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Intimate Partner Violence: A Systematic Literature Review

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Abstract

Intimate partner violence (IPV) and domestic violence have devastating effects on the health and well-being of people exposed to abuse. It is known that up to 75% of IPV episodes occur after a woman leaves her abuser, and women who seek help are most likely to suffer aggravated assaults or murder when trying to leave an abusive relationship (Cook & Nash, 2017). IPV screening has been well-studied as evidenced by the prolific research literature, however a synthesis of primary care actions that support the safety and well-being of women experiencing IPV is lacking. This systematic review compares traditional primary care intervention to interdisciplinary actions to determine which interventions offer increased incidences of reported safety behaviors and general well-being of women exposed to IPV. Criteria for article inclusion in the review include peer-reviewed, English-language studies that quantitatively and/or qualitatively examined traditional primary care interventions in adult women (age 18 years and older) disclosing IPV. Articles that examined interdisciplinary interventions to support the safety and overall well-being of adult women disclosing IPV were also included. A clinical phenomenon noted within the literature is the significance of social connectedness as a variable for improved safety and health. The results of the literature review reveal that the usual primary care intervention of brief counseling did not improve safety or well-being of women exposed to IPV. Interdisciplinary actions including advocacy, referrals, mentoring programs, and home visiting encounters demonstrated increased safety behaviors and improved mental health of women experiencing IPV.

Keywords: intimate partner violence, domestic violence, primary care, interventions, safety, well-being

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According to the World Health Organization (WHO, 2017), one in three women throughout the world will experience physical and/or sexual violence by an intimate partner or sexual violence by a non-partner. In Minnesota last year, at least 19 women were murdered by a current or former intimate partner (Minnesota Coalition for Battered Women, 2018). Five friends, family members, or bystanders were murdered in domestic violence altercations, and at least 12 minor children were left without a mother due to murder by an intimate partner (Minnesota Coalition for Battered Women, 2018). These staggering statistics are only a glimpse into the global problem of violence against women. The World Health Organization (2013) identified that a clear majority of IPV is not reported. Universal screening for intimate partner violence is a standard of care recommended by the United States Preventative Services Task Force (USPSTF, 2016) in women of child-bearing age. Evidence-based primary care interventions must be identified for the health and safety of women who screen positive for IPV. The purpose of this systematic review is to explore the available evidence in search of effective interventions to improve the health, safety, and well-being of women exposed to IPV.

Background

IPV is defined as “an intentional control or victimization of a person with whom the abuser has had or is currently in an intimate, romantic, or spousal relationship” (Cook & Nash, 2017, p. 45). IPV and domestic violence are terms often used interchangeably, however IPV is a form of domestic violence that occurs between two people engaged in a close personal, emotional, or sexual relationship (Smith et al., 2017). Different types of IPV include “physical abuse, sexual assault, coercion, social isolation, emotional abuse, economic control, and deprivation” (Cook & Nash, 2017). IPV is non-discriminatory; it affects people of all cultures,

social standing, backgrounds, and genders, including people who identify as gay, lesbian, and transgendered (Cook & Nash, 2017).

In the United States, approximately 27% of women experience sexual violence, physical violence, and/or stalking from IPV (CDC, 2012). Some reported impacts of IPV on women include fear, concern for safety, post-traumatic stress disorder, physical injuries, development of sexually transmitted infections, unwanted pregnancies, lack of healthcare, lack of safe housing, and lack of economic stability (Breiding, Basile, Smith, Black & Mahendra, 2015). In the United States, women who experience intimate partner violence are 70% more likely to have cardiac disease, 60% more likely to have asthma, and are 70% more likely to drink excessively than women who are not exposed to IPV (Bair-Merritt et al., 2014). Health care providers may be the sole contact for women experiencing IPV, and screening for IPV in the clinical setting is strongly recommended and a widely accepted standard of practice (Gupta et al., 2017). IPV is a global concern that has complex, long-term, multi-faceted ramifications on all populations served by primary care clinicians; therefore, it is necessary that evidence-based guidelines be established to guide interventions beyond screening for IPV in the clinical setting. This systematic review seeks to find evidence-based interventions to support primary care decisions to improve safety and overall well-being of women exposed to IPV.

Clinical Phenomenon

The clinical phenomenon observed in the literature is that interdisciplinary actions and increasing social contact opportunities through referrals, advocacy agents, mentor-support programs, and home-visiting programs enhances safety behaviors and mental health in women experiencing IPV (Bair-Merritt et al., 2014, Gupta et al.; 2017; Rivas, 2015). Maslow's (1943) theory of human motivation and hierarchy of needs, suggests the most basic of human needs

include feelings of safety and security. Physiological, safety, and security needs must be met for a person to be able to move forward to attain other higher ordered needs (Maslow, 1943). Social connection, thus decreased isolation, empowers women to initiate actions to meet safety and security needs (Bair-Merritt et al., 2014; Parker, 2014; Prosman, Lo Fo Wong, Romkens, & Lagro-Janssen, 2014). Failure to meet these needs may result in social isolation and increased risk for physical and mental harm. Knowing the incidence, prevalence, and devastating sequelae associated with IPV, it seems prudent to ask the following clinical question, "In adult females experiencing IPV or domestic violence, how do interdisciplinary actions, compared to traditional primary care without interdisciplinary intervention, impact the safety and overall well-being of women?"

Methods

The search strategies utilized for this systematic review included electronic database searches and review of lists of references from articles selected for the review. Electronic database search engines used include Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Database of Systematic Reviews (CDSR), PsycINFO, and PubMed (see Table 1 in the Appendix for the general subjects included in each database selected). Key words were utilized independently and in combinations for the selected database searches. Key words included IPV, domestic violence, primary care, interventions, safety, and well-being. Restrictions added to the CINAHL search included full-text only, references available, peer-reviewed, English language, research article, and abstract available. Restrictions added to search for CDSR included full-text only, references available, English language, and peer-reviewed. The PsycINFO search was limited to include full-text only, references available, English language, peer-reviewed, and abstract available. Restrictions added to the PubMed search included full-

text only, references available, English language, peer-reviewed, research article, and abstract available. The search for all databases was restricted to articles published from 2012 to 2017 (see Table 1 in the Appendix for a comprehensive description of restrictions applied to each database search).

Data Abstraction Process

In total, 19 articles from PubMed, 3 articles from CDSR, 9 articles from CINAHL, and 23 articles from PsycINFO were selected for review based on inclusion of all key terms within the title and findings within the abstract that appeared to inform the clinical question. A total of 5 articles accounted for duplication within the search, therefore 49 articles were reviewed for inclusion or exclusion in this review (See Table 2 in Appendix for a summary of keywords and keyword combinations, databases searched, and the number of articles identified).

Methodological Assessment

Search restrictions in the review included studies that quantitatively and/or qualitatively examined traditional primary care interventions in adult women disclosing IPV. Also, articles that examined interdisciplinary interventions to support the safety and overall well-being of adult women (< 18 years of age) disclosing IPV were included. Some of the studies included women < age 18 and/or children and were excluded. Studies which took place in a hospital or school setting were excluded. Articles were also excluded if they were identified as a research proposal without published data (See Table 3 in Appendix for listing of all articles examined and associated inclusion or exclusion criteria and rationale).

Based on the inclusion/exclusion criteria, 12 studies were selected for inclusion in the final systematic review. Melnyk and Fineout-Overholt (2015) suggest a Hierarchy of Evidence to categorize the strength of research evidence. Level one evidence includes systematic reviews;

level two evidence includes randomized-controlled trials; level three evidence includes controlled cohort studies; level four evidence includes uncontrolled cohort studies; level five evidence includes case studies, qualitative and descriptive studies; and evidence-based practice implementation, and level six evidence includes expert opinions (Melnyk and Fineout-Overholt, 2015). The articles selected for the review include four articles with the strongest or level I evidence, three articles with level II evidence, one article with level III evidence, two articles with level IV evidence, and two articles with level 5 evidence (see Table 4 in Appendix for a detailed description regarding each study's purpose, design, strength of evidence, variables, findings, and implications). Articles were critically appraised using Melnyk & Fineout-Overholt's (2015) rapid critical appraisal checklists pertinent to each study design.

Literature Summary

The following section of this paper will discuss study characteristics and research interventions and actions identified in the literature. Research interventions including primary care-usual care and interdisciplinary actions are further explored for their relationship to safety and overall health and wellbeing of women experiencing IPV.

Study Characteristics

The selected studies included sample populations of adult females, ages > 18 years old, who screen positive for IPV or disclose history of IPV. Each of the selected studies for review included a study purpose of exploring individual, group, or systems-level interventions to decrease IPV, increase safety planning, improve reported quality of life, or improve mental and physical health. The research settings included primary care (four studies), primary care or other outside settings including but not limited to women's shelters and mental health clinics (five

studies), family planning and reproductive clinics (two studies), and public health clinics (one study).

Research interventions and actions

The major types of interventions discussed in the literature includes primary care intervention-usual care and interdisciplinary actions. The studies explored used one or the other method; there was no comparison of primary care intervention and interdisciplinary actions in this review. The literature review undertaken here sought to examine and compare both intervention types for impact on safety and overall well-being of women experiencing IPV.

Primary care intervention: Usual care. Primary care intervention- usual care in the clinic setting include traditional visits with a primary care provider (physician or advanced practice clinician). A total of four out of the 12 studies identified short counseling sessions as the provider intervention for women experiencing IPV (Foster et al., 2015; Gupta et al., 2017; Hegarty et al., 2013; Miller et al., 2016). The results of IPV intervention with short counseling sessions were mixed. One study showed that open-ended questioning during counseling by the primary care provider increased the provider's understanding of the survivor of IPV's coping mechanisms; this understanding led to increased feelings of trust between provider and patient (Foster et al., 2015). Another study showed that short, nurse-led, individual counseling sessions in a public health clinic showed initial benefits including: reduction in physical IPV ($p=0.03$), increased safety planning, improved quality of life, and increased use of community IPV resources ($p=0.02$; Gupta et al., 2017). Unfortunately, the benefits diminished after three months-time (Gupta et al., 2017). Other studies have shown that short counseling sessions by providers do not improve quality of life or overall mental health of survivors of IPV, which were evaluated by self-report questionnaires given to the participants. Improvement in safety planning

measures (p=0.03) and awareness of IPV resources were reported (Hegarty et al., 2013; Miller et al., 2016). In consideration of the evidence, the benefit of short, provider-led counseling sessions in the clinic cannot be consistently achieved.

Interdisciplinary actions. Interdisciplinary actions include actions within the clinic setting and actions that include other disciplines within and outside of the primary care clinic. Four interdisciplinary actions identified in the literature include referrals, patient advocacy, home visits, and mentor-support programs.

Referrals to outside sources include those to mental health, IPV advocate, social workers, and community-based IPV agencies (Gupta et al., 2017; Jahanfar, 2014; Miller et al., 2016; Parker & Gielen, 2014). The research is mixed regarding the benefit of referrals to outside sources. Gupta et al. (2014) found that initial benefits of referral, including reduction of IPV exposure, reduction of reproductive coercion, increase in safety planning, improved mental quality of life, and increased use of community support resources, were statistically significant for only a short duration of time. Miller et al. (2016) showed support for education including referral to IPV advocates to increase knowledge of local resources and improve patient self-efficacy of women experiencing IPV. Parker and Gielen (2014) demonstrated evidence supporting referral to mental health providers and community-based IPV agencies for women experiencing IPV; the evidence was inconclusive for referral to the criminal justice system and police based on self-report from women experiencing IPV and specifically due to reported mistrust with the justice system and police. Additional research is required to explore the barriers to referral including safety concerns and availability of long-term support systems for adult women survivors of IPV.

Patient advocacy involves the support of an individual trained in addressing the needs of women experiencing IPV. Patient advocacy as an interdisciplinary action to impact safety and overall well-being of women experiencing IPV is examined in five out of the 12 articles reviewed in this study (Bair-Merritt et al., 2014; Jahnafar, 2014; Miller, Tancredi, Decker, McCauley, et al., 2016; Parker & Gielen, 2014; Rivas, 2015). A systematic review by Bair-Merritt et al. (2014) reported several interdisciplinary actions (including patient advocacy) that contributed to the perception of improved safety and overall well-being of women experiencing IPV. Safety and well-being were examined using surveys of safety behaviors , danger assessment tools, and physical and emotional health self-report scores. Patient advocacy by an IPV advocate, nurse, or paraprofessional was shown to increase a sense of empowerment in survivors of IPV (Bair-Merritt et al., 2014). A sense of empowerment has been shown in multiple studies as a factor for increased safety planning in women experiencing IPV (Bair-Merritt et al., 2014; Parker, 2014; Prosman et al., 2014). Safety-planning strategies “increase resources and choices for leaving or reducing the risk for future violence” (Parker, 2014, p.584). A systematic review by Rivas and colleagues (2015), examined 13 randomized control trials (RCTs) with 2141 participants, and reported statistically insignificant evidence to support advocacy. Nurse-based advocacy (Gupta et al., 2017) was shown to offer short-term benefit in safety planning (p=0.04) and improved mental health of survivors of IPV (p=0.03). A systematic review by Parker (2014), comprised of 9 RCTs and 757 participants, highlighted the complexity of individual cases of IPV and the role of advocacy in addressing safety measures and safety plans. In summary, patient advocacy has mixed evidence to support its’ implementation.

Home visits for women survivors of IPV as an interdisciplinary action were identified in two systematic reviews (Bair-Merritt et al., 2014; Jahanfar, 2014). Bair-Merritt et al. (2014)

found that outside contacts, including home visits between IPV advocates (social workers) and women experiencing IPV, decreased exposure to IPV, increased reported physical and mental health, increased safety planning, and increased use of community resources for IPV survivors. Jahanfar, et al. (2014) identified three studies regarding IPV in pregnant women where home visit support was delivered, however the results were not statistically significant. Therefore, there is mixed-support in the literature for the benefit of home visits as an interdisciplinary action to support women experiencing IPV.

Mentor-support programs were actions identified in two of the 12 studies examined in this review (Bair-Merritt et al., 2014; Prosman, Wong, Romkens, & Lagro-Janssen, 2014). Bair-Merritt et al. (2014) discussed the benefit of a mentor-support person for mothers experiencing IPV where women with long-term connection to a mentor reported significantly lower incidence of IPV after 12 months of the intervention. A qualitative study conducted by Prosman et al. (2014) found that women survivors of IPV report increased feelings of empowerment and improved coping abilities when paired with an IPV mentor. As discussed above, feelings of empowerment have been shown to lead to increased safety behaviors in women experiencing IPV (Bair-Merritt et al., 2014). In addition, women survivors of IPV reported decreased isolation, development of a trusting relationship with the mentor, and readiness to access community supports for safety (Prosman et al., 2014). In summary, mentoring relationships seem to be a positive intervention for women suffering IPV.

Research Gaps

Identified research gaps include the long-term benefits of primary and interdisciplinary interventions and their effect on safety and overall well-being of women experiencing IPV. The research shows that the improved safety and well-being of women attributed to interdisciplinary

actions decreases over time; therefore, evidence to support long-term interventions and actions are necessary to guide clinicians. Additional research is needed that explores primary care-based interdisciplinary actions and the development of trusting relationships to empower women experiencing IPV.

Discussion

The articles reviewed for this study report a lack of consistency in delivered interventions and measured outcomes for the support of women experiencing IPV. Of the interventions discussed, usual primary care interventions (including brief counseling sessions) are not supported in the literature as an evidenced- based action for a sustained positive affect on women experiencing IPV. Therefore, as a primary care intervention, brief counseling sessions following disclosure of IPV require additional analysis of the content of counseling to determine best practices. Hamberger et al. (2014) write “a real finding [from this study is] that being asked about IPV and discussing IPV with one’s physician does not automatically lead to feeling healthier, no matter how supportive the doctor-patient relationship” (p. 589). In other words, support from primary care clinicians does not meet the IPV survivor’s need for safety and security (Maslow, 1943) therefore higher order needs for support are not perceived as beneficial. Alternative methods to improve IPV survivors’ safety and security will likely improve their overall perception of well-being.

Interdisciplinary actions including referral and patient advocacy show potential in the literature to support the benefits for women experiencing IPV. Referrals to clinic-based services and referrals to outside sources of IPV support are demonstrated to improve short-term reduction in IPV, increased safety planning, and improved short-term mental health. Gupta et al. (2017) states “Trial findings indicate that the nurse-delivered intervention yielded statistically

significant improvements in safety planning and mental quality of life at 3 months following baseline. These intervention effects… were not observed at 12 months post-intervention" (p.9). Research that explores the effects of long-term advocacy, community connectedness, and ongoing support for women experiencing IPV may provide a framework or timeline for intensive services to support women.

Interdisciplinary actions including home visits and mentor-support programs have less evidence to support their use for women experiencing IPV when compared to other examined interventions in this study. However, available data on home visiting and mentor-support programs do demonstrate the benefits of trusting relationships that increase report of empowerment and safety planning among women experiencing IPV. These findings may suggest that qualitative research examining the actions that are associated with a trusting relationship between the clinician or mentor and the woman experiencing IPV could provide valuable insight to guide strategies to improve safety, empowerment, and overall wellbeing of women survivors of IPV.

Clinical Significance for Advanced Practice

Advanced practice registered nurses (APRN) are ideal clinicians to address the detrimental physical and psychosocial health effects of intimate partner violence. Holistic APRN practice examines the emotional, spiritual, social, and physical domains of wellbeing and takes into consideration how each health domain impacts the other. Margaret Newman's Theory of Health as Expanding Consciousness asserts that the nurse "functions to recognize patterns in patients by forming relationships with patients and connecting with patients in an authentic way" (Masters, 2015, p. 205). In recognizing patterns of behavior in women experiencing IPV, nurses can clarify the patient patterns of interacting with the environment and provide insight into action

possibilities for transformation and facilitate changes in behavior to support safety and well-being (Masters, 2015). APRNs in primary care interact with patients over time and develop meaningful relationships based on trust, acceptance, and collaboration. This literature review highlights the importance of trusting relationships and long-term support to improve quality of life and health status of survivors of IPV.

Limitations

Limitations of this review include lack of consistency across studies regarding the types of interventions utilized, the settings, and the measured outcomes. The focus on adult women excluded interventions that support the health and safety of other populations including men, adolescents, and children. Also, none of the studies included same-sex relationships. Many of the population samples in the included studies were large and representative of the population, however generalizability is difficult to achieve knowing the complexity of each woman's unique situation surrounding IPV.

Clinical Practice Recommendations

The literature is clear that interdisciplinary actions including referral, patient advocacy, home visiting, and mentor-support programs have a potential positive effect on safety and overall well-being of women experiencing intimate partner violence. Therefore, interdisciplinary interventions are recommended over primary care-usual care, or short counseling sessions, by a primary care clinician. Short counseling sessions by a primary care clinician have not been shown to improve safety and overall well-being of women experiencing IPV; however, there is evidence that suggests that building trusting relationships does increase report of empowerment and safety planning among women experiencing IPV. Thus, a call for additional research that

examines establishment of trusting relationships and content of counseling topics with women experiencing IPV over time is warranted.

Education Recommendations for Clinicians

Understanding the complexity of the effects of IPV on survivors is necessary to adequately address the needs of the patient. Education in screening for IPV, responding to a disclosure of IPV, actions if IPV is suspected, and accessing interdisciplinary services are responsibilities of the clinician caring for any person experiencing IPV. The CDC have published guidelines for clinicians that focus on the prevention of IPV (Niolon, Kearns, Dills, & Rambo, 2017). Topics of focus in the CDC guidelines include "Teaching [about] safe and healthy relationships, engaging influential adults and peers, disrupting the developmental pathways towards partner violence, creating protective environments, strengthening economic supports for families, and supporting survivors of IPV to increase safety and lessen harms" (Niolon et al., 2017). Addressing IPV concerns from a primary intervention perspective is within the scope and expertise of APRNs. The CDC guidelines also include the current evidence for supporting the implementation of primary care prevention of IPV (Niolon et al., 2017). This research could be used to inform curriculum development for IPV education of primary care clinicians.

Conclusion

In conclusion, interdisciplinary actions including advocacy, referral, mentoring programs, and home visiting are recommended actions in primary care to promote safety behaviors and increase the overall wellbeing of women experiencing IPV. The care of victims of IPV appears to be most effective when the interdisciplinary team works together to bring shared expertise and

resources to meet the needs of survivors of IPV (Bair-Merritt et al., 2014; Gupta et al., 2017; Parker & Gielen, 2014; Prosman et al., 2014). The literature confirms that traditional intervention or usual care without interdisciplinary intervention rarely results in any long-term health benefits for survivors of intimate partner violence. Further research could elevate the clinician's understanding of the lived experience of IPV and the long-term needs of survivors of IPV. Hamberger et al. (2014) suggest that it may be beneficial for clinicians to view the experience of IPV as a condition requiring chronic health management. The physiologic and psychological effects of IPV necessitate compassion, understanding, a non-judgmental approach toward each person's individual circumstances, and trust-building actions extended over time. Having an awareness of the evidence to support actions and knowledge of local interdisciplinary resources will help to guide clinicians to provide the best evidence-based actions to improve safety and overall well-being of women experiencing IPV.

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Appendix

Table 1

Database Search Description

Database (or Search Engine)	**Restrictions Added to Search**	**Dates Included in Database**	**General Subjects Covered by Database**
1. CINAHL	Full Text; References Available; English Language; Peer Reviewed; Research Article; Abstract Available	2012 through 2017	"Provides full text access to e-books about nursing and 29 core nursing journals. Also provides citations and summaries to articles, books, dissertations, proceedings, and other materials about all aspects of nursing and allied health, including cardiopulmonary technology, emergency service, health education, medical/laboratory, medical assistant, medical records, occupational therapy, physical therapy, physician assistant, radiologic technology, social service/health care, and more" (MSU Mankato, 2017).
2. Cochrane Database of Systematic Reviews (CDSR)	Full Text; References Available; English Language; Peer Reviewed	2012 through 2017	"Cochrane Collection Plus is the most comprehensive collection of databases from the Cochrane Library. Cochrane Collection Plus is an essential source of high quality health care data for both providers, patients and those responsible for researching, teaching, funding, and

			administrating at all levels of the medical profession" (MSU, Mankato, 2017).
3. PsycINFO	Full Text; References Available; English Language; Peer Reviewed; Abstract Available	2012 through 2017	"Provides citations and abstracts to articles and books about psychology and disciplines related to psychology such as psychiatry, education, business, medicine, nursing, pharmacology, law, linguistics, and social work" (MSU, Mankato, 2017).
4. PubMed	Full Text; References Available; English Language; Peer Reviewed; Research Article; Abstract Available	2012 through 2017	"Provides citations, abstracts, and selected full text to articles about medicine, nursing, dentistry, veterinary medicine, the health care system, and the preclinical sciences" (MSU, Mankato, 2017).

Table 2

Data Abstraction Process

Date of Search	**Key words**	**Hits in PubMed**	**Hits in CDSR**	**Hits in CINAHL**	**Hits in PsycINFO**
10/13/17	“Domestic violence” AND “interventions”	432	5	94	836
10/14/17	“Domestic violence” AND “interventions” AND “primary care”	39	3	9	45
10/14/17	“Domestic violence” AND “interventions” AND “primary care” AND “safety”	**10**	**2**	**5**	**11**
11/7/17	“Intimate partner violence” AND “interventions”	1372	2	174	1047
11/8/17	“Intimate partner violence” AND “interventions” AND “primary care”	134	1	15	68
11/9/17	“Intimate partner violence” AND “interventions” AND “primary care” AND “safety”	**9**	**1**	**4**	**12**

***BOLD** = articles reviewed for match with systematic review inclusion criteria, based on terms.

Table 3

Characteristics of Literature Included and Excluded

Reference	**Included or Excluded and Document**	**Rationale**
Bair-Merritt, M., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., Cronholm, P. (2014). Primary care–based interventions for intimate partner violence: a systematic review. *American Journal of Preventive Medicine, 46*(2), 188-194. doi:10.1016/j.amepre.2013.10.001	Included	A systematic review that explores interventions administered in primary care clinics and outside primary care clinics for women experiencing intimate partner violence.
Beard, J. W. (2013). Adolescents and child maltreatment. *NASN School Nurse, 29*(2), 71-74. doi:10.1177/1942602X13517721	Excluded	Incorrect patient population
Bede, F. (2016). Female genital mutilation. *InnovAiT, 9*(7), 395-403. doi:10.1177/1755738016643103	Excluded	Incorrect setting
Biddle, V. S., Kern, J., Brent, D. A., Puskar, K. R., & Sekula, L. K. (2014). Student assistance programs for students at risk for suicide. *The Journal of School Nursing, 30*(3), 173-186. doi:10.1177/1059840314525968	Excluded	Incorrect patient population. Incorrect setting.
Bounds, D., Julion, W. A., & Delaney, K. R. (2015). Commercial sexual exploitation of children and child welfare systems. *Policy, Politics, and Nursing Practice, 17*(3), 156-169. doi:10.1177/1527154415583124	Excluded	Incorrect patient population.
Cicero, E. C. & Wepp, L. M. (2017). Supporting health and wellbeing of transgender students. *The Journal of School Nursing, 33*(2), 95-108. doi:10.1177/1059840516689705	Excluded	Incorrect patient population
Cruz, M., Cruz, P. B., Weirich, C., McGorty, R., & McColgan, M. D. (2013). Referral patterns and service utilization in a pediatric hospital-wide intimate partner violence program. *Child Abuse & Neglect, 37*(8), 511-519. doi:10.1016/j.chiabu.2013.03.007	Excluded	Hospital-based study; not performed in primary age. Population is pediatrics and focus of the review is adult patients.
Ellison, J. R. (2014). 'I didn't think he remembered': healing the impact of domestic violence on infants and toddlers. *Zero to Three, 35*(2), 49-55.	Excluded	Population is pediatrics in this study; review is focused on adults.
Feder, G., Davies, R., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., & ... Howell, A. (2011). Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomized controlled trial. *Lancet, 378 North American Edition* (9805), 1788-1795. doi:10.1016/S0140-6736	Excluded	Incorrect outcomes
Ford-Gilboe, M., Varcoe, C., Scott-Storey, K., Wuest, J., Case, J., Currie, L. M., & ... Wathen, C. N. (2017). A tailored online safety and health intervention	Excluded	Research proposal only.

Reference	Included or Excluded and Document	Rationale
for women experiencing intimate partner violence: the iCAN plan 4 safety randomized controlled trial protocol. *BMC Public Health, 17,* 1-12. doi:10.1186/s12889-017-4143-9		
Foster, E. L., Becho, J., Burge, S. K., Talamantes, M. A., Ferrer, R. L., Wood, R. C., & Katerndahl, D. A. (2015). Coping with intimate partner violence: qualitative findings from the study of dynamics of husband to wife abuse. *Families, Systems, & Health, 33*(3), 285-294. doi: 10.1037/fsh0000130	Included	Health care providers can identify individual coping strategies to improve safety based on the unique female exposed to intimate partner violence.
Grace, L. G., Starck, M., Potenza, J., Kenney, P. A., & Sheetz, A. H. (2012). Commercial sexual exploitation and the school nurse. *The Journal of School Nursing, 28*(16), 410-417. doi:10.1177/1059840512448402	Excluded	Incorrect patient population, incorrect setting.
Gupta, J., Falb, K. L., Ponta, O., Ziming, X., Abril Campos, P., Arellano Gomez, A., & ... Olavarrieta, C. D. (2017). A nurse-delivered, clinic-based intervention to address intimate partner violence among low-income women in Mexico City: findings from a cluster randomized controlled trial. *BMC Medicine, 15*1-12. doi:10.1186/s12916-017-0880-y	Included	Examines nursing interventions in a primary care setting to decrease exposure to intimate partner violence.
Harvey, L. B., & Ricciotti, H. A. (2013). Nutrition for a healthy pregnancy. *American Journal of Lifestyle Medicine, 8*(2), 80-87. doi:10.1177/1559827613498695	Excluded	Incorrect patient population.
Hamberger, L., Ambuel, B., Guse, C., Phelan, M., Melzer-Lange, M., & Kistner, A. (2014). Effects of a systems change model to respond to patients experiencing partner violence in primary care medical settings. *Journal of Family Violence, 29*(6), 581-594. doi:10.1007/s10896-014-9616-3	Included	Examines systems level change in a primary care setting regarding intimate partner violence screening, violence reduction, and women's health and wellbeing following intervention.
Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., Astbury, J., Taket, A., Feder, G., & Gunn, J. (2013). Screening and counseling in primary care settings for women who have experienced intimate partner violence (WEAVE): a cluster randomized control trial. *Lancet, 382*(9888), 249-258. doi:10.1016/s0140-6736(13)60052-5	Included	Examines physician-led counseling in a primary care setting and outcomes for women living with intimate partner violence.
Hegarty, K., Tarzia, L., Murray, E., Valpied, J., Humphreys, C., Taft, A., Gold, L., & Glass, N. (2015). Protocol for a randomized controlled trial of a web-based safety decision aid for women experiencing domestic violence (I-DECIDE). BMC Public Health, 15, 763. doi:10.1186/s12889-015-2072-z	Excluded	Research proposal only.
Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry, 28*(5), 519-532. doi: 10.1080/09540261.2016.1210103	Excluded	Full-text article not available for review.

Reference	Included or Excluded and Document	Rationale
Hildebrant, E. (2016). Understanding the lives and challenges of women in poverty after TANF. *Policy, Politics, and Nursing Practice, 17*(3), 156-169. doi:10.1177/1527154416672204	Excluded	Incorrect topic, not related to intimate partner violence or domestic violence.
Herbert, I. L. (2016). The changed injury landscape, more on injury prevention roles for the lifestyle physician, and more than "limited progress" since injury in America. *American journal of lifestyle medicine, 10*(1), 10-13. doi:10.1177/1559827615609032	Excluded	Incorrect topic, not related to intimate partner violence or domestic violence.
Hooker, L., Small, R., & Taft, A. (2016). Understanding sustained domestic violence identification in maternal and child health nurse care: process evaluation from a 2-year follow- up of the MOVE trial. *Journal of Advanced Nursing, 72*(3), 533-544. doi:10.1111/jan.12851	Excluded	Study focus is on screening, not post-screening interventions.
Huang, D., Hunter, Z., & Francescutti, L. H. (2012). Alcohol, health, & injuries. *American Journal of Lifestyle Medicine, 7*(4), 232-240. doi:10.1177/1559827612468836	Excluded	Incorrect topic, not related to intimate partner violence or domestic violence.
Jahanfar, S. (2014). Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews*, (11). doi:10.1002/14651858.CD009414.pub3	Included	Systematic review examining interventions for pregnant women experiencing domestic violence.
Krishnan, S., Subbiah, K., Chandra, P., & Srinivasan, K. (2012). Minimizing risks and monitoring safety of an antenatal care intervention to mitigate domestic violence among young Indian women: The Dil Mil trial. *BMC Public Health, 12*(1), 943. doi:10.1186/1471-2458-12-943	Excluded	Study results not available; proposal for study only
La Flair, L. N., Bradshaw, C. P., Mendelson, T., & Campbell, J. (2015). Intimate partner violence and risk of psychiatric symptoms: the moderating role of attachment. *Journal of Family Violence, 30*(5), 567-577. doi: 10.1007/s10896-015-9681-2	Excluded	Wrong outcomes.
Mazyck, D. E., & Galemore, C. A. (2012). All things NASN- the 2012 annual report. NASN School Nurse, 27(4), 212-220. doi:10.1177/1942602X12449359	Excluded	Incorrect patient population, incorrect setting.
Miller, E., Tancredi, D. J., Decker, M. R., McCauley, H. L., Jones, K. A., Anderson, H., James, L., & Silverman, J. G. (2016). A family-planning clinic-based intervention to address reproductive coercion: a cluster-randomized control trial. Contraception, 94, 58-67. doi: 10.1016/j.contraception.2016.02.0090010-7824	Included	Examines provider delivered counseling regarding intimate partner violence in a family planning clinic.
Midgley, E. (2016). Elder abuse. InnovAiT, 10(2), 105-111. doi:10.1177/1755738016647415	Excluded	Incorrect research topic.

Reference	Included or Excluded and Document	Rationale
Monheit, A. C. (2012). Good news and not-so-good news. *The Journal of Healthcare Organization, Provision, and Financing*. doi:10.5034/inquimjrnl_49.01.08	Excluded	Summary article, not pertinent to systematic study inquiry.
Oakhill, E. (2016). Postnatal depression. *InnovAiT, 9*(9), 531-537. doi:10.1177/1755730016654292	Excluded	Informational article, not a research article.
Pallitto, C., Garcia-Moreno, C., Stoeckl, H., Hatcher, A., MacPhail, C., Mokoatle, K., & Woollett, N. (2016). Testing a counselling intervention in antenatal care for women experiencing partner violence: a study protocol for a randomized controlled trial in Johannesburg, South Africa. *BMC Health Services, 16*(1), 630. doi:10.1186/s12913-016-1872-x	Excluded	Study results not available; proposal for study only
Parker, E. M., & Gielen, A. C. (2014). Intimate partner violence and safety strategy use: frequency of use and perceived effectiveness. *Women's Health Issues, 24*(6), 584-593. doi:10.1016/j.whi.2014.08.001	Included	A systematic review of safety interventions of women experiencing intimate partner violence and decreased risk of revictimization.
Pocock, L., & Sutton, J. (2014). Health needs of prisoners. *InnovAiT, 8*(1), 24-29. doi:10.1177/175573801955555	Excluded	Incorrect patient population.
Prosman, G., Wong, L. F., Römkens, R., & Lagro-Janssen, A. (2014). 'I am stronger, I'm no longer afraid…', an evaluation of a home-visiting mentor mother support programme for abused women in primary care. *Scandinavian Journal of Caring Sciences, 28*(4), 724-731. doi:10.1111/scs.12102	Included	Examines primary care intervention of referral to a home-visiting mentor for women living with intimate partner violence.
Reader, T. W. & Gillespie, A. (2013). Patient neglect in healthcare institutions: a systematic review and conceptual model. *BMC Health Services Research, 13*, 156. doi:10.1186/1472-6963-13-156	Excluded	Incorrect research topic.
Rees, S., & Silove, D. (2014). Why primary health-care interventions for intimate partner violence do not work. *The Lancet, 384*(9939), 229. doi:10.1016/S0140-6736(14)61203-4	Excluded	Low-quality evidence; opinion-based article.
Rhodes, K. V., Grisso, J. A., Rodgers, M., Gohel, M., Witherspoon, M., Davis, M., & ... Crits-Christoph, P. (2014). The anatomy of a community health center system-level intervention for intimate partner violence. *Journal of Urban Health, 91*(1), 107-121. doi:10.1007/s11524-013-9816-9	Excluded	Incorrect research topic; focuses on screening and not interventions.
Rhodes, K. V., Rodgers, M., Sommers, M., Hanlon, A., & Crits-Christoph, P. (2014). The social health intervention project (SHIP): protocol for a randomized controlled clinical trial assessing the effectiveness of brief motivational intervention for problem drinking and intimate partner	Excluded	Incorrect setting, incorrect research topic.

Reference	Included or Excluded and Document	Rationale
violence in an urban emergency department. *BMC Emergency Medicine, 14*, 10. doi:10.1186/1471-227x-14-10		
Rivas, C. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews*, (12). doi:10.1002/14651858.CD005043.pub3	Included	Systematic review that examines advocacy IPV interventions by a primary care provider, by referral to outside services, and by multi-disciplinary interventions (multiple networks/systems).
Sohal., A., Feder, G., & Johnson, M. (2012). Domestic violence and abuse. *InnovAiT, 5*(12), 750-758. doi:10.1093/innovait/ins198	Excluded	Information article, not a research study.
Szilassy, E., Drinkwater, J., Hester, M., Larkins, C., Stanley, N., Turner, W., & Feder, G. (2017). Making the links between domestic violence and child safeguarding: an evidenced-based pilot training for general practice. *Health & Social Care in the Community, 25*(6), 1722-1732. doi:10.1111/hsc.12401	Excluded	Incorrect patient population.
Taft, A. & Cobmbini, M. (2017). Healthcare system responses to intimate partner violence and middle-income countries: evidence is growing, and the challenges become clearer. *BMC Medicine, 15*(1), 127. doi:10.1186/s12916-017-0886-5	Excluded	Information article, not a research study.
Taft, A. J., Hooker, L., Humphreys, C., Hegarty, K., Walter, R., Adams, C., & ... Small, R. (2015). Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomized trial. *BMC Medicine, 13*(1), 150. doi:10.1186/s12916-015-0375-7	Included	Nurse-led screening and intervention model for intimate partner violence to examine safety planning and referrals compared to standard care.
Tarzia, L., Murray, E., Humphreys, C., Glass, N., Taft, A., Valpied, J., & Hegarty, K. (2016). I-DECIDE: an online intervention drawing on the psychosocial readiness model for women experiencing domestic violence. *Women's Health Issues, 26*(2), 208-216. doi: 10.1016/j.whi.2015.07.011	Excluded	Proposal for research study, does not include original research in article.
Tol, W. A., Greene, M. C., Likindikoki, S., Misinzo, L., Ventevogel, P., Bonz, A. G., . . . Mbwambo, J. K. K. (2017). An integrated intervention to reduce intimate partner violence and psychological distress with refugees in low-resource settings: study protocol for the nguvu cluster randomized trial. *BMC Psychiatry, 17*, 13.	Excluded	Proposal for research study, does not include original research in article.
Tyrrell, M., Hilleras, P., Skovdahl, K., Fossum, B., & Religa, D. (2017). Voices of spouses living with partners of neuropsychiatric symptoms related to dementia. *Dementia*. doi:10.1177/1471301217693867	Excluded	Incorrect research area.

Reference	Included or Excluded and Document	Rationale
Williamson, E., Jones, S. K., Ferrari, G., Debbonaire, T., Feder, G., & Hester, M. (2015). Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. *Primary Health Care Research and Development, 16*(3), 281-288. doi: 10.1017/S1463423614000358	Excluded	Focus of research is on provider training, does not include patient outcomes for research.
Van Parys, A. S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate partner violence and pregnancy: a systemic review of interventions. *PLoS One, 9*(1), e85084. doi:10.1371/journal.pone.0085084	Excluded	Incorrect patient population.
van Rosmalen-Nooijens, Karin A. W. L., Wong, L. F., Prins, J. B., & Lagro-Janssen, A. (2017). The need for control, safety, and trust in healthcare: a qualitative study among adolescents and young adults exposed to family violence. *Patient Education and Counseling, 100*(6), 1222-1229. doi: 10.1016/j.pec.2017.02.008	Excluded	Incorrect patient population.

Table 4

Literature Review of All Studies Included

Citation	**Study Purpose**	**Pop (N)/ Sample Size (n) /Setting(s)**	**Level of Evidence/ Design** (Melnyk & Fineout-Overholt, 2015)	**Variables/ Instruments**	**Intervention(s)**	**Findings**	**Implications**
Bair-Merritt, M., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., . . . Cronholm, P. (2014). Primary care–based interventions for intimate partner violence: a systematic review. *American Journal of Preventive Medicine, 46*(2), 188-194. doi:10.1016/j.amepre.2013.10.001	To summarize primary-care based interventions for patients experiencing intimate partner violence (IPV).	n=18-2708 s=primary-care setting(PCS)or PCS & outside clinic settings	Level I Systematic review	IV= primary care (PC) interventions DV= IPV reduction, improvement in health, safety-promoting behaviors, use of IPV community-based resources Safety assessment tools Danger assessment tools	Brief provider-led counseling Clinic-based visit with IPV advocate Clinic-based visit with social worker Nurse-led case management visits Clinic-based visit with psychologist Follow up phone calls Community resource list &/or IPV education video Peer mentors & home visits	Reduction in IPV Improvement in health Safety-promoting behaviors Use of IPV community-based resources	Listed interventions support implementation of various strategies to promote safety and overall well-being of patients experiencing IPV. Additional research is necessary to determine which interventions are most effective and in other areas of primary care Reproductive health visits may be an ideal setting to address IPV and implement interventions. Additional research needed to support this area.
Foster, E. L., Becho, J., Burge, S. K., Talamantes, M. A., Ferrer, R. L., Wood, R. C., & Katerndahl, D. A. (2015). Coping with intimate partner violence: qualitative findings from the study of dynamics of husband to wife abuse. *Families, Systems, & Health, 33*(3), 285-294. doi: 10.1037/fsh0000130	To understand the coping strategies used by women living with IPV.	n= 200 s= 6 PCS	Level IV Mixed-methods study	COPE scale In-depth interviews	Counseling Individualized safety planning (SOS-DoC)	Intervention necessary beyond screening Open-ended questioning elicits greater understanding of coping than screening alone	SOS-DoC framework can help providers assess individual patient coping mechanisms Understanding coping mechanisms can be a starting point for intervention planning Understanding can lead to increased trust between provider and patient who

Citation	**Study Purpose**	**Pop (N)/ Sample Size (n) /Setting(s)**	**Level of Evidence/ Design** (Melnyk & Fineout-Overholt, 2015)	**Variables/ Instruments**	**Intervention(s)**	**Findings**	**Implications**
							often has lost trusting abilities due to IPV
Gupta, J., Falb, K. L., Ponta, O., Ziming, X., Abril Campos, P., Arellano Gomez, A., & ... Olavarrieta, C. D. (2017). A nurse-delivered, clinic-based intervention to address intimate partner violence among low-income women in Mexico City: findings from a cluster randomized controlled trial. *BMC Medicine*, *15*1-12. doi:10.1186/s12916-017-0880-y	To assess if nurse-led interventions would decrease IPV and increase safety planning, use of community resources, and mental health in low-income women.	n= 950 s= 42 public health clinics	Level II Randomized controlled trial	DV= women experiencing IPV IV= nurse-delivered interventions IPV screening tool Baseline, 3 months, & 15-month follow-up surveys	IPV screening, referrals, health/safety risk assessments Initial & follow-up counseling sessions	Significant reduction of IPV in past year ($P < 0.01$) in both control and treatment groups Significant reduction of reproductive coercion ($p < 0.001$) in treatment group Significant increase in safety planning ($p < 0.01$) in both control and treatment groups Improved mental quality of life ($p < 0.01$) in both control and treatment groups Increased use of community resources ($p < 0.01$) in treatment group	Over time, the intervention statistical significance decreased. Thus, the authors of this study acknowledge the short-term benefits of the nurse-led interventions, and postulate that future research involving multiple sectors may meet the long-term needs of the IPV exposed population. Primary care clinics with nursing intervention for patients experiencing IPV using a medical-home model may support the long-term needs of the population, based on the typical longevity of primary care management over the lifespan.
Hamberger, L., Ambuel, B., Guse, C., Phelan, M., Melzer-Lange, M., & Kistner, A. (2014). Effects of a systems change model to respond to patients experiencing partner violence in primary care medical settings. *Journal of Family Violence*, *29*(6), 581-594. doi:10.1007/s10896-014-9616-3	To examine the effectiveness of a systems level change on IPV screening, violence reduction, and health and wellbeing of women experiencing IPV in PCS.	n=35 s= 4 family medicine clinics	Level IV Longitudinal cohort study	Health care change from within model (control group= usual care, intervention group=systems model change using above model) Abuse assessment screening (AAS) Conflict Tactics scale - 2 (CTS-2)	Intensive 60- 90-minute session at PCP completing surveys and checklists (completed from retrospective visits in PCS)	All participants report IPV screening as potentially beneficial Safety concerns identified including screening without providing a reason, not screening privately, and not addressing the sensitivity of the information shared are potentially harmful actions by the clinician.	Small study demonstrates benefit from systems level changes to support the health, wellbeing, and safety of women experiencing IPV.

Citation	**Study Purpose**	**Pop (N)/ Sample Size (n) /Setting(s)**	**Level of Evidence/ Design** (Melnyk & Fineout-Overholt, 2015)	**Variables/ Instruments**	**Intervention(s)**	**Findings**	**Implications**
				CDC Healthy Days Core module Safety behavior checklist Connection to community, safety, and satisfaction with care self-report measure Consequences and symptoms of injury self-report checklist Doctor & Nurses asking patients about violence self-report measure		Women in intervention group report increased levels of being asked about IPV, less sexual violence than control group, and increased safety behaviors in both groups.	
Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., Astbury, J., Taket, A., Feder, G., & Gunn, J. (2013). Screening and counseling in primary care settings for women who have experienced intimate partner violence (WEAVE): a cluster randomized control trial. *Lancet, 382*(9888), 249-258. doi:10.1016/s0140-6736(13)60052-5	To assess if brief counseling sessions, delivered by family practice physicians, would increase quality of life, safety planning and behaviors, and mental health of women experiencing IPV.	n=52 MDs & 272 patients MDs randomized s=PCS	Level III Cluster RCT	World Health Organization Quality of Life-BREF (QOL-BREF) Mental health score (SF-12) Questionnaire regarding safety plan Safety-Promoting behavior checklist	Brief counseling sessions delivered in PCS by MDs who received additional training regarding IVP (Healthy relationships training program)	Brief counseling sessions were not well attended QOL p=0.8 @ 6 months p=0.5 @ 12 months SF-12 p=0.46 @ 6 months p=0.15 @ 12 months More than 5 safety behaviors p=0.37 & p=0.52 @ 12 months Ever have safety plan p=0.57 @ 6 months p=0.03 @ 12 months	Brief counseling sessions by MDs did not improve QOL, safety behaviors, or overall mental health; safety plan development significantly increased with intervention group by 12 months. Additional research is necessary to identify interventions in PCS that improve safety behaviors, QOL, and mental health of patients experiencing IPV.

Citation	**Study Purpose**	**Pop (N)/ Sample Size (n) /Setting(s)**	**Level of Evidence/ Design** (Melnyk & Fineout-Overholt, 2015)	**Variables/ Instruments**	**Intervention(s)**	**Findings**	**Implications**
Jahanfar, S. (2014). Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews*, (11), doi:10.1002/14651858.CD009414.pub3	To examine the effectiveness and safety of interventions to decrease or reduce IPV against pregnant females in reproductive health clinic	n=3417 participants 10 studies included in review	Level I Systematic review	IV= interventions to prevent or reduce IPV DV= pregnant women experiencing IPV Current abuse score (CAS) Conflict tactics score (CTS)	Prenatal home visits Wallet-sized cards with listings of community IPV services Intensive advocacy Referral to social and psychological professionals Interactive, computer based-screening, education, and advocacy	Insufficient evidence to support interventions or reduce domestic violence against pregnant females Low-quality RCTs Lack of consistency of outcomes measured across studies	Additional research is needed to examine interventions to decrease violence and support safety interventions against pregnant women. Primary care providers are in an excellent position to implement safety interventions, studies examining interventions delivered in PCS and in collaboration with reproductive health and/or other advocacy specialists.
Miller, E., Tancredi, D. J., Decker, M. R., McCauley, H. L., Jones, K. A., Anderson, H., James, L., & Silverman, J. G. (2016). A family-planning clinic-based intervention to address reproductive coercion: a cluster-randomized control trial.	To examine the effectiveness of provider delivered interventions addressing reproductive coercion	n=3687 s=25 family planning clinics	Level II Randomized, controlled trial	DV: females experiencing reproductive coercion IV: Providers randomized to deliver ARCHES training, counseling, and referral to IPV advocate	Addressing reproductive coercion in health settings (ARCHES) training protocol Counseling sessions Referral to IPV advocate	Intervention group did not have significant reduction in reproductive coercion or IPV. No reduction in unintended pregnancies @ 12 months. Increased knowledge of IPV resources is significant ARR=3.48 (95 % CI) Intervention group reports greater self-efficacy following intervention AMD =0.06 (95% CI)	Research supports LARCs as an option to prevent reproductive coercion (RC). Primary care providers and reproductive clinicians should present this option to females in PCS and sexual health clinics. Research is needed to determine greater self-efficacy and supportive interventions to lessen RC.
Parker, E. M., & Gielen, A. C. (2014). Intimate partner violence and safety strategy use: frequency of use and perceived effectiveness. *Women's Health Issues*,	To examine the frequency women experiencing IPV report safety strategies and their effectiveness to	n=160-757 s=clinics, shelters, medical centers	Level I Systematic review	DV= females experiencing IPV IV=safety interventions	Referral to mental health provider or community-based agencies for IPV	Resistance strategies do not protect the victim and can increase the risk for harm	The research provides the clinician with information about how various individuals may behave in response to experiencing IPV. Safety of the women

Citation	Study Purpose	Pop (N)/ Sample Size (n) /Setting(s)	Level of Evidence/ Design (Melnyk & Fineout-Overholt, 2015)	Variables/ Instruments	Intervention(s)	Findings	Implications
24(6), 584-593. doi:10.1016/j.whi.2014.08.001	decrease the risk of reoccurrence of violence.			Safety strategy index (SSI) Community agencies assessment	Help from informal sources (family, friends) Help from formal sources (advocate, health care provider, police, clergy)	Seeking formal or informal sources (nurse, doctor, friend) for assistance is beneficial; mixed results of benefit from police or criminal justice system.	experiencing IPV is of uttermost importance, and further research is needed to support specific interventions for safety. Women should be informed that increased resistance can lead to increased harm.
Prosman, G., Wong, L. F., Römkens, R., & Lagro-Janssen, A. (2014). 'I am stronger, I'm no longer afraid…', an evaluation of a home-visiting mentor mother support programme for abused women in primary care. *Scandinavian Journal of Caring Sciences, 28*(4), 724-731. doi:10.1111/scs.12102	To evaluate factors of mother-mentoring programs for women who are abused	n=14 s=PCS	Level V Qualitative study		Structured interviews to examine the lived experience of living with IPV and mentoring mother home visit interventions Mentor support program (MeMoSA)	Non-judgmental listening, equivalence, bonding, building trust, and providing individualized support and advocacy are themes conceptualized from the interviews	Patience and involvement Of mentoring mothers creates relationships of trust that are often broken in women with IPV. Referral program may be initiated in PCS to support women experiencing IPV and increase feelings of security.
Rivas, C. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews*, (12). doi:10.1002/14651858.CD005043.pub3	To assess the effects of advocacy interventions in or outside of healthcare settings in women who experience IPV	n=2141 13 trials s=community shelter, antenatal, health care clinics	Level I Systematic review	6 forms of abuse scale 3 QOL scale 3 depression scales	Intensive advocacy interventions (30-80 hours)	Moderate short-term benefit of QOL and decreased physical abuse; small short-term benefit in mental health (decreased depression) Net benefit of advocacy is uncertain Setting benefit is uncertain	Advocacy interventions provide benefit to increase QOL, therefore it is important that advocacy is delivered consistently and over longer periods of time than studied previously. Additional research is needed to examine the setting delivery benefit of advocacy and the long-term outcomes of extended support systems for women experiencing IPV.
Taft, A. J., Hooker, L., Humphreys, C., Hegarty, K., Walter, R., Adams, C., & ... Small, R. (2015). Maternal and child health nurse screening and care for mothers experiencing	To assess maternal-child health (MCH) nurse led intervention model to screen, seek disclosure, provide	n=1269 8 MCH teams (nursing and patients)	Level II Non-randomized, controlled study.	IV: nurse led screening and interventions for IPV DV: women experiencing IPV	Improving maternal and child healthcare for vulnerable adults (MOVE) intervention	Design demonstrates increased safety planning over 36 months	Nurse led screening and initial care after disclosure of IPV demonstrates increased safety of mother and child through increased participation in safety planning over a period of 3

Citation	Study Purpose	Pop (N)/ Sample Size (n) /Setting(s)	Level of Evidence/ Design (Melnyk & Fineout-Overholt, 2015)	Variables/ Instruments	Intervention(s)	Findings	Implications
domestic violence (MOVE): a cluster randomized trial. *BMC Medicine*, *13*(1), 150. doi:10.1186/s12916-015-0375-7	safety planning, and referrals for women experiencing IPV.	4 control groups 4 intervention groups s=reproductive health clinic					years. Implementing the nurse-led model should be examined in PCS in future studies for applicability.
van Rosmalen-Nooijens, Karin A. W. L., Wong, L. F., Prins, J. B., & Lagro-Janssen, A. (2017). The need for control, safety, and trust in healthcare: a qualitative study among adolescents and young adults exposed to family violence. *Patient Education and Counseling*, *100*(6), 1222-1229. doi: 10.1016/j.pec.2017.02.008	To gain understanding of the health care needs of young adults exposed to violence.	n=12 s=various, participant's choice	Level V Qualitative study	NA	Semi-structured face to face interviews	Themes include difficulty with trusting others, mental health concerns, ongoing feelings of lack of safety. All participants were interested in help to cope, some felt responsible for the IPV, and felt that seeking help would be disloyal to the family, thus help was not sought.	Clinicians gain an understanding of the lived experience of IPV for young adults through qualitative study. Providing time to allow disclosure, expression of emotions, and building relationships and trust are factors that can support young adults with IPV.