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REPERAGE ET INTERVENTIONS AUPRES DE FEMMES VICTIMES DE VIOLENCES CONJUGALES DANS LE CADRE DES SOINS PRIMAIRES : UNE REVUE SYSTEMATIQUE

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REPERAGE ET INTERVENTIONS AUPRES DE FEMMES VICTIMES DE VIOLENCES CONJUGALES DANS LE CADRE DES SOINS PRIMAIRES : UNE REVUE SYSTEMATIQUE

Résumé

Introduction

1 femme sur 3 dans le monde est victime de violences physiques et/ou sexuelles au cours de sa vie, le plus souvent infligées par un partenaire intime. La violence conjugale évolue de manière cyclique et s'intensifie progressivement si rien n'est fait pour y mettre fin. Les conséquences physiques et mentales sont importantes et toutes les catégories sociales sont touchées. **Cette étude a pour but d'identifier les interventions existantes pour aider les victimes de violences conjugales dont l'efficacité a été évaluée dans le cadre des soins primaires.**

Méthode

Une revue systématique des articles publiés entre septembre 2003 et décembre 2023 a été menée à partir de 3 bases de données : Medline via Pubmed, PsycInfo, et Central via Cochrane Library. L'équation de recherche a été élaborée à partir d'une combinaison de quatre critères : le fait d'être une femme de plus de 16 ans, avoir été victime de violences conjugales, l'existence d'interventions luttant contre les violences conjugales et le contexte des soins primaires.

Résultats

3017 articles ont été sélectionnés par notre équation de recherche, 7 études ont finalement été incluses. 6 interventions ont été décrites dont : une intervention brève basée sur le modèle "Psychosocial Readiness" (efficacité significative sur la dépression), le protocole "March of Dimes" qui comprend une brochure avec un plan de sécurité en 15 points pour augmenter l'adoption de comportements de sécurité (efficacité dans la diminution des menaces d'abus), ou une intervention psycho-éducative. Les 4 principaux critères d'évaluation ont été fondés sur des scores cliniques axés sur la santé mentale ou la qualité de vie.

Conclusion

Ces résultats mettent en lumière l'utilité d'intégrer dans les soins primaires un repérage de la violence conjugale, suivi d'interventions qui peut prendre diverses formes, généralement de courte durée. Un modèle inspiré du SBIRT (Screening, Brief Intervention, and Referral to Treatment) dans le domaine de l'addictologie pourrait constituer une approche intéressante pour de futures recherches.

Mots clés : femmes, violences conjugales, soins primaires, interventions.

SCREENING AND COUNSELLING FOR INTIMATE PARTNER VIOLENCE IN PRIMARY CARE: A SYSTEMATIC REWIEW

Abstract

Introduction

1 in 3 women worldwide is a victim of physical and/or sexual violence during her lifetime, most often inflicted by an intimate partner. Violence between intimate partners evolves cyclically and becomes progressively more intense if nothing is done to stop it. The physical and mental consequences are significant, and all social categories are affected. **This study aims was to identify available counselling program to help IPV victim whose effectiveness has been evaluated in primary care.**

Method

Systematic review of articles published since September 2003 up to December 2023 searching through 3 databases: Medline via Pubmed, PsycInfo, and Central via Cochrane Library. Research equation elaborated using a combination of four research topics: women patients, intimate partner violence, counselling, and primary care setting.

Results

3017 articles were selected by our search strategy, 7 studies were finally included. 6 interventions format was described as brief counselling based on the Psychosocial Readiness Model (significant effectiveness on depression), March of Dimes protocol which includes a brochure with a 15-item safety plan to increase adoption of safety behaviors (efficiency in decreasing threats of abuse), or psychoeducational intervention. 4 mains evaluation criteria were founded as clinical score focused on mental health or quality of life.

Conclusion

These results bring to light the usefulness to integrate in primary care some screening on IPV, followed by some counselling intervention which may take various form, usually of short duration. A model inspired by the SBIRT in the addictology field could be an approach for futures investigations.

Key words: women, intimate partner violences, primary cares, counselling

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SERMENT D'HIPPOCRATE

En présence des enseignants et enseignantes
de cette Faculté,
de mes chers condisciples
et selon la tradition d'Hippocrate,
je promets et je jure d'être fidèle aux lois de l'honneur
et de la probité dans l'exercice de la Médecine.

Je donnerai mes soins gratuits aux indigents,
et n'exigerai jamais un salaire au-dessus de mon travail.

Admis(e) dans l'intérieur des maisons, mes yeux
ne verront pas ce qui s'y passe, ma langue taira
les secrets qui me seront confiés et mon état ne servira pas
à corrompre les mœurs ni à favoriser le crime.

Respectueux(euse) et reconnaissant(e) envers mes Maîtres,
je rendrai à leurs enfants
l'instruction que j'ai reçue de leurs parents.

Que les hommes et les femmes m'accordent leur estime
si je suis fidèle à mes promesses.

Que je sois couvert(e) d'opprobre
et méprisé(e) de mes confrères et consœurs
si j'y manque.

Madame et Messieurs les membres du jury

Monsieur le Professeur Jean-Pierre LEBEAU

Je vous remercie de m'avoir accordé l'honneur de présider ce jury. Recevez ma sincère reconnaissance pour votre enseignement et votre disponibilité.

Monsieur le docteur Christophe RUIZ

Je suis enchanté de vous compter parmi les membres du jury de cette thèse. Recevez mes remerciements les plus sincères.

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Monsieur le docteur Maxime PAUTRAT

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Table of contents

Abreviations

CI: Confidence Interval
GP: General Practitioner
IPV: Intimate Partner Violence
MeSH: Medical Subject Headings
M: Mean
MD: Mean Difference
MI: Motivational Interviewing
PRISMA: Preferred Reporting Items for Systematic Review and Meta-Analysis
PROSPERO: International Prospective Register of Systematic Reviews
SBIRT: Screening, Brief Intervention, and Referral to Treatment
SUD: Substance Use Disorder

Introduction:

The World Health Organization defines intimate partner violence as " behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and partners“ (1).

1 in 3 women worldwide is a victim of physical and/or sexual violence during her lifetime, most often inflicted by an intimate partner (2). In Europe, this prevalence is about 22% (3). In 2018 in France, 87% of the victims of such violence are women and only one victim in five reported having filed a complaint (4).

Violence between intimate partners evolves cyclically and becomes progressively more intense if nothing is done to stop it (5). It goes through a succession of phases: tension, violence, justification, "honeymoon" and then tension again (6). The main contributing and aggravating factors are a young age (20 to 24 years old), pregnancy, professional instability and above all the financial dependence of women with no personal income (7,8). In addition to the physical after-effects, victims may suffer psychological damage in the form of fear, guilt, loss of self-esteem and autonomy, isolation and stress (9). Some of these women may not report the violence or may return to live with their abuser (10). This may be allowed by a phenomenom described as "coercive control" which focuses on the perpetrator's pattern of oppressive and repetitive behavior toward the victim, such as deprivation of rights and resources, surveillance, and micro-regulation and control of behavior (11). The physical and mental consequences are significant, and all social categories are affected (12).

85% of female victims of sexual violence who have sustained physical injuries report a lack of medical attention (13). Very few victims received medical attention following their attack, less than 5% consulted a doctor or been hospitalized (13). However, the positive impact on the health of victims by these professionnels is increasingly being demonstrated internationally (14). They also have effective screening tools at their disposal (15). The role of the general practitioner is central in detecting such violence, taking the history, noting the injuries, drawing up an initial medical certificate and referring the patient (16,17). This is why violence against women was included in the training of doctors and midwives in 2013 (18,19). The question of systematic screening is still open to debate (20). The World Health Organization does not recommend systematic screening, given the lack of improvement in women's health after screening (21), while the US preventive services task force, a group of independent, voluntary prevention experts, recommends systematic screening for all women of childbearing age, given the few negative effects reported following screening (22).

This debate could be explained by the difficulty to associate a counselling and follow up with the screening of IPV victims. This study aim was to identify available counselling program to help IPV victim whose effectiveness has been evaluated in primary care.

Method:

Search strategy:

Systematic review of articles published since September 2003 up to December 2023 searching through 3 databases: Medline via Pubmed, PsycInfo, and Central via Cochrane Library. Research equation elaborated using a combination with keywords adapted for each database as MeSH terms for Pubmed (b).

Four search terms were included in the search strategy: women patients, intimate partner violence, counselling and primary care setting.

Eligibility criteria:

We included articles on studies with the following characteristics:

-patients women > 16 years old

-patients with a history of intimate partner violence by their own confession and after screening by doctors or paramedical staff

Intimate partner violence criteria was accepted here in various ways in the studies: fear of the partner in the past months, physical abuse, sexual abuse, emotional abuse and coercive control.

-screening action with follow-up (educational session, motivational interviewing, counselling for relationship and emotional issues)

-any counseling or intervention

-primary care settings

We did not include articles on studies with the following characteristics:

-studies about intimate partner violence with screening only

-studies based on focused population (pregnant women, homeless people, women's veterans, HIV-positive patients, race-based focus group).

Studies selection:

Articles were first screened on title, regarding the question of interest. Then, 2 authors independently reviewed the abstracts of the remaining studies. If suitability was presumed, full-text articles were collected. Double-reading permitted comparison. If disagreements occurred, they were discussed with a third author to find a consensus.

Data extraction:

For each included study, characteristics were summarized in the table 1:

-name of the study, publication date and author

-location and country

-characteristics of the screening process

-characteristics of the included population with inclusion and exclusion criteria

-aim of the study

-method used

-psychometrics data: acceptability, feasability and limits

For each counselling program, characteristics were summarized in the table 2:

-type of intervention
-characteristics of control group
-duration of the intervention
-number of sessions
-follow-up time
-efficiency criteria

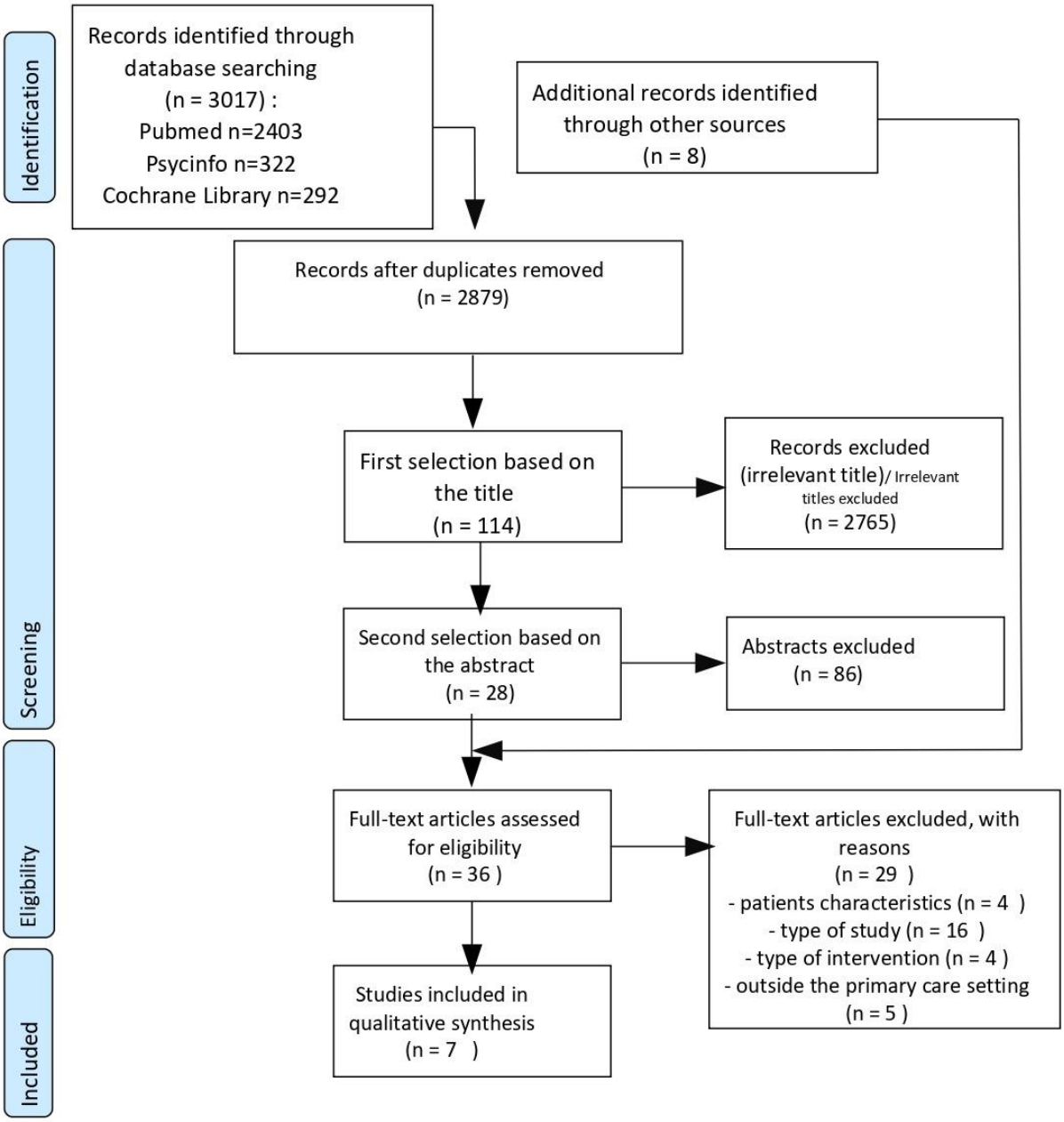

Figure 1. Flowchart of included studies

Protocol and Registration:

Our systematic review of the literature was registered in PROSPERO: no.
We followed the recommendations of the PRISMA (23) to write this review. (a)

Results:

Study selection:

3017 articles were selected by our search strategy. After duplicates removed, 2879 articles were examined. After exclusion of 2843 articles on title and abstract and addition of 8 other trials identified by other sources, 36 articles were assessed for eligibility by full-text reading. Finally, 7 studies were included (24–30) (figure 1).

Characteristics of included studies:

In relation to the seven included articles, the number of patients in each trial ranged from 41 to 906. Five studies were multicentric studies (26–30). The majority was carried out in the United States (24,25,28–30). Characteristic detailed of each article were summarized in Table 1.

Setting and population:

Five trials were conducted in medical centers (family planning clinics and primary care public health-clinics) (24,25,28–30) and 2 in rural and urban doctor's offices (26,27). Three trials involved adolescents (>16 years old) (26–28).

Characteristics of interventions:

Type of passation:

-variety in duration (20-60min)
-number of sessions: 1 to 6, except for one trial where the number of intervention sessions is open-ended (25)

Type of intervention:

-brief counselling intervention based on the Psychosocial Readiness Model (26,27)
-March of Dimes protocol (29) which includes a brochure with a 15-item safety plan to increase adoption of safety behaviors
-assistance with education and card ressources giving (28)
-MI (24,30)
-psychoeducational intervention (25)
-psychotherapeutic counseling (25)

Four trials only consisted in counseling session(s) (26–29).
Two trials associated a first personal face-to-face counseling session to three to six phone calls between five minutes to one hour duration (24,30).
One trial associated an individual psychotherapeutic counseling session to a six-week psychoeducational group counseling program (25).

Table 1. descriptive table of selected studies

STUDY	SETTING	SCREENING TOOL	POPULATION/INCLUSION CRITERIA	OBJECTIVE(S)	METHOD	FEASABILITY/ACCEPTABILITY/LIMITS
Secondary Prevention of Intimate Partner Violence, Judith M. McFarlane, January/February 2006	Two primary care public healthclinics and two Women, Infants & Children (WIC) clinics in a large urban area. U.S.	Nurses used the Abuse Assessment Screen (AAS) in two questions. A woman was positive for abuse by responding yes to one question.	N=360, aged 18 to 45, to be positive to the AAS	To assess the comparative safety behaviors, use of community resources, and extent of violence following two levels of intervention.	A randomized, two-arm, clinical trial : -a wallet-sized referral card -a 20-minute nurse case management protocol	Lack of a placebo group. Inability to mask participants and providers to treatment condition (budget limitations).
The domestic violence survivor assessment (DVSA) : a tool for individual counceling with women experiencing intimate partner violence, Jacqueline Dienemann, 2007	Montgomery County Department of Health and Human Services Montgomery County, U.S.	Individual psychotherapeutic counseling (IPTC) is offered to any IPV survivor who agrees to commit to work on her safety and personal issues.	N=355, come to the Abused Persons Program as self-referrals survivor of IPV or to be referred by the court as IPV victims, to first attend a six-week PEGC group program if referred by the court as IPV victims	To examine the stage of change for 12 personal and relationship issues commonly faced by survivors of IPV.	A one-page grid with the 12 issues arranged in rows containing five sets of phrases each. To be completed by counselors after one or two visits and then every three months until discharge from the PTIC individual counseling program.	Feasibility to use in practice to measure the impact of counseling.
Can a Health Clinic-Based Intervention Increase Safety in Abused Women? Results from a Pilot Study, Tameka L. Gillum, 2009	a primary healthcare clinic for the uninsured Baltimore, U.S.	Women>18 years of age seeking care were screened for IPV in a private room by a member of the study team. Those women screening positive for recent (past year) IPV were invited to participate in the study.	N=41, Age>18, IPV within the past year	To assess whether women screening positive for IPV in a primary healthcare setting and participating in clinic-based telephone intervention experienced an increase in their engagement in safety-promoting behaviors.	A randomized controlled trial. A clinic-based telephone intervention with a personalized counseling session and a series of six phone calls over 3 months	Small sample. Selection bias (women personality-related).
A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion, Elizabeth Miller, March 2012	Four free-standing urban family planning clinics Northern California, U.S.	Two violence screening questions : “Have you ever been hit, kicked, slapped, or choked by your current or former partner?” and “Have you ever been forced to have sex against your will?	N=906, Aged 16 to 29, English and Spanish-speaking females, seeking care in participating family planning clinics	To evaluate evolution in reports of reproductive coercion, IPV, awareness and utilization of IPV-related resources, and relationship status.	A randomized controlled trial. Audio computer-assisted surveys prior to a clinic visit and 12 to 24 weeks later.	Intervention feasible and replicable. But small number of clusters and participants, short follow up interval.

Table 1. continued

STUDY	SETTING	SCREENING TOOL	POPULATION/INCLUSION CRITERIA	OBJECTIVE(S)	METHOD	FEASABILITY/ACCEPTABILITY/LIMITS
Motivational interviewing and intimate partner violence: a randomized trial, Audrey F. Saftlas, October 2013	Two family planning clinics Sioux City, Iowa, U.S.	Computer-based, self-administered screening tool programmed in Microsoft Access.	N=204, family planning clinics setting, Age >18, IPV within the past year, not pregnant, Not incarcerated	To evaluate the effectiveness of an individually tailored intervention delivered through the technique of motivational interviewing.	A 20-minute baseline questionnaire self-administered and computer-based followed by a one hour face-to-face educational session at baseline. Then, three 10 to 15 minutes motivationnal interviewing telephone sessions conducted 1, 2, and 4 months postenrollment.	Phone number disconnected. Mailing address no longer valid. No harms attributable to the intervention were recorded.
Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial, Kelsey Hegarty, April 2013	Enrollment of 52 family doctors from clinics Victoria, Australia	A mail was sent which assessed the frequency of eight health and life style issues, including how often in the past 12 months women were afraid of their partner or ex-partner.	N=731, From 55 urban and rural doctors, Aged 16 to 50, Afraid of their partner or ex-partner within the past year, No cognitive impairment or poor English-language skills	To assess whether brief counselling from family doctors trained to respond to women identified through IPV screening would increase women's quality of life, safety planning and behaviour, and mental health.	Training of doctors. Invitation to women for one-to-six sessions of counselling for relationship and emotional issues.	Good attendance feeling.
Two-year follow up of a cluster randomised controlled trial for women experiencing intimate partner violence: effect of screening and family doctor-delivered counselling on quality of life, mental and physical health and abuse exposure, Kelsey Hegarty, 2020	Enrollment of 52 family doctors from clinics Victoria, Australia	A mail was sent which assessed the frequency of eight health and life style issues, including how often in the past 12 months they were afraid of their partner or ex-partner.	N=731, From 55 urban and rural doctors, Aged 16 to 50, Afraid of their partner or ex-partner within the past year, No cognitive impairment or poor English-language skills	To assess whether differences in depression found at 12 months would be sustained at 24 months and differences in quality in life, general mental and physical health and IPV would emerge.	Training of doctors. Invitation to women for one-to-six sessions of counselling for relationship and emotional issues.	Good attendance feeling. Some negative and positive partner behaviours where described, no between-group difference was detected.

Evaluation criteria:

Clinical scores focused on mental symptoms:

-mental health: Short-Form Health Survey (SF-12) (26,27), Hospital Anxiety Depression Scale (HADS) (26,27,31), Center for Epidemiologic Studies Short Depression Scale (CES-D-10) (24,30)
-post-traumatic stress disorder: Davidson Trauma Scale (DTS) (24,32), Composite Abuse Scale (26, 27)
-improvement in self-efficacy: Domestic Violence Coping and Self-Efficacy Scale (DVSA) (30)

Clinical score focused on quality of life indicators (≥6 in last month):

"WHO Quality of Life-Bref dimensions" (WHOQOL-Bref), 26 questions measuring 4 domains: physical, mental, environmental and social (like pain and discomfort, medical treatment, energy, sleep, ability to perform daily living activities, capacity for work) (26,27).

Data on prevalence of IPV:

Differences in the number of threats of abuse, assaults, danger risks for homicide, events of work harassment (29).

Data focused on appropriation of IPV services:

Use of community resources (29) or awareness of IPV services and reproductive coercion (male partners' verbal pressure to get women pregnant and birth control sabotage like condom manipulation and other active interference with contraceptive methods) (28).

Efficiency:

Brief counselling intervention (26,27):

-effectiveness in reducing symptoms of depression (HADS depression score ≥8: odds ratio 0,3 (0.1-0.7; p=0.005) at 12 months

-lack of efficacity in improving quality of life compared to usual cares (WHOQOL-Bref physical: MD=1.5, 95% CI -2.9 to 5.9; psychological: MD=-0.2, 95% CI -4.8 to 4.4; social: MD=-1.4, 95% CI -8.2 to 5.4; environmental: MD=-0.8, 95% CI -4.0 to 2.5; SF-12: MD=-1.6, 95% CI -5.3 to 2.1) at 24 months

The March of Dimes protocol (29):

Efficiency in decreasing threats of abuse (M= 14.5%; 95% CI 12.6-16.4), assaults (M= 15.5%, 95% CI 13.5-17.4) and danger risks for homicide (M= 2.6%; 95% CI 2.1-3.0) with significantly more safety behaviors from women by 24 months (M= 2.0%; 95% CI 1.6-2.3).

Family planning clinic-based intervention (28):

Significant reduction of male partners' verbal pressure to get women pregnant and birth control sabotage (71% reduction in the odds of pregnancy coercion among participants in intervention clinics compared to participants from the control clinics).

Motivational interviewing techniques (24,30):

-in Tameka L. Gillum intervention (a on-site counseling session and six telephone counseling sessions over a 3-month period) (24), results demonstrated that women who received the clinic-based intervention engaged in significantly ($p<0,001$) more safety-promoting behaviors than did women in the control group

-in Saftlas AF intervention (an initial face-to-face session and three telephone sessions administered 1, 2 and 4-months postenrollment) (30), it suggests a beneficial effect on reducing depressive symptoms. Intent-to-treat analyses of depressive symptoms showed indications of a greater decrease in adjusted mean score for MI versus referral women (CES-D-10 score: 4.2 and 2.6; $p=0.07$) despite a lack of statistical significance at the 5% due to a lower than projected sample size

Psychoeducational intervention and psychotherapeutic counseling (25) :

Significant ($p<0.001$) effect of the interventions on survivor change over time, controlling for influencing factors. The strongest intervention component was participation in PTIC individual counseling ($p<0. 001$) and resource referrals and other services (domestic violence emergency shelter, support group, and informational session in IPV) ($p<0.05$). Participation in PEGC group counseling was not significant.

Table 2. characteristics of counselling programs

	INTERVENTION	CONTROL GROUP	DURATION	NUMBER OF SESSIONS
COUNSELLING SESSION(S)	March of Dimes protocol (nurse case management) (29).	Wallet-sized referral card (safety plan and sources for IPV services).	Case management sessions by nurses : 20 minutes.	Five.
	Family planning clinic-based intervention : assistance (identifying harm reduction behavioral strategies), education (contraception, local IPV and sexual assault resources), business card-size intervention cards (28)	Standard-of-care : filing mandated reports, documenting IPV in the chart, giving a list of violence victimization ressources.	<1min or longer discussions if IPV or reproductive coercion was disclosed.	No data.
	Brief counselling intervention (based on the Psychosocial Readiness Model) (26)	Usual care by their GP.	30-minute counselling sessions by their GP for relationship issues and their emotional wellbeing.	1 to 6 counselling sessions (6 month period).
	Brief counselling intervention (based on the Psychosocial Readiness Model) (27)	Usual care by their GP.	30-minute counselling sessions by their GP for relationship issues and their emotional wellbeing.	1 to 6 counselling sessions (6 month period).
COUNSELLING SESSION AND TELEPHONE CALLS	Personalized counseling session, multiple phone calls over 3 months (24).	Health information brochures, list of community resources, monthly phone call.	Phone calls ranged from 5 minutes to 1 hour (average duration of 20 minutes).	One interview + six phone calls over 3 months.
	Motivationnal interviewing techniques (reflective listening, identifiction of feasible individual goals and small steps to increase self-efficacy and feelings of control) (30)	Meeting with a certified domestic abuse advocate who provided written materials and referrals to community-based ressources.	A 1-hour face-to-face educational session at baseline, followed by three 10 to 15 minute motivationnal interviewing telephone sessions conducted 1, 2, and 4 months postenrollment.	Four.
COUNSELLING SESSION(S) AND PSYCHOTHERAPEUTIC CARE	-IPTC : individual psychotherapeutic counseling (25) -PEGC : six-week psychoeducational group counseling program (25)	Not avalaible.	Number of counseling sessions open-ended but short-term.	Within six months.

Table 2. continued

	INTERVENTION	FOLLOW-UP TIME	EFFICIENCY CRITIRIA
COUNSELLING SESSION(S)	March of Dimes protocol (nurse case management) (29).	A 24 month period (collecting data at 6, 12, 18 and 24 month).	Significantly fewer threats of abuse (-14,5%), assaults (-15,5%) and danger risks for homicide (-2,6%) Significantly more safety behaviors by 24 months
	Family planning clinic-based intervention : assistance (identifying harm reduction behavioral strategies), education (contraception, local IPV and sexual assault resources), business card-size intervention cards (28)	Via a baseline and follow-up survey at 12-24 weeks post-intervention.	71% reduction in the odds of pregnancy coercion among participants in intervention clinics.
	Brief counselling intervention (based on the Psychosocial Readiness Model) (26)	Postal surveys at 6 and 12 months.	Decreasment in symptoms of depression at 12 months No improvement in women's quality of life, safety planning and behaviour, or global mental health at 12 month
	Brief counselling intervention (based on the Psychosocial Readiness Model) (27)	Postal surveys at 6 months, 12 months and 24 months.	Decreasment in symptoms of depression at 12 months No improvement in women's quality of life, safety planning and behaviour, or global mental health at 24 months
COUNSELLING SESSION AND TELEPHONE CALLS	Personalized counseling session, multiple phone calls over 3 months (24).	3-month period.	Significantly more safety-promoting behavior.
	Motivationnal interviewing techniques (reflective listening, identifiction of feasible individual goals and small steps to increase self-efficacy and feelings of control) (30)	One time before randomization and again at the 6-month follow-up visit.	Suggest a beneficial effect on reducing depressive symptoms (but non satistical significance at the 5% level)
COUNSELLING SESSION(S) AND PSYCHOTHERAPEUTIC CARE	-IPTC : individual psychotherapeutic counseling (25) -PEGC : six-week psychoeducational group counseling program (25)	Between 2001 and 2004.	Efficiency of the transtheoretical model of change to the process of change in moving to a violence free life.

Discussion:

Main results

This systematic review identified and summarized the characteristics and the efficiency of six interventions validated in primary care settings to help women victim of IPV after screening.

The positive results that stand out the most from the study are the reduction of symptoms of depression (26,27,30) and a commitment to better safety-promoting behavior (24,29). Those trials bring to light the usefulness to integrate in primary care some screening on IPV, followed by some counselling intervention which may take various form, usually of short duration.

However, the study did not demonstrate a reduction in the number of IPV or an improvement in quality of life after intervention.

Comparison with the literature

In comparison with literature, the results of our review are consistent compared to general findings of some other reviews. A systematic review published in 2003 by C. Nadine Wathen (33) focused on assessing the effectiveness of shelter stays in reducing IPV showed that among women who have spent at least 1 night in a shelter that there was fair evidence that women receiving a specific program of advocacy and counseling services reported a decreased rate of reabuse and an improved quality of life. In a systematic review published in 2014 by Megan H. Bair-Merritt (34) summarizing primary care-based interventions for patients experiencing IPV, most studies demonstrated patient-level benefit subsequent to primary care IPV interventions (framed around discussion of cycles of violence, safety-promoting behaviors and referral to local IPV community-based resources). Common articles were found between our studies (24,28,29), however our study stands out in its quest to evaluate the criteria of intervention efficacy, whereas Megan H. Bair-Merritt's review focuses on the search for existing interventions. In a meta-analysis of randomized controlled trials published in 2020 by David T Turner (35) examining the efficacy of psychosocial interventions for IPV among women in low and middle-income countries, psychosocial interventions reduced any form of IPV by 27% at shortest (relative risk (RR)=0.73) and 25% at longest (RR=0.75) follow up. Our study differs from that of David T Turner in its desire to seek interventions that are brief and available in primary cares, and in its less restrictive choice of population.

In a randomized controlled trial published in 2014 by Sebastian E. Baumeister (36), a brief intervention, the QUIT intervention (37) of brief clinician advice and up to two drug-use health telephone sessions, was conducted in federally qualified health centers among adult patients with risky (non-dependent) drug use to investigate effects on change in health-related quality of life. The trial found a marginally significant effect on improvement in physical health component summary score, and significant and stronger effect on the SF-12 physical component among patients with greater frequency of initial drug use. Although in a different field from IPVs, this trial sharing as common denominator it’s a brief intervention in primary care involving motivational interviewing training for caregivers. It also highlights the partial improvement in one of the components (in this case, the physical component) of quality of life following this brief intervention.

Within the limits of what we have found in the literature, it would seem that carrying out an intervention has an effect on IPV victims. However, these results are tempered by the difficulty of measuring the effectiveness of these interventions. This can be partly explained by the complexity of what characterizes a person's quality of life, as not only the person's physical health must be taken into account, but also their psychological health and social context, as described in Engel G.'s bio-psycho-social model (38). For comparison with the above-mentioned studies, cautious interpretation of the results of these studies should be made as the heterogeneity and limited availability of randomized control trials demonstrate risk of bias as limitations.

Creating a scientifically discriminating research protocol is a complex process that is not always achievable. In the context of IPV, for example, there are ethical considerations to be taken into account in the study, such as the absence of a placebo. In spite of this, the consistency of the results encourages us to work on the idea of an intervention after screening for IPV to improve the situation.

Strengths and limitation

We used numerous keywords to create the most comprehensive search equation possible in the three main databases. A professional from the university documentation department helped us to design the search equations. Despite this, we may have missed some studies that could have been included. However, we believe we have limited this by double-blind selection on the basis of the abstract and arbitration by a third party who hardly needed to intervene. In addition, each bibliography of full-text articles has been checked to make sure we haven't missed out on a potential study to include.

The notion of “counselling” as search term in the research question was difficult to define. This led us to use a wide variety of keywords relating to this criterion in order not to miss out on an intervention related to our research question. The reading of each abstract individually, and then the full texts when necessary, enabled us to retain only the brief aspect of the intervention.

There is considerable heterogeneity between studies in terms of interventions, outcome measures and data format. In the absence of a reference brief intervention in the field of IPV, the studies in our review each have a different control arm and are not comparable with each other. Similarly, the efficacy evaluation criteria are variable and differ from one study to another. However, despite this heterogeneity, the results are consistent in terms of improvement in depression and adoption of safe behaviors across several studies.

A possible selection bias is the exclusion from the final selection of certain studies because they had been carried out with specific populations (pregnant women, homeless people, women's veterans, HIV-positive patients, race-based focus group).

Conclusion

Perspectives

This systematic review does not allow to conclude on the effectiveness of counselling programs in reducing IPV in primary care. However, these studies through interventions are encouraging in terms of the beneficial effects on the health of the women concerned by acquiring safety behaviors and reducing depressive symptoms. IPV victims and people with a SUD share similarities: fear of talking, guilt, state of influence, privacy area domain, stigmatization. In the field of addictology, the SBIRT protocol has demonstrated its effectiveness on individual health in the short term in people with substance use disorders and is the subject of recommendations for primary care practice (39,40). Brief Intervention, lasting from 5 to 30 minutes spread over one to four sessions (38), differs from motivational interviewing in that the patient is given explicit advice, in contrast to motivational interviewing where the patient has to work out for himself why and how to change his behavior (c). A SBIRT protocol adapted for IPV victims could be help women to quite a toxic relationship.

In a recent qualitative study, a mirror-effect mechanism was described as a key-opportunity to help IPV victim (41). When the mechanism of the cycle of violence and the role of coercive control and its consequences in IPV are explained to the woman victim, the woman identifies with it, and this reminds her of her own situation as a victim, helping to combat ambivalence and reinforce awareness, leading to a more positive approach to ending IPV. To date, no brief intervention has been devised that incorporates the use of this mirror-effect in the management of IPV. It would be interesting to create a brief intervention based on the mirror effect, and then evaluate its effectiveness on criterias such as quality of life or reduction in IPV.

Bibliographie:

1. world health organization. Violence Info - Intimate partner violence [Internet]. 2022. Disponible sur: https://apps.who.int/violence-info/intimate-partner-violence/

2. Violence à l'encontre des femmes [Internet]. [cité 13 avr 2024]. Disponible sur: https://www.who.int/fr/news-room/fact-sheets/detail/violence-against-women

3. World Health Organization. Devastatingly pervasive : 1 in 3 women globally experience violence [Internet]. NEW YORK; 2021 mars. Disponible sur: https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence

4. Les Lettres de l'Observatoire national des violences faites aux femmes | Arrêtons les violences [Internet]. [cité 13 avr 2024]. Disponible sur: https://arretonslesviolences.gouv.fr/les-lettres-de-l-observatoire-national-des-violences-faites-aux-femmes

5. Walker L. Battered Women Syndrome and Self-Defense. Notre Dame J Law Ethics Public Policy. 1 janv 2012;6(2):321.

6. Lenore E. Walker. The battered Woman - The cycle of violence [Internet]. 1979. Disponible sur: http://ghshlawfirm.com/uploads/4/0/2/5/4025045/abuse.pdf

7. Jaspard M. Nommer et compter les violences envers les femmes : une première enquête nationale en France. Popul Sociétés. 2001;364.

8. Jaspard M, Saurel-Cubizolles MJ. Violences envers les femmes et effets sur la santé. Présentation de l'enquête nationale sur les violences envers les femmes en France (Enveff). Jaspard M Ed Violences Envers Femmes En Fr Une Enq Natl Paris Doc Fr. 2003;229-66.

9. HAS. Repérage des femmes victimes de violences au sein du couple - Méthode Recommandations pour la pratique clinique [Internet]. Disponible sur: https://www.has-sante.fr/upload/docs/application/pdf/2019-09/170919_reperage_des_femmes_victimes_de_violences_au_sein_du_couple_texte_recommandations.pdf

10. Sénat, Bouchoux C, Cohen L, Courteau R, Jouanno C, Kammermann C, et al. Rapport d'information fait au nom de la délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes sur l'évaluation des dispositifs de lutte contre les violences au sein des couples. Paris: Sénat; 2016.

11. Andreea Gruev-Vintila and Francisca Toledo. Le contrôle coercitif: repérer les violences au sein du couple dans les interactions et le rapport de pouvoir entre l'auteur et la victime. L'emprise Violences Au Sein Couple Éric Martinent Isabelle Rome Eds. 2021;(Paris: Dalloz):277-90.

12. Dillon G, Hussain R, Loxton D, Rahman S. Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature. Int J Fam Med. 23 janv 2013;2013:1-15.

13. Violences au sein du couple et violences sexuelles : les principales données. Lettre de l'Observatoire national des violences faites aux femmes 2022. Observatoire national des violences faites aux femmes, Mission interministérielle pour la protection des femmes contre les violences et la lutte contre la traite des êtres humains, Ministère des affaires sociales, de la santé et des droits des femmes, Secrétariat d'Etat chargé des droits des femmes.; 2022.

14. Zaher E, Keogh K, Ratnapalan S. Effect of domestic violence training. Systematic review of randomized controlled trials. Can Fam Physician. 2014;60(7):618-24.

15. Preventive Services Task Force, Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation.

Ann Intern Med 2012. 2012;156(11):796-808:W-279, W-80, W-81, W-82.

16. Royal Australian College of General Practitioners. Abuse and violence. Working with our patients in general practice. Melbourne: RACGP; 2014. ((4th edition)).

17. Toward Optimized Practice (TOP) DOVE CPG WORKING Group. Doctors opposing violence everywhere (DOVE). [Edmonton, AB: Toward Optimized Practice.]; 2015.

18. Loi n° 2014-873 du 4 août 2014 pour l'égalité réelle entre les femmes et les hommes. 12949; 2014.

19. Mission interministérielle pour la protection des femmes contre les violences et la lutte contre la traite des êtres humains. Les violences faites aux femmes : une urgence de santé publique. Intervention de la Mission interministérielle pour la protection des femmes contre les violences et la lutte contre la traite des êtres humains (MIPROF). Paris: MIPROF; 2015.

20. National Institute for Health and Care Excellence. Domestic violence and abuse: multi-agency working. Public health guideline. London: NICE; 2014.

21. World Health Organization. Responding to intimate partner violence and sexual violence against women. Geneva: WHO; 2013. (WHO clinical and policy guidelines.).

22. U.S. Preventive Services Task Force, Moyer VA. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med; 20163.

23. Moher D, Liberati A, Tetzlaff J, Altman DG; The PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097.;

24. Gillum TL, Sun CJ, Woods AB. Can a Health Clinic-Based Intervention Increase Safety in Abused Women? Results from a Pilot Study. J Womens Health. août 2009;18(8):1259-64.

25. Dienemann J, Glass N, Hanson G, Lunsford K. THE DOMESTIC VIOLENCE SURVIVOR ASSESSMENT (DVSA): A TOOL FOR INDIVIDUAL COUNSELING WITH WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE. Issues Ment Health Nurs. janv 2007;28(8):913-25.

26. Hegarty K, O'Doherty L, Taft A, Chondros P, Brown S, Valpied J, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. The Lancet. juill 2013;382(9888):249-58.

27. Hegarty K, Valpied J, Taft A, Brown SJ, Gold L, Gunn J, et al. Two-year follow up of a cluster randomised controlled trial for women experiencing intimate partner violence: effect of screening and family doctor-delivered counselling on quality of life, mental and physical health and abuse exposure. BMJ Open. déc 2020;10(12):e034295.

28. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. Contraception. mars 2011;83(3):274-80.

29. McFarlane JM, Groff JY, O'Brien JA, Watson K. Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial. Nurs Res. janv 2006;55(1):52-61.

30. Saftlas AF, Harland KK, Wallis AB, Cavanaugh J, Dickey P, Peek-Asa C. Motivational interviewing and intimate partner violence: a randomized trial. Ann Epidemiol. févr 2014;24(2):144-50.

31. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. Acta Psychiatr Scand. juin 1983;67(6):361-70.

32. Davidson JRT, Book SW, Colket JT, Tupler LA, Roth S, David D, et al. Assessment of a new self-rating scale for post-traumatic stress disorder. Psychol Med. janv 1997;27(1):153-60.

33. Wathen CN, MacMillan HL. Interventions for Violence Against Women: Scientific Review. JAMA. 5 févr 2003;289(5):589.

34. Bair-Merritt MH, Lewis-O'Connor A, Goel S, Amato P, Ismailji T, Jelley M, et al. Primary Care–Based Interventions for Intimate Partner Violence. Am J Prev Med. févr 2014;46(2):188-94.

35. Turner DT, Riedel E, Kobeissi LH, Karyotaki E, Garcia-Moreno C, Say L, et al. Psychosocial interventions for intimate partner violence in low and middle income countries: A meta-analysis of randomised controlled trials. J Glob Health. juin 2020;10(1):010409.

36. Baumeister SE, Gelberg L, Leake BD, Yacenda-Murphy J, Vahidi M, Andersen RM. Effect of a primary care based brief intervention trial among risky drug users on health-related quality of life. Drug Alcohol Depend. sept 2014;142:254-61.

37. Gelberg L, Andersen RM, Afifi AA, Leake BD, Arangua L, Vahidi M, et al. Project QUIT (Quit Using Drugs Intervention Trial): a randomized controlled trial of a primary care-based multi-component brief intervention to reduce risky drug use. Addiction. nov 2015;110(11):1777-90.

38. Engel GL. THE BIOPSYCHOSOCIAL MODEL AND THE EDUCATION OF HEALTH PROFESSIONALS*†. Ann N Y Acad Sci. juin 1978;310(1):169-81.

39. Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a Public Health Approach to the Management of Substance Abuse. Subst Abuse. nov 2007;28(3):7-30.

40. Babor TF, Del Boca F, Bray JW. Screening, Brief Intervention and Referral to Treatment: implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. Addiction. févr 2017;112(S2):110-7.

41. Dr Emeline PASDELOUP. EXPLORATION DU PROCESSUS DE L'EMPRISE DANS LES VIOLENCES CONJUGALES FAITES AUX FEMMES DE SON INSTALLATION A SA PRISE DE CONSCIENCE [Internet] [thèse]. [TOURS, FRANCE]: Médecine; 2021. Disponible sur: http://memoires.scd.univ-tours.fr/Medecine/Theses/2021_Medecine_PasdeloupEmeline.pdf

Appendix:

(a) PRISMA Checklist

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location - Page
TITLE			
Title	1	Identify the report as a systematic review.	1
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	5
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	15
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	15
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	16
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	16
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	16
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	16
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	16
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	16-17
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	16-17
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	16
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Not applicable
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Not applicable
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Not applicable
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Not applicable
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Not applicable
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Not applicable
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Not applicable
Reporting bias	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Not

Section and Topic	Item #	Checklist item	Location - Page
assessment			applicable
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Not applicable
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	18
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Not applicable
Study characteristics	17	Cite each included study and present its characteristics.	Table 2
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Table 1
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	21-22
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Table 1
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	21-22
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Not applicable
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Not applicable
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Not applicable
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Not applicable
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	25
	23b	Discuss any limitations of the evidence included in the review.	26
	23c	Discuss any limitations of the review processes used.	26
	23d	Discuss implications of the results for practice, policy, and future research.	26
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	17
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Not applicable
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Not applicable
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Not applicable

Section and Topic	Item #	Checklist item	Location - Page
Competing interests	26	Declare any competing interests of review authors.	Not applicable
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Not applicable

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

(b) Search equations:

PubMed:

(("adult"[Mesh] or "person"[Mesh] or "woman"[Mesh] or "spouse"[Mesh] or "crime victim"[Mesh] or "vulnerable population"[Mesh] or "patient"[Mesh] or "survivor"[Mesh] or "battered woman"[Mesh] or "domestic partner" or "wife" or "ex-partner" or "married person" or "spousal notification" or "vulnerable population" or "underserved population" or "underserved patient" or "disadvantaged population" or "sensitive population group" or "crime victim" or "victimization" or "abused woman" or "adult" or "person" or "woman" or "spouse" or "crime victim" or "vulnerable population" or "patient" or "survivor" or "battered women") and ("intimate partner violence"[Mesh] or "domestic violence"[Mesh] or "spouse abuse"[Mesh] or "physical abuse"[Mesh] or "sex offense"[Mesh] or "emotional abuse"[Mesh] or "behavior control"[Mesh] or "aggression"[Mesh] or "family conflict"[Mesh] or "sexism"[Mesh] or "prejudice"[Mesh] or "combined abuse" or "coercive control" or "intimate partner violence" or "domestic violence" or "spouse abuse" or "physical abuse" or "sex offenses" or "emotional abuse" or "behavior control" or "aggression" or "family conflict" or "sexism" or "prejudice") and ("crisis intervention"[Mesh] or "brief psychotherapy"[Mesh] or "psychosocial intervention"[Mesh] or "counseling"[Mesh] or "motivational interviewing"[Mesh] or "directive counseling"[Mesh] or "brief advice" or "brief intervention" or "screening and brief intervention" or "brief treatment" or "solution focused brief therapy" or "short-term psychotherapy" or "early medical intervention" or "crisis intervention" or "brief psychotherapy" or "psychosocial intervention" or "counseling" or "motivational interviewing" or "directive counseling"))

Psycinfo and Chochrane library:

(("adult" OR "person" OR "woman" OR "spouse" OR "crime victim" OR "vulnerable population" OR "patient" OR "survivor" OR "battered woman" OR "domestic partner" OR "wife" OR "ex-partner" OR "married person" OR "spousal notification" OR "vulnerable population" OR "underserved population" OR "underserved patient" OR "disadvantaged population" OR "sensitive population group" OR "crime victim" OR "victimization" OR "abused woman") AND ("intimate partner violence" OR "domestic violence" OR "spouse abuse" OR "physical abuse" OR "sex offense" OR "emotional abuse" OR "behavior control" OR "aggression" OR "family conflict" OR "sexism" OR "prejudice" OR "combined abuse" OR "coercive control") AND ("crisis intervention" OR "brief psychotherapy" OR "psychosocial intervention" OR "counseling" OR "motivational interviewing" OR "directive counseling" OR "brief advice" OR "brief intervention" OR "screening and brief intervention" OR "brief treatment" OR "solution focused brief therapy" OR "short-term psychotherapy" OR "early medical intervention"))

(c) Effectiveness criteria for WR Miller's brief intervention to reduce alcohol consumption:

FRAMES: (acronym):

Feedback: providing patients with information on the frequency and quantity of their alcohol consumption

Responsability: the responsibility for changing behaviour lies exclusively with the patient, not the therapist

Advice: moderation advice is clearly given to the patient

Menu: the patient is given a choice or menu, offering various options relating to the quantity, timing and pace of alcohol consumption

Empathy: the therapist shows empathy, avoids condescension and value judgments, and values the patient's efforts and achievements

Self-efficacity: the therapist seeks to strengthen the patient's personal resources in favour of change

Vu, le Directeur de Thèse

Vu, le Doyen
De la Faculté de Médecine de Tours Tours, le

CHUDY Raphaël

36 pages – 2 tableaux – 1 figure – 3 annexes

Résumé :
Introduction : 1 femme sur 3 dans le monde est victime de violences physiques et/ou sexuelles au cours de sa vie, le plus souvent infligées par un partenaire intime. La violence conjugale évolue de manière cyclique et s'intensifie progressivement si rien n'est fait pour y mettre fin. Les conséquences physiques et mentales sont importantes et toutes les catégories sociales sont touchées. **Cette étude a pour but d'identifier les interventions existantes pour aider les victimes de violences conjugales dont l'efficacité a été évaluée dans le cadre des soins primaires.**

Méthode : une revue systématique des articles publiés entre septembre 2003 et décembre 2023 a été menée à partir de 3 bases de données : Medline via Pubmed, PsycInfo, et Central via Cochrane Library. L'équation de recherche a été élaborée à partir d'une combinaison de quatre critères : le fait d'être une femme de plus de 16 ans, avoir été victime de violences conjugales, l'existence d'interventions luttant contre les violences conjugales et le contexte des soins primaires.

Résultats : 3017 articles ont été sélectionnés par notre équation de recherche, 7 études ont finalement été incluses. 6 interventions ont été décrites dont : une intervention brève basée sur le modèle "Psychosocial Readiness" (efficacité significative sur la dépression), le protocole "March of Dimes" qui comprend une brochure avec un plan de sécurité en 15 points pour augmenter l'adoption de comportements de sécurité (efficacité dans la diminution des menaces d'abus), ou une intervention psycho-éducative. Les 4 principaux critères d'évaluation ont été fondés sur des scores cliniques axés sur la santé mentale ou la qualité de vie.

Conclusion : ces résultats mettent en lumière l'utilité d'intégrer dans les soins primaires un repérage de la violence conjugale, suivi d'interventions qui peut prendre diverses formes, généralement de courte durée. Un modèle inspiré du SBIRT (Screening, Brief Intervention, and Referral to Treatment) dans le domaine de l'addictologie pourrait constituer une approche intéressante pour de futures recherches.

Mots clés : femmes, violences conjugales, soins primaires, interventions.

Jury :
Président du Jury : Professeur Jean-Pierre LEBEAU

Directeurs de thèse : Docteur Emeline PASDELOUP,
Docteur Maxime PAUTRAT
Membre du Jury : Docteur Christophe RUIZ

Date de soutenance : 16 mai 2024