The Longitudinal Impact of an Internet Safety Decision Aid for Abused Women

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Introduction: Women experiencing intimate partner violence (IPV) navigate complex, dangerous decisions. Tailored safety information and safety planning, typically provided by domestic violence service providers, can prevent repeat IPV exposure and associated adverse health outcomes; however, few abused women access these services. The Internet represents a potentially innovative way to connect abused women with tailored safety planning resources and information. The purpose of this study was to compare safety and mental health outcomes at baseline, 6 months, and 12 months among abused women randomized to: (1) a tailored, Internet-based safety decision aid; or (2) control website (typical safety information available online).

Design: Multistate, community-based longitudinal RCT with one-to-one allocation ratio and blocked randomization. Data were collected March 2011–May 2013 and analyzed June–July 2015.

Setting/participants: Currently abused Spanish- or English-speaking women (N=720).

Intervention: A tailored Internet-based safety decision aid included priority-setting activities, risk assessment, and tailored feedback and safety plans. A control website offered typical safety information available online.

Main outcome measures: Primary outcomes were decisional conflict, safety behaviors, and repeat IPV; secondary outcomes included depression and post-traumatic stress disorder.

Results: At 12 months, there were no significant group differences in IPV, depression, or post-traumatic stress disorder. Intervention women experienced significantly less decisional conflict after one use (β= -2.68, p=0.042) and greater increase in safety behaviors they rated as helpful from baseline to 12 months (12% vs 9%, p=0.033) and were more likely to have left the abuser (63% vs 53%, p=0.008). Women who left had higher baseline risk (14.9 vs 13.1, p=0.003) found more of the safety behaviors they tried helpful (61.1% vs 47.5%, p<0.001), and had greater reductions in psychological IPV ((11.69 vs 7.5, p=0.001) and sexual IPV (2.41 vs 1.25, p=0.001) than women who stayed.

Conclusions: Internet-based safety planning represents a promising tool to reduce the public health impact of IPV.

INTRODUCTION

Annually, an estimated 6.9 million U.S. women are raped, physically hurt, or stalked by an intimate partner/ex-partner. Health sequelae of intimate partner violence (IPV) include depression; post-traumatic stress disorder (PTSD); suicidality; chronic fatigue; insomnia; headaches; gastrointestinal, respiratory, and gynecologic problems; traumatic brain injury3,4; and physical injury.8 Globally, a third of female homicides are perpetrated by intimate partners, including an average of three U.S. women murdered each day.5

Foundational work in empowerment by Mary Ann Dutton9 was used as the model for the intervention to increase safety and improve health outcomes with women in abusive relationships. Specifically, the empowerment model for the intervention addressed three key factors: (1) protection, a focus on increasing safety for women and their families; (2) enhancing decision making around safety; and (3) reducing exposure to violence to support healing of the health effects of IPV. Safety planning is an evidence- and empowerment-based intervention intended to support abused women’s decision making around the relationship, relocation, and other safety issues for self and family, typically provided within clinic- and community-based formal services (e.g., healthcare settings and crisis services).9,10 Safety planning that is individualized, with attention to abused women’s priorities, level of risk, and resources, has been shown effective in reducing exposure to violence and, ultimately, in improving health. Abused women are often unaware of safety planning services11 and the majority (48.7%–67.8%) never access them, navigating complex, dangerous, potentially fatal decisions alone.12–14 However, many do have safe Internet access (e.g., at home, work, public library, or at family/friends’ homes), representing a promising area for potential innovation to increase access to safety planning for abused women. Therefore, the purpose of this study was to examine the effectiveness of a previously developed Internet-based safety decision aid for abused women.15

Decision aids help people facing challenging decisions understand their options, consider possible benefits and harms, and participate in decision making.16 Decision aids are well established as effectively supporting informed decision making regarding complex screening and treatment decisions (e.g., end-of-life choices) and reducing decisional conflict, a state of uncertainty stemming from feeling uninformed/unclear about personal priorities/values around a decision.16,17 The safety decision aid in this study is designed to help abused women understand and feel more certain in decisions, more informed, more clear on priorities, and more supported in decisions, and therefore less conflicted in taking action to increase safety and improve health while reducing risk of repeat and near-lethal violence when planning to stay or end the relationship.

To test the intervention’s effectiveness on safety and mental health outcomes over 12 months, this research team conducted a longitudinal RCT (Internet Resource for Intervention and Safety). This study compared the intervention with a control condition (typical IPV information available through advocacy websites). The research team hypothesized the intervention would reduce decisional conflict, increase safety behaviors, and reduce repeat IPV exposure (primary outcomes) and that intervention group women would report greater reduced depression and PTSD symptoms (secondary outcomes).

METHODS

Four academic centers conducted this community-based RCT with a one-to-one allocation ratio (ClinicalTrials.gov identifier #NCT01312103). The research team recruited adult women in Arizona, Maryland, Missouri, and Oregon who were English/Spanish speaking, reported physical, sexual, or emotional abuse or threats of violence by a current male/female intimate partner in the past 6 months, were comfortable with computers, and had safe Internet and e-mail accounts the abuser could not access. As previous research has demonstrated that the majority of abused women never seek assistance from traditional resources such as shelter or crisis lines,12–14 each multisite team recruited widely, with postings online (e.g., Craigslist) and flyers in community-based settings where women might seek health and social services (e.g., health clinics) and other community locations (e.g., college campuses, women’s bathrooms in coffee shops). To increase enrollment of monolingual Spanish speakers, multisite teams also employed additional multiple recruitment strategies using Spanish-language recruitment materials in online and community venues targeted toward this population (e.g., Spanish-language radio, websites, community agencies). All recruitment materials referred to a woman’s health study about unsafe relationships and a requirement for access to a safe computer with Internet and provided an e-mail address/toll-free number for study inquiries. The majority of participants (82.8%) reported that they learned about the study from an online advertisement.

Sample size calculation assumed 20% attrition and provided 0.90 power to detect a significant group by time interaction regarding a primary outcome (increasing safety behaviors) using a medium effect size (0.58) from a previous intervention.18,19 Computerized blocked randomization provided intrastate stratification and for participants with children (aged 4–18 years) at home, ensuring each state’s groups remained relatively balanced. The randomization sequence (concealed from research assistants [RAs]) was programmed into a secure tracking database separate from the study website by the study programmer, who had no participant contact. Participants were blinded to group assignment.

Study Sample

Potential participants contacted RAs via telephone for eligibility screening, verbal informed consent, and enrollment. RAs entered
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