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Gender-Based Violence

I-DECIDE: An Online Intervention Drawing on the Psychosocial Readiness Model for Women Experiencing Domestic Violence

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A B S T R A C T

Background: Domestic violence (DV) perpetrated by men against women is a pervasive global problem with significant physical and emotional consequences. Although some face-to-face interventions in health care settings have shown promise, there are barriers to disclosure to health care practitioners and women may not be ready to access or accept help, reducing uptake. Similar to the mental health field, interventions from clinical practice can be adapted to be delivered by technology.
Purpose: This article outlines the theoretical and conceptual development of I-DECIDE, an online healthy relationship tool and safety decision aid for women experiencing DV. The article explores the use of the Psychosocial Readiness Model (PRM) as a theoretical framework for the intervention and evaluation.
Methods: This is a theoretical article drawing on current theory and literature around health care and online interventions for DV.
Results: The article argues that the Internet as a method of intervention delivery for DV might overcome many of the barriers present in health care settings. Using the PRM as a framework for an online DV intervention may help women on a pathway to safety and well-being for themselves and their children. This hypothesis will be tested in a randomized, controlled trial in 2015/2016.
Conclusion: This article highlights the importance of using a theoretical model in intervention development and evaluation.

Domestic violence (DV) is defined as any physical, sexual, psychological, or economic violence that occurs between former or current spouses or partners (Council of Europe, 2011). It is a common social problem worldwide, and one that is distinctly gendered (Ellsberg & Heise, 2005; World Health Organization, 2013). Although it is true that the lifetime prevalence of isolated violent acts within relationships is comparable between genders, repeated, coercive, sexual, or severe physical violence is largely perpetrated by men against women (World Health Organization, 2013). Women experience more frequent and severe DV, are more likely to sustain serious injury and fear for their lives than men (Taft, Hegarty, & Flood, 2001).

The prevalence of DV is particularly alarming in light of its association with a range of negative health outcomes for women and children (World Health Organization, 2013). Research consistently shows that abused women are at increased risk of depression, anxiety, posttraumatic stress disorder, and suicide (Rees et al., 2011), as well as physical problems (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). Children of these women

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also experience negative health and developmental effects, whether as targets of violent behavior or witnesses to it (Bedi & Goddard, 2007).

Despite these negative outcomes, there is limited evidence of effectiveness for interventions in health care settings, with inconclusive results in terms of the effects on women's physical and psychosocial well-being (Bair-Merritt et al., 2014; Feder et al., 2009; Ramsay et al., 2009; Ramsay, Feder, & Rivas, 2006; Taft et al., 2013). There are barriers within health care settings that may prevent effective response. Many women are uncomfortable with revealing that they are experiencing DV, even if the issue is raised in a sensitive manner by the health professional (O'Doherty, Taft, McNair, & Hegarty, in press). They may feel that the abuse is not serious enough to mention (Hegarty & Taft, 2001) or worry about disclosure if their abusive partner sees the same health care professional (Hegarty & Taft, 2001). The pathway to disclosure can be long and challenging for women, and by the time the health professional becomes aware of the abuse, if at all, they may have missed a valuable opportunity to intervene earlier and more effectively (Reisenhofer & Taft, 2013).

Offering a DV intervention in an online format may assist in overcoming some of the barriers encountered in health care settings. Online interventions are being increasingly used as a way of self-managing health conditions, with promising results (Murray, Burns, See Tai, Lai, & Nazareth, 2005). Lintvedt et al. (2013) point out that an Internet-based intervention is constantly available and accessible from any location. This flexibility allows women to access the intervention at unexpected times when an abusive partner is not present, as opposed to the health care setting where they must schedule an appointment. Delivering an intervention online also allows women to self-identify and self-manage without disclosure to a third party. This may be particularly beneficial for women who are unable or unwilling to disclose the abuse to a health care professional and would not attend a specialized support service because they do not perceive themselves as a 'DV victim' (Zink, Elder, Jacobson, & Klostermann, 2004). An online format may also facilitate equity of access for groups of women who might otherwise be disadvantaged, such as women in remote or rural locations, women with disabilities, or women who are closely monitored by an abusive partner. In Australia, currently more than 80% of households have access to the Internet (Australian Bureau of Statistics, 2014) and in the United States it is more than 75% of households (File & Ryan, 2014). Women who do not have safe Internet access at home often have access in other locations such as family or friends' homes, public libraries, or community agencies (Australian Bureau of Statistics, 2014). Minority groups and lower income earners often access the Internet wirelessly using a smartphone (Zickuhr & Smith, 2012).

In a recent systematic review of online health interventions, Webb, Joseph, Yardley, and Michie (2010) examined the role of theoretical background, behavior change techniques, and mode of delivery on the intervention's effectiveness. They found that increased use of theory to inform the intervention led to a greater effect size. In terms of behavior change techniques, the most valuable were found to be information provision, self-monitoring, and problem solving, with action planning and the provision of feedback also having significant positive effects. Interventions that provided an 'enriched information environment' and offered automated tailored feedback were found to have significant effects on behavior change.

This article describes I-DECIDE, an online healthy relationship tool and safety decision aid for women experiencing DV in Australia developed by the authors and adapted from the IRIS online decision aid (Glass, Eden, Bloom, & Perrin, 2010). We explore the theoretical and conceptual development of this innovative online intervention, rather than reporting on data or findings. The article first outlines existing work—both online and clinical—that the I-DECIDE intervention builds on. It then explores the Psychosocial Readiness Model (PRM) as a theoretical framework for DV interventions (Chang et al., 2010; Cluss et al., 2006), and explains the causal pathway for how I-DECIDE operationalizes this theory in practice.

Previous Work Informing I-DECIDE

Interventions for DV

I-DECIDE is informed by pilot work on an online DV intervention conducted in the United States (Glass et al., 2010; the *IRIS* Project). To our knowledge, IRIS is the first such intervention developed to date, with similar interventions being developed in New Zealand (Koziol-McLain et al., 2015) and Canada (NCT02258841). Drawing on the theoretical framework of empowerment (Dutton, 1992), the U.S. intervention focuses on reducing decisional conflict, while also increasing safety behaviors. Dutton's empowerment model focuses on increasing women's safety and enhancing choice making and problem solving, and is a commonly used model for DV interventions. The IRIS intervention takes the form of a website designed to help women identify and decide on the relative importance of a range of possible competing priorities, and having done this, develop an appropriate safety plan. In a preliminary study, Glass et al (2010) found that after a single use, women felt more supported in their decisions ($p = .012$) and had less total decisional conflict ($p = .014$). Most of the participants in the preliminary study, however, had already left an unsafe relationship, and the results of a larger trial that includes women who are still being abused have yet to be determined.

I-DECIDE also builds on the *weave* project (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008), a randomized, controlled trial that evaluated the effectiveness of a face-to-face counselling intervention in the primary care setting for women experiencing fear of a partner (Hegarty et al., 2013b). The doctors in the intervention group were provided with training in the delivery of a counselling intervention involving woman-centered care, active listening, motivational interviewing techniques, and nondirective problem solving to validate and respond to the woman's experiences and feelings (Hegarty et al., 2013b). The I-DECIDE intervention aims to translate aspects of the *weave* counselling intervention, namely, tailored responses and messaging and the use of motivational interviewing and nondirective problem solving tools into an online format. It can thus be seen as a form of therapeutic intervention, which differentiates I-DECIDE from the other similar websites being developed in the United States, Canada, and New Zealand, which are primarily decision aids.

The counselling intervention in *weave* was based on the PRM. The intervention was designed to increase women's awareness of the abuse, her sense of perceived support through being listened to and validated by the doctor, and her self-efficacy through safety planning and nondirective problem solving. The results showed that women who received the invitation for counselling felt more supported by the doctor, had more safety discussions with the doctor, felt more self-efficacious, and were less depressed (Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014). The