# Public Stigma toward Women Victims of Intimate Partner Violence: A Systematic Review

(SUBMITTED* VERSION FOR PUBLICATION IN AGGRESSION AND VIOLENT BEHAVIOR)

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*Note that this version may have mistakes and things that were changed afterwards for the published version. Contact author for published manuscript: lmurvartian@us.es

## Highlights

- Public stigma towards women victims of IPV is a barrier for the recovery and liberation process of violence.
- Certain societal norms and perceptions were associated with stigmatizing responses such as victim-blaming or the minimization of the abuse.
- Nondisclosure of violence and not seeking help were the most studied consequences of stigma.
- Future research should continue to explore the factors that explain this stigma in more detail and the associations between them.
- Further efforts should be made to educate and raise awareness among the population, including service providers, for which the recommendations against stigma presented in this systematic review may be useful.

## Abstract

Public stigma towards women victims of intimate partner violence (IPV) has been proven to undermine their recovery. However, research on this topic is still recent. This systematic review aimed to analyze the way this stigma was studied, how stigma operates and to identify priority actions to combat it. Searches for peer-reviewed articles published between 2010 and 2021 were conducted in six databases. The articles selected were limited to empirical studies in English, in which participants resided in high-income countries and providing results on public stigma towards women victims of IPV. A total of 29 articles were included. Stigma was normally not the primary focus of the studies, most articles did not drew upon any stigma theoretical model to contextualize their findings and qualitative methodologies predominated. We summarized a series of components explaining the stigma functioning through an explanatory model including: social norms and perceptions, public stigmatizing responses and its consequences for victims. Factors such as ethnicity increased or decreased the stigma. Not disclosing the abuse and not looking for help were the most frequently mentioned consequences. Only one intervention and a few strategies to reduce the stigma were identified. Implication of these findings for research and practice were discussed.



*Keywords:* public stigma; intimate partner violence; women; recovery; disclosure; help-seeking

## 1. Introduction

Intimate partner violence (IPV) is a global problem that refers to physical aggression, controlling behavior, sexual coercion, and/or psychological abuse directed toward an intimate (ex)partner, causing physical, sexual, or psychological trauma (World Health Organization [WHO], 2021). Twenty-seven percent of women between the ages of 15 and 49 who have been in an intimate relationship report they have suffered physical and/or sexual IPV (WHO, 2021). This can have direct negative consequences for women's physical, mental, and reproductive health, indirect adverse health effects for the women's children, as well as social and economic costs for families and societies. In this study, we focus on IPV defined as violence perpetrated by a man against a woman who is/was his partner.

Society plays a very important role in the prevention of IPV and in women's abilities to end their abusive relationships and recover from them (WHO, 2021). A multitude of factors influence and determine women's decisions and opportunities regarding leaving their partners. Apart from individual (e.g., financial dependence) and interpersonal (e.g., the need to protect their children) aspects, community-oriented (e.g., social support) and sociocultural (e.g., social norms about women's roles in a relationship) forces are involved in this process (Barrios et al., 2020; Pokharel et al., 2020). However, IPV is still often considered exclusively a problem attributed to the individual or the couple (Moncó, 2011, p. 218-219). Given the importance of society in women's help-seeking actions and recovery, a systematic review was conducted of the public stigma faced by IPV victims.

### *1.1. Stigma about IPV*

Stigma has been defined by several authors in terms of sociology and social psychology. For instance, Goffman's influential theory of stigma (1963) described stigma as a mark of failure and shame that damages one's normal identity. Link and Phelan (2001) added that stigma is the result of power which is exerted to label and stereotype the

stigmatized, leading to social separation, loss of status, and discrimination. Pescosolido and Martin (2015) highlighted the complexities in how stigma functions, arguing stigma can only be explained in light of interrelated multilevel factors (individual and societal) and processes (biological, geographical, and historical). In this respect, they draw attention to the general lack of studies about stigma's feedback loops and interconnected components and processes (Pescosolido & Martin, 2015). Applications of the concept of stigma to the context of IPV are still recent.

To our knowledge, the first explanatory theory or model of IPV to explicitly include and explore the constituent components of stigma is the one proposed by Overstreet and Quinn (2013). They asserted that being labeled as a "victim" of IPV constructed an image of them being responsible for the abuse and exhibiting passivity and weakness. This social construction would lead to "victims" being blamed, discriminated against, and isolated, among other responses, by society. The authors presented three types of stigma: cultural stigma (where society invalidates victims' IPV experiences and respective individual and interpersonal consequences occur), internalized stigma (where victims endorse stigmatizing views about themselves), and anticipated stigma (where victims apprehend negative reactions from others who are likely to find out about their abuse). Murray et al. (2018) recently validated the integrated IPV stigmatization model, in which different types of stigma emerge from the combination of components and sources of stigma. The sources are based on the three types of stigma proposed by Overstreet and Quinn, to which Murray et al. added another two: enacted stigma (women victims' experiences where they felt they were the target of discrimination and prejudice from others) and perpetrator stigma (actions from the abuser that perpetuate IPV stigma, such as isolating the victim or making her feel ashamed). Negative beliefs, attitudes, and behaviors toward women who experience IPV – by virtue of

the fact that they experience IPV – constitute public stigma; this is the stigma we examine in this review.

Murray et al. (2018) initially included some components of stigma from existing literature and previous research findings in their IPV stigmatization model: “blame” (being held responsible for the abuse), “shame” (being treated in a way intended to cause humiliation or distress), “discrimination” (being treated differently or judged), “loss of status” (not being valued as more powerful than or equally powerful to others who do not experience abuse), “isolation” (being ostracized by others), “dismissal/denial” (facing issues where they are not believed, their abuse is downplayed, or others “look the other way”), and “blatant unprofessionalism” (receiving responses that are unethical or against victims’ rights to competent care). They finally decided to reduce the number of components to five: “blame”, “isolation”, “negative emotions” (including shame and other painful emotions), and other components that are not captured in the principal ones.

It is worth noting that blame (self-blame and other blame), contrary to isolation and loss of status, as a component of stigma leading to poor mental health and difficulty in seeking help, has been extensively studied, which Murray et al. (2018) found to be the most common in their sample in the United States. Although the present study focuses on public stigma, it cannot be overstated that different sources of stigma are always interrelated. For instance, public stigma leads to its internalization, and internalized and anticipated stigma reinforce, and otherwise give feedback to each other (Murray et al., 2018; Pescosolido & Martin, 2015).

*1.2. Public stigma on IPV research and importance*

Further research on public stigma is needed. First, stigma influences the types of sanctions used against perpetrators, help-seeking by the victim, and third-party responses (Crowe & Murray, 2015). Therefore, intervention tactics mitigating public stigma must be

developed, and sensitive assessment instruments should be designed to identify and screen for stigma and develop and evaluate interventions to mitigate it. To date, the only measurement instrument for stigma on IPV is the Intimate Partner Violence Stigma Scale (Crowe et al., 2021). However, it is still being validated and does not focus on public stigma, directing its attention only toward internalized, anticipated, and perpetrator stigma and isolation.

*1.3. Current systematic review of the literature*

Beliefs and attitudes toward IPV have been widely studied in the last few years (Ferrer-Pérez et al., 2019; Gracia et al., 2020); however, they represent a part of stigma and leave out other behavioral components (Maticka-Tyndale & Barnett, 2020). To our knowledge, only two systematic reviews have been conducted that included (limited) information about public stigma on IPV. One of them strictly focused on samples of women victims from the United States (Kennedy & Prock, 2018). Blame, dismissal/denial of the abuse, and discrimination against victims were identified from professionals (court personnel, medical staff, and mental health providers) and social networks. Further, the negative consequences of stigma on mental health were also mentioned. The other review analyzed barriers to seeking help in the context of intimate partner sexual violence (IPSV) and found that social stigma involving the normalization of IPSV and isolation in rural communities prevented help-seeking. Selected studies from that review were carried out in the United States (Wright et al., 2021).

In this systematic review, we focus on studies conducted in high-income countries (as classified by the World Bank, 2021) addressing public stigma of women victims of IPV. The focus on studies from high-income economies ensures a manageable sample size and reflects the fact that most existing studies on public stigma have been carried out in these contexts. It also follows conventions of other global studies on IPV which classify results similarly in

large income groups for analytical purposes (WHO, 2021). Further to these pragmatic reasons, we focus on studies from high-income countries because prior research indicates trends in predictors and risks of IPV for women living in low- and middle-income countries to high-income countries (Coll et al., 2021). McDougal et al. (2019) suggest that women's financial status and autonomy may influence experiences of IPV, public stigma, and help-seeking pathways. Thus, there is analytical value in narrowing the scope of this review to studies carried out in high-income countries despite the significant heterogeneity that exists in average individual and household income levels within and across high-income countries.

### *1.4. Research questions*

Taking all of this into consideration, the research questions for this systematic review are framed as follows:

RQ1) How has public stigma towards women victims of IPV been studied?

a) Did stigma have a central or secondary role in the studies?

b) What theoretical models of stigma do the studies draw upon to contextualize their stigma findings, if any?

c) How has stigma been measured?

RQ2) How does public stigma toward women victims of IPV operate?

RQ3) How can we end this stigma?

## 2. Methods

This review was undertaken following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) recommendations (Moher et al., 2015).

### *2.1. Search strategy*

Searches for peer-reviewed journal articles covering the period between January 2010 and June 2021 were conducted in six databases: Web of Science, Scopus, PsychINFO, PUBMED, Dialnet, and the Cochrane Database of Systematic Reviews. Titles, abstracts, and

keywords were searched for the following phrases: (stigma* AND (“partner abus*” OR “partner aggress*” OR “intimate partner violen*” OR “intimate violen*” OR “intimate terrorism*” OR “domestic violen*” OR “domestic abus*” OR “domestic violen* offen*” OR “violen* relation” OR “violen* between parent*” OR “violen* between partner*” OR “partner violen*” OR “spous* abus*” OR “battere*” OR “violen*against wom*n” OR “marital violen*” OR “marital abus*” OR “husband* abus*” OR “dating violen*” OR “family violen*” OR “situational violen*” OR “abus* relation*” OR rape OR “sexual violen*” OR “sexual agress*” OR “sexual abus*” OR gender NEAR/3 violen*). Four terms related to sexual violence were included because sexual violence is sometimes referred to in the context of an intimate relationship.

*2.2. Eligibility criteria*

The inclusion criteria for the selection of studies were as follows: 1) English texts; 2) findings on public stigma toward women victims of IPV perpetrated by a man who is her (ex)partner; 3) empirical research; 4) participants over the age of 11 when they were victims of IPV; 5) samples from high-income countries; and 6) for quality control, published in peer-reviewed journals.

Studies were excluded when 1) texts were not in English; 2) they did not report findings on public stigma toward women victims of IPV perpetrated by a man who is her (ex)partner; 3) they were not empirical studies (e.g., scoping reviews); 4) study participants who were victims of IPV were under the age of 12; 5) samples were not from high-income countries; and 6) they were not published in peer-reviewed journals. Note that with regard to the second criterion listed above, for example, stigma was only mentioned in the introduction section; it also featured in the texts as other types of violence, such as sexual violence that was not perpetrated by an (ex)partner or violence in war conflicts, as well as other types of stigma, such as internalized stigma.

In addition, regarding eligibility, the samples of the studies included in our review could be composed of victims, professionals, family members, and community samples, among other sources, as long as stigma directed at victims by society was evidenced in some way (e.g., professionals talking about the stigma they believe exists, victims expressing the stigma they suffered from others, and so on). However, on the contrary, victims expressing internalized stigma of their own is another type of stigma and falls outside our inclusion criteria; examples of this could be the shame, guilt, and other negative emotions they felt. It is essential to clarify that this is referred to as "internalized stigma". Second, those samples composed of victims that included a small percentage of men were not excluded because eliminating the study if it had a high representation of women victims could mean relevant loss of information on the study topic.

After the deletion of duplicates, titles and abstracts were screened for the above criteria by two reviewers: ML (principal investigator) and SJ. The same reviewers independently analyzed the full texts of the remaining articles. In both stages, ML reviewed 100% of the results, and SJ reviewed a randomly assigned subset constituting 30% of the total, which exceeded the recommended minimum of 20% (Ojeda & Del-Rey, 2021). Following this, disagreements in both cases were discussed with a third reviewer (DC), and consensus was reached.

*2.3. Data extraction*

Data were extracted with a standardized spreadsheet by ML and reviewed by SJ. Data collected included author(s) name(s), year of publication, journal, predominant country where participants lived, aim of the study, sample(s), type of study (cross sectional, longitudinal, qualitative, and so on), stigma role in the study ("central role" when stigma was relevant in the focus of the study or "secondary role" when it was not so relevant or not mentioned in the

focus of the study), stigma theoretical model, stigma measurement, findings on how stigma operates, and actions to combat stigma.

*2.4. Data analysis and data reduction*

Relevant excerpts from the articles were selected to answer RQ2 on how stigma operates and RQ3 on how to combat stigma. The excerpts were coded, and a series of themes and subthemes were elicited directly from the data using techniques of content analysis (Prior, 2020). For RQ2, the extracts were also coded based on the seven components of IPV stigma proposed by Murray et al. (2018), described above. Therefore, seven subthemes—"blame", "discrimination", "loss of status", "isolation", "shame", "dismissal/denial", and "blatant unprofessionalism"—were included under the theme "stigmatizing reactions". We chose these components instead of the five in the authors' final proposal because they were more precise. Associations between themes on how stigma operates were then explored. All themes and subthemes extracted from reading the selected articles were agreed on by ML and SJ. First, they were extracted individually by each team member. Then, through analysis and discussion, the themes and subthemes were confirmed and redefined if possible or eliminated. This process was repeated until the analysis yielded no new relevant information.

*2.5. Quality assessment*

The Mixed-Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018) was used to assess the methodological quality of the studies selected because it is designed for the appraisal of qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed-methods studies. It consists of two previous screening questions and five criteria that should be met. A total score is discouraged, and therefore, detailed information about which criterion is met and not met is then provided. Quality assessment was done by ML and reviewed by SJ. As explained above, reliability was calculated from the full-text review of articles by researchers ML and SJ.

## 3. Findings

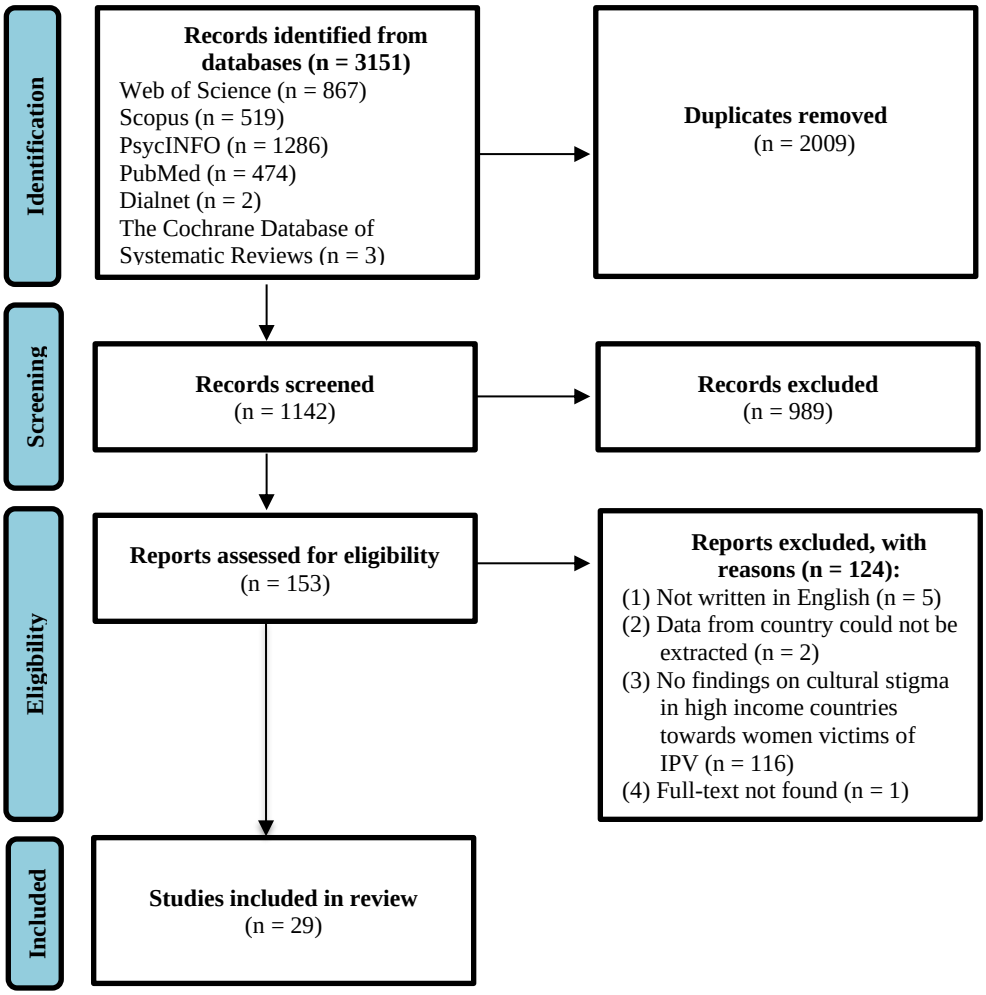
The results, according to our objectives, are shown below.

### *3.1. Study selection*

The database searches resulted in 1142 non-duplicate citations. Figure 1 presents the PRISMA selection process flowchart. The interrater reliability for the assessment of the eligibility of 30% of full-text screened studies was .72 (Cohen's k). The reviewers disagreed on seven studies, and this was discussed until a consensus was reached. Finally, 29 articles met the criteria and were included in this systematic review. All the references of these articles were scanned, but no other new relevant studies were found.

**Figure 1.**

*PRISMA flowchart for the inclusion process.*



*3.2. Study characteristics*

Table 1 provides a detailed description of study characteristics, and only the major points are discussed here. Research on the topic of our systematic review has gradually been increasing over the years; 13 of the articles included were from the last two years (2020–2021). Furthermore, 16 studies were composed of only victims, six of which included a small percentage of men victims of IPV; the rest were women victims only. Six studies included professionals who provided some type of support or care for women (healthcare providers and VAW shelter professionals, among others). Six studies included community samples, two of which were adolescents. Out of a total of 17 items that included victims, there is evidence that 13 self-identified with various races or ethnicities. One study included women victims, men, and professionals; another included women victims and non-victims and professionals. In relation to the country in which the sample participants lived, the USA was the most frequent, followed by other countries, as shown in Table 1.

Three of the studies had mixed-methods designs, 22 were qualitative, and four were quantitative. Although the MMAT tool found some of them had certain methodological weaknesses, they were not eliminated since all of them reached acceptable or high-quality standards. The aspects that showed lower quality were diverse. In qualitative studies, the analysis procedure was sometimes not explained in detail. In quantitative analyses, on the other hand, on some occasions, there were problems with the sample, either related to representativeness or an inadequate explanation of participant selection criteria. The aims of the studies varied, including the analysis of barriers to recovery and recommendations against stigma, among others (Table 2).

*3.3. Ways of studying stigma*

Regarding the role of stigma in the included studies, this appeared to have a secondary role in 22 studies and a central role in seven. Among these seven studies, some

focused on 1) defining the nature and components of IPV stigma (Crowe & Murray, 2015; Murray et al., 2018; Murray et al., 2015), 2) the relationship between stigmatizing reactions to disclosure and depressive symptoms (Overstreet et al., 2019), 3) the stigma from professional helpers (Crowe & Murray, 2015; Nikolova et al., 2021), and 4) presenting recommendations (Murray et al., 2016) or an evidence-based intervention to fight stigma (Mason et al., 2017) (Table 1).

In relation to theoretical models of stigma that the included studies drew upon to contextualize their stigma findings, we found that only 12 grounded their study in models about stigma and 17 did not. The IPV stigmatization model by Overstreet and Quinn (2013) was the most popular (N = 5), followed by Goffman's (1963) theory of stigmatized identities (N = 4), Link and Phelan's (2001) conceptualization of stigma (N = 4), and Murray et al.'s (2018) proposal of sources and components of stigma in IPV (N = 4) (Table 1).

Third, according to the way stigma was measured, most of the methods used were qualitative. The most popular techniques were interviews (N = 16) (six in-depth and 10 semi-structured) and focus groups (N = 8). These were followed by surveys (N = 5), content analysis of tweets (N = 1), Delphi (N = 1), participant observations (N = 1), and non-participant observations (N = 1). Among the very few validated quantitative instruments were the "Social Reactions Questionnaire" (SRQ; Ullman, 2000) for sexual assault adapted to IPV (N = 1) and the "Modified Rape Myth Acceptance Scale" (RMA; Payne et al., 1999) (N = 1) for measuring stigmatizing reactions. One study contained five items designed by the authors to measure social distance (Table 1).

**Table 1.**

*Main characteristics of studies included in the present systematic review.*

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| Tarshis (2020) | Find barriers and facilitators in employment-seeking for victims of IPV. | USA. Employment-seeking women victims of IPV. N=16. Mean age: 36 (SD = 7.6). - Purposive sampling. | White; 31.25%; African American, 25%; South Asian, 12.5%; Latin-American, 12.5%; Arab, 6.25%; East Asian, 6,25%; mixed/other, 6.25%. 37.5% unemployed. | Qualitative, Grounded theory<br>Semi-structured interviews | 5/5 | SR | None |
| Rizkalla et al. (2020) | Find barriers and facilitators to primary care for rural Indigenous women victims of IPV and recommendations for service-providers. | Canada. Primary care providers. N=31 (90% women, 10% men). - Purposive sampling. | 50% Indigenous. | Qualitative - Grounded theory, Community-Based Participatory Research<br>Focus groups and semi-structured interviews | 5/5 | SR | None |
| Smye et al. (2020) | Explore Indigenous women's experiences of leaving/staying in IPV relationships and make recommendations. | Canada. N=50: Indigenous (n=25) and non-Indigenous women victims of IPV (n=5), men (n=10) and victims' services/support workers (n=10). - Purposive sampling. | 50% Indigenous women victims | Qualitative - Ethnographic, descriptive exploratory<br>In-depth interviews, focus groups, photovoice, and participant observation. | 5/5 | SR | None |
| Meier et al. (2020) | Understand women's perception of their sexual abuse experience and its relationship with reproductive health and health care access. | USA. Women victims of sexual violence. N=16. Mean age: 47.3 ± 11.6. - Purposive, voluntary and snowball sampling. | White/Caucasian, 43.8%; Black/African-American, 43.8%; Latina/Hispanic, 12.5%. | Qualitative - Grounded theory<br>Semi-structured in-depth interviews | 5/5 | SR | None |
| Bellia et al. (2019) | Explore nurses' perceptions of Sexually Transmitted Infections in the context of IPV and its relationship with nursing care. | Australia. Nurses. N=8 (87.5% women, 12.5% men). Age: 27-54. - Purposive, convenience and snowball sampling. | - | Qualitative - Exploratory descriptive design<br>Semi-structured interviews | 5/5 | SR | None |

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| Mackenzie et al. (2020) | Examine women's disclosures of abuse to GPs using candidacy. | UK. Women victims of IPV who did not currently view themselves to be at risk. N=20. Age: 20-late 60's. - Purposive sampling. | - | Qualitative<br>Semi-structured interviews | 5/5 | SR | Goffman (1963), Link & Phelan (2001), Murray et al. (2013), Murray et al. (2018), Overstreet & Quinn (2013) |
| Overstreet et al. (2019) | Find out if stigmatizing reactions to IPV disclosure influences depression more than general negative reactions, and if this is mediated by avoidance coping strategies. | USA. Women currently victims of IPV. N=212. Mean age = 36.63. - Voluntary sampling. | Black, 67%; White, 20.3%; Latinas, 8.5%; multiracial, 4.2%. Average duration of current relationships: 6.47 years. | Quantitative - Cross sectional correlational<br>Interviews and the Social Reactions Questionnaire (Ullman, 2000) adapted to IPV instead of sexual assault | 4/5 | CR | None |
| Almqvist et al. (2018) | Explore mothers' experiences on being asked about IPV exposure at a Child Healthcare Centre and the prevalence of IPV among the mothers. | Sweden. Mothers from Child Health-care Clinics. N=128. - Convenience sampling. | Swedish, 86%; European, 4%; non-European, 10%. | Qualitative<br>Semi-structured interviews | 5/5 | SC | None |
| Murray et al. (2018) | Find out if the Integrated IPV Stigmatization Model provides a useful framework and most common sources and components of stigma. | USA. 13.6% were living in a different country. Victims of IPV. N=279 (97.1% women, 0.03% men). Mean age: 39.39 (SD = 10.47). - Convenience, voluntary and snowball sampling. | Caucasian/White, 80.3%; African American, 9.7%; Hispanic/Latino/Latina, 9.3%; Other, 4.7%; Native American, 3.2%; Asian, 1.4%. | Mixed-methods: qualitative and frequencies<br>Survey | | CR | Overstreet & Quinn (2013), Byrne (2000), Link &Phelan' (2001), Crowe & Murray (2018), Goffman (1963) |
| Simon-Kumar et al. (2017) | Explore culturally informed interventions used by front-line workers. | New Zealand. Front-line practitioners working with migrant and refugee communities. N=9. - Purposive sampling. | Diverse ethnicity: Filipino, Zimbabwean, Indian, Maori, European/Pakeha. | Qualitative<br>Key-informant interviews and focus groups | 5/5 | SC | None |
| Mason et al. (2017) | Increase professionals' knowledge about the intersection between IPV, mental | Canada. Frontline workers. N = 1111: in VAW shelters (n = 262), VAW | - | Mixed-methods: qualitative and | 3/5 | CR | Murray et al. (2018), Crowe |

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| | health, and substance use, change stigmatizing beliefs about it and provide them with skills. | counsellors (n = 237), in mental health (n = 229), in addiction treatment settings (n = 167), in "other" services (n = 149), in more than one sector (n = 49). Age: 20-39, 49%; 40-59, 42%; more than 60, 6%; missing data, 2%. Pre and posttest from n=624 participants - Convenience sampling. | | quantitative quasi-experimental with pre-post intervention<br>Online pre and posttest to assess changes in participants and a survey for the intervention evaluation | | | & Murray (2015) |
| MacGregor et al. (2017) | Examine workers IPV information, awareness of employer/union-provided IPV resources or obligations, suggestions for IPV reduction in the workplace and differences in respondent characteristics. | Canada. Canadian workers currently employed. N=8429 (n=6323 women, n=1642 men). Age: less than 25, 2.4%; 25-64, 94.7%; more than 64, 2.9%. - Voluntary and convenience sampling. | 4.7% Indigenous. 85% permanently employed. | Qualitative<br>Survey | 4/5 | SR | None |
| Bacchus et al. (2016) | Explore perinatal home visitors' and women's experiences in the Domestic Violence Enhanced Home Visitation Program using mHealth technology or a home visitor administered, paper-based method. | UK. N=51: home visiting staff (n=23) and women (n=26) Women's age: 16-19, 15.38%; 20-23, 42.3%; 24-27, 26.92%; 28-35, 15.38%. 30.77% of the women used computer-based DOVE method; 69.23%, Home visitor (paper based). Home visitors' age: 25-66. Nonparticipant observations with 4 African American women. Age: 21, 25%; 20, 50%; 35, 25%). - Convenience sampling. | Women: White, 46.15%; African-American, 30.77%; mixed ethnic origin, 15.38%; did not report it, 7.69%. 69.23% had suffered IPV in the year before current pregnancy. | Qualitative<br>Semi-structured interviews and non-participant observations. | 5/5 | SR | Overstreet & Quinn (2013) |
| Ragusa (2017) | Analyze rurality's influence on women's IPV experiences and help needed for healing. | Australia. Women victims of IPV living in rural areas. N=36. Age: 21-77. - Purposive and snowball sampling. | Australian-born, 86%; Internationally-born 14% (African refugees or from New Zealand). Of the Australian-born, 67% were Caucasian and 33%, Indigenous. | Qualitative - Grounded theory<br>In depth-interviews | 5/5 | SR | McCleary-Sills et al.(2015) |
| Saint Arnault & O'Halloran (2017) | Understand the healing of women receiving IPV services. | Ireland. Women receiving Domestic Violence services in a rural region and who were out of their abusive relationship and in stable homes. N=21. Mean age: 45.5 (SD=7.6). - Purposive and voluntary sampling. | - | Qualitative<br>Semi-structured interviews | 5/5 | SR | Murray et al. (2018) |

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| Murray et al. (2016) | Identify priority actions for eliminating stigma of IPV and sexual violence. | USA. Experts from organizations to address domestic/sexual violence. N=16 (93.75 % women, 6.25% men). - Convenience sampling. | White/Caucasian, 68.75%; Latina/Latino,25%; African American, 6.25%; Native American, 6.25%. | Qualitative<br>Delphi | 4/5 | CR | Byrne (2000), Crowe & Murray (2015), Link & Phelan (2001), Overstreet & Quinn (2013) |
| Meyer (2016) | Examine victims' experiences in trying to rebuild a victimization-free identity after various years of severe IPV. | Australia. Women victims of severe IPV in their most recent intimate relationship and separated from the abusive partner. N=28. Mean age: 38 (SD=11.3). - Convenience sampling. | Australian-born or had migrated from New Zealand or Great Britain, 89.28%; from South Africa, 3.57%; from Malaysia, 3.57%; from the Philippines, 3.57%. 92.9 % had experienced emotional and physical abuse; 39.29% also sexual abuse; 57.1% attempts and/or threats of being killed by their abusive partner during the relationship and/or around the time of separation. | Qualitative<br>Semi-structured in-depth interviews | 5/5 | SR | Goffman (1963) |
| Murray et al. (2015) | Analyze the most frequent co-occurring types of stigma and the stigma experience depending on the form of abuse. | USA. Victims of IPV who had been out of any abusive relationship for at least 2 years. N=343 (76.68% women). Mean Age: 39.7 (SD = 10.4). - Convenience sampling. | White, 63.6%; African-American, 7.9%; Latino/Latina, 7.6%; Native American, 2.6%; Asian/Asian-American, 1.2%; other, 3.5%. | Quantitative - Cluster analysis<br>Survey | 3/5 | CR | Link & Phelan (2001), Overstreet & Quinn (2013), Crowe & Overstreet (2018) |
| Crowe & Murray (2015) | Find out whether common descriptors of stigma apply to IPV and whether victims experience stigma from professionals. | USA. Women and men (mostly women) victims of IPV and who had not suffered from IPV for 2 years. N=231. Mean age: 39.60. Interviews: n=12 (100% women) and mean age, 45.1 (SD = 12.4). Survey: n=219 (96.8% women, 1.83% men) and mean age, 39.3 (SD = 10.5). - Snowball, convenience and voluntary sampling. | Interviews: White, 75%; African American, 16.67; multiracial, 8.33%. Survey: from the USA, 86.30%; from other countries, 12.33% (African-American, 10.96%; Asian, 0.91%; White, 78.08%; Latino/Latina, 2.28%; Native American, 5.02%; and other, 4.57%). | Mixed-methods: Qualitative and descriptive analysis<br>In-depth interview and survey | 4/5 | CR | Byrne, P. (2000) |
| Ragusa (2013) | Analyze the IPV and legal help-seeking experiences of rural women. | Australia. Women victims of IPV. N=36. Mean age: 40. - Purposive and snowball sampling. | 75% were rural born. Caucasian, 67%; Indigenous, 19%; African refugees, 14%. 75% of abusive | Qualitative - Grounded theory | 5/5 | SR | Goffman (1968, 1967a, 1967b) |

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| | | | partners had criminal records and convictions for offences. | In-depth interviews | | | |
| Gavey & Schmidt (2011) | Map a discourse of the trauma of rape. | Australia. Community sample. N=29 (75.86% women, 24.14% men). Mean Age: 37. - Purposive, convenience and snowball sampling. | Pakeha, 6.9%; New Zealand Indian, 17.24%; Maori, 3.45%; Fijian Chinese, 3.45%; Romanian, 3.45%; other, 3.45%. 55.17% knew a rape victim; 27.58% did not; 10.34% did not answer. | Qualitative - Discursive approach<br>Focus group | 5/5 | SR | None |
| Reich et al. (2021) | Examine the reasons why victims of sexual violence did not report the abuse. | USA. Tweets #WhyIDidntReport. N=469. 10% described their own gender; 70% of the times, it was a woman. - Random sampling. | 25% mentioned being under 18 at the time of the abuse. 48% provided information of the perpetrator's gender; 95% of the times it was a man. 45% provided information from the perpetrator; 17% corresponded to an intimate partner. | Qualitative<br>Content analysis | 5/5 | SR | None |
| Iles et al. (2021) | Study the effects of disclosure content, listener gender, and year in college on listener's reaction. | USA. Undergraduate students. N=391 (64.2% women). Mean age: 19. - Convenience sampling. | Caucasian, 66.3%; African-American, 7.5%; Latino/a, 6.5%; Asian, 15.8%; Pacific Islander, 0.5%, Native American, 2.3%; Mixed, 2.8%. 54% on first year in a bachelor's degree program; 22%, on second; 15%, on third; and 9% on fourth. | Quantitative randomized<br>Modified Rape Myth Acceptance Scale (Payne et al., 1999) and items to measure social distance | 3/5 | SR | Goffman (1963, 1968), Krebs (1975), Jost & Banaji (1994) |
| Vil et al. (2021) | Explore the IPV reasons and solutions from residents of high-risk IPV black communities. | USA. Black Licensed Practitioner Nursing students residing in high-risk IPV communities. N=22 (n=20 women) Mean age: 40 (SD=13.45). - Convenience and voluntary sampling. | 45% reported perpetrating abuse (some in self-defense). | Qualitative<br>Focus group | 5/5 | SR | None |
| Donovan et al. (2021) | Analyze IPV experiences of single mothers who are doctors, barriers to help-seeking and impact on their job. | UK. Single women doctors who had experienced domestic violence. N=21. Mean age: 34. - Convenience sampling. | - | Qualitative<br>In-depth interviews | 5/5 | SR | None |
| Storer & Casey (2021) | Examine teens' discourse on dating abuse. | USA. Adolescents. N=113 (65.49% women; 34.51% men). Age: 14-17. - Convenience and purposive sampling. | White, 49.56%; African American, 26.55%; Latino/a, 14.16%; Asian American, 4.42%; American Indian, 1.77%; Middle Eastern, 1.77%; Multiracial or "Other", 10.62%. | Qualitative<br>Focus group | 5/5 | SR | None |

| Author (Year) | Aim of the study | Sample (Predominant country they live in, N, age, sampling) | Ethnicity and other descriptive sample data | Type of study and stigma measurement | MMAT Tool | Stigma role | Theoretical model* |
|---|---|---|---|---|---|---|---|
| Nikolova et al. (2021) | To find out if decisions advocating waiver under the FVO are influenced by stigma (varying depending on the relationship status of IPV victims). | USA. Women victims of family violence. N=237. Age: under 25, 22.78%; 26-35, 48.95%; 36-45,48.95%; over 45, 7.59%. - Convenience sampling. | African American, 40.08; White, 30.38%; Latina, 3.38%; Asian, 16.46%; "other"/"multi-ethnic", 9.28%. | Quantitative correlational<br>Outcomes from variables in a waiver granting guide | 5/5 | CR | None. |
| Gonzalez-Guarda et al. (2021) | Analyze characteristics desired by IPV victims of HIV and sexually transmitted infection testing services. | USA. Victims of IPV from a family justice center or shelters. N=25 (96% women; 4% men). Mean age: 34.09 (SD=8.30). - Convenience sampling. | Hispanic, 64%; Black, 32%. All had been tested for HIV at some point in their life, but only 32% were tested through the family justice center or at the shelters. | Qualitative<br>Focus group | 5/5 | SR | None |
| Manrai (2021) | Examine the factors that late adolescents think facilitate or prevent disclosure of Online Sexual Abuse. | UK and Chile. Adolescents. N=51 (50.98% women, 49.02% men). Age: 15-20. - Convenience and voluntary sampling. | University students living in Scotland and originally from England, India, Japan, Russia and Scotland, 11.76%; Latin-American students living in Chile, 88.24%. | Qualitative<br>Semi-structured interview and focus group | 5/5 | SR | None |

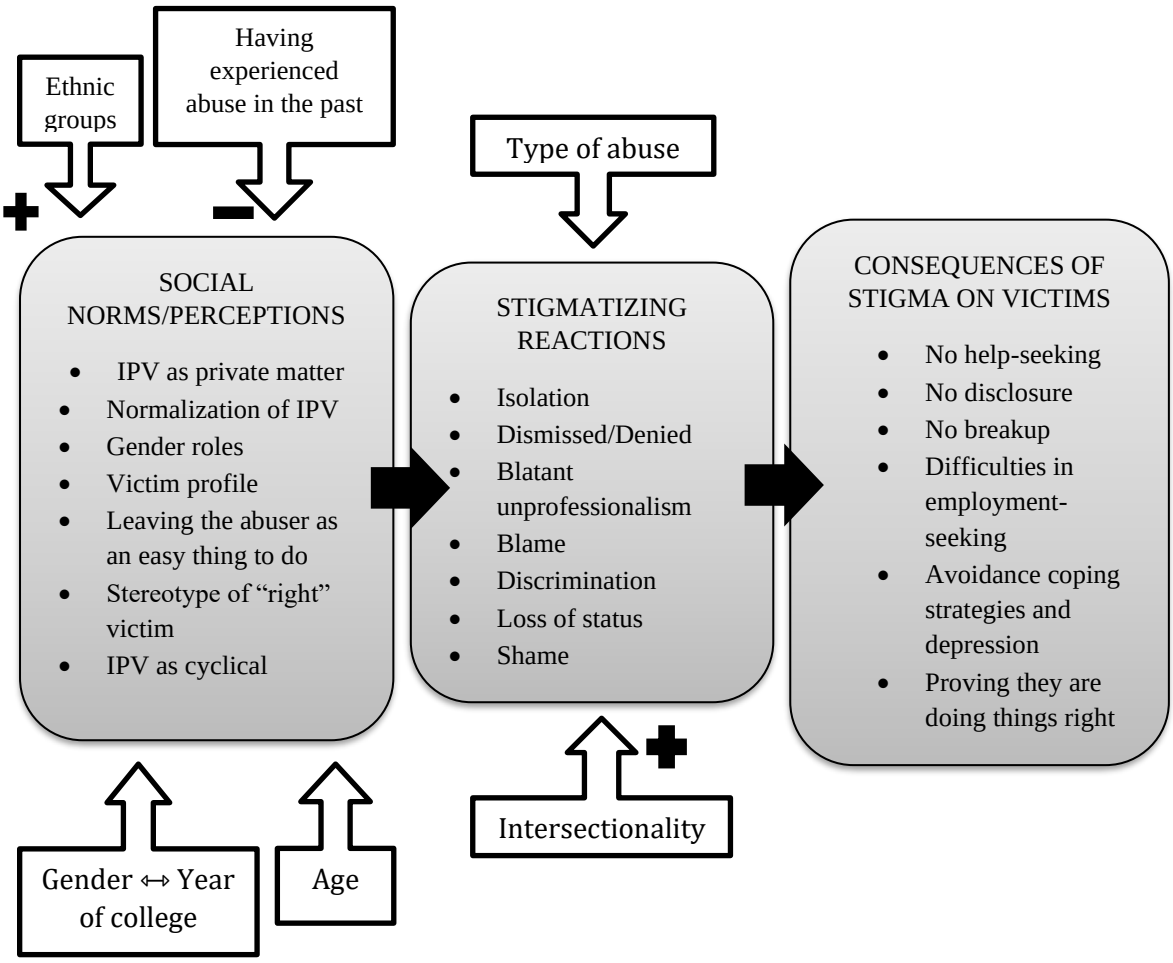
CR, Central role; SR, Secondary role. References to the theoretical models cited can be found in each article.

*3.4. Functioning of public stigma: an explanatory model based on review of studies*

Figure 2 shows a diagram of an explanatory model of public stigma, which we constructed following a descriptive content analysis, including coding of the selected articles into emergent themes and subthemes, and the associations between them. The detailed findings from each study that contributed to creating this model can be found in Table 2 in the Appendix. In the following sections, the main constitutive themes and subthemes of the content analysis, represented in pictorial format in the model, are briefly described.

**Figure 2.**

*Explanatory model of public stigma toward women victims of IPV.*




Modulating factors are represented inside the outer squares. The arrows represent their influence on stigma; + indicates an increase in stigma; and – represents a decrease in the

same. Modulating factors of social norms/perceptions refer to characteristics of the ones who stigmatize.

*3.4.1. Social norms and perceptions*

Societal norms and perceptions were identified in the reviewed articles as factors that drive stigma. They are found in laws, policies, media, and culture (Murray et al., 2016) and include the notion that IPV is a private matter that should not be discussed publicly (Bellia et al., 2019; Meier et al., 2020; Murray et al., 2016). The nuances related to social norms and perceptions also contributed to regarding IPV through the lens of gender roles—especially to tolerating it as part of being a good wife (Simon-Kumar et al., 2017) or mother (Murray et al., 2016; Smye et al., 2020)—and the normalization of violence. In some cases, IPV was not even seen as a crime (Murray et al., 2016; Simon-Kumar et al., 2017). Further, the assumption of a victim profile with being weak (Murray et al., 2016), lacking education (Donovan et al., 2020; Murray et al., 2016), and coming from a lower socioeconomic status (Bellia et al., 2021), as well as the idea that leaving the abuser was an easy thing to do (Meyer, 2016; Murray et al., 2016) was mentioned in the studies analyzed. Both cases show a lack of awareness of the complexity of IPV and the diversity of experiences and the victims themselves. In addition, there were two subthemes identified in the articles, specifically referring to professionals. On one hand, there was a stereotype that defined what a "right" victim was: she should be in the process of making the right choices in life (e.g., no other abusive partners in the past), not be presenting other issues such as substance abuse, and be ready to leave the abuser (Iles et al., 2021; Mackenzie et al., 2020; Murray et al., 2016) or have been out of the relationship for a long period of time (Nikolova et al., 2021). On the other hand, one study discussed the perception that IPV is cyclical, which is driven by the belief that victims who break up with their abusers will easily end up in another violent relationship (Bellia et al., 2019). Thus, women who did not match these social norms and

stereotypes went unnoticed, were blamed and judged, and did not receive adequate care from professionals and support from general society.

*3.4.2. Stigmatizing reactions*

The analysis of the studies also captured seven types of stigmatizing responses from society toward IPV victims, that correspond exactly to Murray et al.'s (2018) stigma components presented in the Introduction section of this review. In fact, stigmatizing reactions were present in 22 studies.

*3.4.2.1. Isolation*

Isolating women was one of the two most frequent stigmatizing reactions among the studies (n = 11). Victims' ostracization from society (Crowe & Murray, 2015; Iles et al., 2021; Murray et al., 2018; Murray et al., 2015; Saint Arnault & O'Halloran, 2017); professionals not supporting them due to the stereotype defining what the "right" victim is (Mackenzie et al., 2020); and the erroneous idea that leaving the abuser is easy all made women constantly prove they were not contributing to their own victimization (Meyer, 2016). Isolation was even stronger when different stigmatized identities intersected (Murray et al., 2016), and this hampered help seeking (Reich et al., 2021; Simon-Kumar et al., 2017) and led to avoidance coping strategies and depression among the victims (Overstreet et al., 2019).

*3.4.2.2. Dismissed/denied*

The following instances are the other most common responses (n = 11) after victims disclosed accounts of the abuse they faced: not believing them, not taking it seriously, "looking the other way", explicitly shutting them up, dissuading them from reporting, or not processing reports (Crowe & Murray, 2015; Meier et al., 2020; Meyer, 2016; Murray et al., 2015; Overstreet et al., 2019; Ragusa, 2017; Ragusa, 2013; Reich et al., 2021). These responses were easily triggered if women did not fit the victim profile (Donovan et al., 2021) or the stereotype of the "right" victim (Murray et al., 2016), leading women to be diagnosed

with a psychological disorder instead of receiving IPV support (Mackenzie et al., 2020). This worked as a barrier to disclosure (Manrai, 202) and help seeking (Manrai, 2021; Reich et al., 2021).

*3.4.2.3. Blatant unprofessionalism*

Inadequate responses from service providers were frequent (n = 10) and present in all professional settings (González-Guarda et al., 2021; Mason et al., 2017; Ragusa, 2017; Ragusa, 2013; Reich et al., 2021; Mackenzie et al., 2020; Nikolova et al., 2021). One study proved that they were most common in law enforcement agencies and courts and that the most prevalent responses were blaming the victims and denying and dismissing the abuse (Crowe & Murray, 2015). We do not specify these actions because they are already mentioned across the rest of the subthemes. Stigma from professionals affected their decision to leave the abuser (Smye et al., 2021) and forced them to constantly prove that they were doing things right (Meyer, 2016).

*3.4.2.4. Blame*

Society in general, including perpetrators and survivors of IPV, held victims responsible for the abuse, even more when women did not match the stereotype of the "right" victim. This subtheme appeared frequently (n = 9) in the studies (Crowe & Murray, 2015; Murray et al., 2018; Murray et al., 2016; Murray et al., 2015), and there was one that distinguished between two ways of blaming the victims: 1) direct culpability, if they thought victims chose to stay in the violent relationship or were responsible for the behavior of the aggressor, and 2) indirect culpability, if they perceived women were acting stupid, blinded by love, brainwashed, or showed weakness or incapability (Storer & Casey, 2021). Social blaming led to difficulties in finding employment (Tarshis, 2020), disclosing (Manrai, 2021), searching for help (Manrai, 2021; Reich et al., 2021), adopting coping strategies, and maintaining good mental health (Overstreet et al., 2019).

*3.4.2.5. Discrimination*

Treating victims differently or judging them (Murray et al., 2015) was a common response in the studies (n = 9). These reactions were even more frequent among professionals. Service providers who believed in the stereotype defining the "right" victim judged women for not making the right decisions (Mackenzie et al., 2020) and determined they would not receive financial resources (Nikolova et al., 2021). Others discriminated against victims who had children, driven by the gender-based stereotype that places more responsibility of childcare on women (Smye et al., 2020). In addition, thinking that leaving the abuser was easy on the part of society led to their harsh judgment of victims who were back with their abusers (Meyer, 2016). This, together with the previous gender role, resulted in children being separated from their mothers if they did not immediately leave their abusers (Murray et al., 2016). On other occasions, women could be suspended from college or fired from their jobs after disclosing accounts of the sexual abuse they faced (Manrai, 2021). Discrimination contributed to victims not disclosing the abuse (Manrai, 2021) and similarly not seeking help (Manrai, 2021; Reich et al., 2021).

*3.4.2.6. Loss of status*

Not valuing women as more powerful than or equally powerful to others not experiencing abuse (Crowe & Murray, 2015; Murray et al., 2018; Storer & Casey, 2021) was not a response found as frequently as the other stigmatizing responses (n = 6). When they searched for help, some professionals pitied them (Gonzalez-Guarda et al., 2021). Other women would not seek help in order to avoid experiencing stigma from their employers and co-workers who thought they were passive. Similarly, they did not seek help from property owners who considered them a problem for others (Murray et al., 2016). The loss of status was particularly emphasized in the case of sexual violence, as people thought this type of

violence was especially traumatic. In such cases, all areas of their lives would be irrevocably damaged (Gravey & Schmidt, 2011).

*3.4.2.7. Shame*

Social shaming around IPV appeared less frequently (n = 5) (Crowe & Murray, 2015; Murray et al., 2018; Murray et al., 2015). It was an obstacle to seeking employment (Tarshis, 2020), disclosing accounts of abuse, and searching for help (Manrai, 2021).

*3.4.3. Consequences of stigma on victims*

This theme was present when the consequences of stigma were mentioned. It was divided into seven subthemes that have already been mentioned in the previous section. The most frequent (n = 5) was "no help-seeking" (Manrai, 2021; Murray et al., 2016; Ragusa, 2017; Reich et al., 2021; Simon-Kumar et al., 2017). It was followed by "no disclosure" (n = 4) of abuse (Bellia et al., 2019; Manrai, 2021; Meier et al., 2020; Murray et al., 2015). Finally, each of the following four subthemes were only mentioned in one study. First, "no breakup", as to not leaving the abusive relationship (Smye et al., 2020). Second, "avoidance coping strategies and depression", which alluded to suffering from depression as a direct consequence of stigma or suffering from depression as a result of their avoidance coping strategies fueled by the stigma faced (Overstreet et al., 2019). Third, "proving they are doing things right", referring to any action from victims aimed at demonstrating to others that they did not contribute to their own victimization (Meyer, 2016). Finally, "difficulties in employment-seeking" (Tarshis, 2020), where stigma was considered to be a barrier to finding a job.

*3.4.4. Modulating factors*

This theme alluded to factors facilitating or reducing stigmatizing reactions. The following subthemes were identified: The first was labelled as "intersectionality"; we refer to the studies that explicitly indicated women could suffer more than one stigma at the same

time as victims of IPV and due to other attributes, such as ethnicity and age, among others. It was present in five studies: two referred to intersectionality in general (Murray et al., 2016; Tarshis, 2020), one to victims of IPV also diagnosed with sexually transmitted diseases (STD; Bellia et al., 2019), one to indigenous women victims of IPV (Smye et al., 2020), and one to co-occurring IPV, mental health issues, and substance use (Mason et al., 2017). The second subtheme emerged on the role that having experienced IPV in the past plays in exerting stigma. However, the direction in which it modulated the stigma was unclear.

In one study, survivors of past sexual assault presented fewer isolating reactions toward the victims (Iles et al., 2021), whereas another one stated that survivors of IPV sometimes forgot about their previous experiences and blamed victims in the present (Murray et al., 2016). Moreover, there were two studies that associated the idea that IPV was a "private matter" and the normalization of violence with certain ethnic groups (Meier et al., 2020; Simon-Kumar et al., 2017). In addition, a single study explored the association of gender and college year with the acceptance of rape myths (Iles et al., 2021), suggesting that men scored higher on rape myths. It also suggests that women have been in college longer. Furthermore, the type of abuse was also associated with high or less stigma, with verbal abuse attracting significantly more stigma than physical abuse (Murray et al., 2015). Finally, a single study mentioned that the idea that IPV was a private matter varied depending on the age of the person who stigmatized (Bellia et al., 2019).

### *3.5. How to end stigma*

In order to answer this question, we created one theme for interventions and another one for recommendations that will contribute to eradicating stigma. Recommendations were then organized into subthemes. The results for each study are shown in detail in Table 2 in the Appendix.

#### *3.5.1. Interventions*

There was only one intervention presenting statistically significant improvements in stigmatizing attitudes from professionals toward women with co-occurring IPV, mental health issues, and substance use, among other results (Mason et al., 2017). It was an educational intervention on how to identify and respond to these intersecting realities. Changes in participants were measured with pre- and post-tests, and the workshop was evaluated with positive results. The most common changes included acknowledging the impact of stigmatizing beliefs and attitudes on their practice, challenging them, and learning alternative approaches for asking questions about abusive experiences. Better understanding of women victims, viewing them as experts, thinking before speaking, and choosing words wisely were less frequently found themes.

*3.5.2. Recommendations*

Eight studies mentioned strategies to combat stigma, which, by decreasing order of frequency, were organized into the following seven subthemes: “making the invisible visible”, “education”, “addressing victims’ unique needs”, “changing to a view of resilience/resistance”, “adequate support policies and structures”, “intersectional approach”, and “holding offenders accountable”. We will now briefly describe them in the same order.

The most frequent strategies (n = 6) aimed at ending social silence around IPV by making violence visible. These included actions such as routine screening for IPV in perinatal healthcare settings, considering that there is an increased risk for mothers experiencing abuse from their partners during and after pregnancy (Almqvist et al., 2018; Bacchus et al., 2013). Efforts to increase dialogue about IPV (McGregor et al., 2017; Murray et al., 2016) as well as the need to incorporate the role of survivors were highlighted. By making their stories of overcoming violence visible, they could serve as advocates for preventing abuse suffered by other women; they could also be role models for those who have experienced IPV for the moment, they make the decision to leave the relationship (Meier et al., 2016; Murray et al.,

2016; Smye et al., 2020). The recommendation following this was educating society (n = 5). It was proposed that knowledge about IPV and safe and healthy relationships could be increased through public health campaigns and public announcements, among others, also targeting children and their families (McGregor et al., 2017; Murray et al., 2016; Rizkalla et al., 2020; Vil et al., 2021). Training for professionals on the nature of IPV and how to deal with victims was also suggested (Almqvist et al., 2018).

The five remaining actions to reduce stigma were much less frequent. The following four subthemes were identified only twice. First, since there is no victim profile and no identical experiences of violence, it was recommended that practitioners attend to the unique needs of women. This included listening to their specific stories, addressing particular cultural issues, taking them into account when making decisions, and adapting to the stage of recovery that women were in (Murray et al., 2016; Smye et al., 2020). Second, the need to turn the image of victims from being weak or passive into that of being empowered and strong, for example, by celebrating their private accomplishments (Murray et al., 2016), was strongly encouraged. Women victims discussed the importance of showing that they were stopping the violence and going forward despite their experiences (Smye et al., 2020). Third, studies highlighted the importance of improving policies and structures involved in women's recovery process, assuring society that women were adequately supported (Murray et al., 2016; Smye et al., 2016) and offenders were being held accountable (Smye et al., 2016). Fourth, analyzing stigma from the lens of intersectionality was suggested (Murray et al., 2016; Smye et al., 2020). Finally, focusing on holding the offender accountable, apart from supporting the victims, was mentioned once (Murray et al., 2016).

*3.6. Bias in Studies*

Two main limitations were found in the studies included in this review. First, stigma was always measured explicitly with self-informed measures. Second, differences in stigma

were not always analyzed by important influencing factors such as ethnicity or whether or not sexual violence was being perpetrated by an intimate partner. Finally, a few studies included a small percentage of men victims of IPV in their samples.

## 4. Discussion

The aims of this review were to analyze the way public stigma toward IPV women victims has been studied in high-income countries in the last 10 years and to thoroughly explore how stigma operates and what can be done to end it. The results of the selected studies came from a variety of participants (victims, professionals, community samples, among others) often residing in the USA. Among these studies, qualitative methodologies predominated. We will start presenting the results for RQ1, and then, the findings for RQ2 and RQ3 will be discussed together.

### *4.1. Ways of studying stigma*

It is significant to note that stigma was normally not the focus of the investigations. Less than half of the studies were based on a theoretical stigma model, among which the models used by Overstreet and Quinn (2013) and Murray et al. (2018) were the only ones specific to IPV stigma. In terms of how stigma was measured, qualitative techniques were frequently seen among the selected articles. This could be regarded as positive, as it makes it possible to analyze the complexity of stigma (Pescosolido & Martin, 2015) from the lens of intersectionality (Barrios et al., 2020) and to combat the stereotype of victims, which is stigmatizing in its own way (Goodmark, 2008; Mackenzie et al., 2020). However, we also suggest the development of quantitative instruments to measure stigma and the use of implicit ways of studying the most imperceptible stigmatizing reactions, such as indirect culpability (Storer & Casey, 2021). Implicit measures have started to be successfully used in the last few years to analyze IPV acceptability (Gracia et al., 2015), implicit theories (Ducate, 2021), and

attitudes, adding new relevant information compared to explicit measures (Ferrer-Pérez et al., 2020).

*4.2. Stigma functioning and priority actions for its eradication*

It has been proven that social norms and perceptions play a key role in public stigma, driving negative responses from society toward victims and hindering their recovery. This supports the relevance of current studies on widespread attitudes and beliefs about IPV (Ferrer-Pérez et al., 2019; Gracia et al., 2020) and the association between traditional gender roles and IPV (Evcili & Daglar, 2021; Reyes et al., 2016; Rai & Choi, 2018). However, there is still no agreement in the literature on how to define social norms (Rai & Choi, 2018).

Stigmatizing beliefs, such as those that rationalize the statement "leaving the abuser is an easy thing to do" or that use stereotypes defining the "right" victim, demonstrate the need to understand the complex process of recovering from violence. Women's agency in the context of IPV, referring to the control women can exert on their decision-making (McCleary-Sills et al., 2016), has traditionally been associated with the ability to leave abusers and not to engage with them afterwards. However, several studies have shown that women are not just victims or agents, and their actions to resist and overcome violence are diverse (Cala, 2011, p. 51; Campbell & Mannell, 2016; Hamilton, 2010; Mannell et al., 2015). The process of recovery and liberation from violence may naturally include leaving and returning to their abusers several times, and after ending the relationship, the abuse frequently continues. Additionally, recovery does not end when they leave abusers, as it involves other processes, such as recovering social networks that they lost due to loss of control, experiencing isolation from their abusers, and improving their psychological well-being (Cala, 2011, p. 47-49; Hamilton, 2010).

To recover, women have to break the silence to which they have been subjected by their aggressor (Cala, 2011, p. 49); however, it was clear that IPV was still considered a

private matter in society, supporting recent findings from Pokharel et al.'s study (2020) on the factors influencing women's silencing. This is why making violence visible and educating society on how IPV functions and how to give adequate responses to violence are recommended in the studies selected for this review. Learning that each experience of violence is unique, and therefore considering the needs of each woman, instead of thinking that there was a victim profile, was equally relevant.

In relation to stigmatizing reactions, Murray et al.'s (2018) components proved to constitute a useful and sufficient framework for organizing the variety of responses found in the studies. All components, apart from shame and loss of status, appeared in approximately one-third of the studies. Further, stigma was directed at victims by society without exceptions, including professionals from specialized and non-specialized IPV services. Given that service providers stigmatize victims as much as anyone else, all reactions in the model sometimes overlapped with the subtheme of "blatant unprofessionalism". Considering stigma from professionals as the source of stigma rather than as a component in Murray et al.'s (2018) model is proposed.

Women struggle with other factors at both micro (financial dependence, fear of perpetrator) and macro (gender roles, normalization of violence) levels before deciding to disclose the abuse to a professional (Pokharel et al., 2020). For this reason, once they have taken this difficult step, it can be devastating to encounter professionals who stigmatize them. Accordingly, it should be noted that only one intervention was found that included stigma reduction among the objectives, even though it was not specifically aimed at combating stigma. It was aimed at professionals and reported satisfactory results. For this reason, we propose the development and implementation of this type of intervention for all service providers who may meet IPV victims in their work (at least with reference to social, health, and law enforcement services). In addition, we support Murray et al.'s (2018) suggestion

about further analyzing which stigmatizing reactions are more frequent depending on professional settings, as they found them to be different.

Moreover, it was demanded that the recommendations above be extended to the structures and policies involved in the recovery process. As explained by Pescosolido and Martin (2015) through their proposal of the stigma complex, they should not be overlooked, as they reinforce and accommodate stigmatizing practices, behaviors, and so on, further restricting the opportunities that can be availed by stigmatized people.

Furthermore, the negative consequences of stigma on victims mentioned in the Introduction section (Crowe & Murray, 2015; Kennedy & Prock, 2018; Wright et al., 2021) were confirmed. In fact, not disclosing the abuse and not seeking help from either formal or informal agents were the most common repercussions, with the latter increasing the risk of mental health problems and physical danger (McCleary-Sills et al., 2016). Difficulties leaving abusers, finding a job, or recovering from depression were also mentioned.

Although it appeared infrequently, it seems important to highlight that victims had to constantly prove that they were doing things right if they did not match societal expectations related to how they are or should behave. Other studies (not included in this review) have examined the existence of a victim stereotype that sees them as traumatized, weak, and damaged in all areas (Dutton, 1996; Hamilton, 2012); they have also analyzed the fact that women cannot go back to the abuser because, if they do, they would be perceived as contributing to their own victimization (Ferrer et al., 2019; Storer & Casey, 2020). Not making this extra effort to prove that they are doing things right could lead to their isolation from friends and family, to not having access to help from professionals, or to even judicial sentencing errors (Goffman, 1996; Goodmark, 2008).

In line with the above, it is worth noting the desire of the victims to show the world that despite all these difficulties, they resisted violence and overcame the abuse after all

(Smye et al., 2020). Viewing women as resilient instead of weak, incapable, or passive was also proposed in the reviewed studies, and so was viewing victims as advocates for the prevention of other acts of abuse.

Moreover, some modulating factors of stigma were mentioned in a few articles and should be further studied in the future, being careful about the fact that identifying certain attributes with higher stigma does not contribute to victim stereotypes. Bellia et al. (2015) discussed how nurses perceived that considering IPV a private matter was more frequent among older people and certain ethnic groups, which may be true and, at the same time, prevent nurses from asking these people about violence.

Finally, it was significant that only five studies alluded to victims' intersecting stigmas, especially considering race or ethnic diversity in the studies selected. Recent literature has been critical in this regard (Barrios et al., 2020; Choi & Rai, 2018). Some suggestions for an intersectional approach in qualitative research include dedicating enough time and reflection to all stages, considering the researcher's role and involving the community in the analysis (Baird, 2021); for quantitative analysis, on the other hand, using complex statistical tools, such as mediation and moderation models, or multilevel techniques is recommended (Lazega & Snijders, 2016).

### *4.3. Limitations*

Some of the reviewed articles included a very small percentage of men victims of IPV in the sample, but we considered them since the majority were women and eliminating them could mean a loss of relevant information for the study. However, this may bias the extracted results. Moreover, we are aware that this model is only an initial proposal that cannot be generalized and that there may be other explanatory factors for stigma that have not been included. This is because our search was limited to those studies that explicitly used the term "stigma". Finally, the study was limited to high-income countries and did not include sexual

and gender minorities. The latter decision was based on unique factors associated with victims of IPV belonging to sexual and gender minorities. Even though there are commonalities among cisgender heterosexual victims, these are exacerbated and create additional vulnerabilities (Everhart & Hunnicut, 2014; Goodmark, 2013; Longobardi & Badenes-Ribera, 2017).

*5. Conclusion*

Stigma in IPV played a central role in only a few studies, and most studies were not based on any stigma theoretical models. Although stigma has primarily been studied with qualitative methodologies, it has not been examined from an intersectional approach. Regarding how stigma operates, social norms and perceptions about IPV and gender roles drove stigmatizing reactions from society, which corresponded to Murray et al.'s (2018) components of stigma. The most frequent consequences were not disclosing the abuse and not looking for help. Some modulating factors of stigma, such as suffering the intersection of other stigmatized attributes, apart from being a victim of IPV, were identified. In relation to actions to reduce stigma, only one evidence-based intervention was found among the selected studies, which yielded positive results in a sample of professionals. Strategies to combat stigma were suggested in a few studies, among which educating society and making violence visible were the most prevalent.

Future research should confirm the findings presented, and implicit measures and quantitative instruments to measure stigmatizing responses as well as evidence-based interventions and recommendations to eradicate stigma should be developed. We emphasize the need to combat stigma from professionals who may encounter IPV victims in their work due to the key role they play in the recovery process.

*6. Implications for practice and research*

Future research based on theoretical models of stigma and with a focus on public stigma toward victims of IPV is needed, allowing confirmation and extension of our findings. Further examination of specific associations between different factors in the model and modulating factors is advised. Also, the use of implicit measures of stigmatizing responses in order to explore the most covert manifestations of stigma is encouraged, and so is the development and validation of quantitative instruments that would allow the generalizability of results. In addition, evidence-based interventions aimed at stigma reduction should be designed for which the recommendations in this systematic review may be useful. An intersectional research approach that takes into account overlapping social identities and a clear distinction between violence exerted toward women and men in studies about stigma is strongly recommended too.

Implications for practice and policies include investments in training programs to make professional helpers culturally sensitive against stigma, making sure that their services are respectful of each woman's recovery process, address their particular needs, and do not inherently consider breaking up as the only solution. Public campaigns to prevent and combat stigma aimed at the general population as well as policies that provide support to victims and address multiple layers of stigma should be implemented. Special efforts to combat the silence around IPVAW and change to a more empowering and resilient view of victims should also be made.

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## Appendix.

## Table 2.

*Findings on how stigma operates and recommendations and interventions to fight stigma of the studies included in the review.*

| Author (Year) | Factors and associations between factors explaining how stigma operates | Recommendations and interventions to fight stigma |
|---|---|---|
| Tarshis (2020) | People need to stop victim shaming **(Shame)** and blaming **(Blame) → Difficulties in employment seeking**<br>Intersectional stigmas (race, gender, etc.) **(Intersectionality).** | |
| Rizkalla et al. (2020) | | Public health campaigns about IPV in primary care (**Education**). |
| Smye et al. (2020) | - **Blatant unprofessionalism:** They were stigmatized and discriminated when trying to seek help, even more if they had children (**Gender role → Discrimination)** → Affected the decision of staying/leaving the abusive relationship (**No breakup**).<br>- Cumulative stigmas suffered by Indigenous victims (**Intersectionality).** | Telling their stories of Indigenous women victims makes violence visible (**Making the invisible, visible**), fights intersecting stigmas (**Intersectional approach**), shows others their strength and resistance (**Changing to a view of resilience/resistance**) and should be used for improving IPV support services and structures (**Addressing victims' unique needs, Adequate policies and structures).** |
| Meier et al. (2020) | Silence about sexual abuse was a social norm in black culture (**IPV as Private matter)** → Nobody believed victims (**Dismiss/Denial**) → A barrier to conversation about suffering IPV (**No disclosure).** | Victims telling their stories, being advocates for prevention for others (**Making the invisible, visible**). |
| Bellia et al. (2019) | - **Intersectionality** between stigma in Sexually Transmitted Disease and Domestic Violence<br>- IPV is taboo (**IPV as private matter),** even more among older people (**Age**) → They keep quiet (**No disclosure).**<br>- Societal beliefs, stereotypes and lack of education about IPV caused stigma.<br>- Nurses thought IPV would happen with another partner (**IPV as cyclical**) and victims came from low socioeconomic status (**Victim profile**). | |
| Mackenzie et al. (2020) | **Blatant unprofessionalism:** If they were not "the right" victims (**Stereotype of "right" victim**) → they did not receive support (**Isolation**), they were judged as not making the right decisions (**Discrimination**). Professionals knew they were being raped and did nothing, waiting for her to disclose, or diagnosed them with a psychological disorder (**Dismiss/Denied**). | |
| Overstreet et al. (2019) | - The most common stigmatizing reaction was being told that they could have done more to prevent IPV (**Blame**); the least common, pulling away from the victim after disclosure (**Isolation**).<br>- Stigma → **Depression/Avoidance coping strategies → Depression.** | |

| Author (Year) | Factors and associations between factors explaining how stigma operates | Recommendations and interventions to fight stigma |
|---|---|---|
| Almqvist et al. (2018) | | - Professionals from child health-care centers asking about IPV routinely (**Making the invisible, visible**).<br>- Nurses should know about IPV and the need to be empathetic, humble, have enough time and privacy when asking about IPV (**Education**). |
| Murray et al. (2018) | The IPV Stigmatization Model was useful and included five components of stigma: **Loss of status, Isolation, Blame** (the most prevalent), Negative emotions **(Shame),** Other. | |
| Simon-Kumar et al. (2017) | In ethnic minority communities: **Normalization of IPV (**not considered a crime), **Gender role** of being a good wife (contradicting IPV disclosure) and rejection of victims from the community (I**solation**) → They didn't report (**No help-seeking**). | |
| Mason et al. (2017) | Stigmatizing beliefs and attitudes from professionals (**Blatant unprofessionalism**) about women experiencing co-occurring IPV, health issues and substance use (**Intersectionality**). | Educational intervention on how professionals should identify and respond to co-occurring IPV, mental health issues and substance use. They had to read a manual/complete online module and then attend an in-person workshop. Acknowledging the impact of stigmatizing beliefs on their practice, challenging them and learning alternative approaches for asking questions about women's experiences were the most common changes. Better understanding, viewing women as experts, thinking before speaking and choosing words wisely, less frequent. |
| MacGregor et al. (2017) | | - Increasing dialogue about IPV at workplace so that it is not taboo (**Making the invisible, visible**)<br>- Information about IPV support, prevalence, etc. at workplace (**Education**). |
| Bacchus et al. (2016) | | Screening for IPV raised awareness, making it "more of a common thing" to talk about (**Making the invisible, visible**). |
| Ragusa (2017) | - Stigma difficulted seeking help (**No help-seeking).**<br>- Previous experiences with authorities not believing them (**Blatant unprofessionalism: Dismiss/Denial).** | |

| Author (Year) | Factors and associations between factors explaining how stigma operates | Recommendations and interventions to fight stigma |
|---|---|---|
| Saint Arnault & O'Halloran (2017) | - Family of the woman and batterer rejected her after breaking up (**Isolation**). | |
| Murray et al. (2016) | - Victim-blaming (**Blame**) from society, perpetrators and other victims **(Having experienced violence in the past).**<br>- Social beliefs and perceptions about IPV. The Perception she engaged in "risky behaviors" (**Stereotype of the "right" victim**) → increased blaming attitudes (**Blame**) and not believing them (**Dismiss/Denied**). Some people thought IPV was not a crime (**Normalization of violence**), that it was a **Private matter,** victims were weak women or had a lack of education (**Victim profile**), perceived **Leaving the abuser as an easy thing to do** or had unrealistic standards of what it means to be a mother **(Gender role).**<br>- Employers and co-workers saw them as passive and landlords saw them as a problem for tenants (**Loss of status) →No help-seeking.**<br>- People distanced from the victims (**Isolation).**<br>**- Blatant unprofessionalism:** Professionals easily removed their children if they did not leave the abuser immediately (**Gender role, Leaving the abuser as an easy thing to do → Discrimination).**<br>- Not believed (**Dismiss/Denied**) and judged for not leaving sooner (**Discrimination**) → Less likely to seek help (**No help-seeking).**<br>- Characteristics of the victim's identity add other layers to stigma (**Intersectionality) →** Less support **(Isolation).** | - Professionals should be trained (**Education**) to provide support for the unique needs of each woman, unique cultural issues, letting her decide what is best for her and meet her at her stage in recovery (**Addressing victims' unique needs**).<br>- Engaging society in acquiring knowledge (**Education**) and dialoguing about IPV (**Making the invisible, visible**), children and families learning about healthy, safe relationships **(Education).**<br>- Ensuring policies hold offenders accountable, support victims (**Holding offenders accountable**) and address all layers of stigma **(Intersectional approach, Adequate policies and structures**).<br>- Society should support victims in publicly sharing their empowering stories of overcoming IP, so they can also become role-models that victims can look to when they decide to leave the abuser and celebrate private accomplishments (**Making the invisible, visible, Changing to a view of resilience/resistance**). |
| Meyer (2016) | Professionals (**Blatant unprofessionalism**), family, etc., judged them for returning to the abuser and did not support/listen to them (**Leaving the abuser as an easy thing to do → Discrimination, Isolation, Dismiss/Denied**) → Women had to prove they were not contributing to their own victimization (**Prove they are doing things right**). | |
| Murray et al. (2015) | - Co-occurrence of **Blame** and **Discrimination; V**ictims' secrecy **(No disclosure)**, **Shame,** being treated in prejudicial ways **(Discrimination)** and **s**ocial exclusion **(Isolation).**<br>- The high stigma group victims reported the highest rates of verbal abuse (**Type of abuse**). | |
| Crowe & Murray (2015) | The most stigma from professionals was exerted by law enforcement or court system and it was mainly **Dismiss/denied** and **Blame.** But all components (also **Loss of status**, **Isolation**, **Blatant unprofessionalism**, **Shame** and D**iscrimination**) were found, and frequency varied depending on the type of professionals. | |
| Ragusa (2013) | Magistrates and police did not take the abuse seriously **(Blatant unprofessionalism: Dismiss/denial**). | |

| Author (Year) | Factors and associations between factors explaining how stigma operates | Recommendations and interventions to fight stigma |
|---|---|---|
| Gavey & Schmidt (2011) | "Rape trauma" discourse: thinking it affected all areas of life forever and women were specially traumatized (**Loss of status**). | |
| Reich et al. (2021) | Reactions to disclosure by family and friends in order of frequency: Not believing them/minimizing the abuse (**Dismiss/ denial)** > Blaming them (**Blame)** > **S**hutting them down (**Dismiss/ denial**) > Dissuading them from reporting (**Dismiss/ denial**) > Sending them away (**Isolation)** and punishing them (**Discrimination)** → All these les to no reporting **(No help-seeking).** | |
| Iles et al. (2021) | - Men or women who had been longer in college → more rape myths → more social distance (**Isolation)**.<br>- Past experiences with sexual assault **(Having experienced violence in the past)** → fewer rape myths → less social distance **(Isolation).** | |
| Vil et al. (2021) | | Public service announcements against stigma in IPV (**Education**). |
| Donovan et al. (2021) | Society could not see doctors as victims (**Victim profile → Dismiss/denial**). | |
| Storer & Casey (2021) | They blamed victims (**Blame**). 1) Direct culpability (thinking victims chose to stay in the abusive relationship and influenced the behavior of the aggressor or) 2) Indirect culpability (thinking women were acting stupid, blinded by love, brainwashed, were weak/incapable) (**Loss of status).** | |
| Nikolova et al. (2021) | **Blatant unprofessionalism:** Victims residing with their abuser/had ended the relationship recently, even when telling the type and severity of IPV and impact on their' health, in comparison with those who had been out of the relationship for a longer period (**Stereotype of "right" victim)** → were given less waiver recommendations (**Discrimination**). | |
| Gonzalez-Guarda et al. (2021) | Pitied by professionals because of their suffering IPV (**Blatant unprofessionalism: Loss of status**). | |
| Manrai (2021) | Victims were suspended from school/lost their jobs (**Discrimination**), people looked at what the girl was doing/wearing, not at the abuser **(Blame), Shame** → It prevented help seeking **(No help-seeking),** disclosure **(No disclosure).** | |

*Sub-themes for findings on how stigma operates and themes for recommendations to fight stigma are written **in bold.**