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Review

Women's journey to safety – The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance

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ABSTRACT

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

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

Contents

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1. Introduction

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

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

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

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

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

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

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

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

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

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

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

2. Methods

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

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