandez Ruiz, 2005; Ikonomopolous et al., 2017; Johnson et al., 2020; Tiwari et al., 2011; Trabold et al., 2018; Vela et al., 2016) and one study utilized both modalities (Echeburua et al., 2014). Echeburua et al. (2014) found that Cognitive Behavioral Therapy (CBT) was moderately more effective in reducing PTSD symptoms and improving functioning in everyday life when the victim received both individual and group services, rather than solely individual services. Similarly, Choi et al. (2018) found that both a CBT group and a mutual support group were equally effective in reducing depression and revictimization. Group interventions provide several benefits for IPV victims that may account for the stated advantage over individual services. Groups highlight shared experiences and allow participants to learn from each other (Dies, 1995; Liu et al., 2013). Allowing spaces for victims to share their experiences and connect with others with similar experiences can improve self-esteem and decrease depression (Liu et al., 2013).

Victims have often been isolated from their support systems; therefore, rebuilding social support is an important variable in recovery from IPV, particularly for ethnic and other cultural minorities (Liu et al., 2012; Mburia-Mwalli et al., 2010; Yoshioka et al., 2003). Group settings can provide a safe environment for rebuilding support systems (Miller et al., 2014). Group interventions allow victims to experience inclusion and respect as they work together to develop the group. Further, group interventions provide opportunities for group members to respond to each other’s needs (Drumm, 2006; Liu et al., 2013).

Group interventions may be particularly suited for couples who exhibit situational violence (Bradley et al., 2014). Stith et al. (2004) found that group-based therapy can reduce the likelihood of IPV in couples who exhibit low-level mutual violence. Similarly, situational violence can be reduced through group interventions that target improvements in couples’ relationships and relationship skills (Bradley & Gottman, 2012; Simpson et al., 2008).

From an organizational perspective, groups are often simpler and more cost-effective to implement than individual services (Miller et al., 2014). This may be a particular advantage in settings where funding and staffing are concerns, such as shelters and community agencies. However, group interventions may not appeal to all victims, particularly when scheduling may be difficult, or for those who are reluctant to share in group settings (Echeburua et al., 2014). Ultimately, the best treatment modality is one that is adapted to the victim’s individual needs (Echeburua et al., 2014).

**Interventions and Study Outcomes**

The intervention type and outcomes of each study are represented in Table 3. Six studies utilized CBT interventions (Choi et al., 2018; Crespo & Arinero, 2010; Echeburua et al., 2014; Habigzang et al., 2018; Johnson et al., 2020), five utilized an arts-based intervention (Aktas Ozkafaci & Eren, 2020; Campbell Kirk, 2015; Hernandez Ruiz, 2005; Ikonomopoulos et al., 2017; Vela et al., 2016), and three utilized relationship education (Bradley & Gottman, 2012; Bradley et al., 2014; Carlson et al., 2018). One study each utilized a career intervention (Davidson et al., 2012), an advocacy intervention (Tiwari et al., 2011), and a trauma-informed brief intervention (TIBI;Trabold et al., 2018). Below, we describe the interventions that were implemented in greater detail, organized according to the outcome data. The primary variables measured in the identified studies were depression, self-esteem, anxiety, exposure to violence/safety improvement, and PTSD which we explore further in the following section. General distress, stress, sleep, anger expression, emotional/mental health disturbances, and life satisfaction were all included in one study each.

***Depression***

Six studies assessed depression, with five reporting statistically significant reductions following the intervention, although one (Choi et al., 2018) acknowledged similar reductions for both the experimental and comparison groups. Four of the studies which measured depression outcomes utilized a CBT intervention (Choi et al., 2018; Crespo & Arinero, 2010; Habigzang et al., 2018; Johnson et al., 2020). CBT interventions for victims in these studies primarily focused on psychoeducation, cognitive restructuring, communication skills, and goal setting. Psychoeducation may impact depression in IPV victims by increasing their understanding of the cycle of IPV which allows them to reconceptualize their experiences and minimize beliefs that they were responsible for the abuse, thereby decreasing feelings of guilt and shame which are associated with depressive symptoms (Habigzang et al., 2018).

Crespo and Arinero (2010) found that both CBT with exposure techniques (*d* = .87) and CBT with communication skills (*d* = 1.98) led to statistically significant large differences in victims’ depression. In their mixed methods study, Aktaş Özkafaci and Eren (2020) found that victims with PTSD who participated in a group-based art therapy intervention experienced a significant decrease in depressive symptoms. The authors attributed the decrease in depression to the intervention allowing the participants to discover their own abilities and take more control within their relationships. Davidson et al. (2012) found no significant changes in depression at post-intervention using a career intervention. However, a small effect on depression (was noted by the eight week follow up. At post-intervention, participants experienced increases in career search self-efficacy and future financial career supports and decreases in perceived career barriers, which may have contributed to improvements in depression by follow up.

***Anxiety***

Five studies assessed changes in anxiety (Aktas Ozkafaci & Eren, 2020; Crespo & rinero, 2010; Davidson et al.,2012; Habigzang et al., 2008; Hernandez-Ruiz, 2005). Four studies reported statistically significant reductions in anxiety (Aktas Ozkafaci & Eren, 2020; Crespo & rinero, 2010; Habigzang et al., 2008; Hernandez-Ruiz, 2005), with one study reporting significant reductions in anxiety at follow up, but not immediately following the intervention (Davidson et al., 2012). Two of the studies which measured anxiety utilized CBT interventions and two utilized art interventions.

In the two studies with art interventions, one used art therapy (Aktaş Özkafaci & Eren, 2020) and one used music therapy (Hernandez-Ruiz, 2005). Similar to their findings on depression, Aktaş Özkafaci and Eren (2020) reported that victims who participated in a group marbling art therapy intervention experienced a significant decrease in anxiety as they shared their experience with each other and gained new perspectives on their abilities and prospective futures. Hernandez-Ruiz (2005) utilized 20 minutes sessions of participant-selected music paired with progressive musical relaxation (PMR) for female victims currently in a shelter. Control group participants laid in silence for 20 minutes and reported mixed effects – some found the quiet time relaxing while others found it distressing as it allowed time for undesirable thoughts and emotions. Experimental group participants exhibited a statistically significant reduction in anxiety. Music may contribute to decreased anxiety by providing a desirable experience and by drawing the attention of the victim, thereby distracting them from undesirable thoughts and emotions. Further, music can increase physiological arousal which is experienced as relaxing (Davis & Thaut, 1989). For IPV victims, physiological arousal may be conditioned to the abuse they have experienced (Dutton & Painter, 1981), so music therapy may allow victims to experience a healthier method of physiological arousal over which they have control.

Habigzang et al. (2018) reported that CBT interventions effectively reduced anxiety symptoms for victims in their sample (*r* = .55). The authors identified two of the CBT components which impacted anxiety - psychoeducation and developing strategies for self-protection. Psychoeducation reduced anxiety by reducing the associated guilt and shame as participants increased their understanding of IPV and the cycle of abuse (Habigzang et al., 2018). Further, as victims developed strategies for self-protection, they perceived themselves as more in control of their lives and possessed more knowledge of their rights and safety promoting resources. Crespo and Arinero (2010) reported that CBT interventions, including either exposure or communication skills training, were similarly effective for reducing anxiety in women IPV victims presenting with subthreshold PTSD symptoms.

***Self-Esteem***

Three studies measured changes in self-esteem, with all three reporting improvements. Choi et al. (2018) and Crespo and Arinero (2010) both implemented CBT interventions. Choi et al. (2018) reported significant but small improvements in self-esteem for participants who received a CBT group intervention (*t* = .60, *d* = 0.1) compared to those who participated in a mutual support group (*t* = -1.11 , *d* = -0.2). Crespo and Arinero (2010) noted improvements in self-esteem for victims with subthreshold PTSD who received a CBT intervention, but the changes were not statistically significant. Vela et al. (2016) implemented a creative journal arts therapy intervention with three women victims in a single case study. Using visual analysis, Vela et al. (2016) determine that two participants’ self-esteem had moderately improved and one had debatably improved following intervention. However, their findings should be interpreted with caution as the participants started the intervention at the same time and the researchers did not utilized a withdrawal phase, both of which limit the ability to draw causal conclusion in single case research.

***PTSD***

Two studies assessed PTSD outcomes and both utilized CBT based counseling interventions. CBT is a well-established and empirically validated intervention for PTSD in IPV victims (Dutton, 1992). Echeburua (2014) found that CBT was effective in reducing PTSD symptoms, with effectiveness increasing moderately (*d* between .369 and .497 between 1 month and 12 months follow ups) for participants who received both individual and group interventions rather than solely individual. Crespo and Arinero (2010) compared the effectiveness of a CBT intervention with exposure techniques and a CBT intervention with communication skills training in reducing PTSD symptoms in victims presenting with subthreshold PTSD. Both interventions were effective in reducing PTSD symptoms, but the process used for the exposure techniques was not defined. Both CBT with exposure (*d* = 1.47) and CBT with communication skills (*d* = 2.12) were effective in reducing PTSD symptoms.

***Exposure to Violence/Safety***

Six studies addressed changes in exposure to violence and safety of the victims (Bradley et al., 2014; Bradley & Gottman, 2012; Carlson et al., 2018; Choi et al., 2018; Miller et al., 2014; Tiwari et al., 2011). Three of the studies which addressed violence utilized a relationship education (RE) intervention. Two of the three RE studies (Bradley et al., 2014; Bradley & Gottman, 2012) utilized the Creating Healthy Relationships Program (CHRP) with low-income couples who had at least one child and who experienced situational violence. CHRP is a psychoeducational couples-based intervention that teaches skills for maintaining healthy relationships (Bradley et al., 2014). Bradley et al. (2014) found that while CHRP was effective in reducing violence related behavior in men as observed by the clinicians, the intervention did not impact the same variable for women and had no impact on IPV as reported by either of these genders in the couple. Alternatively, Bradley and Gottman (2012) reported that CHRP led to an increase in attitude about healthy relationship skills which predicted a reduction in IPV.

Carlson et al. (2018) implemented Within My Reach (WMR), with participants attending individually regardless of their relationship status. WMR is a behaviorally based individual-oriented RE program that focuses on healthy relationship development and skill attainment (Carlson et al., 2018; Pearson et al., 2008). Carlson et al. found that WMR was effective in reducing relationship inequality and conflict related violence, but only for those who began the study reporting greater relationship inequality, or more violence severity = .06).

Choi et al. (2018) studied the impact of a group CBT intervention on victim’s exposure to violence. While the participant’s exposure to violence was reduced, the comparison mutual support group which did not utilize CBT was equally as effective in reducing exposure to violence. Tiwari et al. (2011) utilized an advocacy intervention with Chinese IPV victims. The authors described the intervention as combining Dutton’s empowerment model (see Dutton, 1992) and the Abuse Prevention Protocol (see Parker et al., 1999). The intervention was designed to empower survivors to consider solutions without being directed, process and understand the abuse they experienced, and set and achieve personalized goals (Tiwari et al., 2011). Following the study, participants who received the intervention reported an increase in safety-promoting behaviors and were more likely to implement the behaviors than control group participants.

Lastly, Miller et al., (2014) utilized a combined CBT and empowerment group intervention, Mom’s Empowerment Program (MEP; Miller et al., 2014). MEP is a 10-session group intervention for mothers who have experienced IPV in the past 2 years. The group focuses on psychoeducation about IPV and its impact, skills that promote mental health, and identifying and addressing advocacy needs. Participants in both MEP and the comparison support group reported reduced victimization over time as measured by the Conflict Tactics Scale – Revised Version (Miller et al., 2014).

**Study Limitations**

There were several important limitations which impacted the quality, generalizability, and conclusions of many of the studies. Sample sizes for each study are reported in Table 2. Almost half of the included studies reported small sample sizes for the methods and design analyses they utilized. Small sample sizes limited the ability of the researchers to draw causal conclusions and generalize their results (Campbell Kirk, 2015; Habigzang et al., 2018).

As seen in Table 2, attrition rates were another significant issue for many of the studies. Four studies reported drop-out rates around 44% (Bradley et al., 2014; Bradley & Gottman, 2012; Davidson et al., 2012; Miller et al., 2014) and another four reported dropout rates between 20-30% (Campbell Kirk, 2015; Carlson et al., 2018; Crespo & Arinero, 2010; Echeburua et al., 2014). Seven studies reported no dropouts, although the sample sizes were less than ten in three of those studies (Aktas Ozkafaci & Eren, 2020; Ikonomopoulos et al., 2017; Vela et al., 2016) and one was a qualitative study (Trabold et al., 2018). Lastly, Choi et al. (2018) and Johnson et al. (2010) reported low drop-out rates at 17% and 6% respectively.

Tiwari et al. (2012) boasted an incredibly low 0% attrition rate with 200 participants and the authors identified important aspects of their study that may have impacted participant retention. First, the sample was taken from a relatively stable population of victims (Tiwari et al., 2012). Second, the community center that hosted the study offered well-maintained electronic member records. Further, Tiwari et al. (2012) implemented systematic-field tracking strategies to ensure adequate contact information was collected, scheduled contacts proceeded as planned, and that participant tracing occurred promptly when a research staff noted lack of contact with a participant.

Previous researchers have identified high attrition rates as a concern in IPV research (Abel, 2000; Leal et al., 2020) and drop-out is a common barrier to treatment for IPV victims and survivors (Liu et al. 2013). Competing demands such as work and children, hectic lives, fear of the abuser finding out, or the abuser not allowing them to attend sessions are only a few of the many difficulties IPV victims face in beginning and maintaining treatment (Bradley et al., 2014; Davidson et al., 2012; Habigzang et al., 2018). Attrition can be combatted by shortening the intervention to make attendance less challenging and increasing incentives for attending by providing money, transportation, child-care, and food (Bradley et al., 2014).

Attrition and safety concerns contributed to another limitation many of the studies faced – lack of a control group. Researchers in 6 of the 14 included articles where a RCT was feasible (excluding the qualitative and two single case studies) noted that lack of a control group hampered their ability to rule out many confounding variables. However, the decision to forego a control group was made necessary by ethical and safety concerns, as it may have been harmful to withhold interventions from victims currently in danger (Akta**ş** Özkafaci & Eren, 2020). Further, Aktaş Özkafaci and Eren’s (2020) pilot study showed that victims may not return for the intervention or that researchers may lose touch with victims after being placed on a wait list.

**Discussion**

To address the first goal of our review, we organized the studies according to study participants, modalities, and outcome measurements so that clinicians working with IPV victims may find a concise summary of the evidence base for interventions that may benefit their specific clients. Previous systematic reviews supported CBT as the intervention with the greatest evidence base for supporting victims’ mental health (Trabold et al., 2020). Given the heterogeneity of the population and limitations of current research, we find it difficult to recommend one specific intervention for clinicians working with IPV victims. IPV survivors have a wide variety of life experiences with a range of mental health effects; therefore, no single treatment model exists that will fit the needs of all victims (Warshaw et al., 2013). The needs of victims in shelters may be vastly different from victims seeking community services. Further, the level of violence experienced, whether it is low-level, mutual violence, or power and control related violence, impacts the appropriateness of the services provided. Therefore, treatments should be tailored to meet the specific needs of the participants and the violence sub-type (Bradley et al., 2014). Clinicians may utilize this review to understand current evidence on effective interventions for IPV victims and how those interventions are applied with victims with differing needs and symptoms.

To address the second goal of our review, we reviewed the limitations of the included studies and we now further discuss gaps in the literature on interventions for IPV victims. In 2003, Kubany et al. reported that most interventions for IPV victims were focused on PTSD symptoms but this approach alone failed to address other symptoms caused by IPV, such as depression and anxiety, decreases in self-esteem, and difficulties in daily functioning (Echeburua et al., 2014). Almost 20 years later, we found that researchers have expanded their focus, as only 2 studies assessed PTSD symptoms while multiple studies focused on depression, anxiety, violence or victim safety, and self-esteem. Despite continued expansion of research on interventions for IPV victims, significantly more research is needed to establish which interventions are most effective and for which victims (Abel, 2000; Trabold et al., 2020; Warshaw et al., 2013). Studies that utilize methods to enhance retention, engage victims from diverse backgrounds, studies with larger sample sizes are necessary, and more randomized control trials are necessary (Trabold et al., 2020). Further, in 2013, Warshaw et al. called for more studies which include victims with more severe mental health and substance abuse-related needs. Several of the studies in this review excluded participants with substance abuse and certain mental health diagnoses. Given that substance abuse and mental health diagnoses are highly correlated with IPV victimization (Coker et al., 2000; Lagdon et al., 2014; Smith et al., 2017), further research is needed on interventions that are effective for victims presenting with other mental health concerns as well.

Additionally, studies which address the IPV experiences of LGBTQ+ individuals are needed. IPV has historically been conceptualized as a pattern of behavior in which men attempt to control and dominate women (Carlson & Jones, 2010). Therefore, researchers have primarily focused on IPV experiences of cisgender individuals in heterosexual relationships, leading to a gap in research on IPV experiences of LGBTQ+ individuals (Jacobsen et al., 2015; Reuter et al., 2017), despite the fact that LGBTQ+ individuals are just as likely to experience IPV as cisgender, heterosexual individuals (Dank et al., 2014; Reuter et al., 2015; Reuter et al., 2017). Moving forward, researchers should strive to include LGBTQ+ individuals in studies and conduct specific studies on effective interventions for non-cisgender and non-heterosexual individuals who experience IPV.

Lastly, more qualitative data is needed in order to understand the experiences of victims who receive counseling services (Abel, 2000). Only one qualitative study and two mixed-methods studies met the requirements for this review. Qualitative research would provide valuable insights into victims’ experiences with different interventions and their outcomes and could highlight additional ways to improve attrition (Abel, 2000). Finally, we echo Warshaw et al. (2013) in the call for IPV intervention studies to include as much participant data as possible, even from participants who drop out. Given the high rate at which IPV victims discontinue services, it is crucial that we identify attrition patterns to better understand how to improve services and improve retention.

**References**

\*Indicates the studies included in the systematic review

Abel, E. M. (2000). Psychosocial treatments for battered women: A review of empirical research. *Research on Social Work Practice, 10*(1), 55-77. <https://doi-org.pallas2.tcl.sc.edu/10.1177%2F15527581-00010001-07>

Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M, & Wood, D. S. (2015). Short-term interventions for survivors of intimate partner violence: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 18*(2), 155-171. [10.1177/1524838015602736](https://doi.org/10.1177/1524838015602736)

\*Aktas Özkafaci, A., & Eren, N. (2020). Effect of art psychotherapy using marbling art on depression, anxiety, and hopeless in female survivors of domestic violence with PTSD. *The Arts in Psychotherapy, 71*, 1-11. <https://doi.org/10.1016/j.aip.2020.101703>

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. Journal of Marital and Family Therapy, 25(3), 291–312. [10.1111/j.1752-0606.1999.tb00249.x](https://doi.org/10.1111/j.1752-0606.1999.tb00249.x)

\*Bradley, R. P. C., Drummey, K., Gottman, J. M., & Gottman, J. S. (2014). Treating couples who mutually exhibit violence or aggression: Reducing behaviors that show a susceptibility for violence. *Journal of Family Violence, 29*(5), 549-558. <https://psycnet.apa.org/doi/10.1007/s10896-014-9615-4>

\*Bradley, R. P. C., & Gottman, J. M. (2012). Reducing situational violence in low-income couples by fostering health relationships. *Journal of Marital and Family Therapy, 38*(1), 187-198. <https://doi.org/10.1111/j.1752-0606.2012.00288.x>

\*Campbell Kirk, J. (2015). Dramatherapy with women survivors of domestic abuse: A small scale research study. *Dramatherapy, 37*(1), 28-43. <https://doi-org.pallas2.tcl.sc.edu/10.1080%2F02630672.2015.1101480>

Carlson, R. G., & Jones, K. D. (2010). Continuum of conflict and control: A conceptualization of intimate partner violence typologies. *The Family Journal: Counseling and Therapy for Couples and Families 18*(3), 248-254*.*

\*Carlson, R. G., Wheeler, N. J., & Adams, J. J. (2018). The influence of individual-oriented relationship education on equality and conflict-related behaviors. *Journal of Counseling and Development*, 96, 144-154. <https://doi-org.pallas2.tcl.sc.edu/10.1002/jcad.12188>

\*Choi, A. W. M., Chan, P. Y., Lo, R. T. F., Wong, L. C. L., Wong, J. Y. H., & Tang, D. H. M. (2018). Freeing Chinese abused women from stereotype: A pretest-posttest comparison study on group intervention in refuge centers. *Journal of Evidence-Informed Social Work, 15*(6), 599-616. <https://psycnet.apa.org/doi/10.1080/23761407.2018.1509409>

Coker, A. L., Derrick, C., Lumpkin, J. L., Aldrich, T. E., & Oldendich, R. (2000). Help-seeking for intimate partner violence and forced sex in South Carolina. *American Journal of Preventive Medicine, 19*(4), 216-320. <https://doi.org/10.1016/s0749-3797(00)00239-7>

\*Crespo, M. & Arinero, M. Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. *The Spanish Journal of Psychology, 13*(2), 849-863. <https://doi.org/10.1017/s113874160000250x>

Dank, M., Lachman, P., Zweig, J. M., & Yahner, J. (2014). Dating violence experiences of lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence, 43*(5), 846-857. [10.1007/s10964-013-9975-8](http://dx.doi.org/10.1007/s10964-013-9975-8)

\*Davidson, M. M., Nitzel, C., Duke, A., Baker, C. M., & Bovaird, J. A. (2012). Advancing career counseling and employment support for survivors: An intervention evaluation. *Journal of Counseling Psychology, 59*(2), 321-328. <https://doi.org/10.1037/a0027965>

Davis, W. B., & Thaut, M. H. (1989). The influence of preferred relaxing music on measures of state anxiety, relaxation, and physiological responses. *Journal of Music Therapy, 26*(4), 169-187. <https://doi.org/10.1093/jmt/26.4.168>

Dies, R. R. (1995). Group psychotherapies. In A. Gurman & S. Messer (Eds.), *Essential psychotherapies: Theory and practice* (p. 515-55). New York, NY: Guilford.

Drumm, K. (2006). The essential power of group work. *Social Work with Groups, 29*(2), 17-31. <https://doi-org.pallas2.tcl.sc.edu/10.1300/J009v29n02_02>

Dutton, D., & Painter, S. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology: An International Journal, 6*(1), 139-155.

Dutton, M. A. (1992). Assessment and treatment of posttraumatic stress disorder among battered women. In D. W. Foy (Ed.), *Treating PTSD: Cognitive-behavioral strategies* (pp. 69-98). New York, NY: Guilford Press.

\*Echeburúa, E., Sarasua, B., & Zubizarreta, I. (2014). Individual versus individual and group therapy regarding a cognitive-behavioral treatment for battered women in a community setting. *Journal of Interpersonal Violence, 29*(10), 1783-1801. <https://doi.org/10.1177/0886260513511703>

\*Habigzang, L. F., Aimee Schneider, J., Petroli Frizzo, R., & Pinto Pizarro de Freitas, C. (2018). Evaluation of the impact of a cognitive-behavioral intervention for women in domestic violence situations in Brazil. *Universitas Psychologica, 17*(3). <https://doi.org/10.11144/javeriana.upsy17-3.eicb>

Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707-730. <https://doi.org/10.1037%2Fa0016441>

\*Hernández Ruiz, E. (2005). Effect of music therapy on the anxiety levels and sleep patterns of abused women in shelters*. Journal of Music Therapy, 42*(2), 140-158. <https://doi.org/10.1093/jmt/42.2.140>

Heyman, R. E., Smith, A. M., & Foran, H. M. (2015). Enhanced definitions of intimate partner violence for DSM-5 and ICD-11 may promote improved screening and treatment. *Family Process, 54,* 64 – 81. [10.1111/famp.12121](https://doi.org/10.1111/famp.12121)

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., ... & Pluye, P. (2018). The mixed methods appraisal tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285-291.

\*Ikonomopoulos, J., Cavazos-Vela, J., Vela, P., Sanchez, M, Schmidt, C., & Catchings, C. V. (2017). Evaluating the effects of creative journal arts therapy for survivors of domestic violence. *Journal of Creativity in Mental Health, 12*(4), 496-512. <http://dx.doi.org/10.1080/15401383.2017.1328290>

Jacobsen, L., Daire, A. P., & Abel, E. M. (2015). Intimate partner violence: Implications for counseling self-identified LGBTQ college students engaged in same-sex relationships. *Journal of LGBT Issues in Counseling, 9*(2), 118-135. [https://doi.org/10.1080/15538605.2015.1029203](https://psycnet.apa.org/doi/10.1080/15538605.2015.1029203)

Johnson, M. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and Family, 57*(2), 283–294. <https://doi.org/10.2307/353683>

\*Johnson, D. M., Zlotnick, C., Hoffman, L., Palmieri, P. A., Johndon, N. L., Holmes, S. C., & Ceroni, T. L. (2020). A randomized controlled trial comparing HOPE treatment and present-centered therapy in women residing in shelter with PTSD from intimate partner violence. *Psychology of Women Quarterly, 44*(4), 539-553. <https://doi-org.pallas2.tcl.sc.edu/10.1177%2F0361684320953120>

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experiences of mental health outcomes as a result of intimate partner violence victimization: A systematic review. *European Journal of Psychotraumatology, 5,* 1-12. <https://doi.org/10.3402%2Fejpt.v5.24794>

Leal, J., Cunha, C., Santos, A., & Salgado, J. (2020). Helping clients victimized by intimate partners through stages of change: An emotion-focused approach. *Journal of Contemporary Psychotherapy, 5(*1), 41-48. <http://dx.doi.org.pallas2.tcl.sc.edu/10.1007/s10879-020-09474-4>

Leone, J. M., Johnson, M. P., & Cohan, C. L. (2007). Victim help seeking: Differences between intimate terrorism and situational couple violence. *Family Relations, 56*(5), 427-439. <http://dx.doi.org.pallas2.tcl.sc.edu/10.1111/j.1741-3729.2007.00471.x>

Liu, S., Dore, M. M., & Amrani-Cohen, I. (2013). Treating the effects of interpersonal violence: A comparison of two group models. *Social Work With Groups, 36*(1), 59-72. <http://dx.doi.org/10.1080/01609513.2012.725156>

Mburia-Mwalili, A., Clements-Nolle, K., Lee, W., Shadley, M., & Yang, W. (2010). Intimate partner violence and depression in a population-based sample of women: Can social support help? *Journal of Interpersonal Violence, 25*(12), 2258-2278. <https://doi.org/10.1177%2F0886260509354879>

Meyer, I. H., Dietrich, J., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health, 98*(6), 1004-1006. <https://doi.org/10.2105%2FAJPH.2006.096826>

\*Miller, L. E., Howell, K. H., & Graham-Bermann, S. A. (2014). The effect of an evidence-based intervention on women’s exposure to intimate partner violence. *American Journal of Orthopsychiatry, 84*(4), 321-328. <https://doi.org/10.1037/h0099840>

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., Shekelle, P., & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews*, *4*(1), 1–1. <https://doi.org/10.1186/2046-4053-4-1>

Nichols, E. M., Bonomi, A., Kammes, R., & Miller, E. (2018). Service seeking experiences of college-aged sexual and intimate partner violence victims with a mental health and/or behavioral disability. *Journal of American College Health, 66*(6), 487-495. [10.1080/07448481.2018.1440572](https://doi.org/10.1080/07448481.2018.1440572)

Pearson, M., Stanley, S. M., & Rhoades, G. H. (2008). Within My Reach leader manual. Denver, CO: PREP for Individuals.

Reuter, T. R., Newcomb, M. E., Whitton, S. W., & Mustanski, B. (2017). Intimate partner violence victimization in LGBT young adults: Demographic differences and associations with health behaviors. *Psychology of Violence, 7*(1), 101-109. <https://psycnet.apa.org/doi/10.1037/vio0000031>

Reuter, T. R., Sharp, C., & Temple, J. R. (2015). An exploratory study of teen dating violence in sexual minority youth. *Partner Abuse, 6*(1), 8-28. <http://dx.doi.org/10.1891/1946-6560.6.1.8>

Simpson, L. E., Atkins, D. C., Gattis, K. S., & Christensen, A. (2008). Low-level relationship aggression and couple therapy outcomes. *Journal of Family Psychology, 22*(1), 102-111. <https://psycnet.apa.org/doi/10.1037/0893-3200.22.1.102>

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf>

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spousal abuse. *Journal of Marital and Family Therapy, 29*(3), 407-426. <https://doi.org/10.1111%2Fjmft.12178>

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2003). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couples versus individual couple therapy. *Journal of Martial and Family Therapy, 30*(3), 3015-318. <https://doi-org.pallas2.tcl.sc.edu/10.1111/j.1752-0606.2004.tb01242.x>

\*Tiwari, A., Fong, D. Y. T., Wong, J. Y. H., Yuen, K., Yuk, H., Pang, P., Humphreys, J., & Bullock, L. (2012). Safety-promoting behaviors of community-dwelling abused Chinese women after an advocacy intervention: A randomized controlled trial. *International Journal of Nursing Studies, 49*(6), 645-655. <https://doi.org/10.1016/j.ijnurstu.2011.12.005>

Trabold, N.., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2020). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. *Trauma, Violence, & Abuse, 21*(2), 311-325. <https://doi.org/10.1177/1524838018767934>

\*Trabold, N., O’Malley, A., Rizzo, L., & Russell, E. (2018). A gateway to healing: A community-based brief interventions for victims of violence. *Journal of Community Psychology, 46*(4), 418-428. <https://doi-org.pallas2.tcl.sc.edu/10.1002/jcop.21948>

\*Vela, J. C., Ikonomopoulos, J., Dell’Aquila, J., & Vela, P. (2016). Evaluating the impact of creative journal arts therapy for survivors of intimate partner violence. *Counseling Outcome Research, 7*(2), 86-98. <https://doi-org.pallas2.tcl.sc.edu/10.1177%2F2150137816664781>

Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). A systematic of trauma-focused interventions for domestic violence survivors. National Center on Domestic Violence, Trauma & Mental Health. <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf>

World Health Organization. (2021). Violence against women prevalence estimates, 2018. <https://www.who.int/publications/i/item/9789240022256>

Yoshioka, M. R., Gilbert, L., El-Bassel, N, & Baig-Amin, M. (2003). Social support and disclosure of abuse: Comparing South Asian, African American, and Hispanic battered women. *Journal of Family Violence, 18*(2), 171-180. <http://dx.doi.org/10.1023/A:1023568505682>

**Figure 1**

*MMAT Flow Chart*

Co

Full-text articles excluded and reasons

(n=13)

Non-Mental Health Related Outcomes

Non-IPV victim sample

Pilot/Preliminary Study

Identification

Eligibility

Screening

Included

Studies included

(n=17)

Full-test articles examined for eligibility

(n=30)

Records screened

(n=1853)

Records after duplicates removed

(n=1853)

Records identified through database search

(n = 2046)

Records identified through additional sources

(n=0)

Records removed

(n=1823)

Non-English

Conceptual

Pilot/Preliminary Study

Non-IPV victim sample

No counseling intervention

**Table 1**

*MMAT (Hong et al., 2018) Study Quality Appraisal*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Article** | **2.1** | **2.2** | **2.3** | **2.4** | **2.5** |
| Bradley & Gottman, 2012 | Yes | Yes | 54% | Can’t Tell | Can’t Tell |
| Bradley et al., 2014 | Yes | Yes | 56% | Can’t Tell | Yes |
| Crespo & Arinero, 2010 | No | No | 74% | Can’t Tell | Yes |
| Johnson et al., 2020 | Yes | Yes | 94% | Yes | Yes |
| Miller et al., 2016 | Yes | Yes | 44% | No | Yes |
| Tiwari et al., 2012 | Yes | Yes | 56% | Yes | Yes |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Article** | **3.1** | **3.2** | **3.3** | **3.4** | **3.5** |
| Campbell Kirk, 2015 | Yes | Yes | 73% | Yes | No |
| Carlson et al., 2018 | Yes | Yes | 70% | No | Yes |
| Choi et al., 2018 | Yes | Yes | 83% | Yes | Yes |
| Davidson et al., 2012 | Yes | Yes | 43% | Yes | Yes |
| Echeburua et al., 2014 | Yes | Yes | 57% | No | Can’t Tell |
| Hernandez Ruiz et al., 2005 | Yes | Yes | 100% | Yes | Yes |
| Ikonomopoulos et al., 2017 | Yes | Yes | 100% | No | Can’t Tell |
| Vela et al., 2016 | Yes | Yes | 100% | No | Can’t Tell |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Article** | **5.1** | **5.2** | **5.3** | **5.4** | **5.5** |
| Aktas Oskafaci & Eren, 2020 | Yes | Yes | Yes | Yes | Yes |
| Habigzang et al., 2018 | Yes | Yes | Yes | Yes | Yes |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Article** | **1.1** | **1.2** | **1.3** | **1.4** | **1.5** |
| Trabold et al., 2018 | Yes | Yes | Yes | Yes | Yes |

**Table 2**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Article** | **Study Design** | **Setting** | **Participants** | **N** | **Attrition Rate** |
| Aktas Ozkafaci & Eren, 2020 | Mixed Methods | Private Counseling Center | Female IPVa victims with PTSD**b** | 8 | 0% |
| Bradley & Gottman, 2012 | Randomized, Control | NAc | Low-income couples with children who experience situational violence | 115 | 46% |
| Bradley et al., 2014 | Randomized, Control | NA | Low-income couples with children who experienced situational violence | 115 | 44% |
| Campbell Kirk, 2015 | Non-Randomized, Comparison | IPV Agency & Doctor’s Office | Female IPV victims | 15 | 27% |
| Carlson et al., 2018 | Non-Randomized, No Control | Community Settings | Low-income individuals | 340 | 30% |
| Choi et al., 2018 | Non-Randomized, Comparison | IPV Shelter | Female IPV victims | 120 | 17% |
| Crespo & Arinero, 2010 | Randomized, Control | IPV Agencies | Female IPV victims with subthreshold PTSD symptoms who were abused by a male partner | 53 | 26% |
| Davidson et al., 2012 | Non-Randomized, No Control | NA | Female IPV victims who experienced violence in the past 5 years | 99 | 43% |
| Echeburua et al., 2014 | Non-Randomized, Comparison | IPV Agency | Female IPV victims of male abusers, not residing with the abuser | 161 | 28% |
| Habigzang et al., 2018 | Mixed Methods | Community Counseling Center | Female IPV victims | 11 | 0% |
| Hernandez Ruiz, 2005 | Non-Randomized, Control | IPV Shelters | Female IPV victims who experience violence within 1 month of entering shelter | 28 | 0% |
| Ikonomopoulos et al., 2017 | Single Case | Community Counseling Center | Female IPV victims | 3 | 0% |
| Johnson et al., 2020 | Randomized, Control | IPV Shelters | Female IPV victims | 172 | 6% |
| Miller et al., 2014 | Randomized, Comparison | NA | Female IPV victim mothers | 111 | 44% |
| Tiwari et al., 2011 | Randomized, Control | Community Center | Female IPV victims | 200 | 0% |
| Trabold et al., 2018 | Qualitative | IPV Agency | Female IPV victims | 15 | 0% |
| Vela et al., 2016 | Single Case | Community Counseling Center | Female IPV victims | 3 | 0% |

**a** Intimate Partner Violence. b Posttraumatic Stress Disorder. c Not Available

**Table 3**

|  |  |  |  |
| --- | --- | --- | --- |
| **Article** | **Intervention Type** | **Treatment Modality** | **Outcomes** |
| Aktas Ozkafaci & Eren, 2020 | Arts | Group | Reductions in depression, hopelessness & anxiety |
| Bradley & Gottman, 2012 | REa | Group | Increases in attitude about health relationship skills predicted reductions in IPVb |
| Bradley et al., 2014 | RE | Group | No significant changes in IPV related behavior in women or participant reported IPV for any participants; Significant changes in clinician observed IPV related behavior of men |
| Cambell Kirk, 2015 | Arts | Individual | Significant reductions in mental health distress |
| Carlson et al., 2018 | RE | Individual | Significant changes in relationship equality, controlling violence, and relational conflict for participants experiencing some violence and severe violence; No significant changes in conflict repair for any participants; No changes for participants not experiencing violence |
| Choi et al., 2018 | CBTc | Group | Significant improvements in self-esteem; Both CBT and support group equally effective in improving depression and revictimization |
| Crespo & Arinero, 2010 | CBT | Group | No significant changes in anger expression; Significant differences in PTSDd symptoms, depression, anxiety, and self-esteem; CBT with communication skills more effective for reexperiencing PTSD symptoms; CBT with exposure more effective for avoidance PTSD symptoms |
| Davidson et al., 2012 | Career | Group | Post-intervention, no significant changes in depression and anxiety; At 8-week follow up, significant changes in depression and anxiety |
| Echeburua et al., 2014 | CBT | Both | Reductions in emotional discomfort and PTSD, stronger effect with combined individual and group services than with individual services alone |
| Habigzang et al., 2018 | CBT | Individual | Significant improvements in anxiety, depression, stress, and life satisfaction |
| Hernandez Ruiz, 2005 | Arts | Individual | Significant improvements in anxiety and sleep patterns |
| Ikonomopoulos et al., 2017 | Arts | Individual | Moderate improvements in resiliency and OQe scores for 2 of 3 participants |
| Johnson et al., 2020 | CBT | Individual | Equal improvements in PTSD, revictimization, depression, empowerment and quality of life for both intervention and control group |
| Miller et al., 2014 | CBT | Group | Intervention group reported lower revictimization rates than control group |
| Tiwari et al., 2011 | Advocacy | Individual | Increased engagement in safety-promoting behaviors |
| Trabold et al., 2018 | TIBIf | Individual | Participants described improved physical health, quality of life, and self-esteem; Participants reported that TIBI filled a gap that other approaches weren’t able to address |
| Vela et al., 2016 | Arts | Individual | Debatable to moderate improvements in self-esteem and hope for all 3 participants |

a Relationship Education. b Intimate partner violence. c Cognitive Behavioral Therapy. d Post traumatic Stress Disorder. e Outcome Questionnaire. f Trauma Informed Brief Intervention.