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Evaluation of the Short-Time Empowerment Intervention Package of the Ministry of Health and Medical Education of Iran to Reduce Domestic Violence

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Abstract

Background: Domestic violence is any act to gain authority and control over a spouse, intimate partner, girlfriend/boyfriend, or close family member. Domestic violence against women or intimate partner violence (IPV) is prevalent in many parts of the world, ranging from 15% to 75%, depending on the definition and perception of violence.
Objectives: This study aimed to evaluate the effectiveness of the short-time empowerment intervention package for women with domestic violence developed at the Ministry of Health and Medical Education in Tehran.
Methods: The method of this study was a historical cohort. The researcher-made tool consisted of 30 questions based on the materials contained in the short-time empowerment intervention package. It was provided to 200 women referred to comprehensive healthcare centers who had previously been screened for domestic violence. Of these, 100 people in the experimental group received telephone intervention from a psychologist, and 100 people in the control group received telephone intervention without receiving the intervention. They were asked questions about the tool.
Results: The results showed that there were no significant differences between the two groups of women with intervention and women without intervention in 5 areas of safety capabilities, recognizing high-risk situations, designing strategies to deal with high-risk situations, skills to deal with spouse anger, reduce anxiety and stress for themselves and their children ($P > 0.05$).
Conclusions: The findings indicate that the short-time empowerment intervention package for women with domestic violence could not empower women to prevent the recurrence of violence and needs revision.

Keywords: Effectiveness, Empowerment, Domestic Violence

1. Background

Domestic violence is any act to gain authority and control over a spouse, intimate partner, girlfriend/boyfriend, or close family member (1). According to the World Health Organization (WHO), over 30% of women worldwide have suffered physical or sexual assault (2). Domestic violence against women or intimate partner violence (IPV) is prevalent in many parts of the world, ranging from 15% to 75%, depending on the definition and perception of violence (3). In Iran, 66% of women have been targeted by violence at least once since the beginning of their life together (4). This violence is a global issue because of the direct and indirect expenses and burden on the family and the community. Women subjected to violence throughout their lives are more likely to suffer from depression, anxiety, mental illnesses, post-traumatic stress disorder (PTSD), and suicide than women who have not been abused (5, 6). In public health prevention science, there are three types of intervention: primary prevention, which aims to prevent violence before it happens; secondary prevention, which deals with the immediate response to violence; and tertiary prevention, which addresses long-term care after violence has occurred (7).

WHO defines empowerment as the process by which individuals gain more control over decisions

and behaviors that affect their well-being. In fact, in this process, people dominate their lives and social and political environment, which may be in cultural, social, and political forms (3). Iran's primary health care system begins with the client's referral to a health technician (HT), who performs an initial screening assessment to assess the client's health status (mental and physical). In cases where the initial screening for IPV is positive, the patient is referred to a psychologist at the health center afterward; if the psychologist's supplementary evaluation confirms IPV, the psychologist will provide empowerment services to women victims of IPV at this level. Women's empowerment within the face of IPV in the primary health care (PHC) system in Iran is "the short-time empowerment intervention" package that refers to a woman's ability to form decisions about her life and improve her (and her children's) physical and psychological state. In this package, the aim of intervening in domestic violence is to assist people to get out of the role of victim and gain inner strength to resist being a victim; in other words, this package considers the empowerment of women dependent on two factors: providing security for themselves (and children) against domestic violence and using the supportive and social assets accessible in society (8).

Several intervention studies for women subjected to violence have been conducted. Some of such research has focused on social support, aiming to mobilize support resources and reduce the harmful consequences of violence (9, 10). Stover et al. (11) conducted a home visit intervention and discovered that participants used more court-based and mental health services. In this meta-analysis, primary healthcare interventions in violence against women were examined, and the results showed that primary care interventions of violence against women had positive results (12).

2. Objectives

We need to examine the effectiveness of the short-time empowerment intervention package used to prevent domestic violence against women through their empowerment to determine the best practices. This research aimed to evaluate the effectiveness of the short-time empowerment intervention package for women with domestic violence developed at the Ministry of Health and Medical Education in Tehran, Iran. Therefore, national mental health programs must be reviewed regularly in light of changes and developments in society, and these reviews should be based on the results of evaluating existing programs, assessing the state of society and its requirements, and predicting conditions and potential needs in the future.

3. Methods

3.1. Participants and Data Collection

In this study, which was structured based on a historical cohort and followed the STROBE cohort reporting guidelines (13), the sample size calculation method was based on a similar cohort study (14). Two hundred people were included, and the research sampling method used available samples. The samples included women previously referred to the health centers (HC) whose screening was positive for domestic violence. Those who participated in the empowerment intervention for 2-3 sessions from July to December 2021 were the exposed group (n = 100), and the women who did not attend intervention sessions consisted of the non-exposed group (n = 100). Subsequently, after receiving their telephone numbers and securing their trust, they were contacted, and the questions were asked in the psychologist's room. This process was carried out for two months; at most, 6 months had passed since receiving their intervention. The questionnaire was filled out in January and February 2022.

The inclusion criteria included women screened positive for domestic violence and referred to the center's psychologist. Among them, those who received domestic violence intervention from the psychologist for at least two sessions and less than six months had passed since their intervention sessions were included in the intervention group. Women who did not participate in these interventions for any reason after they were screened positive for domestic violence were included in the control group. The exclusion criteria of this study included more than six months of receiving the domestic violence empowerment intervention, receiving only one session of this intervention, and marital divorce. There were no missing participants based on the historical cohort design, but it was mentioned in the manuscript.

3.2. Measurement Tool

As a measure of this study to assess the tool, a researcher-made evaluation tool based on the main axes and necessities of the "Empowerment Intervention of Violence against Women" of the Ministry of Health was prepared with 30 questions. Ten questions were related to the demographic variables, and 20 questions were

Table 1. Determining the Content Validity (CVI and CVR) of the Tool by Method

Question	CVR	CVI	Question	CVR	CVI
1	1	1	11	1	1
2	1	1	12	0.8	0.9
3	0.8	0.8	13	1	1
4	0.8	0.8	14	1	1
5	1	1	15	1	1
6	0.8	0.8	16	1	1
7	1	1	17	1	1
8	1	1	18	1	1
9	1	1	19	1	1
10	1	1	20	1	1

related to study variables, which included (1) the Power to recognize high-risk situations during the husband's anger and abuse, (2) the Power to deal with high-risk situations during the husband's anger and abuse, (3) power to deal with husband's anger and abuse, (4) power to reduce worries and anxiety about oneself and children and (5) safety measurement is designed. In the tool's design, we tried to use the same content in the domestic violence package. Also, due to the summary of the prevention of domestic violence in the five mentioned areas, the questions of this tool were specifically in these areas. The method of answering the questions was compiled as a Likert scale. To determine the validity of this tool, two methods of qualitative and quantitative content validity were used. After collecting expert evaluations, the required changes in the tool were considered. Content validity was quantitatively calculated based on the opinions of experts by calculating two content validity indexes (CVI) and content validity ratio (CVR) indexes (15). Thus, to calculate the validity of the researcher-made tool for this study, ten professors and experts in the mental health field at the Faculty of Behavioral Sciences and Mental Health of Iran University of Medical Sciences were given CVR and CVI tables. The calculation of their opinions indicated that this tool had an acceptable CVR and CVI in validity assessment, as demonstrated in Table 1. Then, to achieve the reliability coefficient of this tool, Cronbach's alpha method was utilized, resulting in a coefficient of 0.818 (16).

3.3. Data Analysis

Descriptive and inferential statistical methods were used. More specifically, the distribution frequency of the variables and the mean and standard deviation of the quantitative variables were estimated. The chi-square test was used to compare the frequency of variables in the two groups. To compare the means of variables in both groups, an independent *t*-test was utilized. Statistical significance was set as $P < 0.05$. The data were analyzed using SPSS software version 22.0.

4. Results

The study results showed that undergraduate and diploma had the highest frequency in both study groups. Also, more than 80% of the study population in both groups were housewives. More than 60 percent of the people in both groups in Nice were traditionally married, and more than 70 percent had no physical illness. In general, based on the results of Table 2, no significant differences were observed between demographic characteristics in qualitative variables and intervention and control groups ($P > 0.05$).

Table 3 also compares the characteristics of quantitative variables, including mean age, age of marriage, and the duration of marriage in the two groups. Based on the study's results, no significant difference was observed between the means of quantitative variables in the intervention and control groups ($P > 0.05$).

Table 4 determines and compares the mean of study variables, including (1) power to recognize high-risk situations during the husband's anger and abuse (PRS), (2) power to deal with high-risk situations during the husband's anger and abuse (PDS), (3) power to deal with husband's anger and abuse(PDH), (4) power to reduce worries and anxiety about oneself and children(PRW) and (5) safety measurement (SM) is designed in 2 groups of intervention and control. As the results of Table 4 show,

Table 2. Determining and Comparing the Demographic Characteristics of the Subjects in the Two Groups of Intervention and Control

Qualitative Variables and Sub-scales	Intervention Group, No. (%)	Control Group, No. (%)	P-Value [a]
Education			0.49
High school	5 (5)	6 (6)	
Diploma	30 (30)	36 (36)	
Bachelor	57 (57)	50 (50)	
Masters	8 (8)	6 (6)	
PhD	0	2 (2)	
Job			0.17
Housewife	86 (86)	80 (80)	
Employee	14 (14)	17 (17)	
Self-employed	0	3 (3)	
Type of marriage			0.65
Traditional	69 (69)	66 (66)	
Modern	31 (31)	34 (34)	
Number of children			0.8
0	5 (5)	5 (5)	
1	47 (47)	51 (51)	
2	33 (33)	28 (28)	
3	14 (14)	13 (13)	
4	1 (1)	3 (3)	
Physical illness			0.5
Yes	26 (26)	22 (22)	
No	74 (74)	78 (78)	
Taking medication			0.17
Yes	27 (27)	19 (19)	
No	73 (73)	81 (81)	

[a] $P < 0.05$

Table 3. Determining and Comparing the Demographic Characteristics of the Subjects in the Two Intervention and Control Groups

Quantitative Variable	Intervention Group, Mean ± SD	Control Group, Mean ± SD	P-Value [a]
Age	39.34 ± 7.8	38.47 ± 7.4	0.42
Marriage age	23.79 ± 4.74	22.93 ± 4.48	0.18
Duration of marriage	15.37 ± 9.71	15.56 ± 9.79	0.89

[a] $P < 0.05$

Table 4. Determining and Comparing the Mean of Study Variables in the Two Intervention and Control Groups

Variables	Intervention Group, Mean ± SD	Control Group, Mean ± SD	P-Value [a]	Maximum/Minimum Scores
PRS	13.12 ± 2.7	12.23 ± 2.7	0.77	Max: 20, min: 4
PDS	8.53 ± 1.9	7.46 ± 1.8	0.69	Max: 15, min: 3
PDH	8.07 ± 1.87	7.87 ± 1.8	0.25	Max: 15, min: 3
PRW	14.8 ± 2.2	13.69 ± 2.3	0.13	Max: 21, min: 4
MS	13.6 ± 2.5	12.97 ± 2.2	0.48	Max: 21, min: 4

[a] $P < 0.05$

no significant difference was observed in the mean of the variables between the intervention and control groups ($P > 0.05$).

5. Discussion

This study was the first to evaluate the effectiveness of the short-time empowerment intervention package for women with domestic violence. Our study results revealed that women who received the short-time domestic violence empowerment intervention package, in the measures of power to recognize high-risk situations during husband's anger and abuse, power to deal with high-risk situations during husband's anger and abuse, power to deal with husband's anger and abuse, power to reduce worries and anxiety about oneself and children and safety measurement were not different from the control group. These results were obtained when there was no significant difference between the intervention and control groups regarding demographic variables ($P > 0.05$). This means that this study successfully matched the characteristics of the samples.

In teaching the recognize high-risk situations during a husband's anger and abuse, it can be contended that the respondents in both groups gave a high score on the Likert scale to the questions associated with this variable, meaning that women with experience of domestic violence knew in what conditions, situations, and issues their husbands would become angry and commit violence, and the more they lived together, the more familiar they were with these situations. They could better predict their husbands' violence. Ørke et al. (17) claims that victims of IPV are less likely to infer violent situations than women who have not experienced domestic violence, which can be a risk factor for a return to domestic violence. This finding contradicts the findings of the current study. The results of the Petersson and Thunberg (18) study, on the contrary, revealed that IPV victims' perceptions of the likelihood of violence can be a reliable predictor of how to stop its recurrence.

The psychologist advised clients that the best course of action was to avoid arguing with an angry husband and leave a violent scenario to gain the power to manage high-risk circumstances during the husband's anger and abuse. Surprisingly, however, the women in the intervention group and those in the control group were the same for this characteristic. According to certain studies, partnerships with other women who had experienced abuse could help them manage high-risk domestic violence situations more efficiently (19). The psychologist gave the women the tools to deal with the husband's rage and abuse, which has been shown in certain studies to be effective (20, 21). Additionally, it appears that the short-term intervention package for the empowerment of women with IPV should be changed to incorporate factors such as self-esteem, self-efficacy, and women's decision-making capacity that positively influence the empowerment of women with domestic violence (22, 23). The guidelines in this package were ineffective in decreasing women's anxiety, even though some research emphasized the usefulness of reducing stress and anxiety symptoms and preventing the recurrence of domestic violence against women (24, 25). Finally, the results demonstrated that developing a safety plan in violent situations and giving women physical and psychological safety training were ineffective uses of the short-term intervention package empowering IPV. Lynch et al.'s study (26) found that adopting a suitable safety plan was the best approach for women who had been victims of domestic abuse.

The health system's organizational structure, the implementation method, or the domestic violence intervention package's content in the variables under study may have contributed to the observed lack of effectiveness. First, the focus of domestic violence interventions should shift from preventing its recurrence

to preventing its occurrence. The structure of mental health should include prevention of the first type and the application and follow-up of domestic violence interventions against women. Additionally, the provision should be broadened during the implementation of this package rather than being confined to health centers. This becomes crucial when vulnerable women look for support and assistance. Psychologists' comments and recommendations should be considered and implemented because they may assist women more significantly than only as psycho-social educators. Furthermore, the package's content should determine the group of women it is intended for because those in danger of domestic violence need longer and more comprehensive interventions. This demonstrates the need for continuous assessment of national mental health programs.

5.1. Research Limitations and Prospects

This study had some limitations. First, the samples of this study were from only one city in Iran (Tehran). They were selected only from health centers under the supervision of the Iran University of Medical Sciences. Second, the sensitivity of the domestic violence issue and the prevalence of COVID-19 prevented information collection through face-to-face meetings. Among them were the fear of disclosing information, refusal to answer, and non-cooperation of the samples, the presence of the phone number belonging to the person's husband instead of the subjects' phone number, the low number of domestic violence cases in some health centers, and the possibility of missing and falling of the samples, especially in the control group, who had refused the intervention in the past. Third, this study examined the empowerment intervention package for women with domestic violence only in terms of the content variables, and it is necessary to examine the structure and inventory system in which this package is implemented. Future studies should be conducted to investigate the mental health system in the field of domestic violence against women, focusing on the prevention of the first type. Also, further studies are warranted to increase the reliability of our findings, such as randomized controlled trial studies. Moreover, it is suggested to conduct qualitative studies on domestic violence to identify its causes.

5.2. Conclusions

The results of the current study indicated that a short-time empowerment intervention package for women with domestic violence, which includes the variables of "feel of safety", "recognize high-risk situations during husband's anger and abuse", "designing strategies to deal with high-risk situations during husband's anger and abuse", "power to deal with husband's anger and abuse" and "power to reduce worries and anxiety about oneself and children" was not effective in empowering women victims of domestic violence who referred to Tehran health centers for domestic violence. The mental health program for abused women should be given more support. Instead of providing abundant psychosocial education in the brief domestic violence empowerment intervention package to provide empathy for women suffering, encouraging them to join empowerment and designing related programs seems effective. Future well-designed intervention studies can provide better evidence for the effectiveness of the empowerment program.

Footnotes

Authors' Contribution: N. Memaryan conceived and designed the evaluation and drafted the manuscript. F. Taaki participated in designing the evaluation, performed parts of the statistical analysis, and helped draft the manuscript. F. Taaki re-evaluated the data, performed the statistical analysis, and revised the manuscript. F. Taaki collected the data and interpreted them. N. Memaryan re-analyzed statistical data and Sh. Ghahhari, M. Lotfi revised the manuscript. All authors read and approved the final manuscript.

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