The Effect, Prevention, and Intervention of Intimate Partner Violence on Depression

Hongmin Dai[1†], Shenghao Guo[2†], Zheming Luo[3†*]

[1] *Stoneleigh Burnham School, Greenfield, 01301, United States*
[2] *Valley Christian High School, San Jose. 95111, United States*
[3] *Xi'an Jiaotong Liverpool University, Suzhou, 215028, China*
[*] *Corresponding author. Email: Zheming.luo17@student.xjtlu.edu.cn*
[†] *These authors contributed equally.*

ABSTRACT

Intimate partner violence (IPV) is becoming a global issue and gaining increasing attention for its detrimental consequences. This paper combines research related to intimate partner violence and depression to systematically analyze their associations. We examined physical, psychological, sexual, and economic abuse in the intimate relationships, and found that physical abuse (and sexual abuse) may induce fear, jeopardize senses of safety or disrupt one 's self-identity, leading to depression; psychological abuse demonstrates stronger predictive power on victim's depression and shows more prevailing effect in the long-term; economic abuse happens when the victim's financial freedom is being limited, which increases insecurity and forced reliance on the abuser. Prevention and intervention methods are discussed to determine their effectiveness against IPV causing depressive symptoms. This study contributed a systemic review focusing on IPV, particularly its effect on depression, to the extant literature, and identified further research gaps in long-term effective intervention methods.

Keywords: *Intimate partner abuse, domestic violence, physical abuse, psychological abuse*

1. INTRODUCTION

Intimate partner violence (IPV) refers to the psychological, physical, or sexual abuse of a partner, usually against women, in an intimate relationship. Physical abuse involves harmful actions such as pushing, hitting, kicking, and sometimes using guns or knives which can cause trauma or injury [1]. While psychological abuse usually accompanies, including using ridicule or humiliation as verbal abuse; and threats and dominance to control the victim's activities [2]. Other typologies of IPV also include economic abuse or sexual abuse as forms of violence in an intimate relationship.

IPV has become increasingly prevalent. It can reach anyone, regardless of their age, income, ethnicity, belief, or nationalities. According to the result of national surveys in the United States, about 25%-30% of women have experienced at least one type of abuse by an intimate partner in their lifetime [3]. Rural areas were reported to have the highest prevalence rate of IPV, particularly among women [4]. Isolating a victim can be much more easily done in rural areas where transportation and communications are limited. Values in rural areas often become a co-prosecutor leading to more damage to victims where ideas such as "self-reliance, 'standing by your man', and family and group loyalty,' were prevailing. Large urban areas, as opposed to rural areas, showed the lowest rate of IPV possibly because of more developed economics, up-to-date awareness, more independency, and easier access to social supports.

IPV was found to have a significant effect on victims' health sequelae, both physically and psychologically. Victims were shown to have increased risks of injury, disability, chronic pain, back pain, headaches, and other physical discomforts. Moreover, the risk of mental seaquakes such as insomnia, anxiety, depression, PTSD, and suicidal ideation would also increase [3]. Specifically, depression is one of the major consequences of IPV. As Beydoun and his colleagues reported [4], people who have experienced IPV were of a two- to three-fold increased risk of being diagnosed with major depressive disorder and a 1.5 to 2-fold increased risk to have depressive symptoms compared to those without IPV history.

Co-morbidity of depression among IPV victims also commonly occurs, accompanied by anxiety disorders, insomnia, post-traumatic stress disorder (PTSD), and suicidality [3]. Future research is needed to systemic evaluate the underlying mechanism of IPV leading to depression. Some argued that IPV itself can be a major cause of depression, while others identified various mediators attempting to specify the casual relationship. Examples include perceived power [5], cognition schema, coping strategies [6], etc.

Therefore, this study reviewed the association between IPV and depression, in terms of physical, psychological, and economic abuse, and discussed their different effect leading to depression. The underlying mechanism between IPV and depression and the prevention and intervention methods for future clinical practices were also summarized.

2. THE EFFECT

2.1 Physical abuse

Physical violence in an intimate relationship often refers to non-accidental harmful actions such as pushing, hitting, and slapping by a partner that may cause physical injuries to the other. Sexual abuse can also be categorized under physical abuse, as many times victims will be physically forced [7]. It happens when sexual action is coerced in an intimate relationship without consent. According to the research [8], the prevalence of IPV and major depression in women is higher than in men. Prior research explored this gender difference in terms of neuroendocrinology, cognitive styles, and social roles relating to the stressors of these roles. But further research is needed for a more systemic understanding.

Although the causes of physical violence vary between samples, there are some common risk factors proposed by a large body of research. For instance, the low education level of both partners causes ineffective communication, which increases the likelihood of physical violence. Other risk factors are power differences, inadequacies in employment, lack of family income, the number of children, and alcohol and substance abuse [9].

Depression is usually being identified as a reaction to physical violence rather than the abuse being considered a consequence of depression; however, a study hypothesized that women who have already been diagnosed with depression are more likely to experience physical violence [10]. Physical violence increases women's fear and undermines their self-esteem while reducing their sense of safety. Therefore, women's mental well-being is threatened by generating negative feelings to the extent of showing symptoms of depression, or post-traumatic disorder (PTSD). According to the study, women who are physically abused appeared to show a higher level of depression symptoms [11]. Based on the research conducted among 33 battered women, the severity of depression increases as the frequency, form, and consequences of physical aggressiveness increase [8]. Another research that followed 51 battered women for two and a half years found that symptoms of depression tend to relieve when women are no longer abused [8]. This phenomenon was also supported by another group of researchers measured by the Center for Epidemiologic Studies Scale-Depression that, from the collected sample, the prevalence of severe depression decreased from approximately 36% to 16%, and women are no longer depressed raised from 17% to 42% [12].

2.2 Psychological abuse

Walker first identified the psychological phenomenon unique to the population of battered women [13], which set up the basis for future research and practices of psychological abuse. Psychological abuse was then characterized as forms of jealousy, verbal abuse/criticism, and social isolation that often-accompanied physical abuse. Following his work, others had raised additional typologies, such as threats of harm to self, threats about relationship, threats of harm to personal property, etc., as means to control partners. Until Tolman systematically research, the concept of psychological abuse was settled. He identified phenomenal categories, issues in assessment, measurement, legal, and ethical considerations [2]. And two fundamental domains, including *dominance/isolation abuse* (e.g., demand for compliance/subservience, isolation, suspiciousness, etc.) and *emotional/verbal abuse* (e.g., devaluing, humiliation, yelling, swearing, etc.) were raised, which became the most commonly-used categorization in the psychological abuse area.

Based on the overall review of extant research, the average prevalence rate of psychological abuse is astoundingly high around 80%, with 40% of women and 32% of men reporting psychological aggression, and 41% of women and 43% of men reporting coercive control [14]. It seems to be the most common form of abuse, with the percentage at least 2 to 4 times as large as other abuses. Particularly, no significant gender differences were found among psychological IPV [14].

The high prevalence of psychological abuse does not blunt its adversity. A dearth of research shed light on psychological abuse, arguing for its detrimental effect. Psychological abuse would significantly damage the victim's physical health [15-16] and disrupted one's mental health conditions [3, 15-16]. In terms of depression, some identified it as a unique contributor to the prediction of depressive symptoms when controlling the effect of physical IPV [16-19]. In Orava and his colleagues' research, when covering the effect of verbal

abuse, the statistical differences between battered women and non-battered women on depression were not significant [17]. Dutton's study of abused women also found that symptoms of depression would be largely predicted by psychological abuse rather than by physical abuse [18]. And even worse, some found out that it may be more detrimental, compared to other forms of abuse [16, 19]. In Coker and his colleagues' study, physical and psychological IPV scores were both analyzed in the effect on depression, which turned out the higher psychological IPV scores were more strongly associated with the outcome than were physical IPV scores [16]. Others had also reported consistent results [19].

As can retrieve from previous literature, psychological IPV usually has accumulative effects that can prolong across periods [20-21]. The intensity, frequency, and persistence of the psychological abuse would increase the severity of the depression, as the longer, the more frequent the psychological abuse was, the more severe the depressive symptoms can be found. Also, the chronicity of psychological abuse is the most prolonged, compared to other types. In Bonomi's study, victims experiencing psychological abuse more than five years ago still reported higher depression scores [21], and a similar result was found in Hill et al.'s study of women experiencing psychological IPV two years ago [20]. It is articulated that psychological aggression is the only form of abuse that can produce such a persistent effect, urging attention to future studies of prevention and intervention.

2.3 Economic abuse

Economic abuse happens when the victim is limited financially. For example, the victim is not allowed to spend money on daily necessities or restricted to the amount spent by a second party. Another form of economical abuse is when the victim is not informed about the financial income power of their situation. This creates a sense of dependence on the abuser for financial power.

Economic abuse most likely occurs in relationships that have one party economically depending on the other. The greater the income difference is, the more possible the economic abuse will form. Gelles found that occupational status is what determines whether or not a woman will choose to stay in the abusive relationship, with the lower wages being more likely to stay [22]. Rusbult and Martz conducted research supporting that if a woman has less economic dependence, she would have a lower chance of returning to her abuser [23].

There isn't much research conducted showing a direct correlation between economic abuse and depression. However, by the forming of economical abuse, where the victim's financial freedom is being restricted, we can connect the limited financial power to the increased risk of depression. The victim may suffer from economical constraints, with lessened financial freedom, impairing their autonomy and keeping them from escaping. The less financial freedom is, the riskier the depression would be incurred, with an increase of 17%-51% [24].

2.4 Other consequences of IPV

Current research attempts to seek a more specific explanation of why IPV leads to depression. Power imbalance, as one of the consequences of IPV, was examined. Filson et al. argued that power imbalance is a major mediator between IPV and depression [5] that can be commonly observed in intimate violence. Usually, the perpetrator tends to seek power and control, while victims are forced to give up autonomy [5]. Victims may usually experience a decrease in perceived control and further leading to depression.

Another impairment caused by IPV is related to one's cognitive schemas. Based on emotional processing theories of trauma [25], physical and sexual abuse can disrupt victims' cognitive schemas relating to self and the external world, which may produce maladaptive cognition impairing one's mental condition. Numerous studies have raised similar arguments referring to its distressing effect on cognition. According to Calvete et al. [6], maladaptive cognition may mediate the effect between IPV and depression. The disruptive cognitions associated with beliefs of helplessness, powerlessness, and loss of control, demonstrate an akin effect to perceived powerlessness, which increases the risk of depression. This can also significantly disrupt victims' concepts of self-efficacy and self-esteem, with a devastating impact on self-identity [26]. To proceed, coping as a sequential result of cognitions would be also disrupted, incurring damages to active reactions, resiliency, and recovery [27]. People who experience repetitive IPV tend to adopt coping strategies such as avoidance, disengagement, and denial, which may exacerbate their depressive symptoms. It may keep them from acknowledging the situation, making proactive responses such as seeking social support, or making attempt to leave.

3. PREVENTION METHODS

Although future research is needed to validate the effectiveness of the prevention of IPV, there are still a few approaches concluded by past research that can be used to mitigate the negative consequences of IPV and reduce its recurrence. Community services have been the most common strategy for preventing domestic violence. Specifically, direct community services such as telephone hotlines, shelters, and individualized case management have been proven to be able to lower the risk of recurrence of violence. In the study, battered women were followed up for 2 years with half of them

being exposed to relative services or counseling; those who received services reported experiencing lesser violence than those who did not have access to such services [28].

A vital element in the method explained above is social support, where people receive support from others through social networks. Since IPV occurs in the context of the community, social support can offer help by creating an engaging and supportive environment [29]. Four major social supports are emotional, instrumental, informational, and appraisal. Emotional support refers to accompanying the victims/survivors and offering them mental support and caring such as listening and comforting. Instrumental support involves mainly tangible assistance from a trustworthy person to take on the responsibility for the victims to deal with the ongoing issues or offer practical solutions. Informational support provides advice based on knowledge and information as well as offers education regarding IPV. Appraisal support helps to improve one's self-esteem and confidence, which can help guide them to retrieve their sense of worth. Since the common strategy used in IPV is the isolation from family and friends, enhancing social networks may support battered women to escape from their abusive partners.

Alcohol or other drugs addiction in both partners tends to have a relationship with severe violence against women. It increases women's vulnerability to IPV, limiting their ability to reach for help, and increasing their dependency on the abusive partner. Hence, controlling the use of alcohol or other drugs may lower the risk of severe IPV [28]. Still, more research is needed to explore the impact of alcohol/drug use on the severity of IPV. In short, even though the methods listed above have been introduced in many practices, more systemic research is needed to examine their effectiveness.

4. INTERVENTION METHODS

4.1 Intervention for Perpetrators

Duluth Model Treatment. The Duluth Model is one of the most common interventions in the United States and Canada in domestic violence. Based on this model, it is explained that the underlining premises of partner abuse are driven by the patriarchal ideology and sociocultural concepts that men enforce control and dominance as means to exhibit power [30]. The goal of the treatment usually incorporates re-education and challenging the abuser's patterns, empowering the victims and holding the perpetrator accountable for their actions [30]. However, the model also drew increasing criticisms, particularly focusing on its effectiveness and professional setting. It is argued that the effectiveness of the intervention is much of the result of "selectivity" As several meta-analyses indicated, the effectiveness of the model in reducing IPV recidivism is insufficient [31-32]. And on the other hand, growing controversies about the competency and accountability of facilitators were also raised [33], as it does not require the practitioner to have professional degrees. And the program seems to have limitations in incorporating cultural diversity of ethnics, which failed to suffice multi-cultural requirements [33]. More in-depth exploration is needed to validate such an argument and to further its treatment effectiveness.

Cognitive-behavioral Treatment (CBT). Cognitive-behavioral Treatment for IPV is also the most common intervention approach in the US. It usually incorporates two forms: group or individual sessions, in which learning non-violence is the primary goal. It involves changing a patient's mindset, whereas in the IPV settings, therapists work to challenge violent behaviors, point out the pros and cons of violence, and provide training skills for alternatives [34]. However, studies of treatment effects showed inconsistent results. Particularly in some research, CBT intervention effectiveness is argued to be mild [35], which is considered a result of insufficient engagement and inadequate collaboration between clients and practitioners.

Motivational Intervention. Motivational interviewing (MI) is a person-centered approach, with a collaborative and goal-oriented style of communication, aiming to strengthen participants' motivation and commitment to changes. As in the treatment programs of IPV, high non-attendance rate, drop-out, low motivation to change, and limited engagement are common factors reducing treatment effect, MI provides instrumental guidance to improve. It has been found to have a significant contribution to reducing the dropout rate, increasing participants' engagement, and bringing changes to reluctant behaviors [36]. Also, Motivation interviewing can be incorporated into other treatment settings (i.e., CBT) to increase treatment engagement and effectiveness.

4.2 Intervention for Victims

Intervention for victims usually involves shelter, advocacy, and counseling support for women. Sullivan and his colleagues examined the effectiveness of shelter provided for IPV victims. The program involves women at least 1 night's stay in the shelter, along with a 10-week one-on-one advocacy and counseling program, set to be 4-6 hours [37]. Follow-up research only showed a significant reducing effect on the 2-year interview and failed to identify ideal effectiveness in the 12-month and 3-year follow-up based on the review [34]. However, participants did report an improvement in life quality across time, as well as their abilities to obtain resources and social support.

Interventions for prenatal women were also examined. In a study conducted in Hong Kong [38], pregnant women receiving a 6-week empowerment

intervention reported a significantly lower rate of psychological abuse, and reduction in physical abuse, with higher physical functioning and lower depression scores compared to control groups. However, the study only followed participants for 6 weeks and failed to identify its long-term effectiveness. And further, according to the study reviewed by Stover and his colleagues [34], despite the counseling showed reducing the effect of violence in the short-term, long-term effect were unable to retrieve.

4.3 Conjoint Treatment

Behavioral Couple Treatment (BCT). Behavioral couple treatment is specified in treating IPV co-occur with substance abuse. BCT requires conjoint meetings with couples, where a non-substance-abusing partner is involved in the support of the other' sobriety. In the program, the Sobriety contract will be discussed, and interpersonal skills would be trained as part of the interventions [39]. A study done by Fals-Stewart and his colleagues [40] supported BCT's effectiveness in reducing the recidivism of violence among substance abusers compared to individual treatment. And such intervention also reported a lower dropout rate on the effect of IPV treatment. Overall, BCT is reported to be especially effective for co-occurred substance-abusing IPV in reducing violence.

Domestic Violence-Focused Couples Treatment (DVFCT). Domestic violence-focused couples' treatment was designed to eliminate all forms of violence (physical, psychological, sexual, etc.), enhance self-responsibility, and strengthen relationships [39]. It starts with separated gender counseling using solution-focused brief therapy and proceeds into conjoint therapies. The treatment procedure involves psychological education imparting IPV knowledge, constructing safety plans, and other safety skills. In Stith et al.'s review [39], the effect of DVFCT is evident in the reduction of violence for both men and women completing 18-week of sessions. But in general, studies examining the effectiveness of DVFCT are still in an ongoing process, where further exploration is needed.

5. CONCLUSION

This study reviewed the associations between different types of IPV and depression, prevention methods of IPV, and ongoing intervention approaches for IPV couples. Specifically, we found that the severity of depression tends to change with the physical aggressiveness, and the symptoms caused by physical abuse tend to relieve when the victim is no longer abused. But as physical abuse is particularly damaging in multiple areas of the victim's life, it is a major threat to the victim's health and sometimes even to their survival. Sexual abuse falling under this category that is often exerted to force sexual compliance on the victim usually incurs similar damages. Psychological abuse often co-occurs with physical abuse and is usually accompanied by different mental distress such as depressive symptoms, insomnia, anxiety, PTSD and suicidal ideation, etc. And many have argued that psychological abuse shows the strongest predictive power of the deleterious effects on mental health among all abuses, particularly in depressive symptoms. And further, the depression caused by psychological abuse is more persistent across time, requiring longer periods of recovery. It calls for the attention of researchers and practitioners to identify the issues aiming for more powerful prevention, detection, and intervention.

The central factor for prevention methods is social support due to the phenomenon of isolation being a commonly used strategy. Social support makes it much easier for abused women to reach for help and can result in many engaged members and a supportive community environment. In terms of intervention, a large body of research has been conducted to examine different interventions in deterring IPV. Participants' engagement and motivation to change demonstrate a critical role for treatment methods to be effective, as low motivation and engagement usually lead to a high drop-out rate and low effectiveness, failing the interventions. However, results from current studies showed an insufficient effect on long-term deterrence. Further research is needed to explore strengthened intervention aimed at improving participants' engagement and enhancing long-term effectiveness.

This review provided systemic insights into the association between IPV and depression and raised an alert on the role of psychological abuse. For future studies, more should focus on identifying long-term effective interventions for IPV, where it can engage both perpetrators and victims to work towards long-term benefits.

REFERENCES

[1] Krug EG, Mercy J A, Dahlberg L L, et al. The world report on violence and health[J]. The Lancet, 2002, 360(9339): 1083-1088.

[2] Tolman R M. The Development of a Measure of Psychological Maltreatment of Women by Their Male Partners[J]. Violence and Victims, New York: Springer Publishing Company, 1989(3): 159–177.

[3] Beydoun H A, Beydoun MA, Kaufman JS, et al. Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: a systematic review and meta-analysis[J]. Social science & medicine, 2012, 75(6): 959-975.

[4] Peek-Asa C, Wallis A, Harland K, et al. Rural disparity in domestic violence prevalence and access to resources[J]. Journal of women's health, 2011, 20(11): 1743-1749.

[5] Filson J, Ulloa E, Runfola C, et al. Does Powerlessness Explain the Relationship Between Intimate Partner Violence and Depression?[J]. Journal of Interpersonal Violence, 2010, 25(3): 400–415.

[6] Calvete E, Corral S, Estévez A. Factor structure and validity of the Revised Conflict Tactics Scales for Spanish women[J]. Violence against women, 2007, 13(10): 1072-1087.

[7] Diagnostic and statistical manual of mental disorders (DSM–5-TR)[EB/OL]. DSM-5, [2022-03-26]. d.

[8] Campbell J C, Kub J, Belknap R A, et al. Predictors of depression in battered women[J]. Violence against women, 1997, 3(3): 271-293.

[9] Jeyaseelan L., Sadowski L.S., Kumar S., Hassan F., Ramiro L.,&Vizcarra B. World studies of abuse in the family environment–risk factors for physical intimate

[10] Feldbau-Kohn, S., Heyman, R. E., & O'Leary, K. D. Major depressive disorder and depressive symptomatology as predictors of husband to wife physical aggression. Violence and Victims, 1998, 24(1)

[11] Cascardi, M., Daniel O'Leary, K., & Schlee, K. A. Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. Journal of family violence, 1999, 23(3), 227-249

[12] Campbell, J. C., Sullivan, C. M., & Davidson, W. S. Depression in women who use domestic violence shelters: A longitudinal analysis. Psychology of Women Quarterly, 1995 27(2), 237-255.

[13] Walker L E. The battered woman[J]. 1979.

[14] Carney M M, Barner J R. Prevalence of Partner Abuse: Rates of Emotional Abuse and Control[J]. Partner Abuse, 2012, 3(3): 286–335.

[15] Coker A L, Davis K E, Arias I, et al. Physical and mental health effects of intimate partner violence for men and women[J]. American Journal of Preventive Medicine, 2002, 23(4): 260–268.

[16] Taft C T, O'Farrell T J, Torres S E, et al. Examining the correlates of psychological aggression among a community sample of couples.[J]. Journal of Family Psychology, 2006, 20(4): 581–588.

[17] Orava T A, McLeod P J, Sharpe D. Perceptions of control, depressive symptomatology, and self-esteem of women in transition from abusive relationships[J]. Journal of Family Violence, 1996, 11(2): 167-186.

[18] Dutton M A, Goodman L A, Bennett L. Court-involved battered women's responses to violence: The role of psychological, physical, and sexual abuse[J]. Violence and Victims, 1999, 14(1): 89-104.

[19] Tiwari A, Fong D, Chan K, et al. Identifying intimate partner violence: comparing the Chinese abuse assessment screen with the Chinese revised conflict tactics scales[J]. BJOG: An International Journal of Obstetrics &Gynaecology, 2007, 114(9): 1065–1071.

[20] Hill T D, Schroeder R D, Bradley C, et al. The long-term health consequences of relationship violence in adulthood: An examination of low-income women from Boston, Chicago, and San Antonio[J]. American Journal of Public Health, 2009, 99(9): 1645-1650.

[21] Bonomi AE, Thompson RS, Anderson M, et al. Intimate Partner Violence and Women's Physical, Mental, and Social Functioning[J]. American Journal of Preventive Medicine, 2006, 30(6): 458–466.

[22] Gelles, R.J (1976). Abused wives: Why do they stay? *Journal of marriage and the Family*, 38, 659-668

[23] Rusbult, C. E., & Martz, J. M. (1995). Remaining in an abusive relationship: An investment model analysis of nonvoluntary dependence. *Per-personality and Social Psychology Bulletin, 21*, 558–571.

[24] Finn J. The stresses and coping behavior of battered women[J]. Social Casework, 1985, 66(6): 341-349.

[25] McCann I L, Pearlman L A. Vicarious traumatization: A framework for understanding the psychological effects of working with victims[J]. Journal of traumatic stress, 1990, 3(1): 131-149.

[26] Aguilar R J, Nightingale N N. The impact of specific battering experiences on the self-esteem of abused women[J]. Journal of family violence, 1994, 9(1): 35-45.

[27] Calvete E, Corral S, Estévez A. Cognitive and coping mechanisms in the interplay between intimate partner violence and depression[J]. Anxiety, stress, and coping, 2007, 20(4): 369-382.

[28] Morocco, K. E., & COL#, T. B. Preventing intimate partner violence: screening is not enough. Jama, 2009,302(5), 568-570.

[29] Mancini J A, Nelson JP, Bowen G L, et al. Preventing intimate partner violence[J]. Journal of Aggression, Maltreatment & Trauma, 2006, 13(3-4): 203–227.

[30] Pence E, Paymar M, Ritmeester T. Education groups for men who batter: The Duluth model[M]. Springer Publishing Company, 1993.

[31] Babcock J C, Green C E, Robie C. Does batterers' treatment work? A meta-analytic review of domestic violence treatment[J]. Clinical psychology review, 2004, 23(8): 1023-1053.

[32] Feder L, Wilson D B. A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior?[J]. Journal of Experimental Criminology, 2005, 1(2): 239-262.

[33] Bohall G, Bautista M J, Musson S. Intimate partner violence and the Duluth model: An examination of the model and recommendations for future research and practice[J]. Journal of family violence, 2016, 31(8): 1029-1033.

[34] Stover C S, Meadows A L, Kaufman J. Interventions for intimate partner violence: Review and implications for evidence-based practice[J]. Professional Psychology: Research and Practice, 2009, 40(3): 223.

[35] Dunford F W. The San Diego Navy experiment: an assessment of interventions for men who assault their wives[J]. Journal of consulting and clinical psychology, 2000, 68(3): 468.

[36] Soleymani S, Britt E, Wallace-Bell M. Motivational interviewing for enhancing engagement in intimate partner violence (IPV) treatment: A review of the literature[J]. Aggression and Violent Behavior, 2018, 40: 119-127.

[37] Sullivan CM, Tan C, Basta J, et al. An advocacy intervention program for women with abusive partners: Initial evaluation[J]. American journal of community psychology, 1992, 20(3): 309-332.

[38] Tiwari A, Leung W C, Leung T W, et al. A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong[J]. BJOG: An International Journal of Obstetrics & Gynaecology, 2005, 112(9): 1249-1256.

[39] Stith SM, McCollum E E, Amanor-Boadu Y, et al. Systemic perspectives on intimate partner violence treatment[J]. Journal of marital and family therapy, 2012, 38(1): 220-240.

[40] Fals-Stewart W, Kashdan T B, O'Farrell T J, et al. Behavioral couples therapy for drug-abusing patients: Effects on partner violence[J]. Journal of substance abuse treatment, 2002, 22(2): 87-96.