

# Interventions on Women Under Intimate Partner Violence: An Integrative Review

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## Abstract

The present study is aimed to determine the interventions on women under intimate partner violence. This integrative review was performed by searching in international (Web of science, PubMed, Scopus Science direct, and EMBASE) and national (SID and magiran) databases were searched from inception to December 31, 2018. The keywords used included “interventions” OR “IPV” OR “intimate partner violence”. The search of studies, data extraction and screening conducted by two researcher. Of 2782 studies 30 studies included in final stage. These studies were mainly investigated the effect of the intervention type on domestic violence against women. Of these, 17 studies focused on victims of domestic violence, of which 7 focused on supporting and empowering victims of violence, and 7 were interventional studies, and the remaining 3 studies were online and computer-based interventions. Another category of interventions focused on training and empowerment of health professionals and providers (7 studies), and two studies focused on both groups of DV victims and care providers. In addition to the DV victims and care providers, 4 studies included community factors in interventions. It also seems that carrying out comprehensive and adequate interventions on women under domestic violence is needed.

**Key Words:** Domestic Violence; intimate partner violence; Interventions; Women; integrative review

## Background

IPV is one of the most common problems in the world today, so eliminating it is one of the Sustainable Development Goals (SDGs) [1]. According the Centers for Disease Control and Prevention (CDC) the term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. IPV includes four types of behavior: Physical violence, Sexual violence, Stalking, and Psychological aggression [2]. According to the latest WHO statistics in 2013, the global prevalence of IPV is 30% [3]. Women with IPV are at high risk for immediate and long-term psychological depression (the most common violence-induced psychological consequence [4-8], low level of social support [4], post-traumatic stress syndrome [5,6], anxiety, sleep disorders, emotional disturbances,

memory loss, poor self-esteem, fears, worries, and poor social communication [6], substance abuse, digestive disorders and chronic pain syndrome [8], more alcohol consumption, more unwanted pregnancies, and increased violence-induced abortions [7]. There has been a growing attention, at the international level, to the potential role played by health services in identifying and supporting women who have experienced violence and facilitate their referral to specialized services [6,9]. To meet the multiple complex needs that women experience with IPV in low-income and middle-income countries, the health sector needs to show a coordinated, comprehensive, and integrated response [10]. As a common worldwide health problem, preventing and combating violence against women requires interaction between different strata of society. To improve the quality of life as well as the mental health status of women with DV, gender and culture-based cultural and security interventions are also necessary [11]. To ensure their effectiveness, interventions seeking to reduce IPV and its consequences should consider the complexity of women’s experiences

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of IPV. Despite the greater recognition of IPV as a major public health problem and evidence suggesting women victims of IPV use healthcare services more frequently, little effort has been made to develop interventions aimed at reducing IPV or its consequences. A number of reviews have concluded that there is weak evidence that supports specific interventions for women victims of violence, especially interventions in health centers or those to whom health care providers can refer women [12]. Previous meta-analyses on violence interventions show that these interventions have a limited efficiency since they are all in one form and do not pay attention to the diversity of characteristics, needs, and levels of risk that distinguish IPV victims [13]. Considering the global importance of domestic violence against women and its high prevalence [14,15] and multiple IPV-induced physical and psychological consequences [4-8,16], and consequently the need for comprehensive interventions for the prevention and treatment of domestic violence victims, the present study was conducted to review the previous studies on interventions for women with domestic violence.

### **Materials and Method**

Inclusion studies included descriptive, population-based, cohort, and case control studies that were conducted on women under IPV. Clinical trial, review, letter to editor studies, low-quality studies, studies that did not allow access to the full text version, and studies written in languages other than Persian and English were excluded from the study. The International (PubMed, Science Direct, WOS, Scopus, and Embase) and National (Scientific Information Database (SID) and Magiran) databases were searched for relevant studies without time limits in English and Persian languages from inception to 30 December 2018. The MEDLINE search strategy was adopted to search in other databases. Boolean operators (AND, OR, and NOT), Medical Subject Headings (MeSH), and related text words were used for search using the following keywords: "Interventions", "Surveillance plan", "intimate partner violence" and "IPV". The last Search was conducted in 20 February, 2019. Extracted data items included: first author; year of publication; Age; Design; and intervention characteristics.

### **Results**

A total of 2782 articles were retrieved in searched databases. Out of 2110 non-duplicated studies in the

title and summary screening process, 2053 studies were excluded due to inappropriate titles. Out of 57 studies, 30 had eligibility criteria. Out of 27 excluded studies, two studies were letter to the editor, two studies were case report, 20 studies were published in Non-English and non-Persian language non from same data, and three studies did not meet the minimum quality requirements for inclusion in the study. Of the 30 studies reviewed, 17 were experimental studies (randomized controlled trial), 4 quasi-experimental studies, 5 systematic review studies, 3 mixed studies, and 1 qualitative study. Studies have mainly focused on the effect of the intervention type on IPV, of which 17 studies focused on victims of DV, of which 7 studies focused on the support and empowerment of violence victims, 7 studies on psychological interventions; and 3 studies on online and computer-based interventions. Another category of interventions (7 studies) emphasized the training and empowerment of health professionals and providers and two studies focused on both groups of DV victims and care providers. Four studies also included community factors in interventions in addition to victims and care providers [17-20]. The effects of interventions were evaluated as pre and post-intervention evaluations and often followed by follow-ups 3, 6, 9, 12, and 18-months after the intervention. Studies were carried out in various countries such as Uganda, Nepal, Canada, the United States, Mexico, the Netherlands, South Africa, Tanzania, Peru, India, Portugal, Ethiopia, England, Colombia, Denmark, Belgium, and New Zealand and encompassed diverse cultural backgrounds in relation to the DV phenomenon.

### **Discussion**

The studies reviewed had implemented interventions in three groups focused on women victims of violence, care providers, community factors. In women-centered study group, some studies focused on empowerment and support. Fanslow's intervention focused on raising women's awareness of the cycle of violence, safety planning, and referral to supportive organizations such as shelters [21]. Constantino et al. carried out an intervention aimed to provide resources for women, including information about resources, time to access resources, if available, and an environment for dialogue with counselors and friends [22]. Similarly, Cripe et al. carried out an intervention to empower pregnant women under domestic violence by giving a referral card so as to use legal and social services, supportive counseling, training and guidance on safety issues [23]. Two studies

also included screening for IPV in the routine health screening, referral and supportive care, safety planning and counseling for harm reduction, and one 3-month follow-up counseling session was implemented for women subjected to domestic violence [24,25]. Findings of a systematic review carried out by Alvarez et al. who focused on interventions on women with DV have referred to interventions such as brochures, safety planning, referral, support, guidance, home visits, and group sessions for behavioral change [26]. A multi-dimensional systematic intervention carried out by Rhodes who targeted both women victims and men who committed violence, includes 3 preparation stages (social health assessment), implementation stage (social health distribution, creation of a social marketing campaign, social health distribution survey, creation of social marketing campaign, the presence of a trained family health advocate, presence an IPV advocate) and a stabilization stage (continued education of care providers, social marketing, and social health monitoring) [27]. An intervention called “DIL MIL” targeting young married women, their mothers, and spouses in India was implemented as a group session for each group and joint sessions on communication skills training, gender-based violence, family health, reflection of culture and gender roles, intergenerational communication, empowerment for change, culture, and leadership [28]. Van Parys’s intervention consisted of the following three sections: a questionnaire, a referral card at a size of a bank card, containing contact details of the IPV assistance services on one side and guidance for increasing safety behavior on the other side and a gift coupon, and two interviews [29]. Another category of women-centered interventions was based on psychological treatments along with supportive and safety measures. Kiley et al. carried out a psychological and evidence-based intervention that was carried out exclusively on any IPV-induced psychological risks with an emphasis on safety planning, and empowerment (raising awareness about violence and its cycle, risk assessment, and protection methods), taking into account a list of social resources along with the address and telephone number [30]. This model consists of four stages: 1) Start: Thinking about violence against women and HIV as issues that require health workers and community members to work together and strengthen their power to address these issues. 2) Awareness: Increased awareness about community acceptance of men’s exercise of power against women that increases violence against women and HIV. 3) Support: Support for women and men who are directly affected by these

issues. 4) Action: Take actions to prevent violence against women and HIV [31]. Similar to the above intervention, a community-based study included holding sessions with local institutions and beneficiaries to examine barriers to implementing IPV interventions, as well as increasing beneficiaries’ engagement to prevent domestic violence against women, social mobilization, making women aware of gender equality, social rules and norms, raising the spouses’ level of awareness and participation and educating community representatives to engage them in changing traditional attitudes [20]. Clark et al. also conducted radio plays based on a social behavior change strategy, with interactive voice response and SMS service for listeners. They aimed to prevent IPV through three key approaches of support, social mobilization, and behavioral change (Clark et al., 2017) [19]. In his systematic review, Bouery stated that the following structural interventions are effective in preventing domestic violence: financial interventions (financing programs, support for women’s production, unconditional loans), social interventions (participatory learning, community mobilization, multimedia approaches), and economic / social interventions (gender training, livelihood education (creating the future), sexual health education, paired and gender training, cash transfers, support groups for women with gender dialogue for couples) [18].

## Conclusion

It seems that carrying out comprehensive and adequate interventions for women under domestic violence requires a multi-dimensional perspective and integration of interventions based on the needs of women under violence, care providers, and social factors.

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