

Digital and eHealth Interventions for Intimate Partner Violence: A Scoping Review of 74 Studies with Attention to Psychological Abuse and Outpatient Mental Health Care*

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Abstract

Intimate partner violence affects about one in three women, and psychological abuse lies at the core of most abusive relationships. Many survivors avoid specialist services, so digital and information and communication technologies are increasingly proposed to widen access to support. Their scope and their fit with routine mental health care remain poorly mapped, and psychological abuse is rarely treated as a distinct outcome. This scoping review addresses that gap. It asks which digital and eHealth interventions exist for intimate partner violence, how far they engage psychological abuse, and how relevant they are to outpatient mental health care. Following the framework of Arksey and O'Malley and PRISMA-ScR guidance, we searched PubMed and Scopus for English sources published between 2015 and 2025. Records were screened by title, abstract and full text. We charted source type, digital modality, abuse focus and reported outcomes, without risk-of-bias appraisal. Seventy-four sources met the criteria, including randomised trials, study protocols and evidence syntheses. Interventions spanned safety apps, eHealth websites, telehealth, chatbots, screening tools, education and perpetrator programmes. Psychological abuse was named in most readable sources but was seldom measured on its own. Reported effects on violence were small, while depression and anxiety improved more often. Almost none of the studies were based in psychiatric settings. The field is active but uneven. Distinct measurement of psychological abuse and integration into outpatient mental health pathways emerge as clear priorities.

Keywords: intimate partner violence; psychological abuse; information and communication technologies; eHealth; mHealth; digital health; telehealth; outpatient mental health

Introduction

Intimate partner violence describes physical, sexual and psychological harm by a current or former partner. It also covers controlling behaviour such as isolation, surveillance and economic restriction (Vranda and Cicil, 2022). The World Health Organization estimates that about a third of women worldwide experience such violence at some point (El Morr and Layal, 2020). Psychological abuse is the most common element across abusive relationships. It often precedes and accompanies physical harm. Its effects on mental health are serious and include depression, anxiety and post-traumatic stress disorder (Linde et al., 2020; Emezue et al., 2022).

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Despite this burden, few people who experience abuse reach specialist services. Shame, fear of the partner, cost and limited availability all act as barriers (Koziol-McLain et al., 2018; Hegarty et al., 2019). Safety planning is the cornerstone of specialist support, yet it reaches only a small share of those who need it (Glass et al., 2017). These gaps have driven interest in digital health. Websites, smartphone applications, text messaging, video consultation and conversational agents can offer private, flexible and low-cost contact. These are information and communication technologies (ICT) applied to a health and social problem, and their modality, usability and governance shape whether they help (El Morr and Layal, 2020). The pandemic accelerated this shift and made remote support a practical necessity (Emezue, 2020). The field has grown quickly, but its breadth has not been well mapped. This review maps digital and eHealth interventions for IPV, with attention to psychological abuse, and asks how the field relates to outpatient mental health care. Three questions guided the work. What types of information and communication technology for IPV have been studied, and through which modalities? To what extent is psychological abuse addressed as a focus or as an outcome? What does the mapped evidence imply for outpatient and community mental health services? A scoping review suits these questions, since the aim is to chart the nature, range and extent of activity rather than to judge the effectiveness of a single intervention (Arksey and O'Malley, 2005; Peters et al., 2020).

Methods

This review followed the scoping-review framework of Arksey and O'Malley (2005), updated by Peters et al. (2020), and it is reported in line with the PRISMA extension for scoping reviews (Tricco et al., 2018).

Eligibility Criteria

Eligibility followed a Population, Concept and Context structure. The population was people affected by IPV and the professionals who support them. The concept was digital or eHealth interventions, tools or evidence syntheses that address IPV, with attention to psychological abuse. The context was support, screening, education and clinical or community care, read with an interest in outpatient mental health. Sources were included when they described a digital component, focused on IPV or partner abuse with an abuse-related or mental-health outcome, and were relevant to support, screening, education or synthesis. Records on child maltreatment, sexting, problematic smartphone use and general pandemic mental health were excluded when partner abuse was not the focus.

Information Sources and Search

PubMed and Scopus were searched for the period 2015 to 2025, restricted to English. The search combined a digital block, with terms such as eHealth, mHealth, telehealth, app, web-based, chatbot and computerised, and a violence block, with terms such as intimate partner violence, domestic violence, psychological abuse, emotional abuse and coercive control. A three-way overlap with outpatient psychiatry returned no records, so outpatient mental health was carried as an interpretive context, not a filter.

Selection of Sources of Evidence

Two reviewers assessed records independently against the criteria at title, abstract and full-text level, and disagreements were resolved through discussion. After de-duplication, 344 unique records remained. Ninety met the criteria at abstract level and were sought for retrieval. Full texts were available for 76, while 14 could not be obtained and were not assessed further. Two of the 76 were excluded at full text. One described a generic stress-management programme in which IPV was only a background variable. The other described digital abuse as a form of harm rather than an intervention. Seventy-four sources were included. One was available only as a scanned image without a text layer, so its abstract was used in place of the full text. The selection process is shown in Figure 1.

Data Charting

Source type, country, digital modality, abuse focus including whether psychological abuse was named, study population and reported outcomes were charted. Where completed studies reported effect estimates, these were charted as reported by the authors. In keeping with scoping-review methodology, no formal critical appraisal of risk of bias was undertaken, since the aim was to map the field rather than to grade individual studies (Peters et al., 2020).

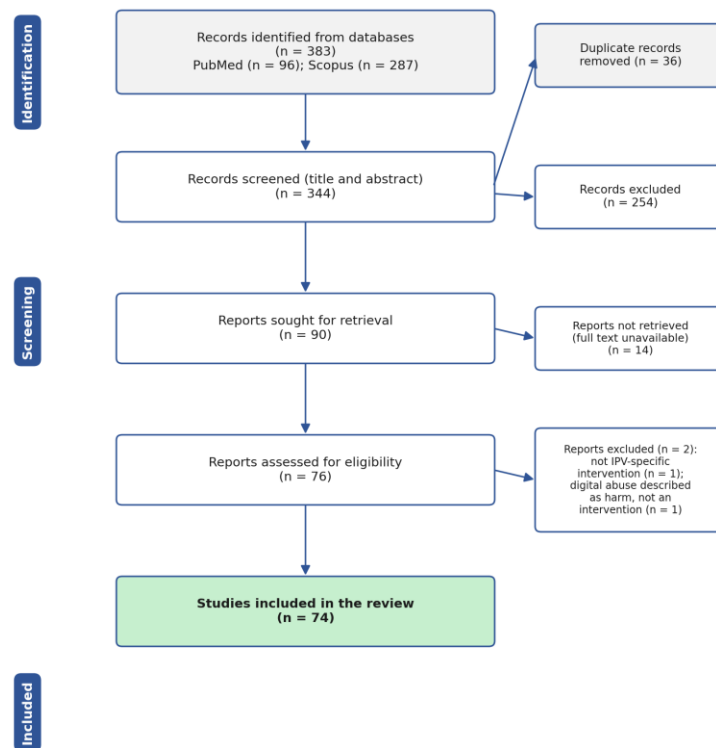


Figure 1. PRISMA-ScR flow diagram of the selection of sources of evidence.

Results

Characteristics of the included sources

Seventy-four sources met the criteria and had a retrievable full text. They were drawn from PubMed and Scopus. The set was diverse in design. It contained 17 completed randomised trials, 14 trial or study protocols, and 12 evidence syntheses, alongside qualitative, development, feasibility, commentary and methodological work. A descriptive summary is given in Table 1. Two features of the map matter for interpretation. Fourteen sources are protocols that describe planned studies without results, so the body of completed evidence is smaller than the count suggests. Several reports also belong to the same programme of work. The SAFE, STOP and myPlan, isafe, I-DECIDE and iCAN families each appear in more than one report, so the number of distinct interventions is lower than the number of sources. Digital modalities overlapped within single tools. App or mobile components and web or online components were near universal. Text messaging, computerised modules and telehealth or video were common. Chatbots and conversational agents were the smallest group. Psychological abuse or coercive control was named in 47 of the 73 readable sources, yet it was seldom measured as an outcome in its own right. Almost all sources were based in antenatal care, primary care or public health. Outpatient psychiatry was practically absent as a setting.

Table 1. Characteristics of the included studies (n = 74).

Characteristic	n
Source type	
Completed randomised trials	17
Trial or study protocols	14
Evidence syntheses (systematic, meta-analytic, umbrella)	12

Characteristic	n
Qualitative or user-experience studies	10
Design or development reports	6
Feasibility or pilot studies	5
Commentary or practice guidance	4
Descriptive or methodological studies	3
Mixed-methods or implementation studies	2
Other	1
Digital modality (not mutually exclusive)*	
App or mobile health component	73
Web-based or online component	73
SMS or text-message component	44
Computerised module	31
Telehealth or video component	28
Chatbot or conversational agent	6
Abuse focus*	
Psychological abuse or coercive control named	47

*counts among the 73 sources with a readable full text. Modality categorier are not mutually exclusive.

Types of Digital Intervention Identified

Safety decision aids and safety-planning apps formed the largest functional group. The isafe tool in New Zealand combined risk assessment with a tailored action plan (Koziol-McLain et al., 2018). The myPlan family applied a similar logic in the United States and elsewhere (Glass et al., 2017; Decker et al., 2020), and the I-DECIDE and iCAN Plan 4 Safety tools moved this work into self-directed online formats (Hegarty et al., 2019; Ford-Gilboe et al., 2020). A version for adolescents and a version for friends of survivors were also developed (Glass et al., 2024; Bloom et al., 2023). eHealth support websites such as SAFE offered modules on relationships, support, mental health and social support, with interactive features (van Gelder et al., 2023). Telehealth and tele-counselling delivered therapy and guidance into the home (Constantino et al., 2015; Vranda and Cicil, 2022). Computerised brief interventions were embedded in clinical settings, including the Computerized WORTH programme in community corrections (Gilbert et al., 2016). Antenatal care was a frequent host setting, through the Safe Pregnancy and STOP programmes (Henriksen et al., 2019; Flaathen et al., 2022; Andreasen et al., 2023; Fernandez Lopez et al., 2022). Conversational agents and chatbots formed a small but growing group (Miner et al., 2016; De Filippo et al., 2023; Ngunjiri et al., 2023; Saboury Yazdy et al., 2022). Screening and detection methods used digital data in new ways, from digital antenatal screening to text mining of police records and prediction from wearable data (Andreasen et al., 2024a; Karystianis et al., 2018; Metcalf et al., 2025). Provider education was a further strand (Divakar et al., 2019; Eckerstrom et al., 2025; Magalhaes et al., 2022). A small group of programmes addressed people who use violence and is best read separately from survivor tools (Gilchrist et al., 2023; Hegarty et al., 2023).

Reported Outcomes

Because this is a scoping review, the findings below are charted as reported by the authors. They are not pooled, and no judgement of effectiveness is made (Peters et al., 2020). The evidence syntheses set the broad picture. The meta-analysis by Linde et al. (2020) pooled 14 trials and reported no benefit, with null estimates across IPV, psychological violence, depression and post-traumatic stress disorder. The meta-analysis by Emezue et al. (2022) pooled 17 trials with 4,590 survivors and reported small reductions in psychological violence (SMD -0.34 at zero to six months),

anxiety and physical violence, with no effect on post-traumatic stress disorder or sexual violence. The comparative review by Cantor et al. (2023) reported outcomes similar to in-person care across IPV, depression and coercive control. Recent reviews reported reductions in depression, anxiety and post-traumatic stress disorder, although the source journals vary in standing (Ghahari, Validabady and Salehi, 2025; Theinkaw and Poowaruttanawiwit, 2025; Yu et al., 2026). The completed trials show where reported effects concentrate. Safety, decisional conflict and self-efficacy shift more often than violence exposure, while mental health outcomes improve in several trials but not all. Effects sometimes appear only in particular groups, as with indigenous Maori women in the isafe trial (Koziol-McLain et al., 2018). A few trials report reductions in violence, including Computerized WORTH (Gilbert et al., 2016) and a gamified chatbot in South Africa (De Filippo et al., 2023), and the STOP intervention reported reduced depressive symptoms among pregnant women (Andreasen et al., 2024b). Representative sources and their reported findings are listed in Table 2.

Table 2. Selected Sources of Evidence and Reported Findings

Source	Country	Design	n	Modality	Reported finding
Linde et al. (2020)	Multi	SR and meta-analysis (14 trials)	1,668	eHealth (mixed)	No pooled effect on IPV, psychological violence, depression or PTSD
Emezue et al. (2022)	Multi	SR and meta-analysis (17 RCTs)	4,590	Technology-based	Small reductions in psychological violence (SMD - 0.34), anxiety, physical violence
Cantor et al. (2023)	Mainly USA	Comparative review (16 studies)	10,731	Telehealth	Outcomes similar to in-person care for repeat IPV, depression, coercive control
Koziol-McLain et al. (2018)	New Zealand	RCT	412	Web decision aid (isafe)	IPV and depression effects limited to Maori women (SVAWS -12.44)
Glass et al. (2017)	USA	RCT	720	Internet decision aid	Reduced decisional conflict and psychological IPV
Hegarty et al. (2019)	Australia	RCT	n/r	Website (I-DECIDE)	Self-efficacy higher (MD 1.3 at 6 months); no effect on depression
Ford-Gilboe et al. (2020)	Canada	RCT	462	Online (iCAN)	Both arms improved; no advantage for tailored version
van Gelder et al. (2023)	Netherlands	RCT	198	eHealth website (SAFE)	No difference between arms; both reduced anxiety and fear
Gilbert et al. (2016)	USA	RCT	306	Computerised (WORTH)	Computerised arm reduced physical, injurious and sexual IPV
Decker et al. (2020)	Kenya	RCT	352	Safety app (myPlan)	Improved safety preparedness; IPV fell in both arms
Glass et al. (2024)	USA	RCT	617	App (myPlan Teen)	Reduced physical and sexual perpetration and suicide behaviour
De Filippo et al. (2023)	South Africa	RCT	19,643	Chatbot (WhatsApp)	Gamified arm reduced IPV at 3 months; no effect on depression
Andreasen et al. (2024b)	Denmark and Spain	Nested cohort	1,545 screen-positive	Digital screening + video (STOP)	Depression reduced within intervention (EPDS MD -3.9)

Source	Country	Design	n	Modality	Reported finding
Flaathen et al. (2022)	Norway	RCT	251	Tablet video (Safe Pregnancy)	No difference in quality of life, safety behaviour or IPV

Note: Findings are charted as reported by the authors and are not appraised for risk of bias. (SR= systematic review, RCT= randomized controlled trial, SMD= standardized mean difference, MD= mean difference, N/r= not reported here)

Discussion

The map shows an active field that is uneven in maturity. Completed randomised trials are outnumbered by the sum of protocols, syntheses and early-stage work, and the same programmes recur across many reports, so the number of distinct interventions is modest. Two findings cut across the corpus and shape how the rest should be read. Psychological abuse is named often but is seldom measured on its own, and outpatient psychiatry is almost absent as a setting. Both matter more once the pattern of reported effects is examined. That pattern, of small effects on violence exposure alongside more frequent gains in mental health, should not be read as failure, because it follows in part from how the outcome is framed. A person who experiences abuse cannot unilaterally end a partner's behaviour, so violence cessation is a demanding endpoint for a tool used by the survivor. The outcomes that move more readily are the ones the survivor can influence, such as decisional conflict, self-efficacy, safety behaviour and help-seeking (Glass et al., 2017; Hegarty et al., 2019). Method adds to this picture. Many trials compare a full tool against a static version of the same website, so both arms receive an active digital resource, both improve, and the between-arm contrast shrinks toward the null (van Gelder et al., 2023; Ford-Gilboe et al., 2020). High attrition at follow-up weakens the contrast further (van Gelder et al., 2023), and benefit sometimes concentrates in particular groups, as in the isafe trial, where it was confined to indigenous Maori women (Koziol-McLain et al., 2018). The syntheses themselves frame these tools as an addition to a coordinated response rather than a standalone cure (Emezue et al., 2022). Violence cessation, then, is often the wrong primary endpoint, and the field is better judged by the mental health and safety outcomes these tools are designed to shift.

That reframing exposes a deeper gap. If mental health is where digital tools act, the form of abuse that drives most mental harm should be measured directly, yet the corpus rarely captures psychological abuse as a separate outcome. Composite scales absorb it into a single score, and only two syntheses report it on its own, where the estimate is fragile and sensitive to outliers (Linde et al., 2020; Emezue et al., 2022). Coercive control and emotional abuse are strong drivers of the depression and trauma that bring people into psychiatric care, so a field that cannot measure change in psychological abuse cannot yet judge whether digital tools help with the harm that matters most. The same logic explains why the near-absence of psychiatry is striking, since the outcomes these tools target, including depression, anxiety, post-traumatic stress disorder and self-efficacy, are core to psychiatric practice. Antenatal and primary care host most tools because they offer routine contact and defined screening windows, while outpatient mental health services see high-prevalence populations repeatedly and remain unused. A plausible way to close that gap is stepped and collaborative care. Digital screening could open the topic in a private way, brief support and safety planning could follow, and specialist referral could be offered when risk is high (Andreasen et al., 2024a; Tarzia et al., 2017). Where specialists are scarce, lay-delivered models can extend reach, as in the myPlan adaptation in Kenya that trained lay professionals to administer the tool (Decker et al., 2020), and integrative designs that combine advocacy with psychological content may suit patients who present with comorbid depression and trauma (Micklitz et al., 2023). None of this works without clinicians who feel able to ask about abuse, which is why provider education sits underneath the whole pathway (Divakar et al., 2019; Eckerstrom et al., 2025). Any move into routine care, however, depends on getting safety, privacy and equity right, since digital tools carry risks that are specific to abuse. A partner may monitor a device, and spyware can expose a person who seeks help, so one perinatal trial screened participants for spyware and stalkerware before enrolment and built privacy safeguards into remote delivery, which shows that safety can be engineered rather than assumed (Johnson et al., 2022; Tarzia et al., 2017). The digital divide pulls the other way, since limited connectivity and low digital literacy can exclude the people most at risk (Cantor et al., 2023), and although women-centred design remains uncommon (El Morr and Layal, 2020), tools co-designed with immigrant, refugee and indigenous communities and adapted to language and culture were valued by their users (Sabri, Vroegindewey and Hagos, 2021; Sabri et al., 2025; Armas, Corona and Barrera, 2025; Hartmann et al., 2023; Ngunjiri et al., 2023). Safety by design and equity by design are therefore preconditions, not optional refinements (van Gelder

et al., 2023). Read as information systems, these tools also succeed or fail on modality, usability and adoption, not only on clinical content.

These threads converge on a research agenda. Harmonised outcome sets would let trials be compared and psychological abuse be tracked across studies (Linde et al., 2020), and outpatient psychiatric settings deserve dedicated trials. The newer modalities raise governance questions that should be settled before wide use, since conversational agents have responded unevenly to disclosures of abuse and crisis (Miner et al., 2016), passive sensing and prediction from wearable data raise issues of consent and surveillance (Metcalf et al., 2025), and the secondary use of police records for text mining raises questions of privacy and proportionality (Karystianis et al., 2018). Evidence on programmes for people who use violence remains thin and feasibility-stage (Gilchrist et al., 2023; Hegarty et al., 2023), and many of the protocols charted here have yet to report, so the map should be revisited as those trials complete. These readings should be weighed against the limits of the review. The search used two databases and English only, so PsycINFO, CINAHL and Cochrane were not covered and relevant work may be missed. A scoping review does not appraise risk of bias, so the findings in Table 2 should not be read as graded evidence. The corpus mixes completed studies with protocols, several reports belong to the same programme, the source journals vary in standing, and one source was available only as a scanned image. Grey literature, hand-searching and reference chaining from the included reviews are planned to extend the map.

Conclusion

Digital and eHealth tools for intimate partner violence form a wide and active field. They span safety planning, support, therapy, screening, detection, provider education and a small set of perpetrator programmes. The map shows small reported effects on violence exposure and more frequent reports of improvement in mental health. This pattern is coherent rather than disappointing, since these tools act mainly through safety, self-efficacy and help-seeking, which a survivor can influence, rather than through stopping a partner's behaviour, which she cannot. Two gaps stand out. Psychological abuse, although central to the problem, is rarely charted as a distinct outcome, and outpatient psychiatry is almost absent as a setting. Both are addressable. Dedicated measures of psychological abuse and trials sited in mental health services would let the field test what it currently only assumes. Within outpatient mental health care, digital tools look most useful as a careful adjunct to skilled human support, built from the start around safety, privacy and equity.

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