Women's experiences receiving support online for intimate partner violence: How does it compare to face-to-face support from a health professional?

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Abstract
There is a growing need for novel approaches in supporting victims of intimate partner violence (IPV), particularly as the demand placed on formal services increases. Online interventions in this space have shown a great deal of theoretical promise. However, currently little is known about how women perceive this form of support, and how their experiences of receiving support online might differ from face-to-face approaches. This study aims to address this gap through qualitative interviews with n=16 women who had experienced IPV. Eight of the women had received support via an interactive online intervention, and eight had received a counselling intervention delivered by their general practitioner (family doctor). The findings suggest that many elements of face-to-face support can also be delivered effectively online, leading to greater control over the help-seeking process. On the other hand, a trusting relationship with the GP can also be extremely helpful to women seeking to disclose, and is difficult to replicate online. Which method of delivery is preferred may depend on whether a woman values trust or control in her help-seeking journey. Both online and face-to-face interventions for IPV should focus on providing individualised support that raises awareness, lessens isolation, and considers women's own unique needs and circumstances.

Keywords:
intimate partner violence; consumer health; user studies; women; empirical studies in HCI; computer intervention

Research Highlights
- Support can be effectively delivered both online or via a trained family doctor for women experiencing IPV;
- Online interventions can overcome many barriers to access associated with face-to-face support and provide greater control over the help-seeking process, whereas the family doctor may encourage trust;
- Interventions delivered via the internet need to be able to respond empathetically to women's individual needs, whilst also managing to provide objective advice.

Introduction

Intimate partner violence (IPV) is defined as "any threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults who are partners or ex-partners" (Garcia-Moreno et al., 2015; World Health Organization, 2013a). Although both men and women may use violence in relationships, the overwhelming majority of violence that occurs in the context of an ongoing, systemic pattern of fear and control is perpetrated by men against women (World Health Organization, 2013a). IPV is estimated to affect 1 in 3 women worldwide, and 1 in 4 women in Australia, leading to higher rates of depression, anxiety, suicide, reproductive problems, and injuries (World Health Organization, 2013a). IPV is therefore considered a major public health problem globally (Garcia-Moreno et al., 2015).

Whilst prevention strategies continue to be important long term, it is imperative to concurrently develop effective responses to women already experiencing IPV. Women's needs are often

complex, and their circumstances are affected by a range of factors outside their control (Chang et al., 2010). Despite this, there is general agreement that support plays a key role in a woman's journey to safety and well-being (Afifi et al., 2008; Beeble, Bybee, Sullivan, & Adams, 2009; Bybee & Sullivan, 2005; Cluss et al., 2006; Coker et al., 2002; Coker, Watkins, Smith, & Brandt, 2003; Dillon, Hussain, Loxton, & Khan, 2016). The Psychosocial Readiness Model developed by Cluss et al. (2006), for instance, identifies a woman's perception of support from others, alongside her awareness of the abuse and her self-efficacy as key interrelated factors promoting positive change. If a woman lacks support from those around her, she may struggle to enact change, even if she is aware of the abuse and motivated to make herself safer. Coker and colleagues (2002; 2003) suggest that emotional support may mediate the harmful effects of IPV on mental and physical health, while Beeble et al. (2009) found both mediating and moderating effects of social support on women's well-being when experiencing IPV.

In the context of IPV, support is typically delivered face-to-face, either informally by family, friends and support groups, or formally through specialised services. Studies suggest that support received from specialised services can be beneficial to women experiencing IPV (Constantino, Kim, & Crane, 2005; Evans & Feder, 2015; Sullivan, 2012), however, if women do not identify as a "victim" they may not access these resources (Evans & Feder, 2015; Zink, Elder, Jacobson, & Klostermann, 2004). Furthermore, the demand on specialised services often outweighs their capacity to respond (Council of Australian Governments, 2010). More recently, studies have investigated the potential for health professionals such as general practitioners (GPs), to deliver counselling and support (Hegarty et al., 2013) as an alternative to specialist IPV services. Women experiencing IPV have a higher prevalence of health service use (Garcia-Moreno et al., 2015; Rivara et al., 2007), and the World Health Organization has consequently recognised the health sector as a key point of early intervention (World Health Organization, 2013b). A meta-analysis of qualitative studies suggested that women want health care providers to be non-judgemental, compassionate, and maintain confidentiality (Feder, Hutson, Ramsay, & Taket, 2006). They also need to display a level of understanding regarding the complexity of IPV, and ensure that women are followed up over time (Feder et al., 2006). However, a range of barriers have been identified that may prevent women from accessing GPs or other health care providers (Hegarty & Taft, 2001; Othman, Goddard, & Piterman, 2014; Wester, Wong, & Lagro-Janssen, 2007). These include: fear of being judged or misunderstood (Chang et al., 2005); financial pressures; concern about the partner finding out (Hegarty & Taft, 2001; Rose et al., 2011); and a belief that IPV is a private matter (Hegarty & Taft, 2001; Othman et al., 2014). Qualitative studies show that similar barriers are faced by women trying to disclose to informal supports such as family and friends (Taket, O'Doherty, Valpied, & Hegarty, 2014; Trotter & Allen, 2009)

Targeted interventions delivered via the internet have shown promise as an alternative method of support for women experiencing IPV (Eden et al., 2015; Glass, Eden, Bloom, & Perrin, 2010; Koziol-McLain et al., 2018; Koziol-McLain et al., 2015; Lindsay et al., 2013; Tarzia, Iyer, Thrower, & Hegarty, 2017; Tarzia et al., 2015), with the potential to overcome some of the barriers associated with accessing face-to-face services (Tarzia, May, & Hegarty, 2016). Although there has been increasing attention paid to the negative effects of technology on IPV victims including stalking, harassment and technology-facilitated abuse (Dimond, Fiesler, & Bruckman, 2011; Woodlock, 2017), there are also many positive aspects. For instance, providing that appropriate safety measures are in place (Matthews et al., 2017), the internet is anonymous and easily accessible at any time; important for women whose partners control their physical whereabouts (Lindsay et al., 2013) or who are uncomfortable with the idea of disclosure (Tarzia, Iyer, et al., 2017). The internet can also reach women who are restricted by physical disability or location.

Studies in other health contexts suggest that online interventions and communities can provide good support (Barrera, Glasgow, McKay, Boles, & Feil, 2002; Eysenbach, Powell, Englasakis, Rizo,

& Stern, 2004) that is comparable to face-to-face, yet there is a paucity of research exploring this in the context of IPV. Little is known about how survivors themselves perceive online support in comparison to face-to-face interactions. A recent study focusing on young Australian women (Tarzia, Iyer, et al., 2017) found that their views around addressing IPV using technology were positive, however, they did raise some concerns regarding the capacity for a website or app to deliver support with the same 'human touch' as a counsellor or specialist service. Expanding on this finding, this paper reports on qualitative data from semi-structured interviews with n=8 women who took part in a large randomised controlled trial (RCT) of an online IPV intervention. It compares their views with those of a further n=8 women who had received a face-to-face counselling intervention delivered by a GP as part of a different study. In doing this it compares two forms of IPV support delivered outside of the usual formal settings (e.g. IPV service, crisis centre, refuge) and examines some of the opportunities and challenges of delivering this type of support online. It is important to note that the aim of this paper is not to explore the provision of online support via forums, chat rooms or other informal communities. Whilst there is a broader body of literature examining the potential benefits of connecting people with shared experiences using technology (Barak, Boniel-Nissim, & Suler, 2008; Chung, 2013), there is less information about using the internet to provide 'expert' support and advice.

Materials and methods

The data reported in this paper are drawn from the qualitative process evaluation phases of two Australian RCTs. *Weave* (Hegarty et al., 2013) compared the effectiveness of a GP counselling intervention to treatment as usual. *I-DECIDE* (Hegarty et al., 2015) compared an interactive online healthy relationship tool and safety decision aid to a static website with basic information and standard safety plan. Both studies received approval from The University of Melbourne's Human Research Ethics Committee (HREC 0824166 and HREC 1442953.4).

WEAVE – GP counselling intervention

The *Weave* trial involved n=272 women aged 16-50 who were attending one of the participating general practice clinics and who screened positive for fear of partner in the past 12 months. Women in the intervention arm were invited to receive up to 6 brief counselling sessions with a GP who had received specialist training, whilst women in the comparison arm continued to receive standard care. The counselling sessions focused on woman-centred care and incorporated elements of motivational interviewing, non-directive problem solving and managing safety and confidentiality. The GPs in the intervention arm were given intensive training over several weeks in delivering the intervention, including developing skills in active listening (Gunn et al., 2006), recognising a woman's readiness for change (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008), and effective safety planning. The training involved a combination of educational sessions, self-directed learning and practical sessions with simulated patients.

A total of 28 semi-structured interviews were conducted with women who participated in the study as part of the process evaluation phase (O'Doherty, Taket, Valpied, & Hegarty, 2016). These interviews aimed to explore women's experiences of participating in the trial and involved women in both intervention and comparison arms. Elsewhere, the factors influencing *uptake* of the counselling intervention have been explored (O'Doherty et al., 2016), however, women's *experiences* receiving help from the trained GP have not been examined qualitatively. A total of n=8 women interviewed from the intervention group had chosen to take up the counselling sessions. This subsample was used for the present study, and secondary thematic analysis was undertaken focusing on their experiences receiving support from the specially trained GP.

I-DECIDE – Online healthy relationship tool and safety decision aid

The *I-DECIDE* trial involved n=422 women aged 16-50 recruited online who had experienced physical, psychological or sexual violence or fear of a partner/ex-partner over the previous six

months. These women were randomised to either the online intervention or a comparison website after signing up to the study. The *I-DECIDE* intervention incorporated some key elements of the *Weave* counselling intervention (motivational interviewing, non-directive problem solving, validating and supportive messaging) but delivered them in an online format. The website is described in detail elsewhere (Tarzia et al.,, 2015), but in brief, the *I-DECIDE* intervention consisted of three modules: a healthy relationship tool, a safety module and a priority-setting exercise. The healthy relationship tool provided information on a healthy versus unhealthy relationship, and asked women to reflect and rate the health of their own relationship, their level of fear, and level of safety using visual analogue scales. The safety module used validated self-report tools to measure women's level of danger (Campbell, Webster, & Glass, 2009) and the types of abuse being experienced (Hegarty, Bush, & Sheehan, 2005), and provided tailored feedback messages according to the results (see Fig. 1). The priority-setting module asked women to weigh up four or five (depending on whether they indicated that they had children) different priorities for safety and wellbeing in pairwise comparisons (see Fig. 2) and an algorithm used this information to calculate their top priority. The intervention then presented them with self-guided motivational interviewing and non-directive problem solving exercises, culminating in an individualised plan for action (see Fig. 3). The action plan was developed via another algorithm which selected a short-list of strategies from a larger database based on women's priorities, relationship choices (stay, leave or already left), and level of danger (Tarzia et al., 2015). Women could choose to view the entire database of strategies if they wished. Women in the comparison arm received a basic website with information about healthy relationships, and a static emergency safety plan and resources consistent with what is currently provided by IPV services in Australia.
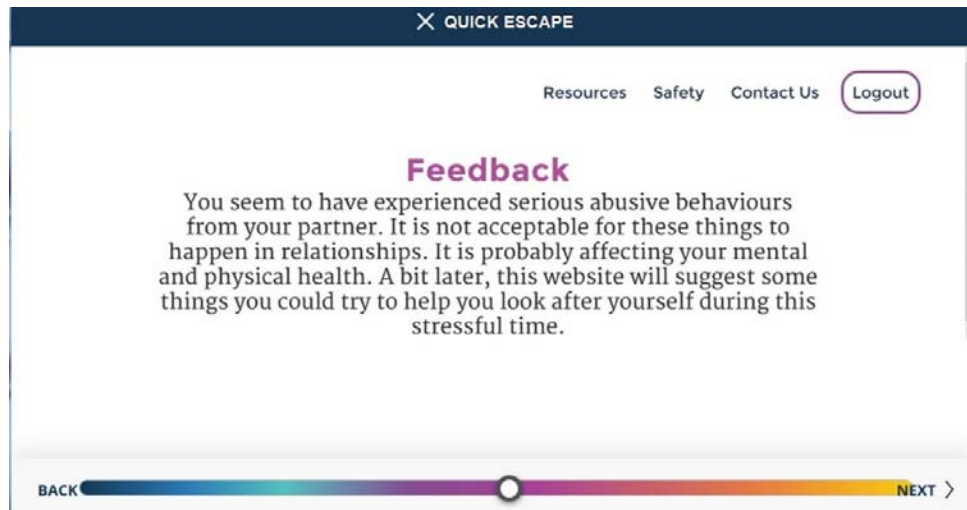

Fig.1 - Example feedback message

Fig. 2 - Priority-setting exercise

Fig. 3 - Example action plan

Process evaluation interviews for the *I-DECIDE* trial are ongoing. For this paper, a subsample of n=8 participants were recruited from the intervention arm of the trial. Purposive sampling was used to recruit women of different ages, educational backgrounds, and level of fear of their abusive partner. Interviews focused on several different aspects of the participants' experiences receiving the *I-DECIDE* intervention, including their feelings about receiving support online, their specific experiences with elements of the intervention, and how it compared with any previous experiences accessing face-to-face support.

Data Analysis
The data from both sets of interviews were drawn together and thematic analysis was conducted with the assistance of the software program, NVivo 10 (QSR International, 2015). Analysis focused on the interventions more broadly and their mode of delivery rather than on specific

elements of the intervention content. Basic descriptive codes were identified and categorised into interpretive codes. Following this initial analysis, a coding framework was devised by LT and RC and applied to the combined dataset. The coding framework was then reviewed by KF and KH, and overarching themes identified. Themes were discussed and revised within the research team until consensus was reached.

Ethics and Safety

Both *Weave* and *I-DECIDE* adhered to strict protocols and held women's safety and wellbeing as a primary concern throughout the research process. In *Weave*, care was taken to disguise initial screening questions about IPV within the broader context of women's health. Surveys and study materials posted to women were designed without any overt references to IPV, and researchers utilised safety protocols during any telephone contact with women. In both studies, women were compensated for their time with small gift vouchers.

In *I-DECIDE*, women were asked to use only a 'safe' email address to sign up to the study (one which the partner or ex-partner who made them afraid did not have access to). They were provided with information on how to set up a free account with Gmail or Yahoo in case they were unsure about the security of their existing email accounts. All study-related emails came from a generic account and had the subject line 'Women's Health Study'. Women were provided with a unique username and password upon signing up which was required to progress beyond the initial front page of the website (which did not state anything overtly about IPV). Although it was suggested that women access the website from a safe computer (e.g. friend's house, public library), instructions on how to clear the browser history and how to create an incognito/private browser session were provided and were accessible at any point. As is standard across IPV-related websites, a 'quick exit' button was displayed at the top of the screen. This enabled women to exit the website quickly with one mouse click should the perpetrator enter the room. The browser automatically opened a new window displaying the Google search engine and redirected the original window to a generic weather website. These measures all represent suggested good practice when developing technological interventions for IPV survivors (Matthews et al., 2017). Lastly, in both studies, researchers carefully monitored the harm versus benefit of participation using the Consequences of Screening Tool (Lock, 2008). Additional ethical and safety issues are described in greater detail elsewhere (Hegarty et al., 2013; Tarzia, Valpied, Koziol-McLain, Glass, & Hegarty, 2017).

Results

Participant demographics are reported below in Table 1.

Table 1. Sample demographics

	Weave (n=8)	*I-DECIDE (n=8)*
Still in relationship	3	0
Mean Age (range)	43 (24-49)	40 (22-51)
Children < 18 at home	6	5
Level of fear at baseline*		
Unknown	0	1
0	0	1
1-2	4	0
3-6	3	1
7-8	1	2
9-10	0	3

*Fear was ranked from 0-10 with 0 being none and 10 being very afraid.

The key distinction between women's views on support delivered by a trained GP and their views on the online intervention can be summarised by the overarching theme of *"Trust versus control".* Four sub-themes were identified within the data that illustrate important aspects of the two modes of support for IPV; for each of these, the views of participants in the two studies have been contrasted: "*Realising this is not OK", "I'm not alone", "Keeping it hidden",* and *"Addressing my needs".*

Realising this is not OK
Awareness-raising was perceived as a key component of support for IPV, whether delivered face-to-face or online. Women across both studies highlighted that they were previously unaware that they were experiencing IPV and that receiving information from an external source was helpful. Women from *Weave* found that this information and awareness-raising was provided effectively by the trained GP. In many cases, the GP's reaction or response to a woman's story acted as a 'sounding board' to confirm what she already suspected but had been unable to articulate or acknowledge. The realisation that the behaviours they had been experiencing were abusive generally happened over time and through multiple consultations with the GP.

> *"I think with each appointment [with the GP] there was that little bit more release... with each one there was that little bit more...feeling of being able to acknowledge that, yes, this actually was abuse."* (P7, *Weave*)

> *"As I was talking to her [the GP] I could see that some of the stuff shocked her so that made me think, 'Oh...it actually wasn't OK'. I guess all this time I had been thinking...'Am I just a weak person...?'"* (P8, *Weave*)

Women acknowledged that it was good to 'talk things through' with the GP, but highlighted the importance of the GP not forcing them to accept that their relationship was abusive before they were ready to do so.

> *"[the GP] never really pushed too much - not in the first [consultation]. Down the track she probably asked a few more questions that opened up some of the issues." (*P7, *Weave)*

In *I-DECIDE,* women found that completing questionnaires about behaviours that may have been happening in their relationships was effective in raising awareness. Although the website provided tailored feedback messages depending on a woman's answers, it was primarily the process of completing the questionnaires themselves that women described as facilitating self-reflection:

> *"You don't realise and...it tells you on the website when you do the surveys... 'Does that person say this to you or say that to you?' I'm like, 'Oh goodness, yes!'* (P1, *I-DECIDE*}

> *"They were just black and white questions. Then when you went through them and there were so many 'yeses' and you think, 'No, this is not okay'."* (P6, *I-DECIDE*)

> *"I had already done a lot of healing...I wasn't having anything to do with him [abusive partner] ...It [the website] just reaffirmed to me not to go back there...[the questions] made me be more aware of, I guess, not to fall back in those traps no matter how lonely I was."* (P3, *I-DECIDE*)

Women's views on whether it was better for awareness-raising to occur verbally or in written form varied. In *Weave*, for instance, one participant articulated the importance of putting words 'out there' and how this could help to clarify otherwise-nebulous thoughts:

> *"By verbalising things you - once you've got it out there, you can't take the words back. So to articulate something perhaps clarifies your thoughts, rather than swimming around and fighting with yourself, in your head."* (P1, *Weave*)

On the other hand, *I-DECIDE* participants explained that the written nature of the website was what was helpful:

> *"I guess it was difficult to see things written down. You think things over and you think them through, but it's quite different to see things written down and to relate to them, which makes it, I suppose, a little bit more real when you try to push things aside."* (P7, *I-DECIDE*)

> *"I think the website has the ability to ask you questions that would be incredibly humiliating and embarrassing if you were asked face to face or speaking to someone."* (P6, *I-DECIDE*)

I'm not alone

Women in both studies highlighted the sense of isolation that accompanies IPV victimisation. Many felt that it was difficult to find someone to talk to, as they were not necessarily able to disclose to friends or family members. The majority of women interviewed from *Weave* found that the trained GP was able to create a safe space to talk, provide support, and be a good listener, all of which made them feel less isolated.

> *"I would just say that there's an overwhelming sense of being looked after, cared for, supported [by the GP]." (*P5, *Weave*)

> *"I really liked the way he [the GP] listened.* (P6, *Weave*)

In particular, a long-term and trusting relationship with the GP facilitated disclosure and made women feel supported:

> *"He has known me, my regular GP, for 23 years. So he's seen me before I was married, through my three children, through being pregnant with them, through a couple of health issues. So he's seen my frame of mind, and what my general demeanour's like. So when he asks me about our family, I feel it's important to be honest with him because he will be my stepping stone for further support, I believe, if I wanted it." (*P1, *Weave*)

In *I-DECIDE*, a sense of support was achieved for many women simply by inputting their information into the website, even though they knew it was not being monitored in real-time:

> *"I found that the website, in the way it was and the way it was written, was like having a supportive group of girlfriends on the computer. That were thinking straight and could help you sort your thoughts out."* (P6, *I-DECIDE*)

> *"I was really touched that there's someone that cares….they're actually listening to me." (*P7, *I-DECIDE*)

For one woman, the fact that a real person was not on the other end of her interactions was actually identified as a positive:

> *"I think sometimes when you're talking to someone…you're very aware that they're mandatory reporters and you're never quite sure, 'If I reveal this, what's going to happen tomorrow?' Whereas with the website, I felt that you could be at one with your own thoughts.* (P6, I-DECIDE)

Primarily, however, the website lessened women's sense of isolation by normalising the experience of IPV. Simply knowing that there was a website dedicated to women's experiences of IPV made them feel less alone.

> *"Knowing that there was something like this helped me to realise that you weren't on your own and it isn't something to be ashamed of and there are a lot of women in the same situation regardless of education or status."* (P3, I-DECIDE)

> *"Obviously, it's terrible to think that other women…go through this, but, to not feel like I was alone, I suppose. I don't know. There was some weird comfort in that."* (P5, I-DECIDE)

Keeping it hidden
The risks associated with disclosure of IPV were acknowledged by women in both studies, although for most women in *Weave*, these risks were less immediate given that they had already left the abusive relationship at the time they received the intervention. Where there were safety concerns associated with traveling to the GP for support, these were circumvented by explaining the study appointments as being related to other health issues.

> *"I still had a fair bit of fear, I guess, in the fact that I was going to the appointments and I was trying to keep it very low key that that's what I was doing and what they were really about…." (*P7, *Weave)*

Women in *I-DECIDE* identified safety benefits associated with delivery of an intervention over the internet.

> *"I found the website was like this big plan - like an architect's plan but….[because of safety issues] you can't have an 'architect's plan' written down about what you're going to do with your life and your relationship in a physical form. The website allowed you to have that." (*P6, I-DECIDE)

> *The internet…lets you do it [work through information and make decisions] in your own time, without being found out. Depending on how unhealthy the relationship is, it isn't very good to be 'sprung on' [found out by your partner]. (*P8, I-DECIDE)

Addressing my needs
A major issue for many women seeking help for IPV is that services or other sources of support do not meet their individual needs. For both the face-to-face and online interventions, there were ways in which women felt that they did, or did not, meet their individual needs. For some women in *Weave*, for instance, the appointments with the trained GP were unsatisfactory due to the doctor not picking up on their feelings:

"I just felt that [the GP] was very: 'Okay, how are you going? What's happening here? Are you feeling this? Is the medication helping... da da da?' You're feeling like a patient with a problem and I don't want to be a patient with a problem. (P3, Weave)

*"It was pretty much, 'Oh well, calm down, here's a number that you can ring tomorrow.'
I was like, but...I'm in a mess now, I need some help now, but I don't know what I need"*
(P7, *Weave*)

[I felt] a bit miserable after the sessions. A bit depressed. Glad that I'd spoken but it was just... [hard] remembering stuff... I couldn't block them [relationship issues] because I had to talk about them so they were all like in my face again. (P8, Weave)

For others, however, the GP was ideally placed to provide support that was tailored to their current priorities and needs, whether this be addressing co-occurring health issues, focusing on safety planning, or helping to clarify their choices.

"[The GP] got me on to the counsellor I'm seeing now. She recommended her." (P4, Weave)

"Having to discuss [the violence] with my daughter at that point... 'Be aware that I might have to just go out of the house'. I had discussed all that with the GP. The GP was the one who was helping prompt me with 'These are the things you need to think about.'" (P7, Weave)

For others, however, even when the response was supportive, it was accessing the GP that was difficult; logistical issues thus prevented the counselling intervention from meeting their needs:

"[The GP is] brilliant, but she's always running late and always running behind time." (P4, Weave)

"I just hadn't finished talking through it perhaps. The thing is she [doctor] is quite a long way away." (P8, Weave)

On the other hand, women in *I-DECIDE* emphasised that online support is easily accessible. Unlike face-to-face support, online support is both affordable and flexible, enabling women to fit it into their busy schedules and at times that were safe.

"I did actually find it very useful in the middle of the night to look at." (P6, I-DECIDE)

"With kids and things like that, if you are in an unhealthy relationship and you want to be proactive, it's hard. The internet is open 24/7 and you make it work in that time." (P8, I-DECIDE)

Participants in *I-DECIDE* also commented on the capacity for online support to be used at a woman's own pace, rather than being rushed through an appointment with a busy health professional. This alleviated pressure for women, giving them greater control over their use of support. Online support could also be 'switched off' if it did not meet women's needs.

"The internet allows you to...You are not put on the spot if you can't think of an answer. You are not on the clock. You can take your time." (P8, I-DECIDE)

> *"It's different with a website. If you don't like it, you can switch it off. If you are with a person you are obliged to sit there any listen to the stuff that's going on." (*P7*, I-DECIDE)*

Tailored responses, even from a website, made women feel like someone cared for them and that their experiences mattered.

> *"I felt like, you know it was all about me. They were talking all about me. I felt like even though they were talking about different situations it felt personal."* (P7, *I-DECIDE*)

> *"The website was so personal to me, I found that by referring back to it, I could think, 'No, that's actually what I really want to do and that's the path I need to follow' and to stay focused on that. So, yeah, I would say the website was very useful in keeping me focused on what I wanted without being influenced too much by other people's experiences or desires or whatever." (*P6, *I-DECIDE*)

There was acknowledgement, however, that the website did not provide individualised support in all cases.

> *"I was a little bit disappointed with the way the questions were geared. It focused on physical violence and nothing on controlling [behaviours]…For me, the other point, identifying are you with someone with mental health issues?"* (P2, *I-DECIDE*)

> *"Because it was more questions than - suggestions. I felt that it was just like a survey so I felt really detached from the whole thing*." (P4*, I-DECIDE)*

Discussion

This qualitative study explored women's experiences receiving face-to-face support for IPV from a trained family doctor and contrasted them with those of women who had received support via an online intervention. To our knowledge, this is the first time that women's views on multiple types of IPV support have been compared when both forms of support are delivered outside of the 'traditional' specialised IPV service. Our findings strengthen the hypothesis that online interventions have great potential in addressing IPV, but also attest to the benefits associated with training GPs to respond to this issue; either option could be a feasible and acceptable alternative to specialist services for women who are unable or unwilling to access these. We suggest that women's preference for support delivered via trained GP or online may depend on whether *trust* or *control* is valued more highly in their help-seeking journey. Although elements of both are naturally required, it was clear from our findings that what was emphasised in *Weave* was subtly different to *I-DECIDE.*

The importance of receiving objective, unbiased information that could help to raise awareness about the health of their relationships was highlighted by women in both studies. Several participants from the *Weave* sample confirmed the important role health professionals such as GPs or counsellors can play in raising awareness of abuse, particularly where there is an existing or trusting relationship. However, a key question to date has been whether online support can also encourage the same level of self-reflection without another person to be a 'sounding board'. In fact, women in *I-DECIDE* suggested that simply filling in questionnaires about behaviours happening in their relationships was enough to raise their awareness and encourage them to think critically about their situation. The process of answering questions independently and seeing how many 'yeses' were inputted was emphasised rather than the tailored feedback messages provided by the online intervention. Women also felt that seeing information written down was a stronger catalyst for awareness than discussing issues in person; some participants

perceived that it was easier to avoid difficult conversations about IPV face-to-face, and others felt that discussing it in person was embarrassing or shameful.

As well as raising awareness, women wanted to feel less isolated and alone. This is consistent with existing IPV literature (Evans & Feder, 2015). Again, the two forms of support differed slightly in how they were able to address this need. For women in *Weave*, feeling cared for by the GP and knowing the doctor was available to support them was highlighted. Women in *I-DECIDE* also felt supported by the website, despite knowing that there was not a person on the other end, however, more commonly they spoke about feeling that the existence of the website confirmed there were other women 'out there' also going through IPV. Although the GP counselling intervention also emphasised the importance of normalising the experience of IPV, this was not mentioned by the participants in *Weave* as being a key factor in making them feel supported.

Safety concerns are paramount in delivering any intervention for IPV. The risks associated with the abusive partner finding out about women's participation have been addressed at length in the existing literature (Krishnan, Subbiah, & Srinivasan, 2012; Tarzia, Valpied, et al., 2017; Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014). Although keeping their help-seeking hidden was important for women in both studies, it was not a major theme in the findings, possibly due to the fact that the majority of participants had already left the abusive relationship and no longer felt fearful for their safety. Consistent with previous studies, (O'Doherty et al., 2016), women in *Weave* suggested that addressing IPV via the GP felt like a safe option, as their visits could easily be explained as being health-related. *I-DECIDE* participants highlighted the ability to help-seek privately, anywhere and at any time when using the internet, and the potential to work through issues without writing things down. No participants expressed concerns regarding the safety of the internet as a medium of intervention delivery. This may be because these particular women were not technologically savvy, or alternatively, because the safety precautions built into the online intervention reassured them that they were not at risk.

Lastly, the importance of tailored support that was individualised to women's circumstances and needs was emphasised by participants in both *Weave* and *I-DECIDE*. There were mixed views on how well each intervention was able to achieve this. In *Weave*, women valued support that took into account co-existing health issues and treated them holistically, facilitating trust. However, where the support offered by the GP was not sensitive to the nuances of how they were feeling, women were reluctant to continue seeing the doctor. Consistent with existing literature (Hegarty & Taft, 2001; Othman et al., 2014; Postmus, Severson, Berry, & Yoo, 2009), structural barriers such as distance and time often meant that the GP intervention did not meet women's needs, even where the doctor themselves was viewed positively. Women in *I-DECIDE* suggested that online IPV interventions can overcome some of these barriers, highlighting the accessibility, flexibility and convenience of using a website to access support. The majority also felt that the intervention was sufficiently tailored to their individual circumstances; where this was not the case, most participants were happy to take only what was relevant. On the other hand, for some women in *I-DECIDE*, the website was not able to provide a response that was individualised enough, either because it did not focus on their particular situation or because it simply could not compare with support from others with lived experience.

Implications for practice

Our findings suggest that many key elements of face-to-face support for IPV such as awareness-raising and lessening isolation can be provided well via the internet. Furthermore, online support can offer additional advantages in some areas such as increased anonymity, privacy and flexibility of access, providing safety mechanisms are in place. For women who value a sense of control over their help-seeking journey, an online IPV intervention that provides women with choices and options may be preferable to seeking help via specialised services or a trained GP. However, ways

to foster trust and empathy in online IPV interventions – particularly when human interactions are not supported – need to be developed in order to make them appropriate for a wider range of women. Some elements of trust and empathy building and human-computer rapport have been discussed in the existing literature around technological interventions in other health contexts (Brave, Nass, & Hutchinson, 2003; Ellis et al., 2017), however, little is known about developing these relationship factors in an online IPV intervention. Future research is recommended to explore this further, including whether the use of avatars or human-like relational agents might be effective.

Our findings also emphasise the importance of providing tailored, individualised support to women experiencing IPV. This obviously presents a greater challenge for interventions delivered online, since they cannot (thus far) adjust their response based on the emotional reaction of the user. This is something that needs to be carefully considered by other researchers or developers of online IPV interventions. Effective strategies for personalising online interventions to women's readiness for change, priorities, type of abuse experienced, and level of safety need to be incorporated in order to maximise engagement and uptake.

Conclusion

This qualitative study aimed to investigate how women experiencing IPV perceive online support relative to face-to-face support delivered by a trained GP. No other study to date specifically explores and contrasts women's perceptions of these two forms of support. Our study did have a number of limitations, including the use of sub-samples from two different RCTs, and the small numbers of women included in the analysis. Differences between the two groups in how many women were still in a relationship with the partner who had made them afraid (n=3 in *Weave* and none in *I-DECIDE*) and in the distribution of fear scores (with *I-DECIDE* participants having higher levels of fear) may also have impacted the findings. Women who were more fearful may have been more likely to value the anonymity of an online intervention than those who were not so concerned about their safety. Our findings also cannot be generalised to other population groups (e.g. women in same-sex relationships, women from culturally and linguistically diverse backgrounds). Nonetheless, the findings add to the knowledge base around the use of online IPV interventions, and help to understand the complexities of women's help-seeking and the factors that influence their uptake of different forms of support.

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