Determining Safe, Equitable and Accessible Virtually Delivered Interventions to Individuals Affected by Intimate Partner Violence: Perspectives of Survivors and Service Providers

By

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Abstract

The COVID-19 pandemic has been linked with increased rates of intimate partner violence (IPV) and associated experiences of compounded trauma. Public health measures introduced to limit the virus's transmission necessitated the delivery of virtual or remote-based interventions to ensure continued access to care and treatment for those affected by IPV. During this rapid shift to virtual care delivery, understanding the barriers to accessing and virtually delivering IPV interventions to these individuals was missed. This dissertation employed a case study design guided by feminist intersectionality to examine factors of safe, equitable, accessible, and virtually delivered trauma-focused IPV interventions from the perspectives of service providers and IPV survivors in Alberta, Canada.

First, a rapid evidence assessment (REA) was conducted to examine the effectiveness, feasibility, and acceptability of trauma-focused virtual interventions for individuals affected by IPV. The findings of this review helped to refine the research questions for this dissertation and inform the design of an embedded single case study analysis. Additionally, the findings from the REA were used to provide timely guidance for service providers and organizational leaders with the implementation of virtual IPV interventions.

The embedded single case study analysis involved two units of analysis. The first unit of analysis involved semi-structured interviews with 24 service providers from the anti-violence sector in Alberta, Canada. In Alberta, the anti-violence sector includes a range of community organizations, agencies, networks, advocacy groups, health centres and primary care clinics that provide domestic and sexual violence-focused services. These include sexual assault centres, mental health counselling centres, women's shelters, transition houses, settlement services, victim and perpetrator services and primary care clinics. The interviews focused on the perspectives and experiences of these providers delivering virtual trauma-focused IPV interventions for a diverse range of individuals during the COVID-19 pandemic.

The second unit of analysis involved a photovoice project among survivors of IPV who exchanged knowledge and experiences on how to strengthen virtual IPV interventions that are safe, accessible, and equitable for a diverse range of individuals. Photovoice draws on the principles of the community-based participatory research (CBPR) method. In this procedure, participants capture their experiences in photographs and written narratives, engage in critical reflections and dialogue around these experiences, and develop policy and practice recommendations. Six female IPV survivors residing in Alberta, Canada, participated in this photovoice project. The interview transcripts and the photovoice narratives were analyzed using inductive thematic analysis.

The findings from the REA demonstrated that virtual IPV interventions incorporating trauma-focused interventions for individuals affected by IPV are scarce. Specifically, online interventions involving trauma-focused treatment for this at-risk group have been limited in scope, and effectiveness data have been only preliminary in nature. There is also limited evidence of the acceptability, feasibility, and effectiveness of virtual IPV interventions for ethnically, culturally, and linguistically diverse populations experiencing IPV.

Moreover, this study revealed that accessibility, equity, and safety in relation to accessing virtual IPV interventions are more complex for individuals affected by IPV, especially those who are socially disadvantaged. Participants in this study acknowledged that pre-existing systemic and institutional barriers faced by underserved individuals impact their access to IPV interventions virtually or in-person. The IPV survivors described how the barriers and challenges they encountered in safely accessing IPV interventions during the pandemic were not specific to virtual settings. Instead, these challenges had resulted from preexisting structural challenges and inequities rooted in systemic oppression. Similarly, service providers in this study highlighted how the pandemic exacerbated structural vulnerabilities already experienced by underserved populations. These structural and systemic issues intensified the barriers individuals affected by IPV faced in seeking help, reducing their virtual access to safe, and equitable interventions.

Ultimately, this qualitative research identified key determining factors for delivering safe, equitable, and accessible virtual trauma-focused intervention across a diverse population. The participants listed empathy, validation, affordability, and cultural safety as the key traits of delivering safe, equitable, and accessible virtual IPV interventions. Furthermore, to ensure virtual interventions are safe and equitable, service providers should address underlying systemic and institutional barriers, including client experiences with discrimination and social exclusion. Moreover, there is a need for greater integration across social, health and political systems. Additionally, service providers, policy and decision-makers should commit to dismantling the systems of oppression causing the inequity of and inaccessibility to culturally safe, and equitable trauma-focused IPV interventions.

Preface

This PhD dissertation followed a paper-based thesis approach in which three stand-alone but interrelated projects were conducted and three unique manuscripts were produced respectively (Chapters 3, 4, 5). Some of the research conducted in this thesis (detailed in chapter 3 and chapter 4) are part of a larger Canadian Institutes of Health Research (CIHR) funded project led by Dr. Stephanie Montesanti at the School of Public Health, University of Alberta. Under the guidance and mentorship of Dr. Montesanti, Winta Ghidei was responsible for data collection, synthesis, and manuscript composition for both these chapters.

Chapter 3 of this thesis has been published as Ghidei, W., Montesanti, S., Tomkow, K., Silverstone, P. H., Wells, L., & Campbell, S. (2022). Examining the effectiveness, acceptability, and feasibility of virtually delivered trauma-focused domestic violence and sexual violence interventions: A rapid evidence assessment. Trauma, Violence, & Abuse. Doi: 10.1177/15248380211069059. Ms. Ghidei was responsible for leading this rapid evidence assessment and her role included identifying and extracting key findings, mentoring a junior graduate (Masters) student to support the review process, and manuscript composition.

Chapter 4 of this thesis is under review in the journal BMC Public Health as Ghidei, W., Montesanti, S., Wells, L., & Silverstone, P. H. (2022). Perspectives on delivering safe and equitable trauma-focused intimate partner violence interventions via virtual means: A qualitative study during COVID-19 pandemic. BMC Public Health. In Review. Ms. Ghidei led the collection, analysis and interpretation of data and manuscript composition for this manuscript.

The photovoice project outlined in chapter 5 is Ms. Ghidei's original work. Guided by Dr. Montesanti, she conceptualized the project, recruited participants, facilitated all photovoice sessions, analyzed data and wrote the chapter. She was also responsible for composition of chapters 1, 2, 6 and 7.

This study received research ethics approval for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta, “Mobilizing Knowledge on the Use of Virtual Care Interventions to Provide Trauma-Focused Treatment to Individuals and Families At-Risk of Domestic Violence During COVID-19”, REB # Pro00101547. The study participants were given detailed information both verbally and written about the aims of the study and the voluntary nature of their participation. Each participant gave their explicit consent.

Dedication

This work is dedicated to all women impacted by intimate partner violence.

Know that you are strong, loved, worthy and you are not alone. You deserve to feel safe and secure. God be with you.

To the women who lost their lives to intimate partner violence, you may be gone but you are not forgotten.

Acknowledgments

First and foremost, I would like to thank God for giving me the opportunity and capacity to pursue this dream, for keeping me sane throughout the process, and for placing the right and supportive people in my life.

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My supervisor, Dr. Stephanie Montesanti, words cannot express how grateful I am for your guidance, instruction, advice, direction, encouragement, and friendship. You have given me more support than what was expected of you. You pushed me when necessary and held my hand when I needed it. You were there for me for my academic and personal challenges, at times, sacrificing your own personal time. You provided me with different work experiences, and training opportunities to ensure I am prepared for my future career. You have shown me by example to follow my passion, and you inspired me to thrive for excellence. It is true when I say, this PhD would not have been possible without you as my supervisor and mentor. I wish there was a better word that can express my gratitude but for now I will simply say thank you.

I am grateful and give acknowledgement to my incredible thesis committee members: Professor Lana Wells and Dr. Peter H. Silverstone. Your wisdom and expertise taught me more than you will ever know. Not only did you provide me with academic guidance but also inspired me, through your work, to want to be better and to do better for society.

A special thanks to the IPV survivors who participated in this study. You, women, have shown me the true meaning of resilience and strength. Thank you for your passion and dedication to this study. I am beyond grateful for you. It has been an honor and a privilege to have been granted access to your stories and lived experiences of IPV. Also, thank you for trusting me in sharing your experiences in dealing with systemic challenges when reaching for IPV supports. Furthermore, to the service providers who participated in this study, thank you for taking the time to share your experiences and recommendations. I also thank you for your service!

Finally, I wish to thank the following funders who supported this research project: the Canadian Institutes for Health Research (CIHR) Operating Grant: COVID-19 Mental Health, Substance Use Service Needs and Delivery, and the Alberta Addiction and Mental Health Research Hub's AMH COVID-19 Seed Grant 2020. I would also like to thank Dr. Montesanti for leading the funding acquisition for this project.

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List of Abbreviations

IPV	Intimate Partner Violence
DV	Domestic Violence
SV	Sexual Violence
GBV	Gender-Based Violence
VAW	Violence Against Women
WHO	World Health Organization
EVAC	Ending Violence Association of Canada
CIHR	Canadian Institute of Health Research
PTSD	Post-Traumatic Stress Disorder
CPT	Cognitive Processing Therapy
CBT	Cognitive Behavioral Therapy
TVI	Trauma- and Violence-Informed Approaches
REA	Rapid Evidence Assessment
CBPR	Community-Based Participatory Research
RCT	Randomized Control Trial

Chapter 1 - Introduction

Prevalence of Intimate Partner Violence

The COVID-19 pandemic has been linked with increased rates of intimate partner violence (IPV) [1]. IPV is defined as "any behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" [2-4]. Before the pandemic, global prevalence of IPV show one in three women were exposed to violence within intimate partner relationships [5]. In Canada, 50% of women experienced IPV after the age of 16, and a woman was killed by her abusive partner every six days [6]. More specifically in Alberta, the province had the third highest rate of police-reported IPV in Canada as well as the highest likelihood of experiencing physical violence and second highest of experiencing sexual violence among women aged 15 and above [7, 8]. Additionally, in the province, one woman experienced some form of IPV from an ex-partner or ex-spouse every hour of every day [9]. In 2019, IPV was considered a serious epidemic by the Calgary police and community agencies in Alberta [10], as Alberta shelters had received more than 60,000 crisis calls during the previous year (2018), while there was a 39% spike of people being turned away in 2019 [11]. Also in 2018, Calgary police responded to over 30,000 IPV-related calls, representing an average two calls per hour [11].

Global statistics reveal a drastic increase in IPV during the COVID-19 pandemic [12, 13]. Studies show, in various parts of the world the prevalence of IPV doubled [14] and tripled [15] during the stay at home orders [16]. During this time, the rates of IPV increased by up to

30% in Canada [17] and calls to IPV hotlines increased by 50%–300% across the country [18]. In a report by the Ending Violence Association of Canada (EVAC), 82% of frontline service providers within the anti-violence sector reported increases in severity of violence experienced by their clients [19].

Furthermore, the prevalence of IPV is grossly underreported for underserved populations [20, 21]. Anecdotal evidence shows the incidence and prevalence of IPV is up to seven times higher within underserved populations in Alberta [22], including Indigenous peoples, immigrants, refugees, racialized individuals, official language minorities, LGBTQ2S+ groups, individuals with disabilities, homeless and precariously housed people, sex trade workers, and individuals with low socioeconomic status [23]. Thus, the available information on IPV does not account for the experiences of individuals from these populations and those with intersecting identities of race, sex, socioeconomic status, and gender identity [20]. Although IPV does not discriminate and is experienced by all races, genders, and age groups, certain factors, such as being a female, non-Caucasian, an immigrant, or of lower socioeconomic status, may increase one's vulnerability to and risk of experiencing or perpetrating IPV [21, 24].

Factors that Contributed to Increased Rate of IPV during the Pandemic

During the COVID-19 pandemic, the additional factor of social isolation has been the most significant contributor to increased rates of IPV [25-29]. Social isolation as a means of coercive control is frequently used by perpetrators, and when physical distancing and isolation are mandated by governments, rates of coercive control are known to increase [25, 29-31]. Moreover, the correlation between families spending more time together and increased level of violence is well documented [31-33]. It is likely that the combination of increased interpersonal time spent with abusers, isolation from friends, families, and networks, and pandemic-related stressors including financial and psychological distress underlies the more frequent incidence and/or severity of IPV cases [34-37], which, in some cases, can be lethal [29]. This high level of stress, financial strain, and limited social support can lead to violence even in relationships where violence did not previously exist [31].

Consequences of Experiencing IPV

IPV is a form of trauma with significant mental health outcomes for individuals and families [38]. Trauma is defined as "an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [39]. The presence of IPV has significant short-term and long-term psychological consequences that range from stress, frustration, anger, and decreased social function to severe depression, anxiety, post-traumatic stress disorder (PTSD), and suicidality [40, 41]. These experiences also impact parenting abilities. Exposure to IPV in children can result in social, behavioral, emotional, and cognitive problems which persist into adulthood and increase the potential for perpetration and victimization of IPV [41-43]. For example, according to the World Health Organization (WHO), growing up in a household where the mother is abused is one of the most common risk factors for perpetration in men and exposure to IPV in the future for females [41, 44]. Therefore, it is important to prevent and mitigate the issue of IPV.

Survivors and individuals experiencing, or at risk of, IPV during the pandemic have been struggling with complex trauma (exposure to multiple trauma) as a result of the violence and COVID-19-related mental distress [45]. As previously highlighted, during the pandemic, individuals experiencing IPV have been cut off from community and support networks. Evidence shows there is a direct relationship between the length of quarantine and level of negative psychological effects (e.g., depression, stress, anxiety) [25, 46]. For some survivors of IPV who have left the abusive relationship, the stay-at-home orders have triggered past traumatic experiences and heightened anxiety [19]. Service providers within the anti-violence sectors across Canada were surveyed by the Ending Violence Association of Canada [19] and highlighted three major concerns for IPV survivors accessing care, treatment or support during the COVID-19 pandemic: (1) clients who depend on face-to-face interactions may face setbacks in their healing process and mental health; (2) delays in family court proceedings may impact some clients' safety from violence; and (3) survivors are not seeking out care, which will have an adverse mental health outcome given they are struggling with complex trauma. As a result, it has been suggested that there is a need to strengthen trauma-focused practices particularly for these individuals during the current pandemic [45].

Trauma-Focused Interventions to Address IPV-Related Concerns

Trauma-focused interventions are specific approaches to therapy that recognize and "emphasize how the traumatic experience impacts an individual's mental, behavioral, emotional, physical, and spiritual well-being" [47]. Often these interventions incorporate "practices that promote a culture of safety, empowerment, and healing" when providing any assistance or support to individuals affected by IPV [48]. The most common forms of trauma-focused interventions offered to survivors of IPV are cognitive-processing therapy (CPT) and cognitive-behavioral therapy (CBT) [49]. Culturally tailored and patient-centered trauma-focused treatments specific to IPV survivors have shown positive outcomes in terms of lowering signs of PTSD and depression among women from diverse population groups [49].

The experiences and perpetration of IPV is embedded in systemic discrimination, inequality and social exclusion that are sustained and reproduced by systems, structures and social norms [50]. Therefore, there is a need to address these systemic issues when providing trauma-focused treatments and other supports to individuals affected by IPV. Recently, scholars have recommended to shift the focus to drawing attention to structural violence and to promote a culture of safety, empowerment, and healing when providing interventions to individuals affected by IPV [51, 52]. This entails recognizing the context in which violence is experienced including the intersections between interpersonal violence, structural violence, and experiences of historical and intergenerational trauma [52]. Thus, such an approach focuses on the experiences of trauma holistically, prevents re-traumatization and aims to empower IPV survivors [52].

Barriers to Delivering and Accessing Trauma Focused Interventions

Different stakeholders and governing bodies take the lead in funding, implementing, and delivering interventions and supports to individuals affected by IPV. These include the social services, primary care, government, justice, education, researchers, and other stakeholders that have capacity to address social, structural, and material structures that produce and promote violence. The anti-violence sector and the health care sector play a major role in leading the delivery of trauma-focused intervention approaches. The anti-violence sector is comprised of community and social service agencies and organizations that directly provide IPV interventions and supports. These include shelters, sexual-assault centers, community-based organizations, and gender-equity advocacy groups.

The anti-violence sector in Canada has historically been overburdened and underfunded [53]. Specifically, multiple funding cuts to the sector since 2002 have resulted in the needs of individuals demanding IPV support going unmet [53-55]. The sector is funded through an unpredictable combination of donations, corporate gifts, and government grants that are mostly focused on short-term project funding [54]. Many organizations which offer IPV interventions must rely on fundraising activities to cover their operational expenses and to pay the salaries of their employees [56]. A report prepared for the Ending Violence Association of British Columbia highlighted the increasing complexities faced by the sector due to changes in policy and practice (e.g., changes in referral and information-sharing policies) within the anti-violence sector [53]. These changes have shifted how the sector responds to IPV and related social problems. Thus, the lack of available core sustainable funding structure, including the inequitable distribution of government funding, changes in policy, and high staff turnover within the anti-violence sector, has had a significant impact on providers and others working with individuals affected by IPV and weakened the capacity of the sector overall [53-56].

While the anti-violence sector face specific challenges related to policy, practice, and resource constraints in responding to the needs of individuals affected by IPV, individuals who seek support also encounter various barriers in accessing trauma-focused interventions. Studies show that the rate of help-seeking among underserved populations from both the anti-violence and health care sectors is low [41, 57]. These are influenced by a complex set of factors, including their identities. Individuals who belong to underserved populations experience difficulties in receiving necessary care or receive lower-quality care, experience different treatment from providers, or are less satisfied with standard of care they receive than the general population [23]. Although these diverse population groups experience different types of barriers, ultimately “there is a remarkable similarity in many of the concerns identified” [23]. The barriers are further compounded for individuals with intersecting identities (i.e., those who belong to more than one of these underserved populations) [58].

In Canada, one in five women reported experiencing racism and culturally insensitive and inferior quality of care within healthcare systems and mainstream social services [24]. These barriers discourage such women from seeking help when experiencing IPV [24, 59]. Systemic oppressions and structural violence are at the core of these inferior quality of care experienced by underserved women [21, 24, 59, 60]. Systemic oppression refers to the conscious or unconscious but normalized ways in which dominant groups use power to marginalize and disempower another group based on perceived differences in order to maintain status and privilege [61]. Some forms of oppression include ableism, classism, colonization, heterosexism, Islamophobia, racism, sexism, and transphobia [61, 62]. Structural violence refers to how societies, including their institutions and policies, are organized in ways that cause harm to underserved populations [39].

The Shift to Virtual Delivery of Trauma-Focused IPV Interventions During the Pandemic

During the stay-at-home mandate, which was introduced to limit the transmission of COVID-19 most IPV interventions abruptly pivoted to virtual delivery [22]. Virtual delivery of interventions incorporates the use of technology to provide communication, education, intervention, or service between a provider and a client [63-65]. Many of these virtually-delivered interventions are also referred as e-mental health, digital health solutions, e-healthcare, telehealth, and telemedicine [63, 64]. These types of interventions can be delivered through videoconferencing, phone calls, mobile applications (“apps”), and web-based portals, to name a few.

The application of virtual delivery of trauma-focused interventions within the healthcare system, and especially for mental health services, was slowly emerging before the COVID-19 pandemic. The few studies previously carried out in users of these virtual interventions within the healthcare system, prior to the pandemic, reported positive outcomes for clients and good feedback from providers [63]. However, virtual delivery of trauma-focused IPV interventions was not widely adopted or considered by service providers within the anti-violence sector pre-COVID-19 and, when used, was restricted to remote areas with limited access to in-person interventions [63]. Since the pandemic, however, the vast majority of those providing interventions to individuals affected by IPV have moved to providing services via virtual platforms. This shift to virtual delivery of interventions provided several opportunities, including providing access to individuals residing in remote locations who may not otherwise be able to receive these services, offering convenience in terms of saving time, removing transportation barriers, and allowing clients to maintain connection with care providers during the pandemic [22].

Although the virtual delivery of trauma-focused IPV intervention was a necessity and provided opportunities for many, during the pandemic, it is important to recognize the specific challenges and barriers associated with the virtual delivery of such interventions to women affected by IPV [66]. For instance, it has been reported that the risks to a women's safety increases when she uses app-based interventions that can easily be accessed by her perpetrator [67]. Moreover, some women may be struggling with unstable or unavailable internet connections, or they may not be able to afford devices such as phones or tablets to receive interventions or support virtually [19, 68, 69]. Additional barriers to uptake of virtual IPV interventions can include issues concerning confidentiality and privacy and not being comfortable with receiving interventions commonly delivered face-to-face over phone or video [19].

Multiple social determinants of health have placed underserved women at a disadvantage during the current pandemic [13]. In addition to the social and structural barriers that existed before the pandemic, underserved populations are especially vulnerable because of its social and economic impacts of the pandemic [19]. Moreover, these populations face multiple barriers with the digital divide, which is characterized by inequitable access to technology and the internet [35]. For instance, there is ample evidence demonstrating digital exclusion among rural communities where broadband access is limited [63, 70]. Racialized populations also face barriers to accessing virtual interventions due to a lack of culturally acceptable and appropriate virtual tools [19].

The Current Study

Although there is growing evidence of positive outcomes of virtual delivery of IPV interventions, [5] evidence of their effectiveness, acceptability, accessibility, safety, and equity across a range of diverse individuals affected by IPV is limited [25]. Moreover, given the scarcity of evidence in relation to effective virtual IPV interventions, limited guidance exists for the anti-violence and health sectors to adequately address the increasing need for virtual interventions for individuals affected by IPV during the pandemic and beyond. In addition, the COVID-19 pandemic has interrupted services and negatively impacted equitable access to resources. As previously stated, unprecedented challenges and barriers have arisen, including limited digital communication infrastructure such as access to smart devices and broadband access, which is compounded by clients' and providers' lack of comfort with virtual delivery of interventions [71]. However, there is limited data on how such challenges have impacted the accessibility and delivery of trauma-focused IPV interventions during the pandemic. Additionally, there is a knowledge gap on what individuals affected by IPV consider to be safe, accessible, and equitable virtual delivery of IPV interventions. Therefore, more research into enhancing safety, accessibility, and equity in the virtual delivery of IPV interventions for a diverse range of individuals is needed.

To this end, using a case study approach within the context of COVID-19, this PhD dissertation aims to qualitatively examine how virtually delivered trauma-focused IPV interventions can be safe, accessible, and equitable for diverse individuals affected by IPV. Specific objectives are as follows:

1. Examine the acceptability, feasibility, and effectiveness of existing trauma-focused virtual IPV interventions for individuals affected by IPV.
2. Explain, from the perspectives of service providers within the anti-violence and health care sectors, what constitutes safe, equitable, and accessible trauma-focused virtual interventions for a diverse range of individuals affected by IPV.
3. Explain, from the perspectives of survivors of IPV, what constitutes safe, equitable and accessible virtually delivered IPV interventions.

Research Paradigm

This research is guided by a constructivist paradigm, which states that knowledge, reality, and rational beliefs are socially constructed based on our interactions and experiences within our society and/or community [72-75]. As indicated by Campbell and Wasco [73], social constructs such as gender, race, class, culture, and economic status are not only lenses through which we examine truth but the building blocks of how our truth is created. Constructivists also claim there are multiple individually-constructed truths [72, 73]. A study guided by a constructivist paradigm aims to "understand the constructions that people initially hold, aiming toward consensus but still open to new interpretations as information and sophistication improve" [75]. The concepts of activism and advocacy are also central to this paradigm [75].

Research paradigms are founded on ontology (nature of reality) and epistemology (nature of knowledge). In this study, a relativist ontology and subjectivist epistemology informed how the research is conducted and interpreted. Relativist ontology indicates that "realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature, and dependent for their form and content on the individual persons or groups holding the constructions" [75]. A subjectivist epistemology, meanwhile, "sees knowledge as created in interaction among investigator and respondents" [75]. Researchers guided by this paradigm are involved in the process through interactive dialogues, and their identities are important parts of the research findings; thus, the researcher identity in this study was an important construct of the research reality [73].

The research approach was enriched by incorporating insights from intersectional feminism that highlight the importance of challenging inequities based on sexism, racism, colonialism, class, and other social factors [74, 76]. Intersectional feminism is an analytical framework that helps us understand the ways in which various forms of inequality and intersecting systems of power relations determine the social locations of groups and individuals, set the stage for social inequalities, and, as a result, inform individual realities and lived experiences [20, 77, 78]. Consequently, access to and delivery of safe, equitable, and accessible virtually delivered IPV interventions should be framed within an intersectional lens that examines how race, ethnicity, ability, socioeconomic status, cultural acceptability, language, and geography intersect to influence these factors. Such a research perspective is grounded in respecting, understanding, and empowering study participants and taking their experiences and stories as valid sources of knowledge [79-81]. Moreover, it is the researcher's responsibility to communicate this knowledge through the individuals' voices [79-81].

Self-Reflection and Researcher Positionality

An intersectional feminist perspective requires a researcher to undertake a continual process of self-reflection and become attuned to how power is used throughout the construction of the research [79-81]. Self-reflection entails interrogating the identity of the researcher (gender, race, class, etc.) as well as her relationship with her participants and its effect on how she conducts the research project [80, 82]. As such, as a Black scholar I consistently questioned how my own identities shaped my research inquiries and how I interpreted the information from my research participants [83]. I continuously examined and reflected on my motives, interpretations, and practices to enhance the perspectives and voices of the participants involved in the research.

Throughout the research, I took on an insider and outsider perspective to my research [84]. In addition to the impact on public health, the issues I address in this dissertation have personal importance. I grew up in a highly patriarchal society where IPV was the norm. Like some of the participants in this study, I have also navigated through gender and race discrimination and survived various forms of abuse throughout my life. My personal life history inspired my passion to challenge the injustice and gender inequity rooted in systemic oppression that contributes to the occurrence of IPV. Therefore, our lives (study participants' and mine) as women are shaped by our experiences of gender inequalities and gender-based violence. These historical similarities and my own reality as a survivor of IPV afforded me an insider position.

Moreover, as a researcher with perceived privileges, I also held an outsider position. This position may have influenced the study participants' openness and trust [85]. However, I chose a research method that is grounded in social justice principles which privileged the voices of the participants, and enabled me to build trust and rapport with them. Moreover, as part of my self-reflection process, I wrote memos throughout the research to examine how my own biases shaped my approach to data collection, interpretation of findings, and decision-making. I engaged in weekly debriefing sessions with my thesis supervisor (Dr. Stephanie Montesanti), who also practices intersectional feminist reflectivity in her own research. Moreover, I challenged myself to remain aware of how my own history and experiences may have shaped the decisions I made through the research process.

Overview of Study Design

This dissertation research adopted an embedded single case study method [86] (see Chapter 2). One of the strengths of a case study is its ability to deal with a full variety of evidence sources – documents, artifacts, interviews, observations, etc. [86]. Therefore, multiple qualitative data collection sources were used to gain a holistic, triangulated, and credible understanding of the delivery of and access to virtual IPV interventions. The data for the study were collected in three phases respectively (Table 1.1). and the data collection processes, and findings of each data source are presented independently in separate chapters (Table 1.2).

Table 1.1: Data collection phases

Phase	**Objective**	**Outcome/Expected Outcome**	**Timeline**
Phase 1	Examine the acceptability, feasibility, and effectiveness of existing IPV interventions.	Inform the development of a theoretical perspective and design of the embedded single case study.	Jan – May 2021
Phase 2	Explain how virtually delivered IPV interventions can be safe, equitable, and accessible – Service provider perspective.	Identify factors that constitute safe, equitable, and accessible virtual IPV interventions for a diverse range of individuals.	Jul – Dec 2021
Phase 3	Explain how virtually delivered IPV interventions can be safe, equitable, and accessible - Survivor perspective.	Identify factors that constitute safe, equitable and accessible virtual IPV interventions and identify priorities for policy and practice recommendation.	Feb – Jun 2022

The first phase of this study focused on developing a rapid evidence assessment (REA) to help guide the design of the embedded single case study (consecutive phases). An REA is “a form of knowledge synthesis that follows the systematic review process, but components of the process are simplified or omitted to produce information in a timely manner” [87]. The full paper detailing the process and findings of this REA is included in Chapter 3, and it has been published in the journal “Trauma, Violence and Abuse” (https://doi.org/10.1177%2F15248380211069059).

In the second phase of this study, semi-structured interviews were conducted with providers within the anti-violence and healthcare sectors in Alberta to qualitatively describe the challenges they experienced when virtually delivering trauma-focused IPV interventions that are safe, equitable, and accessible for their diverse clients during the COVID-19 pandemic. The full manuscript detailing the process and findings of this data source is included in Chapter 4. The manuscript is also under review for publication in a special call ‘*the COVID-19 pandemic and intimate partner violence’* in the journal BMC Public Health.

In the final phase, a photovoice project was hosted with survivors of IPV in Alberta to exchange knowledge and experiences on how to strengthen virtual IPV interventions that are safe, accessible, and equitable for a range of diverse individuals affected by IPV. The full process and outcome of this data source is included in Chapter 5, and an abstract proposal has been submitted for a Call for Chapter Proposals: Creativity and Health.

The following table outlines the contents of each chapter in this PhD dissertation research.

Table 1.2: Outline of the PhD dissertation research

Chapter	Title	Content
1	Introduction	Background information, study rationale and overview of the study design.
2	Methods	The single case study design and data collection approaches used in this study.
3	Examining the effectiveness, acceptability, and feasibility of virtually delivered trauma-focused domestic violence and sexual violence interventions: A rapid evidence assessment.	The process and outcome of the rapid evidence assessment (REA).
4	Perspectives on delivering safe and equitable trauma-focused intimate partner violence interventions via virtual means: A qualitative study during COVID-19 pandemic.	The process and outcome of the semi-structured interviews with service providers.
5	A virtual photovoice project capturing the perspectives and experiences of intimate partner violence survivors in determining safe, accessible, and equitable IPV interventions.	The process and outcome of the photovoice study with survivors of IPV.
6	Explanation building	The analysis of embedded single case study evidence and development and presentation of a revised theoretical proposition.
7	Conclusion	Concluding Remarks

Ethics approval for this study was obtained from the University of Alberta Health Research Ethics Board (Pro00101547).

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Chapter 2 - Methods

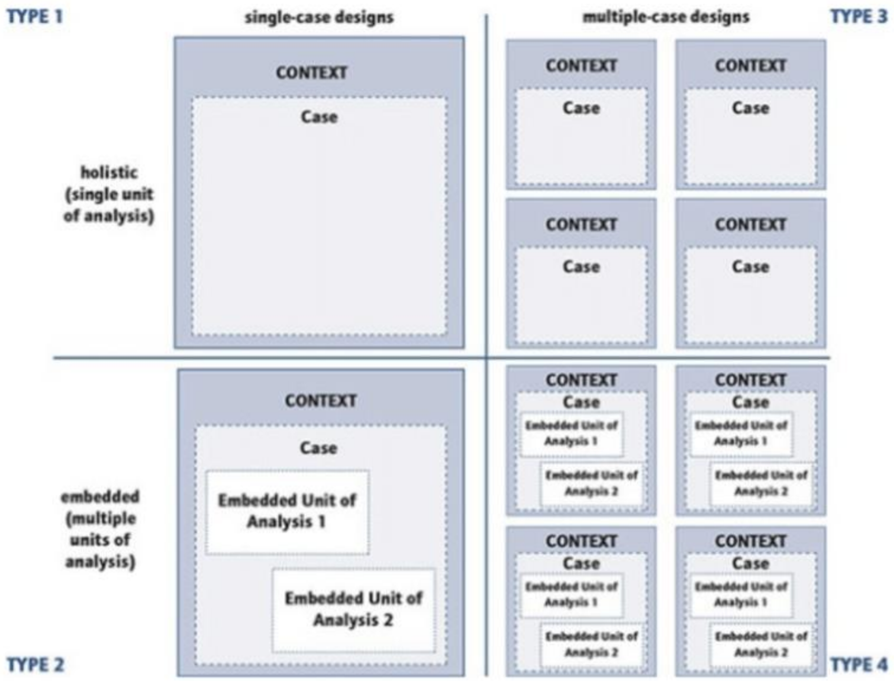
Embedded Single Case Study

A case study is “an empirical inquiry that investigates a contemporary phenomenon (the ‘case’) in depth and within its real-world context” [1]. Case studies work with the relativist perspective and support a constructivist paradigm [1-3]. Case study research asks ‘how’ or ‘why’ questions that are explanatory in nature [1]. In this study, the event of interest is the COVID-19 pandemic. There are two designs for case studies: single case or multiple case studies (Fig 2.1). A single case study is an appropriate approach under the following criteria: (a) the case is considered a critical test of a significant theory; (b) the case is an extreme or unusual “deviat(ion) from theoretical norms and even everyday occurrences;” (c) the case is common and is used “to capture the circumstances and conditions of an everyday situation because of the lessons it may provide about the social processes related to some theoretical interest;” (d) the case is a revelatory case, where “the situation exists when a researcher has an opportunity to observe a phenomenon previously inaccessible to social science inquiry;” and (e) when the case is a longitudinal case which allows “studying the same single case at two or more points in time. The theory of interest would likely specify how certain conditions and their underlying processes change overtime” [1].

Methods experts highlight case study is not to be used as a method in and of itself but rather a design frame which incorporates several methods to support in-depth understanding of the case [3]. The case is determined by boundaries around places and time periods which “are set by spatial, temporal, personal, organizational, or other factors” and specific analytical frameworks (units of analysis) [3]. A single case study design may involve units of analysis at more than one level, which determines if the types of case study are holistic or embedded (Fig

2.1) [1]. That is, if the focus of study is on one unit of analysis, it is considered a holistic single case study; if attention is given to additional subunits, it is considered an embedded single case study. A single case can be replicated by conducting multiple experiments (i.e., redoing the same case study multiple times, sometimes with the same units of analysis and other times changing certain units to see whether the outcome varies across various populations). In that case, the design is a multiple case study design [1].

Fig. 2.1: Basic types of design for case studies as outlined by Yin [1]



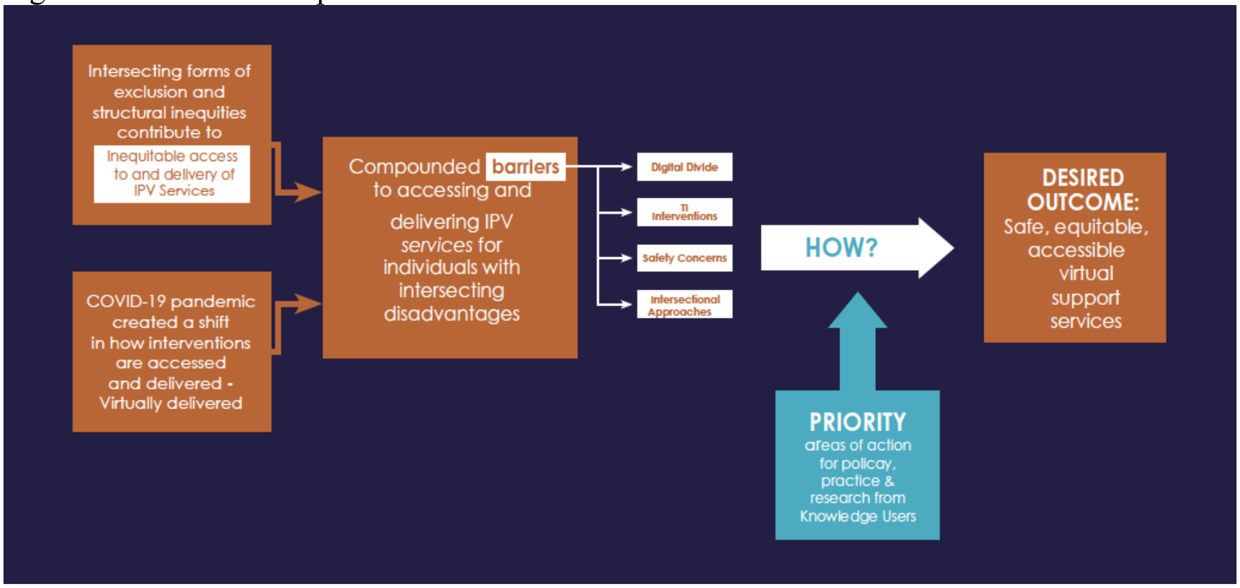
Rapid Evidence Assessment (REA)

An essential part of a case study design is to develop a literature review to “form sharper and more insightful research questions about the topic” and create a theoretical proposition [1]. Therefore, as a first step, a literature review was developed following a rapid evidence assessment (REA) approach, which addresses the first objective of the dissertation project. The purpose for using REA, specifically, as a literature review approach was two-fold: 1) to guide the design and to support theory development for the case study analysis, and 2) to provide timely evidence, for the anti-violence sector, on trauma-focused virtual interventions that can rapidly be used to support individuals affected by IPV during the COVID-19 pandemic. REA provides a timely, valid, and balanced assessment of available empirical evidence related to a particular policy or practice issue [4]. It is a rigorous and explicit method that utilizes a wide range of evidence within a short timeframe. The process includes developing a focused research question, specific search strategy, literature searches, data extraction, and quality appraisal of the identified literature [5]. Through the REA, this study specifically examined the acceptability, feasibility, and effectiveness of available virtually delivered interventions for a diverse range of individuals affected by IPV. The findings from this phase were used to develop a theoretical proposition (Fig. 2.2), and to inform both the design and research questions of the embedded single case study.

Theoretical Proposition

A recommended step in case study designs involves developing a theoretical proposition based on the literature review. This proposition is equivalent to a hypothesis in a quantitative study and would guide the design of the embedded single case study. Thus, based on the identified body of evidence (REA) it was proposed that intersecting forms of exclusion and the contextual factors of COVID-19 have compounded barriers to accessing trauma-focused IPV interventions, and in order to reach to the desired outcome of safe, equitable, and accessible virtually delivered IPV interventions we need to set priority areas of action for policy, and practice identified by the knowledge users – individuals affected by IPV (Fig. 2.2).

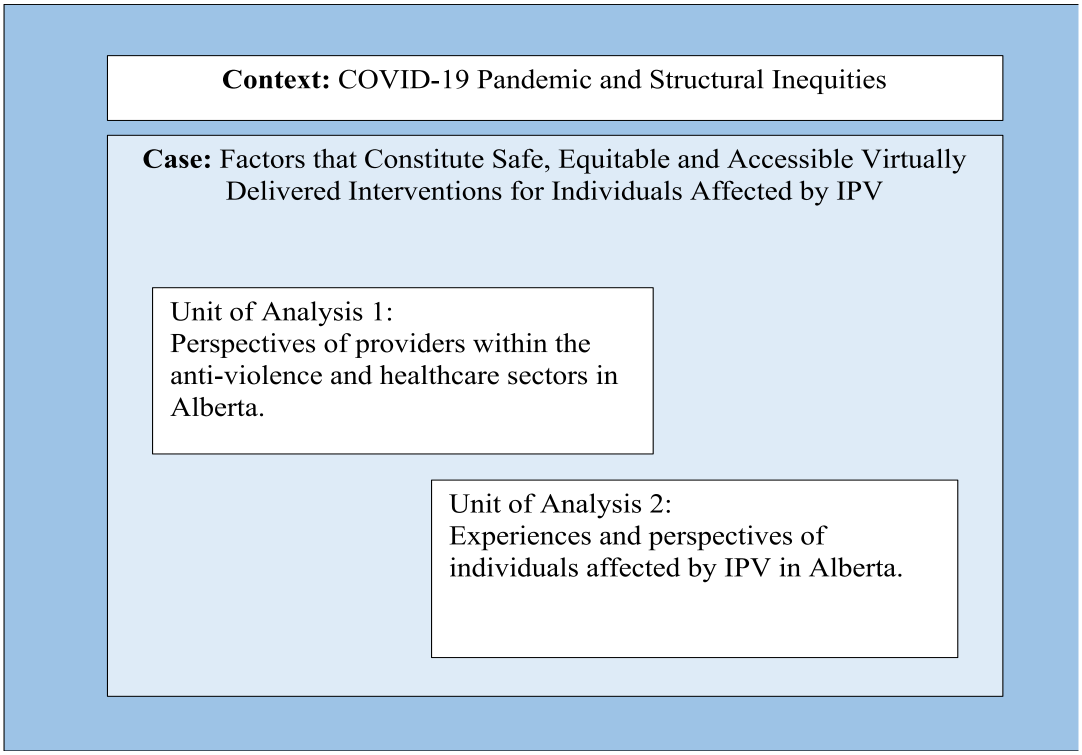
Fig. 2.2: Theoretical Proposition



The Current Embedded Single Case Study

In this doctoral dissertation research, an embedded single case study design is appropriate because the context of COVID-19 has resulted in an extreme and unusual shift to virtual delivery of IPV interventions. This shift can be considered a “phenomenon previously inaccessible to social science inquiry” and thus a revelatory case [1]. In addition, as this shift is becoming the new normal, this case study can be used to “capture the circumstances and conditions of an everyday situation because of the lessons it may provide about the social processes related to some theoretical interest” [1]. Therefore, the research goals meet three of the five criteria for a single case study design outlined by Yin [1]. The case is bounded within the contexts of the pandemic and structural inequities in Alberta, Canada and was measured within a two-year time frame. In this study the embedded single case study focuses on two units of analysis (Fig. 2.3): (1) service providers’ perspective and experience, which was gathered through semi-structured interviews; and (2) IPV survivors' perspective and experiences, which was examined through photovoice.

Fig. 2.3: Embedded single case study on determining safe, equitable, and accessible virtually delivered IPV interventions.



Unit of Analysis 1: Semi-Structured Interviews with Service Providers

For the first unit of analysis, semi-structured interviews were conducted with 24 service providers within the social sector and primary healthcare sector caring for or working with individuals affected by IPV in Alberta. Participants included primary care providers, staff from shelters, sexual assault and crisis centers, executive directors, and managers of shelter services (e.g., the Alberta Council of Women's Shelters) and community and advocacy organizations with a mandate or priority to address IPV. All interviews were conducted virtually via telephone or videoconference and lasted approximately one hour. The qualitative, semi-structured interviews provided evidence on the barriers or challenges experienced by providers in delivering virtual interventions to individuals affected by IPV during the COVID-19 pandemic; more specifically, providers explained what constitutes safe, equitable, and accessible interventions for a diverse range of individuals affected by IPV.

Unit of Analysis 2: Photovoice Project with Survivors of IPV

For the second unit of analysis, individuals with lived experience of IPV were engaged in a photovoice project to exchange knowledge and experiences on how to strengthen virtual IPV interventions that are safe, accessible, and equitable for a range of diverse individuals affected by IPV. Photovoice draws on the principles of community-based participatory research (CBPR) method, in which participants: (1) capture their experiences in photographs and written narratives, (2) engage in critical reflections and dialogue around these experiences, and (3) develop policy and practice recommendations. In this project, six IPV survivors with diverse backgrounds, identifying as female, participated and submitted a total of 16 photos and narratives. They participated in a deep dialogue centered on their lived experiences and identified priorities for policy and practice recommendation.

Analyzing Embedded Single Case Study Evidence – Explanation Building

Finally, a form of case study analysis technique named explanation building [1] was used to pull all the evidence gathered from the two units of analysis and to examine the findings in relation to the theoretical proposition (Fig. 2.2). This process is both deductive and inductive as it relies on the theoretical proposition and the new evidence from the case study findings, respectively [1]. Although the explanation building process is adoptable to the context of each study, the key steps include the following:

1. Developing a theoretical proposition that informs the case study design
2. Comparing the study outcome/data with the theoretical proposition

3. Revising the theoretical proposition as needed
4. Comparing other evidence from within the case study with the revisions (i.e., re-examine evidence from a new (revised) perspective)

In this process, if the outcome of the study aligns with the proposed framework, then the internal validity of the study would be strengthened. However, if the findings divert from the theoretical proposition, a revised framework would be developed, that can better explain the case [1]. In this study, findings of the two units of analysis only partially aligned with the theoretical proposition and therefore, a revised theoretical framework was developed to better explain how IPV interventions can be safer, more equitable and accessible. This revised theoretical framework is discussed in Chapter 6.

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Chapter 3 - Examining the Effectiveness, Acceptability and Feasibility of Virtually Delivered Trauma-Focused Domestic Violence and Sexual Violence Interventions: A Rapid Evidence Assessment[1]

Remarks

Justification for the use of the terms ‘Domestic Violence’ and ‘Sexual Violence’ in Chapter 3

The scope of this study addressed IPV, however, this chapter which reports on the process and findings of the REA uses the terms Domestic Violence (DV) and Sexual Violence (SV). The reason for using these terms in the REA is two-fold: 1) as previously mentioned this evidence was used to inform the anti-violence sector on trauma-focused interventions that can immediately be used to support individuals affected by violence during the pandemic. DV and SV are the common terms used by the anti-violence sector in Alberta and given the interest to utilize the findings to support the sector, the REA was framed as such. 2) There is a paucity of data specific to the term IPV because in some of the literature, the terms IPV and DV are used interchangeably. However, it is important to acknowledge the differences in their definition and forms of violence included within each term. The definitions of DV and SV encompass experiences of IPV, however, the definition of IPV does not include all the forms of violence included in DV and SV. Therefore, by limiting the scope of this study to IPV, forms of violence such as child abuse, elder abuse, roommate abuse, harassment, etc. are excluded from the evidence and analysis included in this study.

The definitions of IPV, DV and SV are as following:

- Intimate Partner Violence (IPV) is defined as any behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of

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[1] This chapter is the final version of the paper published in the journal Trauma, Violence and Abuse.

physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner) [1-3].

- Domestic Violence (DV) is defined as the attempt, act or intent of someone within a relationship, where the relationship is characterized by intimacy, dependency or trust, to intimidate either by threat or by the use of physical force on another person or property. The purpose of the abuse is to control and/or exploit through neglect, intimidation, inducement of fear or by inflicting pain. All forms of abusive behaviour are ways in which one human being is trying to have control and/or exploit or have power over another [4]. Therefore, the perpetrator of such form of violence is not limited to an intimate partner.
- Sexual Violence (SV) is defined as non-consensual sexual contact and non-consensual non-contact acts of a sexual nature, such as voyeurism and sexual harassment. Acts qualify as sexual violence if they are committed against someone who is unable to consent or refuse, for example because of age, disability, misuse of authority, violence, or threats of violence. Sexual violence can occur at an interpersonal or collective level [4].

Introduction

Factors Affecting the Mental Health of Individuals Experiencing Domestic Violence (DV) and Sexual Violence (SV) During the COVID-19 Global Pandemic

The current COVID-19 global pandemic has had a profound impact on the psychological and mental well-being of individuals and families due to financial and employment instability, changes in family routine, and social isolation due to physical distancing measures, school/childcare closures, and changes to health and social care access [5]. Furthermore, the pandemic has interrupted the systems and structures that previously operated to both support the mental health and well-being of individuals and mitigate the risks that contribute to negative mental health outcomes [6-8]. The economic and social stressors brought on by the pandemic has also contributed to a greater risk for violence and conflict in the home [9-12]. High levels of stress, financial strain, and limited social support can lead to violence, even in relationships where it previously was not present [13]. Past studies have shown that natural disasters, crises, epidemics, and pandemics often lead to increased rates of DV and SV [12]. For example, the HIV/AIDS epidemic increased rates of DV [13-15], and natural disasters often lead to an increase in violence against women [13, 16-20].

In Canada, rates of DV and SV has increased by up to 30% since the start of pandemic [21]. In a report published by the Ending Violence Association of Canada (EVAC), it stated 82% of frontline service providers within the anti-violence sector reported increases in the prevalence and severity of violence experienced by their clients [22]. In the early months of the pandemic, reports showed a dramatic surge in calls documented by Kids Help Phone, a national helpline for young people, with a 48% increase in calls about social isolation, a 42% increase in calls about anxiety and stress and a 28% increase in calls about physical abuse [23]. Individuals who experience intersecting forms of inequality are particularly at risk of DV and SV including Indigenous, racialized, immigrant, refugee and newcomer, LGBTQ2S+ people and individuals with physical and cognitive disabilities [24]. All these groups are especially vulnerable because of the social and economic impacts of the pandemic [25].

DV and SV are forms of trauma that can result in significant mental health distress for individuals. The presence of violence and abuse has significant long-term psychological consequences that range from stress, frustration, post-traumatic stress disorder (PTSD), and anger to severe depression [26]. The association between violence against women, mental health and substance use has been studied showing that women who have experienced violence have significantly higher rates of substance use and mental health concerns compared to women who have not [27, 28]. For children, DV related trauma can be cumulative, and is associated with social, behavioral, emotional, and cognitive problems, many persisting into adulthood [29]. Similarly, experiencing sexual abuse is associated with significantly increased risk of mental health problems, including PTSD [30]. Survivors and individuals experiencing, or at-risk of, DV and SV during the COVID-19 pandemic are struggling with compounded or complex trauma as a result of the violence and COVID-19-related mental distress [31]. For some survivors of DV who have left the abusive relationship, the stay-at-home orders have triggered past traumatic experiences and heightened anxiety [22].

During the COVID-19 pandemic, the additional factor of social isolation has been a contributing factor to increased rates of DV and SV [32-36]. Social isolation as a means of coercive control is frequently used by perpetrators, and when physical distancing and isolation are mandated by governments, rates or coercive control are known to increase [13, 32, 36, 37]. Moreover, the correlation between families spending more time together and increased level of violence is well documented [13, 38, 39]. It is likely that the combination of increased interpersonal time spent with abusers, isolation from friends, families, and social networks, and pandemic-related stressors including financial and psychological distress underlies the more frequent incidence and/or severity of DV and SV [9-12], which, in some cases, can be lethal [36].

Access to Trauma-Focused Interventions for Individuals Exposed to DV & SV During the COVID-19 Pandemic

The serious effects of trauma resulting from violence and abuse have led to a call for trauma-focused interventions and supports which prioritizes safe and accessible care for people who are impacted by trauma and violence [10]. Trauma-focused interventions are specific approaches to therapy that recognize and emphasize "how the traumatic experience impacts an individual's mental, behavioral, emotional, physical, and spiritual well-being" [40]. Cognitive-processing therapy (CPT) and cognitive-behavioral therapy (CBT) are the most common forms of trauma-focused interventions offered to survivors of DV and SV [41]. The public-health measures introduced to limit the transmission of the COVID-19 virus have meant that most services (including mental health and trauma-focused interventions) abruptly pivoted to virtual and remote-based delivery [7]. Widespread adoption of remote delivery of DV and SV services and interventions during the pandemic was a major development, yet it proceeded within little research guidance. Research on virtual and remote-based service delivery for individuals experiencing, at-risk of, or survivors of DV and SV is scarce, and little is known about their effectiveness.

Virtual delivery of interventions incorporates the use of technology to provide communication, education, intervention, or service between a provider and a client [42-44].

Virtually delivered interventions include telehealth, telemedicine, eHealth, mHealth, tele-mental health, and telepsychotherapy [45-47]. These types of interventions can be delivered through videoconferencing, phone calls, mobile applications (“apps”), and web-based portals, to name a few [42-44].

The application of virtual and remote service delivery within the healthcare system, and especially for mental health, was slowly emerging before the COVID-19 pandemic. The few studies previously carried out in users of virtual interventions within the healthcare system, prior to the pandemic, reported positive outcomes for clients and good feedback from providers [42]. However, virtual or remote delivery of interventions for DV and SV was not widely adopted or considered appropriate by service providers in this field prior to COVID-19, and when used was restricted to remote geographic areas with limited access to in-person care and treatment [42]. Bayles [48] questioned whether video calls were acceptable for providing therapeutic support, given the loss of physical connection and difficulties observing and interpreting clients’ non-verbal and physical cues without physical proximity. Other scholars identified challenges with remote counselling, raising concerns about exchanging confidential information via these means, given the potential for misinformation [49]. Additionally, safety risks with virtual delivery of exposure therapy, facing memories or situations associated with the experience of trauma, are understudied [50, 51].

Although virtual or remote service delivery has been increasingly employed across healthcare settings, few studies have focused specifically on the benefits, challenges or barriers of virtual or remote delivery of trauma-focused DV and SV interventions [52]. Chen et al [42] highlight benefits of increased volumes of clients served, reduced logistical barriers, decreased no-shows, easier scheduling, protection for people with disabilities or health conditions, and increased access to support for those unable to leave home. However, scholars have also pointed to some disadvantages of virtual or remote-based interventions including, difficulty reading non-verbal communication, loss of intimacy and privacy and increased disparities affecting people unable to use technology [42].

Technology use during COVID-19 has also raised some ethical challenges related to protecting clients' safety and the coercive control tactics used by perpetrators. For instance, it has been reported that the risks to a women's safety increases when she uses app-based interventions that can easily be accessed by her perpetrator [53]. Moreover, some individuals may be struggling with unstable or unavailable internet connections, or they may not be able to afford the required devices, such as a smart phone or tablet, to receive treatment or support virtually [22, 54, 55]. Additional barriers to uptake of virtually delivered interventions can include issues concerning confidentiality and privacy and not being comfortable with receiving care or treatment commonly delivered face-to-face over phone or video [22].

Furthermore, underserved people have faced multiple barriers to accessing virtual or remote-based interventions throughout the pandemic [22]. This has been coined the 'digital divide,' which is characterized by inequitable access to technology and the internet [10]. For instance, there is ample evidence demonstrating digital exclusion among rural communities where broadband access is limited [42, 56]. Some individuals affected by DV and/or SV also face barriers to accessing virtual interventions due to a lack of culturally acceptable and appropriate virtual tools [22].

Although the pandemic has necessitated the leveraging of virtual and remote interventions to increase accessibility and provision of care and treatment for individuals and families experiencing and/or at-risk of DV and SV throughout the crisis [10], evidence of their effectiveness, feasibility, and acceptability across a range of diverse individuals and population groups affected by violence, including interventions that incorporate gender-transformative approaches to trauma (e.g., cultural, historical, and immigration-related trauma), has been limited [32]. Therefore, we conducted a rapid evidence assessment (REA) of existing trauma-focused virtually delivered DV and SV interventions, and their acceptability, feasibility and effectiveness for diverse individuals and families.

Study Objectives

Given the limited knowledge regarding the delivery of effective and culturally-safe virtual and remote-based interventions across a range of diverse DV and SV affected individuals, our REA reviewed published evidence on virtually delivered trauma-focused interventions to support decision-making on the delivery of such interventions for individuals experiencing, at risk of, and survivors of DV and SV during the current public health crisis and beyond. This knowledge synthesis specifically aimed to examine the acceptability, feasibility and effectiveness of these virtual interventions across a range of population groups affected by DV and/or SV. This REA was funded by the Canadian Institute of Health Research (CIHR) COVID-19 Rapid Research in Mental Health and Substance Use initiative.

Method

A REA was undertaken within a five-month time-frame. REA provides a timely, valid and balanced assessment of available empirical evidence related to a particular policy or practice issue [54]. REA is a rigorous and explicit method that utilizes a wide range of evidence required for policy and practice recommendations in a short timeframe. The process is characterized by developing a focused research question, a less developed search strategy, literature searches, and then more simplified data extraction and quality appraisal of the identified literature when compared to traditional systematic reviews [57].

Search Strategy

Three comprehensive search strategies were executed by an expert searcher/health librarian (SC) on the following databases: OVID Medline, OVID EMBASE, OVID PsycInfo, OVID Global Health, Cochrane Library (CDSR and Central), EBSCO CINAHL, Proquest Dissertations and Theses Global, PROSPERO and SCOPUS using controlled vocabulary (eg: MeSH, Emtree, etc) and key words representing the following concepts Search 1: “remote care delivery and “people experiencing domestic violence” and “COVID 19; Search 2: “remote care delivery and “people experiencing domestic violence”; Search 3: “remote care delivery” and “trauma informed care”. Results of all three searches (2133) were exported to Covidence systematic review software, where duplicates (703) were removed. No limits were applied. Additional search was also conducted using Google and Google Scholar to identify studies not published in indexed journals and grey literature sources. A monthly search alert was created using our search terms to allow for notifications of new published literature on the topic and this review was updated accordingly. A call was also sent out to contacts and experts in the field to share their knowledge and/or resources in relation to our objectives. However, no data was received through this strategy.

Study Screening and Selection

Two reviewers (WG, KT) independently screened all potential articles. In the case of disagreement, both reviewers read the paper and discussed until consensus was reached. Full texts of eligible articles were independently screened by these two reviewers (WG, KT), and papers were included into this review only if they satisfied all of the following three inclusion criteria: (1) if it included trauma-focused intervention to individuals and families affected by domestic violence, sexual violence and/or related childhood trauma; (2) if the intervention was delivered virtually; and (3) if the article was published in the English-language.

The first search strategy (virtual care interventions + experience of violence + COVID-19) identified 138 potentially relevant articles. The second search strategy (virtual care interventions + experience of violence) resulted in 1,058 potentially relevant articles. The third search strategy (trauma informed interventions + experience of violence) identified 236 potentially relevant articles. A review of the titles and abstracts resulted in the selection of n = 52, n = 206 and n = 44 articles respectively for full text assessment. The full text was retrieved for all articles, and, 21 studies met the inclusion criteria. The PRISMA Flow Diagrams [58] for the literature search for each search strategy are included in Appendix A.

Quality Assessment

The quality of studies was assessed using the Critical Appraisal Skills Program (CASP) quality assessment tools, namely the CASP Systematic Review Checklist, CASP Qualitative Checklist, and CASP Randomized Controlled Trial Checklist [59]. The developers do not recommend using a scoring system when applying this tool. Thus, included studies were assessed based on the clarity of research objectives, the appropriateness of data collection strategy for the study design, quality of the methodology, whether findings clearly correspond to objectives and if the research is valuable and/or applicable to local settings [59].

Data Extraction and Analysis Process

Two reviewers (WG, KT) independently extracted the following information from included studies into a standard extraction form (Appendix B): author(s), publication date, publication type, population studied, country, study setting, type of virtual care intervention, if the virtual care solution was implemented in the context of an epidemic or pandemic, outcome measures and results, equity considerations and challenges or barriers to implementing the virtual care intervention. Independent extraction by two reviewers ensured the accuracy of included data and that any relevant information was not missed. An inductive, summative content analysis approach was used to analyze the findings [60].

Results

Study Characteristics

A total of 1,432 de-duplicated documents (i.e., academic articles, abstracts and dissertations) were screened, 175 full-text documents were reviewed, and 21 documents were included for analysis. The included articles were published between 2004 and 2019, with majority of articles (n = 19) published after 2011. Study types included systematic reviews (n = 2), scoping review (n = 1), narrative reviews (n = 3), RCTs (n = 5) and quantitative descriptive (n = 5); and three studies came from gray literature sources (i.e., doctoral dissertations, evaluations). Most of the included evidence is from studies conducted in high-income countries (USA, New Zealand, Canada, and Australia), and only one systematic review included a study conducted in a lower middle-income country (Cambodia). Qualifying studies focused on DV related trauma (n = 9), SV related trauma (n = 2) and both DV and SV related trauma (n = 3). The studies included the following populations: adult female survivors only (n = 8), children and youth survivors only (n = 2), and a range of participant groups (i.e., same-sex couples, pregnant and postnatal mothers, perpetrators, and survivors; n = 10). Most of these studies (n = 17) were targeted to English-speaking participants. Only two studies tailored their interventions for Spanish-speaking participants [47, 61].

Characteristics of Virtual Domestic Violence (DV) and Sexual Violence (SV) Interventions

Our review identified two types of trauma-focused virtual DV and SV-focused interventions: (1) digital safety planning tools that are intended to support individuals currently experiencing DV and/or SV; and (2) interventions focused on psychological therapies and treatments for survivors of DV and/or SV. Our review did not identify psychological therapies and treatments specific for individuals experiencing DV and/or SV in the moment.

Digital safety planning tools

Safety planning is defined as a dialogic process that informs and supports an individual exposed to violence or abuse by identifying behaviours they can adopt to increase safety and decrease exposure to violence for themselves and their family at risk [62]. Findings from three RCT studies of internet-based safety planning tools highlighted several important online support tools such as online programs and apps for delivering needed safety services to individuals experiencing DV and/or SV [63-65]. These safety planning tools included *HELPP (Health, Education on Safety and Legal Support and Resources in IPV Participant Preferred)* – an online program [63], *I-DECIDE* – an interactive online tool [66] and *iCAN Plan 4 Safety* — an online tool [67]. These digital support tools predominantly focused on supporting female individuals affected by DV to make informed decisions about their safety and well-being (Table 3.1). *HELPP* and *I-DECIDE* are not yet available to the public, while *iCAN Plan 4 Safety* can be accessed using a weblink for free. These are intended to allow both privacy and real-time access to resources for those at risk and may be particularly appropriate for hard-to-reach populations (e.g., individuals with limited access to technology or individuals residing in remote and rural communities).

Table 3.1: Summary of Safety Decision Aid Tools

Name of program	Target population	Delivery method	Description	Opportunities	Concerns/Challenges	Effectiveness
HELPP [63]	Female survivors of domestic violence (who are not living with perpetrator)	Online program	Focus on education on safety, self-reflection and self-evaluation of risk for mental health distress	Intervention showed improvements in all outcome measures (i.e., anger, anxiety, depression, personal and social support)	Long-term sustainability of outcomes is unknown	Significant improvements were shown in all outcome measures (i.e., anger, anxiety, depression, personal and social support) in a random sample of female survivors.
I-DECIDE [66]	Female experiencing domestic violence	Online interactive tool	Help female self-inform, self-reflect, and self-manage, and focuses more on healthy relationships, rather than only safety decisions.	Available wherever individuals can find safe access to computer/internet	Not tested among other genders and individuals from different ethnic, cultural or socioeconomic groups.	Findings from this intervention indicated positive outcomes on reduced depression, fear and anxiety, as well as increased self-efficacy.
iCAN Plan 4 Safety [67]	Female who have experienced domestic violence in the previous 6 months	Mobile App	Helps female assess their particular situation in terms of setting priorities and safety risks	Allow both privacy and real-time access to resources	Not available to individuals without access to smart phones	The effectiveness of this tool are not yet measured.

In one systematic review, eleven online interventions that focused on personal safety planning to enable female safety while in an abusive relationship were studied [68]. Of the eleven interventions, six focused on personal safety planning that would enable female safety while remaining engaged within the abusive relationship; seven interventions focused on safety planning to support females to physically leave an abusive relationship; and four interventions focused on the provision of services and resources to support females in the immediate aftermath of leaving an abusive situation [68]. Similarly, a more recent systematic review also described self-efficacy and safety decision aids for females in abusive relationships [53]. However, none of the interventions identified in this review focused on supporting women to move on from an abusive relationship and none of the interventions appeared to consider the broader social implications related to DV and SV.

Virtual psychological therapies and treatments

There is strong evidence in support of virtual delivery of trauma-focused treatments such as cognitive-processing therapy (CPT), cognitive–behavioral therapy (CBT) and psychotherapy to a range of survivor participant groups; for example, survivors of sexual violence, children and adolescents, and female survivors of DV [47]. These treatments and therapies (Table 3.2) were delivered through mobile health (mHealth) and videoconferencing technologies to wide range of participant groups who have been removed from their traumatic situation [45, 47, 51, 53, 69-75]. For instance, a smartphone based mobile application called *THRIVE* was developed to address unmet health needs for mothers who have experienced DV and to improve their mental well-being [76]. Vidyo, a videoconferencing software, was also used to remotely deliver CBT to 15 underserved trauma-exposed youth [75].

Table 3.2: Summary of Online Psychological Therapies for Individuals with More Severe Needs

Name of program	Population	Delivery Method	Description	Opportunities	Challenges	Effectiveness
THRIVE App [76]	Mothers who have experienced domestic violence	Mobile health (mHealth) technologies	Program includes three sections: Myself (maternal self-care, stress coping skills), My Child (stress signs in children, talking to children about IPV, mother–child dyadic communication), and My Life (hospital and community-based resources).	Convenience, Lower dropout rates, Increased access to isolated individuals	Requires access to digital technology	Not measured
The Wyoming Trauma Telehealth Treatment Clinic (WTTTC)- Trauma-Focused Treatments [70]	Rural survivors of domestic violence and sexual violence	Videoconferencing and tele-mental health	Trauma-focused psychological services	Reduce mental health care disparities for those living in rural and remote communities	Access to digital technology Access to stable Wi-Fi; Privacy and confidentiality concerns	Clinically significant reduction in PTSD symptoms.
Telepsychotherapy for Treating Childhood Posttraumatic Stress [47]	Children and youth with experience of trauma related to domestic or sexual violence.	Telehealth	Trauma-Focused Cognitive–Behavioral Therapy	Outcome measures indicate reduction in PTSD symptoms	Highly dependent on caregiver involvement	Clinically significant reduction in trauma-related disorder at posttreatment

Effectiveness, Feasibility, and Acceptability of Virtual DV and SV Interventions

Effectiveness and acceptability of safety planning interventions

Evidence from methodologically robust studies that primarily reported on the effectiveness and acceptability of digital safety planning tools, demonstrate positive outcomes on participants' increased safety-promoting behaviors and improved decision-making and self-efficacy skills [53, 61]. In a recent systematic review, three high-quality studies of safety decision aids were examined that provided empowerment and support for women [53]. In one of the included studies, 90% of the female participants left the abusive relationship within a year of receiving the intervention, and in the other two studies more than 70% of the female participants reported gaining important decision-making and self-efficacy skills [53]. Similarly, an RCT study examined the effectiveness of a safety-promoting behavior intervention which was administered over the course of 6 phone calls, and post-intervention follow-up at 3,6, and 12 months [61]. The authors concluded that the intervention was efficacious in that the number of safety-promoting behaviors in the treatment group was greater than in the control group, an effect which was consistent throughout the 18-month duration of the study. The participants in the treatment group also increased the number of safety-promoting behaviors that were observed, and the behaviors remained stable throughout the study timeframe.

Effectiveness, feasibility, and acceptability of virtual psychological treatments

There is evidence from varied methodological study designs demonstrating the effectiveness, feasibility, and acceptability of virtual psychological treatments and care for PTSD and other forms of trauma for some DV and SV survivors. Effective online psychological therapies in these circumstances included CPT, CBT, and tele-psychotherapy which were delivered through real-time (synchronous) technologies, such as telehealth, mHealth, and videoconferencing [45, 47, 53, 69-75].

One study reported on positive outcomes of virtually delivered trauma-focused counselling for survivors in rural and remote settings. The Wyoming Trauma Telehealth Treatment Clinic (WTTTC) is cited as a successful evidence-based program that delivers trauma-focused psychotherapy using remote videoconferencing to rural survivors of DV and SV [53, 71]. In an effectiveness and feasibility study with 15 clients [70], the authors reported large treatment gains among these clients on measures of PTSD and depression symptom severity after receiving psychological services via videoconferencing [70]. In this study, the presence and severity of PTSD was measured using the Post-traumatic Stress Disorder Checklist (PCL) and symptoms of depression were measured using the Center for Epidemiological Studies Depression Scale (CESD). The study showed that the mean score from the PCL questionnaires completed by clients decreased from 54.43 pre-treatment to 34.10 post-treatment, showing an improvement in PTSD symptoms [70]. Clients also completed a self-report measuring depression symptoms (CESD). The mean score from this report decreased from 29.33 pre-treatment to 15.24 post-treatment, showing an improvement in depression symptoms [70]. Additionally, rural survivors of DV and SV who participated in the intervention reported a high degree of satisfaction with videoconferencing administered services. Thus, the findings from this intervention suggest that remote videoconferencing can be an effective means to deliver services to underserved rural DV and SV clients.

CPT has also been successfully delivered via clinical video technology and tele-health [47, 51, 74, 75]. Two of these studies [51, 74] applied prolonged exposure (PE) therapy - a cognitive-behavioral treatment which incorporates “the gradual confrontation of typicallyavoided memories, images, objects, and situations associated with the traumatic experience through exposure exercises." [74]. Valentine et al. [51] used virtually delivered PE-based treatments with veteran survivors of military sexual trauma (MST). The survivors were given the choice to enroll in remote delivery (i.e., clinical video technology) or in-person therapy. In this study full treatment completion rate was similar between in-person delivery and video delivery. However, the researchers report higher attrition rates early in the treatment phase in the participants who received treatments virtually, which coincided with interventions such as early imaginal exposure and written trauma accounts [51]. On the other hand, Steinmetz and Gray [74] did not discuss challenges with attrition in virtual delivery of PE to rural survivors of DV (80%) and SV (20%). In this study, the mean number of sessions attended was 13.33 (SD = 13.89), and meaningful reduction in depressive symptoms (d = 1.24) and PTSD symptoms (d = 1.17) were reported. One study demonstrated effectiveness (i.e., a therapeutic effect) for the treatment of PTSD among military sexual trauma survivors with CPT interventions delivered via clinical video technology [51]. At the same time, in a systematic review of mHealth interventions [45], the findings showed that dropout rates in mHealth interventions were lower compared to in-person interventions. The authors attributed this to participants feeling more comfortable to disclose their circumstances in the virtual environment than during in-person sessions [45].

In one pilot study that examined the effectiveness of trauma-focused CBT (TF-CBT) via telehealth [75], the authors reported that participants showed a clinically significant reduction in PTSD symptoms with a zero drop-out rate. This study specifically assessed technical performance of the telehealth equipment, safety, number of sessions attended, treatment completion rates, and pre- to post-treatment clinical outcomes of PTSD, depression, and anxiety symptoms. All study participants no longer met criteria for PTSD or adjustment disorder at the completion of treatment, demonstrating the effectiveness of this virtual CBT interventions to address PTSD and other forms of trauma. The authors of this study also noted they were able to deliver all treatment components successfully such as, digitally presenting worksheets and written materials using screen sharing function. In a recent follow-up study by the same authors [47], they examined the effectiveness of a tele-psychotherapy intervention that enrolled 70 children and adolescents struggling with PTSD as a result of physical abuse, sexual abuse, and witnessing domestic or community violence [47]. The authors indicate participants showed clinically meaningful symptom change post-treatment and 96.8% of the participants who competed the treatment no longer met diagnostic criteria for a trauma-focused disorder at post-treatment. The authors conclude these results are indicative of potential effectiveness of the virtual treatment delivery format [47].

Equity Considerations in the Design and Delivery of Virtual DV and SV Interventions

There was limited evidence examining the delivery of virtual DV and SV interventions for underserved and at-risk population groups, including Indigenous, LGBTQS2+, newcomers, individuals with disabilities, and other population groups who are at a greater risk of DV and SV. Only two primary studies (a pilot study and an evaluation study) and three reviews (a narrative review and two systematic reviews) discussed the virtual delivery of trauma-focused interventions for individuals from underserved populations. The pilot study reported on the effectiveness of trauma-focused CBT delivered via telepsychotherapy on children and youth exposed to violence or abuse from a range of ethnic and racial minority groups [47]. Telepsychotherapy treatment was delivered to 70 trauma-exposed youth in several underserved communities, and in community-based locations of either schools or patient homes. Results from this study demonstrated clinically meaningful reductions in PTSD symptoms among children and youth. Additionally, in the evaluation study of a new trauma-informed smartphone-based mobile application called THRIVE for mothers who survived intimate personal violence (IPV), were engaged in the user design of the application [76]. This was the only study that reported on the engagement of survivors, as the users of the digital tool, in the mobile application's content, design, safety features, and applicability, thus emphasizing the incorporation of user or client-centered care principles in the design and delivery of the virtual intervention.

Furthermore, a narrative review highlights the importance of inclusive virtual delivery approaches where evidence-based trauma treatments are culturally adopted and delivered by bilingual clinicians [77]. The authors studied the utility, use, and set-up of a tele-mental health program through the Community Outreach Program-Esperanza (COPE) – an existing community outreach program. COPE is a community agency based in South Carolina that provides virtual care services to underserved populations (ethnic minorities, individuals residing in rural/remote areas, and economically disadvantaged populations). The research team also developed guidelines for the delivery of evidence-based, trauma-focused tele-mental health to a range of diverse population groups [77]. The authors also recommend that "clinicians be aware of the families' views of trauma and potential cultural constructs, such as acculturation and ethnic identity, which may impact the treatment process" [77].

In one systematic review [53] the authors noted a gap in research examining the effects of virtually delivered trauma-focused interventions for women with disabilities, immigrant women, and Indigenous women [53]. Similarly, in their systematic review Anderson et al. [45] reported the majority of interventions (77%) they reviewed were exclusively delivered in English and did not take language barriers into consideration.

Barriers to Virtual Delivery of DV and SV-Focused Interventions

Challenges and barriers with the implementation of virtual or remote-based interventions were reported. Among the studies that identified barriers and challenges to delivering and implementing virtual interventions, several accessibility barriers were noted [45, 62, 73, 75, 78, 79]. Barriers to delivering online or web-based applications to some individuals exposed to DV and/or SV, particularly in rural communities, included lack of access to reliable internet or devices such as smart phones, tablets and computers which were necessary to use the online/digital application [62, 73, 75, 78, 79]; unacceptable platforms, especially if participants have to download software or learn how to use new hardware [45]; and challenges with the telehealth equipment such as login challenges [75].

User attrition was also identified as a potential challenge to implementing virtual DV and/or SV interventions [51, 78, 79]. For example, in one study participant attrition was higher at the intervention stage when participants were asked to recount their traumatic experiences [51]. The authors of this study highlight, “this is an unfortunate time for clients to dropout, as they may be experiencing temporary symptom exacerbation, which may reduce their likelihood of reengaging in treatment in the future and may negatively impact treatment expectancy” [51].

Ethical concerns and safety of use by those still at risk of DV and/or SV was also identified as a potential barrier [53, 71, 78, 79]. Most apps and online resources may not have sufficient safety and security provisions, and this increases the risk of violence for individuals who are still living with their abusers, especially if they share a mobile phone with their abuser [53, 78]. In addition, trauma-focused virtual treatment may not be safe for suicidal survivors because of the inability to manage such crisis distally [71]. Other studies in our review highlight challenges with the loss of "therapeutic alliance" in virtual delivery of interventions [79]; and the potential to miss non-verbal cues in virtual settings [73].

Discussion

The findings from this REA suggests that there is limited evidence demonstrating the effectiveness, feasibility, and acceptability of a range of virtual DV and SV interventions. Despite these knowledge gaps, there is methodologically sound evidence on virtual delivery of trauma-focused interventions and psychological therapies for survivors of DV and/or SV. In addition, the evidence examined in this review highlighted several important digital tools for delivering safety planning services to individuals who are impacted by DV. However, to our knowledge safety decision aid tools specific for individuals affected by SV have not been tested. These online safety decision aids focused on women creating a safety and/or action plan in the event of a future partner domestic abuse incident, which, in part, involves clarifying the choices individuals have for leaving an abusive relationship. Furthermore, of the evidence-based safety decision aid tools that were included in the studies reviewed they were predominately focused on females. Thus, there remains a knowledge gap on the effectiveness and acceptability of these online support tools across other gender identities, and for individuals affected by SV. Moreover, individuals affected by DV were not engaged in the design, development of safety features, and applicability of the tools.

There is limited evidence on the effectiveness of psychological therapies and treatments specific for individuals currently experiencing DV and/or SV. However, there is methodologically robust evidence that supports the provision of virtual psychological therapies for reducing psychological symptoms such as depression, anxiety and PTSD for survivors of DV and/or SV who are removed from the abusive situations [51, 53, 66, 78, 80-82]. The effectiveness of virtual psychological therapies was particularly demonstrated for individuals with complex, severe or delayed forms of trauma (i.e., exhibiting symptoms of complex PTSD, have experienced multiple or ongoing traumas, and/or in individuals who have experienced childhood sexual abuse). Effective virtual psychological therapies in these circumstances include CPT, CBT, and telepsychotherapy [47, 53, 73, 75, 83]. Studies that examined the effectiveness and feasibility of videoconferencing as a means of delivering trauma-focused treatment have also shown comparable gains that accrue during traditional in-person services [71, 77, 79]. However, many of these studies involved a small sample size of which can influence research outcomes and the results cannot be generalizable to a larger population. Thus, RCTs with larger sample sizes comparing videoconferencing and in-person treatment are needed to strengthen the evidence-base.

Furthermore, higher dropout rates, the loss of therapeutic alliance, and the potential to miss non-verbal cues in virtual settings were identified as barriers to implementing and measuring the effectiveness of virtual interventions in our REA. Recent studies have also reported similar results [7, 22]. At the same time, challenges related to the virtual delivery of trauma-focused interventions with exposure component (e.g., PE) for DV or SV survivors is not well documented. Our REA identified only two studies that included exposure component (PE) with contradicting findings [51, 74]. However, the participant groups included in these studies were different and faced unique factors associated with their experiences of violence - rural survivors of DV vs veteran survivors of MST [51, 74]. Thus, neither of these findings are generalizable. As a result, our understanding of virtually delivered exposure therapy and the associated safety risks remain to be unknown and calls for further exploration.

Some scholars have suggested that internet-based applications and e-mental health programs are likely to be most effective when used to supplement or facilitate (rather than replace) professional care and provider-client engagement [78]. For example, Brigone and Edleson [78] referred to this as ‘supportive accountability’ – where there is an interface between providers and clients, and the online tools or programs are not solely approached as a self-help tool. However, existing evidence of virtually delivered trauma-focused interventions (including mobile applications and safety decision aid tools) for individuals and families affected by DV and SV provided little evidence of how these virtual interventions can best be promoted or offered by providers in a range of health and community settings.

In addition to the already heightened risks for DV and SV faced by individuals and families during COVID-19 [84], others who experience intersecting forms of inequality are particularly at risk including Indigenous, racialized, non-status, immigrant, refugee and newcomer, LGBTQ2S+ and individuals with disabilities. All these underserved populations are especially vulnerable because of the social and economic impacts of the pandemic [22, 32, 85]. The use of virtual interventions for these individuals and families affected by DV and SV has the potential to reduce mental health care disparities by increasing access to culturally and linguistically competent clinicians [77]. However, underserved populations face multiple barriers with the ‘digital divide’ [10]. While access to the internet or technology was highlighted as a barrier for participants in several studies included in our REA [45, 47, 53, 76, 77] limited consideration was given to the issues of equity and access in the virtual delivery of these interventions.

Guidance from available evidence for how to deliver virtual interventions for different individuals affected by DV and SV, including interventions that incorporate gender-responsive approaches to trauma (e.g., cultural, historical, and immigration-related trauma), is not readily available. Thus, further research is needed to examine the delivery of virtual DV and SV-focused interventions from an intersectional lens, as well as attending to inequities in digital access to virtual treatment or care. Furthermore, most of the studies examined in our review demonstrate intervention effectiveness using traditional scientific methods such as RCTs, which obscures the myriad of factors occurring between an intervention and possible reduction in trauma and mental health disorders. Qualitative research on the experience of clients accessing virtual interventions can improve our understanding of effectiveness and acceptability of such interventions for different individuals.

The articles and systematic reviews examined in our REA also describe the ethical challenges with protecting clients' privacy, confidentiality and safety when accessing and using virtual or remote-based interventions [53, 79]. Practice guidelines for professionals delivering virtual interventions and conducting comprehensive intake procedures to assure appropriateness of treatment for clients have been promoted [53, 79]. Our findings also highlighted the ethical challenges with protecting clients' safety. The coercive control tactics used by perpetrators is a major barrier for some individuals accessing treatment services and supports virtually. As previously indicated, a women's safety concerns increase when she uses app-based interventions that can easily be accessed by her perpetrator [53]. Therefore, more research into enhancing safety features, privacy, and confidentiality in the delivery of virtual interventions for people experiencing DV and SV is needed.

Given the scarcity of evidence in effective virtual or remote-based interventions, this provides limited guidance for anti-violence sectors to adequately prepare for the sudden influx of the need for virtual interventions for individuals affected by DV and/or SV during the COVID-

19 pandemic. As previously indicated, unprecedented challenges and barriers that have arisen include limited digital communication infrastructure such as access to smart devices, broadband access, and compounded by lack of comfort with virtual care technologies by clients and providers [76]. That being the case, as the pandemic continues, virtual interventions are increasingly becoming the "new normal." Therefore, there is a growing need for government investment, and stakeholder involvement in the development, implementation and evaluation of resources and educational materials that are specifically tailored for the delivery of equitable trauma-focused DV and SV interventions.

Implications and Recommendations for Research Policy and Practice

While this REA highlights the paucity of virtual or remote-based interventions, there is promising evidence supporting the effectiveness and acceptability of virtually delivered interventions that can readily be adopted and utilized by organizations and providers serving individuals and families affected by DV and/or SV during the current COVID-19 pandemic and future pandemics. However, virtually delivering equitable and accessible interventions to a wide range of individuals and families affected by DV and/or SV will require an intersectional and systemic approach to ensure uptake by individuals and families most at-risk of violence and abuse. This will require collective effort from researchers, providers and policy makers (Table 3.3). Further research is needed to (1) examine the effectiveness and acceptability of online support tools across sex and gender identity, and for individuals affected by SV; (2) undertake mixed method studies examining the effectiveness of psychological treatments delivered via videoconferencing compared to in-person treatment across a diverse range of population groups; (3) apply an intersectional lens and qualitatively assess the acceptability, feasibility and perceived effectiveness of virtual or remote-based interventions for diverse population groups at a greater risk of DV and SV; (4) examine the safety concerns of virtual delivery of interventions within the context of a pandemic; and (5) develop and evaluate virtually delivered psychological treatments for individuals experiencing DV and/or SV during a pandemic or similar public health crisis when access to services and supports are disrupted.

Table 3.3: List of Implications and Recommendations for Practice, Policy, and Research

Recommendations for Future Research	Further Research is Needed to Examine the Following: 1. The effectiveness and acceptability of online support tools across all gender identities, and for individuals affected by sexual violence. 2. RCTs comparing videoconferencing and in-person treatment, and inclusion of larger samples and structured clinical interviews. 3. Virtual interventions applying an intersectional lens, and there is an urgent need to tackle inequities in digital access to care and treatment. 4. The safety concerns of virtually delivered trauma-focused treatments with exposure component. 5. The effectiveness and feasibility of virtually delivered interventions for individuals experiencing DV and/or SV during a pandemic or similar public health crisis.
Implications for Policy and Practice	Recommendations for Policy and Practice include the following: 1. Practice guidelines for delivering virtual interventions. 2. Engage survivors and other stakeholders in the design, safety features, content and applicability of virtual support tools. 3. Policy measures to ensure sustainable funding resources for the aniti-violence sector to accommodate diverse clients and their unique needs in accessing virtual or remote-based services. 4. Providing access to support resources and treatment during the pandemic, and provincial and national strategies should address potential barriers to accessing services and support preparations for increased intake when public health measures are lifted or when services resume. 5. Developing policy measures to narrow the ‘digital divide’ including funding broadband infrastructure and increasing digital health literacy for vulnerable clients; and increasing global access to digital technologies.

The existing evidence is not sufficient to make specific recommendations for practice; however, providers working with individuals and families affected by DV and SV will need practice guidelines for delivering virtual interventions, which include safety assessment and ensuring appropriateness of virtual treatment for clients. In addition, online tool developers need to be mindful of inequities in digital access and improve their design of virtual tools to be more inclusive, secure, and safe for individuals at risk of DV and/or SV. One of the knowledge gaps noted from the REA is the engagement of clients in the development and design of virtually delivered services and supports. Considering what has already been said about understanding the acceptability of these interventions for different population groups, their perspective and voices in the design, safety features, content and applicability of the virtual support tools is important. In addition, the following policy recommendations can guide the implementation and uptake of equitable and accessible virtual or remote-based interventions during the COVID-19 pandemic and beyond. (1) As previously indicated, the anti-violence sector has already been overstretched and was not prepared for the pandemic-related higher volumes of demand for support. Ensuring sustainable funding resources for organizations which provides an avenue to accommodate diverse clients and their unique needs in accessing virtual or remote-based services during the pandemic and beyond is key [32]. (2) Health systems should continue to ensure that individuals experiencing DV and/or SV and survivors have access to support resources and treatment during the pandemic and future public health crises. Provincial and national strategies should address potential barriers to accessing services (including lack of information about the services and supports available) and support preparations for increased intake when public health measures are lifted or when services resume. Finally, (3) developing policy measures to narrow the 'digital divide' including funding broadband infrastructure and increasing digital health literacy for vulnerable clients; and increasing global access to digital technologies would provide an avenue to improve the acceptability and feasibility of implementing virtual or remote-based interventions for individuals and families affected by DV and SV. These include culturally appropriate, and affordable virtually delivered services and interventions [45].

Limitations

Although this REA followed a systematic approach to reviewing and analyzing the evidence, there are still limitations which reflect primarily the relative dearth of studies in this area. More specifically, limitations include: (1) that it was conducted within a limited timeframe which may have affected the quality and level of analysis; (2) with the aim of scoping all potentially relevant evidence, we included heterogenous sources of data. Thus, it was difficult to compare and rate qualities of the included studies; (3) the heterogeneity of the included evidence also resulted in the lack of consistency of outcome measures for the quantitative studies; (4) we only included articles published in English, and thus we may have missed important information published in a different language; and (5) in this review we were only able to identify virtually-delivered psychological treatments and therapies for survivors, not individuals currently experiencing DV and/or SV.

Conclusions

Virtually delivered trauma-focused interventions for DV and SV are scarce, and effectiveness data for these approaches are preliminary in nature. In addition, the acceptability and effectiveness of virtual trauma-focused interventions for a range of population groups at risk of DV and SV are understudied. However, there is some evidence indicating virtual delivery of DV and SV interventions have the potential to respond to the needs of individuals and families affected by DV and/or SV, especially during COVID-19.

Further robust, large-scale research is required to evaluate a range of virtual or remote-based interventions across diverse population groups to ascertain their effectiveness and acceptability. A stronger evidence-base will allow for the development and implementation of virtual interventions that benefit these at-risk individuals and families. Further, this study shows that inequities in digital access are a barrier to the effectiveness of virtual care. This barrier must be addressed in order for many people experiencing DV and SV violence to take advantage of virtual or remote-based interventions and services.

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Chapter 4 - Perspectives on Delivering Safe and Equitable Trauma-Focused Intimate Partner Violence Interventions via Virtual Means: A Qualitative Study During COVID-19 Pandemic[2]

Background

Intimate Partner Violence (IPV) is a global health problem [1] defined as a behavior, including financial and coercive control, by a current or former intimate partner that causes physical, sexual, or psychological harm. IPV can include physical aggression, psychological and emotional abuse, and sexual coercion either alone or in combination [1]. Although individuals of all gender identities experience IPV, women and girls are most likely to experience severe IPV and associated adverse outcomes, including femicide [1]. Globally, one in three women are exposed to violence within intimate partner relationships [2]. Exposure to IPV in children can result in social, behavioral, emotional, and cognitive problems which persist into adulthood [3-5]. According to the World Health Organization (WHO), growing up in a household where the mother is abused is one of the most common risk factors both for future perpetration by males, and exposure to IPV in females [3, 6].

In Canada, IPV is the leading cause of serious injury and the second leading cause of death among reproductive age women [7]. While no specific group in the Canadian population is exempt from experiences of IPV, research to date has found that different populations may have different experiences of IPV, in terms of its prevalence, characteristics, and impacts [8]. Even though police reports of IPV are low overall, the prevalence of IPV in both police-reported and self-reported metrics in Canada is significantly lower for underserved populations [9, 10]. These populations include Indigenous peoples, immigrants, refugees, racial and ethnic diverse groups,

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official language minorities, LGBTQ2S+ individuals, individuals living with disabilities, those experiencing homelessness or precariously housed, sex trade workers, and individuals of low socioeconomic status [11]. For example, there is a lack of data on IPV against Black women, or any measurement of incidence of coercive control as a form of relationship violence [12, 13]. Much of Canada's national data on IPV or abuse does not provide a breakdown of differing groups of women and gender diverse people. As such, the data presented does not always explain the differing levels and types of violence according to population, or according to intersections of different oppressions, although it is becoming more possible to find examples of research that reveal these intersections (18). Understanding the varied experiences between groups is critical as a better understanding of them will help to develop more appropriate responses, services, programs, or prevention strategies related to IPV. Furthermore, structural barriers in Canada and the US such as the ambiguity of the criminal justice process and racist interactions with the police deter Indigenous, Black and racialized individuals from reporting experiences of abuse to authorities [10].

Moreover, past studies demonstrate that globally, natural disasters, emergencies, and public health crises often lead to increased rates of IPV [14]. For instance, the HIV/AIDS epidemic in the US, Eastern Europe and Africa demonstrated increased rates of IPV [15-17], and natural disasters such as floods and hurricanes have shown to lead to an increase in violence against women [17-22]. During the COVID-19 global pandemic, rates of IPV have been reported to increase by 30% in Canada, reflected in increases in IPV reports and calls to violence hotlines [23]. In a recent report by the Ending Violence Association of Canada (EVAC), 82% of frontline service providers surveyed within the anti-violence sectors in Canada observed an increase in the severity of violence experienced by their clients [24]. IPV severity is also shaped by factors such as financial stain, and increased stress among individuals and families [25, 26].

IPV and Mental Health

IPV is a form of trauma with significant mental health concerns for individuals and families affected [27]. Trauma is defined as "an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" [28]. The presence of IPV has significant short-term and long-term psychological consequences that range from stress, frustration, anger, and decreased social function to severe depression, anxiety, post-traumatic stress disorder (PTSD), and suicidality [3, 29]. Research examining the link between violence against women and depression have found significantly higher rates in those who experienced violence in their lives compared to the general populations of women [30].

Individuals affected by IPV during the COVID-19 pandemic are struggling with complex trauma as a result of the violence and pandemic-related mental distress [31]. Evidence shows there is a direct relationship between the length of quarantine and level of negative psychological effects (e.g., depression, stress, anxiety) [32, 33]. For some survivors of IPV who have left the abusive relationship, the stay-at-home orders implemented during the first and second wave of the pandemic in Canada triggered recollection of past traumatic experiences and heightened their anxiety [24]. IPV survivors were also cut off from community and support networks. In the EVAC report referenced above [24], service providers caring for IPV survivors identified three main concerns for survivors seeking support during the pandemic: (1) clients who depend on face-to-face interactions faced setbacks in their healing process and mental health; (2) delays in family court proceedings impacted some clients' safety from violence; and (3) survivors were not seeking out care, which had adverse mental health outcomes given they were struggling with complex trauma.

Trauma-Focused Interventions for Individuals Affected by IPV

Trauma-focused interventions are specific approaches to therapy that recognize and emphasize "how the traumatic experience impacts an individual's mental, behavioral, emotional, physical, and spiritual well-being" [34]. This approach to care has been promoted globally within the anti-violence sector, including advocacy interventions (e.g., interventions that inform, guide and help individuals to access a range of services and supports, including safety planning); counselling/brief interventions that promote a range of outcomes, such as reducing depression symptoms and increasing empowerment among those who have experienced IPV, interventions based on brief education, cognitive-behavioral, and motivational interviewing approaches; and therapeutic interventions that promote improvement in mental health impacts of violence through more intensive treatments than counselling interventions, such as group therapy. The most common forms of trauma-focused interventions offered to survivors of IPV are cognitive-processing therapy (CPT) and cognitive-behavioral therapy (CBT) [35].

A recent review of trauma-focused interventions for addressing domestic and sexual violence, published by authors of this paper [36], found key therapeutic interventions delivered virtually such as counselling, psychotherapy, and education, showed encouraging results for addressing key aspects of mental health and trauma associated with violence and abuse. However, the findings from the review found that such interventions did not account for the broader systemic inequities that influence and contribute to interpersonal experiences of trauma and violence. Further research is needed to address knowledge-to-practice gaps on implementing trauma-focused approaches within health and anti-violence sectors, that enhance capacity—particularly to analyze and address the root causes of IPV.

Barriers to Accessing Appropriate Interventions and Supports Among Individuals Affected by IPV

An Overburden Anti-Violence Sector

While the demand for anti-violence services has increased over the years in Canada, funding for anti-violence services has not kept pace, contributing to increased pressure on anti-violence workers, and unmet needs among individuals affected by IPV. A decade of austerity measures not only reduced direct funding for organizations within the anti-violence sector, but also increased demand on the sector as a whole, by reducing service provision. Unfortunately, the COVID-19 pandemic struck at a time when IPV services in Canada had been substantially cut, or underfunded, for many years. Multiple funding cuts to the sector since the early 2000s have resulted in the needs of individuals demanding IPV support going unmet [13, 37, 38]. The sector is funded through an unpredictable combination of donations, corporate gifts, and different orders of government grants that are mostly focused on short-term project funding [38]. Many organizations which offer IPV services must rely on fundraising activities to cover their operational expenses and to pay the salaries of their employees [39]. Consequently, anti-violence workers in Canada lack access to adequate salaries and benefits [13, 40]. This has resulted in “skill drain” as workers trained in anti-violence, trauma-informed, survivor centered approaches are leaving the sector for jobs with competitive salaries [13]. Therefore, the lack of available core sustainable funding structure, including the inequitable distribution of government funding, changes in policy, and high staff turnover within the anti-violence sector, has had a significant impact on service providers and others working with individuals affected by IPV and weakened the capacity of the sector overall [13, 37-39]. Moreover, specialist IPV services for underserved communities are in a particularly precarious position. Research by Women's Shelters Canada found that staff turnover and burnout are a major challenge [41]. During the pandemic, EVA Canada surveyed Gender-Based Violence (GBV) organizations and discovered that 81% of frontline workers experienced additional workplace stress due to the pandemic [24]. Additionally, 84% of workers reported health and safety concerns while doing their jobs during the pandemic. The constraints faced by the anti-violence sector has compromised the quality and safety of services and therapeutic interventions delivered to survivors and individuals experiencing IPV. As a result, individuals seeking support fall through the cracks.

Help-Seeking Barriers among Survivors

Even though exposure to IPV involves risks such as physical injury and poor mental health and trauma, disclosing and/or seeking professional help involves several barriers [3]. Studies show that the rate of help-seeking for specialized IPV support among underserved populations from both medical and social providers is low [3, 42]. Factors such as unemployment, low educational status, economic dependence and experiences of violence have been identified as obstacles to disclosure of violence and seeking support [43]. The barriers are further compounded for individuals with intersecting social identities (i.e., those who belong to more than one socially disadvantaged populations) [44]. Existing evidence suggests that Indigenous peoples and ethnic minority women often avoid seeking support from healthcare providers because of feelings of mistrust and fear toward service providers [45, 46].

Systemic inequalities underpin how institutions practice, what services are available, and how services are provided and received by these individuals [10, 47, 48]. Fear of the system and a lack of services are barriers for women and gender diverse people who are trying to get the help they need to leave an abusive situation. In Canada, one in five women has reported experiencing racism and culturally insensitive and inferior quality of care within healthcare systems and mainstream social services [47]. These barriers discourage Indigenous, Black and other racialized women from seeking help when experiencing IPV [47, 48]. For these women, the decision to seek or access help is also influenced by several intersecting factors. These include: (i) cultural norms and patriarchal ideologies which “stigmatize, blame and shame women from exposing IPV or seeking help” [49]; (ii) structural barriers, such as the ambiguity of the criminal justice process, racist interactions with the police and court system, spousal sponsorship policies, legal status, and fear of deportation [10]; and (iii) culturally insensitive care within the healthcare system and mainstream social services [47, 48]. Some examples of these barriers are fear of being blamed for the violence by the police, lack of trust in institutions, fear their partners will be deported and fear that child protective services will become involved and apprehend their children [3, 49-52]. These concerns are especially high for Indigenous and Black women whose children are overrepresented in the child welfare system [53].

A recent study found that mothers who sought help for IPV were warned about mandatory reporting to authority figures by their service providers, which discouraged them from seeking further help [50]. Moreover, within the social sector, some services are not accessible to racialized IPV survivors due to the lack of culturally applicable advertising of available services or a language barrier [10]. Furthermore, women with disabilities face physical and structural barriers to help seeking which include impaired mobility, complete dependency on the perpetrator, and lack of accessible services [54]. However, there is lack of knowledge on factors that influence these women’s help seeking patterns due to homogenizing of these individuals’ experiences across disability categories (physical, cognitive, learning, and developmental disabilities) [54]. Unfortunately, all these issues and concerns were further compounded and exacerbated for individuals with intersecting social disadvantages during the COVID-19 pandemic.

Study Context

Service Delivery Adaptations during COVID-19

During the COVID-19 pandemic in Canada, the public-health measures introduced to limit the transmission of the COVID-19 virus have meant that most services (including mental health and specific trauma-focused interventions) abruptly pivoted to virtual delivery [55]. During the stay-at-home mandate, virtual delivery of interventions and services such as web-services, tele-counseling, telepsychiatry, e-mental health programs, and violence hotlines became vital resources for individuals affected by IPV [2]. Virtual delivery of interventions incorporates the use of technology to provide communication, education, intervention, or service between a provider and a client [56-58]. However, virtual delivery of interventions and services was not widely adopted by service providers within the anti-violence sector prior to the COVID-19 pandemic and, when used, was restricted to remote areas with limited access to in-person services [56]. Since the pandemic, however, the vast majority of those providing services and interventions to individuals affected by IPV moved to providing services via virtual platforms. However, the shift to providing services virtually, although necessary – and beneficial to many – has exacerbated the gap and barriers with delivering trauma-focused interventions to individuals affected by IPV [59].

Trauma-focused IPV interventions are driven by relationship, trust, and safety [60]. However, the loss of human connection and difficulties in re-building trust among individuals affected by IPV, the ethical challenges related to protecting clients' safety and the coercive control tactics used by perpetrators has been cited as challenges with virtual delivery of interventions [56, 60-62]. Moreover, it has been reported that the risks to a women's safety increases when she uses app-based interventions that can easily be accessed by her perpetrator [61]. Inequitable access to these virtually delivered IPV interventions is also a key barrier. For example, some individuals may be struggling with unstable or unavailable internet connections, or they may not be able to afford the required devices to receive treatment or support virtually [24, 63, 64]. The speed at which virtually delivered interventions and services are available to individuals affected by IPV has also raised concerns for service providers within the anti-violence sector. Anecdotal evidence shows, in the province of Alberta, demand for trauma counselling services related to experiences of sexual violence increased during the pandemic, resulting in an average wait-time of 18-months to see a trauma counsellor. Additional barriers to uptake of virtually delivered trauma interventions can include issues concerning confidentiality and privacy and not being comfortable with receiving interventions commonly delivered face-to-face over phone or video [24].

There is limited data on how these challenges have impacted individuals affected by IPV in accessing trauma-focused interventions during the pandemic. Further knowledge in this area is fundamental to enable safe, equitable, and accessible approaches to virtual delivery of IPV-related interventions during the pandemic and beyond. Safety in the virtual delivery of IPV interventions encompass the physical, emotional, and cultural safety of the individual accessing services via videoconferencing, telephone or online. These include having a structured place where the individuals' physical and emotional safety is respected and where they feel empowered "to seek, share, and obtain information, access services, express themselves, enhance psychosocial wellbeing, and more fully realize their rights." [65]. Equity in the virtual delivery of IPV interventions refers to fairness and justice in the availability and distribution of these interventions to a wide range of population groups, and addresses practices that systematically marginalize and stigmatize entire population groups [28]. Finally, accessibility refers to the ability to attain affordable, client-centered, culturally appropriate IPV interventions and services virtually [66]. To this end, this study aimed to qualitatively explain, from the perspectives of service providers in Alberta, the challenges with accessing virtually delivered interventions that are safe, equitable, and accessible for a diverse range of individuals affected by IPV during the COVID-19 pandemic.

Theoretical Lens: Intersectional Feminist Theory

This study is guided by intersectional feminist theory which highlight the importance of challenging inequities based on sexism, racism, colonialism, class, and other social factors [67, 68]. The theory which originated in Black feminist and critical race theories emerged to make the unique experiences and vulnerabilities of marginalized women more visible [69, 70]. The pioneer of this theory, Kimberly Crenshaw, used intersectionality to frame an analysis of violence against women and argued that traditional gender-only analysis did little to explain violence against racialized women [70]. Therefore, the theory underlines the ways in which social categories, including but not limited to race, class, ability, gender, and sexuality, interact to shape IPV experiences [69]. As an analytical framework, intersectional feminist theory provides insights into the ways in which various forms of inequality and intersecting systems of power relations determine the social locations of groups and individuals, set the stage for social inequalities, and, as a result, inform individual realities and lived experiences [9, 50, 71]. Individuals contending with multiple oppressions encounter challenges that may or may not be adequately addressed with mainstream IPV services. Therefore, access to and delivery of virtual interventions that are safe and equitable should be framed within an intersectional lens that examines how race, ethnicity, socioeconomic status, cultural acceptability, language, geography, and disability intersect to influence accessibility of virtual interventions. This research perspective is grounded in respecting, understanding, and empowering study participants and taking their experiences and stories as valid sources of knowledge [72]. Thus, it is the researcher's responsibility to communicate this knowledge through the individuals' voices [72].

Methods

A qualitative embedded single case study approach [73] was used to examine how virtually-delivered IPV interventions can be safe, equitable and accessible for diverse individuals affected by IPV. A "case study is an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real-world context" [73]. In this study, the embedded single case study focuses on two units of analysis: (i) perspectives of service providers', which has been gathered through semi-structured interviews; and (ii) perspectives and experiences of individuals affected by IPV, which will be examined through a photovoice project. Photovoice is an arts-based methodology which draws on the principles of the community-based participatory research (CBPR) method, in which participants capture their experiences in photographs and narratives, engage in critical reflections and dialogue around these experiences, and develop solutions and recommendations for policy and practice [74-78]. This article, however, reports only on the first unit of analysis – interviews with service providers in Alberta, Canada.

Semi-structured interviews were conducted with 24 service providers within the health and anti-violence sectors working with and serving individuals affected by IPV in Alberta (Table 4.1). An interview guide was co-developed by all authors and interviews were conducted by the lead author (WG). The interview guide covered a wide range of topics relevant to the virtual delivery of IPV interventions during the pandemic, and to better understand the facilitators or barriers that individuals affected by IPV might experience in accessing virtually delivered IPV interventions. All interviews were conducted over a two-month period via telephone or videoconference and lasted approximately one hour in duration. The participants were given detailed information both verbally and written about the aims of the study and the voluntary nature of their participation. All participants provided written and verbal consent to participate. Participant interviews continued until data saturation was reached. The study protocol was reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta (REB # Pro00101547).

Participant Recruitment

A purposive maximum variation sampling technique [79], which involves deliberately selecting individuals who fit the criteria for the study and represent diverse populations, was used to recruit participants. Thus, participants from various organizations and geographical locations serving individuals affected by IPV from diverse social, economic, and cultural backgrounds were invited to participate. Interview participants were recruited from existing relationships among the research team and community partners. Research team (SM, LW) have strong relationships with stakeholders within the anti-violence sector in Alberta. These include stakeholders at Sagesse Domestic Violence Prevention Society and IMPACT in Alberta. IMPACT is a provincial collective impact initiative to eradicate domestic violence and sexual violence in Alberta [80]. The initiative brings together a network of over 400 systems and organizations that represent thousands of anti-violence workers “to address shared issues, enhance services and supports across Alberta and identify opportunities for large-scale change” [80]. The study was promoted through IMPACT and email invitations were sent to potential participants asking them if they would like to be interviewed for the study. The email explained what the study is about and the voluntary nature of their participation. Participants in the study included directors, managers, psychologists, counselors, mental health support workers, clinical directors from sexual assault services, family physicians and outreach workers and advocates from the social services sector, health, and school divisions across Alberta (Table 4.1). The majority of participants were female (n=17). Of these female participants eleven were white and six represented racialized individuals (Indigenous, Black and South Asian). Of the male participants (n=4), three were white and one was racialized.

Data Management and Analysis

All the interviews were audio recorded and transcribed with verbal consent of the informants. Interviews were analyzed using QSR NVivo 12 software, to facilitate data management and to enhance the systematic organization and examination of the data. Qualitative data analysis was undertaken by the first and second authors (WG and SM). The analysis specifically focused on the perspectives and experiences of service providers as an indirect source of information about virtual delivery of IPV interventions. Interview transcripts and field notes were analyzed using an inductive thematic analysis process following the six steps outlined by Braun and Clarke [81]. First the researchers familiarized themselves with the data by reading and re-reading the transcripts and getting a sense of what the data is showing. Then interview transcripts were coded and further organized into categories. Next, the codes/categories were reviewed, and patterns were identified. This resulted in the generation of major themes. The first author re-read all the interview transcripts to ensure the themes accurately represent the data and the themes were updated accordingly. Once consensus was reached in the theme development stage, names and definitions were developed that clearly and succinctly describe what each theme means and represents. Finally, the results were used to write up this article. All identifiable information was removed to ensure participants were not recognized through their quotes.

An intersectional feminist perspective requires researchers to undertake a continual process of self-reflection and become attuned to how power is used throughout the construction of the research [75, 82, 83]. Self-reflection entails interrogating the identity of the researcher (gender, race, class, etc.) as well as their relationship with their participants and its effect on how they conduct the research project [83, 84]. As such, researchers in this study continuously questioned how their own identities shaped the research inquiries and how they receive and interpret the information from the participants [85].

Table 4.1 Service Providers' Participant Profile

	Number of Participants
Organizations Type (n)	N=24
Non-Profit Organizations	9
Community-Based Agencies	5
Women's Shelters	3
Primary Care Networks (PCNs)	3
Networks and Collaboratives Addressing Gender-Based Violence	2
School Division	2
Participant Roles	N= 24
Executive Director	5
Clinical Director	3
Program Director	3
Consultant	3
Program or Project Manager/Coordinator	4
Physician	2
Registered provisional psychologist	2
Outreach counselor	1
Clinical supervisor	1
City/Town	N= 24
Edmonton	9
Calgary	6
Spruce Grove, Stony Plain and Parkland County	4
Fort McMurray	1
High River	1
Lethbridge	1
Medicine Hat	1
Red Deer	1

Results

Our findings highlight three interrelated factors that posed challenges to delivering and receiving trauma-focused IPV interventions that are accessible, equitable, and safe for a diverse range of individuals during the COVID-19 pandemic. The following themes emerged from service provider interviews: (i) Acknowledging pre-existing systemic and institutional barriers that impact delivery of and access to any IPV intervention, (ii) How the COVID-19 pandemic changed help-seeking behaviours for IPV interventions, and (iii) Difficulties ensuring client safety in the virtual environment when providing care or treatment for clients. These three factors are discussed in more detail below.

1. Acknowledging Pre-Existing Systemic and Institutional Barriers that Impact Delivery of and Access to Any IPV Intervention

Service providers described the barriers their clients face when accessing IPV-related interventions. These barriers are compounded for underserved and socially disadvantaged groups who experience multiple oppressions related to race, class, ability, sexuality, gender, socio-economic status, and where they live. Service providers described the inequities in access to IPV interventions:

> I think that there is inequity in our system. I think for sure, ethnoculturally diverse communities, black people, indigenous people, people of color, our services are not equitable for them. [P 3]

> At one of the last counts we had over 80 or around 80 languages spoken here, and unfortunately most of the time our services are in English. [P10].

> Because of stigma and systematic racism we see that newcomers and first-generation immigrants are hesitant to reach out for support [P19].

Furthermore, participants highlighted there is a gap in compassionate, client-centered and trauma-informed care for socially disadvantaged populations, instead existing IPV interventions are generalized and generic:

> The current model is very program-centric, that is that the client has to fit the program, and not the program figuring out how to fit the client…you almost have to be a systems navigator to figure out all the different agencies that are in the community, and what service is going to be able to work with that particular client around a particular need. And very often women get referred to services and then come back and say, well, they said they could not help me, I don't fit their mandate or do don't fit their program. [P11]

> And so I think from a systemic level we are forcing people into a box that is not the box that they need...and I think that if we as the social workers, and as the sector, really listened to them, we would see that many of the gaps that we traditionally identify actually are not about gaps in service, but about gaps in how we view what we think the client experience is, and what we think the client needs, versus what the client is actually telling us, and what the stats actually tell us. [P20]

Other providers also identified a gap in interventions designed for gender diverse individuals, persons with disabilities, and a lack of culturally appropriate treatment services for immigrant populations. For underserved populations with intersecting identities these challenges are even greater. Some service providers indicated that there is a gap in the provision of intersectional trauma-focused interventions within the anti-violence sector. One provider explained instead of providing holistic approaches to addressing their clients' intersecting needs, their organization focuses on "either a cultural perspective, or a gender perspective, or an age demographic perspective*,"* this provider added*, "*those [identities] get split out versus having a service that can deal with all of those moving pieces" [P1].

Nonetheless, some service providers explain these gaps in the provision of client-centered interventions are a byproduct of the funding constraints experienced by the anti-violence sector. One provider stated, "I think funding is always a gap." [P19] and continued to explain how lack of sufficient funding complicates the ability to hire more staff, to provide additional training and to ensure the availability of culturally appropriate services. As previously described, anti-violence organizations face significant funding challenges leading to patchwork supports, disconnected systems, resource scarcity, and a workforce that is poorly compensated and at-risk of burning out. The challenges with long wait lists and the inability to provide timely services to individuals affected by IPV was highlighted by participants in this study. Moreover, participants shared the pandemic has depleted their resources and they expressed concern that they may not be able to sustain current outreach programs.

A number of service providers also shared that this lack of funding resources contributed to a lack of coordination, collaboration and transparency among agencies within the anti-violence sector due to competing needs for further funding. As one service provider describes,

> I would say there is lack of coordination and effective service delivery integrated together…I think people struggle with working together sometimes because you're afraid that if you work together and more collaboratively, are you going to lose your autonomy or you're fighting for funding with the person you are collaborating with…I think people do not wake up in the morning, saying, I do not want people to be served appropriately. I

> think it's about our systems get in the way of supporting each other. The health system refers to us constantly but don't fund us. [P 15]

Another provider further explained despite the good intentions of the organizations and providers within the sector, they have not been able to work together towards a common goal as a result of the previously explained constrains: “it’s not that there’s not enough good people in the world, it’s just that they do not see one another’s mandates as linked, especially when it comes to complex social issues in our region.” [P8] The lack of sufficient funding, and the resulting lack of collaboration within the anti-violence sector impacts how individuals affected by IPV can seek, access and use IPV interventions and services. This is illustrated in the following quotes from providers:

> Systems can be self-serving and funding limited. So when that happens I don't think that necessarily families are given all of the information to be able to make a decision for themselves at all times. [P1]

> [IPV survivors] probably find their way to an agency because somebody told them to call, and hopefully that agenda steers them through that and gets them to the right one, but I would say that it's not very trauma-informed. [P15]

In summary, the lack of sufficient resources due to the existing funding structures reinforce competition and lack of collaboration within the anti-violence sector which complicates the existing multi-layered barriers individuals face when accessing IPV interventions and services.

2. How the COVID-19 Pandemic Changed Help-Seeking Approaches for IPV Interventions

The COVID-19 pandemic further exacerbated the previously discussed systemic- and institutional-level challenges in accessing trauma-focused IPV interventions. Despite experiencing complex trauma and intensified levels of violence during the pandemic, initially individuals affected by IPV did not reach for help or supports. Providers shared that multiple barriers kept this group of clients from reaching out for help. The barriers included being trapped with an abusive partner, being disconnected from informal support systems, and worrying about contracting the COVID-19 virus itself. Informal and formal support services are vital to individuals affected by IPV; however, during the pandemic these supports were not easily accessible to these individuals. For example, interview participants shared their experiences and perspectives on the impact of isolation during the pandemic on their clients' help-seeking approaches from informal and formal supports as follows:

> [For] survivors there is an increased risk in that isolation of further victimization because they're not interacting with as many people outside the home. [P23]

> They simply did not feel comfortable in receiving calls, talking, so there has been an impact in their ability to access [support services]. [P7]

Even when some individuals wanted to escape and run to shelters, they were worried about the uncertainties of acquiring the COVID-19 virus. Thus, individuals affected by IPV were forced to make difficult choices between risking their and their families' health or staying in a potentially injurious and traumatizing household. Service providers shared some of their clients' experiences as follows:

> [They had] to make tough decisions about exposing [themselves] to what might be the virus out there, or staying in your home and be safe from the virus not safe from the violence. [P3]

> I think that there is the real fear that exposure to COVID could possibly be potentially worse than what they're experiencing…we had clients trying to contemplate whether or not the possibility of contracting COVID is worth the risk of staying home with the perpetrator. [P7]

Unfortunately, in some cases when individuals affected by IPV tried to reach for support services, the essential services were not always accessible or available to them due to pandemic-related restrictions and challenges. One provider summarizes some of their clients' experiences as,

> I think that COVID has added so much pressure and so much stress. Court dates were stopped. Some services were stopped in terms of our ability to serve everybody. We used to have groups of ten to 12 folks. Now we have groups in person of six. Even Zoom groups were at eight because we did a little gauging on what would be an ideal number for Zoom. And so the accessibility of the services in a time of greater need, I would say, has been cut down, adding to that stress. [P 21]

Additionally, service providers commented in detail on the impact of the digital divide as a barrier to accessing virtually delivered IPV interventions during the pandemic. The digital divide refers to the inequitable access to internet and technology, socio-economic barriers, language barriers, low literacy levels and limited access to virtually delivered interventions and services [86]. Financial barriers and poverty play a major role in an individual's ability to access virtually delivered interventions as explained by one provider, “financially and economically the victim may not have, frankly, a cell phone, or whatever to be able to access virtual care, potentially.” [P4] Majority of the service providers also highlighted the challenges their clients face in their inability to afford and access laptops, cell phones, desktop computers, stable internet, or even internet at all. In some cases, even when an organization is able to provide their clients with the equipment and technology they need, the clients may not be able to access stable internet connection due to their geographical location. One provider explains, “for some of our remote and rural communities, even if we could send a client a tablet to be able to connect with us online, they need effective data or Wi-Fi, or whatever it is. And some rural and remote places in Alberta definitely don’t have that.” [P3]

Similar challenges with internet access were also shared by other service providers as following:

> I think the big barrier right now is that we don’t consider internet connectivity as a fundamental right or as a utility. I think that’s really major that in this day and age and particularly in a pandemic environment, connectivity is literally a lifeline for some people. So, that’s a really serious barrier. [P9]

> How do we get these services to folks if they don’t have that technology, if they don’t have stable Wi-Fi or any Wi-Fi to access? So, I think it exacerbated that ability to reach out and to connect with others because, yes, all these services are still available but to access them, that just creates a bigger gap. [P10]

Some participants insightfully spoke about how digital exclusion experienced during the pandemic is a reflection of pre-existing inequities with access to services. In addition to dealing with financial barriers, IPV survivors from socially disadvantaged populations (e.g., Indigenous, immigrant and homeless individuals) experience an additional layer of inequity when accessing interventions and services virtually. The following quotes from providers describe some of these barriers and challenges:

> As [an Indigenous] woman I believe that the Canadian healthcare system is systematically racist and I think that a lot of that would be lost in that translation or in that transition [to virtual delivery], or it would just exacerbate it. [P10].

> Issues of digital equity are deeply rooted, connected and systemic. To understand if virtual care is acceptable and the factors that influence the use of virtual services, we need ask what bars people from using the services they do have access to? [P3]

> A lot of the clients that are served in Alberta – 50%, 55% are Indigenous women and children. And in their homes and on reserve and even off reserve, whether or not they have the laptops, the internet, Wi-Fi, to be able to access services electronically – I think that would disadvantage them; and probably newcomers [too]. So, I think there would be some disparity in terms of access to services if it went virtual. Like, if that was to become the method of counselling. [P11]

Therefore, individuals affected by IPV from socially disadvantaged populations faced transecting barriers in accessing IPV-related interventions during the pandemic. In addition to the previously identified barriers, individuals with disability also face specific challenges when accessing and using virtually delivered services. Some interview participants shared some of these challenges as follows:

> I’ve worked with the deaf and hard of hearing community, and I know that oftentimes they connect with therapists through face time, but there would be extra barriers during this time period just with technological pieces and being able to access interpreters, that kind of thing. [P23]

> Some people could not be served on Zoom. We have a client with quite profound hearing loss who lip-read. Zoom for them is out...we don’t have any facilitators who know a lot of ASL. [P21]

Therefore, the COVID-19 pandemic and related restrictions, financial strain and the digital divide layered the complexities in seeking and accessing support or therapeutic interventions for socially disadvantaged individuals.

3. Difficulties in Ensuring Safety in the Virtual Environment for Individuals Affected by IPV

As previously indicated, the public health stay-at-home orders during the pandemic isolated individuals affected by IPV which resulted in a more complex set of issues including increased exposure to abusive partners while dealing with barriers to safely seeking for or accessing support services virtually. At the same time, ensuring safety of individuals affected by IPV when they are virtually accessing IPV-related interventions and services was also a complex issue for service providers. In this study, service providers identified safety concerns in relation to security and physical safety when accessing services virtually, emotional safety when receiving services virtually, and cultural safety of available IPV-related interventions.

Service providers in this study highlighted staying at home with an abusive partner who is also dealing with pandemic related stressors exacerbated the risk of experiencing violence for their clients. A service provider shared,

> ...if you're in that vulnerable relationship, and let's say they're having more stressors like financial, or they lost their job and then they can't get their unhealthy coping strategies, like maybe their alcohol or marijuana or whatever it is, we know where they're going to lash out. [P5]

Interview participants also highlighted the severity of violence experienced by their clients during this time was much worse than the providers have ever seen before. A director of an outreach center shared some examples as following: "we're seeing a lot more strangulation…we had one that was an attempted murder. So, the seriousness and the levels of domestic violence has increased" [P 14]. Another service provider attributed these experiences of severe violence to the lack of viable options to safely getaway during the lock downs: "for some of them well they were home alone with their abuser. So, some of the abuse is more extensive than it would have been if they had avenues of escape like going out, going to school, other eyes watching" [P 24].

When and if individuals affected by IPV wanted to reach out for help or support, interview participants indicated, they may not have private and safe physical place where they can access virtual interventions, especially if they are quarantined with their perpetrator. For individuals affected by IPV, being caught in the act of talking to a provider could exacerbate the risk of violence and thus could hinder them from accessing any virtual services at all. A service provider shared how some clients could not access or seek for help virtually due to fear of their abusive partner discovering that they were speaking to a professional:

> I had a case where a lady had finally opened up about her situation at home, and I had to call her, and we couldn't even talk, because she was scared to even say anything, she didn't know where her spouse or partner was, she was still hoping just to be able to come

> see me and be able to talk without having to fear what if I say something, or what if he hears just the slightest word, that makes me in trouble or that I've done something wrong. [P5]

Similarly, other service providers described how it was difficult to reach and provide services virtually to their clients due to concerns for their safety and worry about creating any further harm for their client:

> I think there is a safety and a confidentiality perspective that you can't always get in your home. That you maybe don't actually have access. Even if you can have technology access, that if you're living with somebody who is using violence or could be using violence, that accessing programming is unrealistic. And I do think that community is harder to form in a virtual context. [P20]

> I think the main thing is the safety of the client, if the person is there how to communicate with them, unless they are out of the house...either the perpetrator is there or the children are there who can then tell the perpetrator what the mother was doing. So that communication piece, that's a challenge. [P19]

> The privacy and confidentiality, which connects in some cases to the safety and security, that it just might not be safe in the home for women to electronically connect to their counsellors or support, because it could easily be discovered or overheard. [P11]

To address this, providers suggested setting up safety plans such as safe words between clients and providers, where if the client uses the safe word, the session ends, and they will contact each other in a different predetermined approach. Interview participants shared some examples where providers, staff and organizational leaders had to be creative in how to approach this in a virtual environment. For instance, some providers shared examples of how they developed safety plans with their clients:

> If she showed something on the computer, [the provider and the client] had a sign between them that only the two of them know, that if she displayed that, then that was the therapist's cue that something was going down and she needed help right away. [P14]

> I would mostly check-in, pretend to be a tele-marketer and have a code phrase, and they would respond yes, no, goodbye. And that would give us a clue as to whether they were safe in their home. [P7]

Furthermore, in the event that a client is able to access virtual support or treatment in the absence of their abusive partner, there are still privacy risks that could also jeopardize their safety when accessing IPV interventions virtually. Providers spoke about the importance of modifying their organizations' policies and procedures to protect clients' privacy in the provision of interventions virtually and ensuring security and privacy safeguards when using different virtual platforms.

Service providers also described that it was difficult to implement trauma-focused interventions when there is a risk of triggering and/or re-traumatizing their clients who are receiving treatment from their home – a typical place where the violence has occurred. One service provider explains: "I think some people in their places, their living spaces, it's going to be quite triggering and re-traumatizing. Everything around them could be a trigger." [P 17] This concern was echoed by other providers who explained if their clients are triggered during an in-person session, they were better equipped to manage and support them, while feeling unsure how to manage this in a virtual setting:

> I am hesitant [about virtual services], especially the clientele that I serve, who are coming in for years of domestic violence, I have to be sure that if I am providing trauma care, what kind of support that person has. Often these females have young children, they are living by themselves, I don't know if I'm doing something, and then she gets triggered. There are young babies at home. How can you manage that? [P19]

> … within our groups, there's real vulnerability and safety. You create the safety, and then you can have the vulnerability for them to share with each other. It's totally a different interface sharing in person than it is on a screen. [P21]

In addition to addressing psychological and emotional safety, the importance of incorporating culturally safe approaches to healing trauma when providing IPV interventions virtually was widely discussed by service providers. Some service providers explained that some underserved populations such as, Indigenous peoples, immigrants, and newcomers may not feel safe to share their experiences in a virtual environment due to being misunderstood or that virtually-delivered interventions are not culturally safe for them. This is described in the following quote from a service provider:

> Then of course the cultural aspect is huge, trying to feel that cultural safety when they are talking...so of course they want the person who is sitting across from them, listening to their story, want them not to be judged because they are immigrants, or they are from a certain ethnic background. [P19]

Other providers shared similar perspectives and highlighted the importance of client-centered care by engaging clients and addressing their unique needs in the virtual delivery of IPV interventions. A service provider who shared this viewpoint emphasized the significance of asking underserved populations to see what works for them as follows:

> There may be communities who say for whatever reason this does not work for our community, there is something in our cultural make up that does not fit this. I think we have to find that out first, as opposed to pretending that we know what is best for everybody else…our Indigenous brothers and sisters, what about this work, does it work for them? And let's talk to new immigrants and say does this work, is this right, are you more comforted or less comforted? [P18]

Moreover, service providers expressed the importance of incorporating cultural safety and addressing their clients' experiences of trauma holistically (i.e., addressing structural violence, and generational and historical trauma). One provider gave an example of how their organization promotes holistic interventions which is grounded in the understanding of their client's context, individual barriers and the root causes of their trauma. This provider further explains, *"*their trauma is not just trauma of [IPV]. If you have an indigenous woman waiting into your office, it's also trauma of colonialism and identity and there is all of these intersecting pieces.*"* [P 3]. Other service providers also added,

> I think I would suggest that trauma focused treatment and client-centered treatment, my definition of what it is means that it has to be specialized and adapted. And so, I think that by creating a co-shared understanding with our client about their context and their world is exactly how we do that work. [P3]

> when you're seeing a different culture and the way they talk to each other or the way they handle stress, we can't just say, well, you can't do that here. You really have to approach it in a very easy and kind of non-judgmental way with an education piece...there's so many different cultures, and there's different ideas and ideologies of them...The biggest thing, a lot, would be that validation piece, and being able to let them know that no one can tell you what to do, no one can tell you when to do it...no one can tell you when you're supposed to leave or what you're supposed to do. You have to be totally comfortable and feel safe with whatever your choices are. I think that's a big piece of that virtual care, no matter what kind of culture it is. [P5]
>
> You have to understand that different cultures will have different perspectives...And I honor that. So, I think making sure staff are culturally competent and aware, and respect people's different cultures, faiths and traditions is really important. [P15]

Additionally, having services and interventions delivered by providers of similar cultural background or who speak the same language as the clientele population was also described to facilitate delivery of culturally safe and client-centred services and interventions. This was described for Indigenous and newcomer clients as follows:

> …having available a therapist who has some experience working with Indigenous communities or understands some of the spirituality or narrative practice...[P2]
>
> For individuals that struggle with English it's very difficult to provide virtual services, especially if there isn't a webcam. I wouldn't say they struggle with English, rather we [as providers] struggle with understanding them. It's a bit challenging, and so maybe we

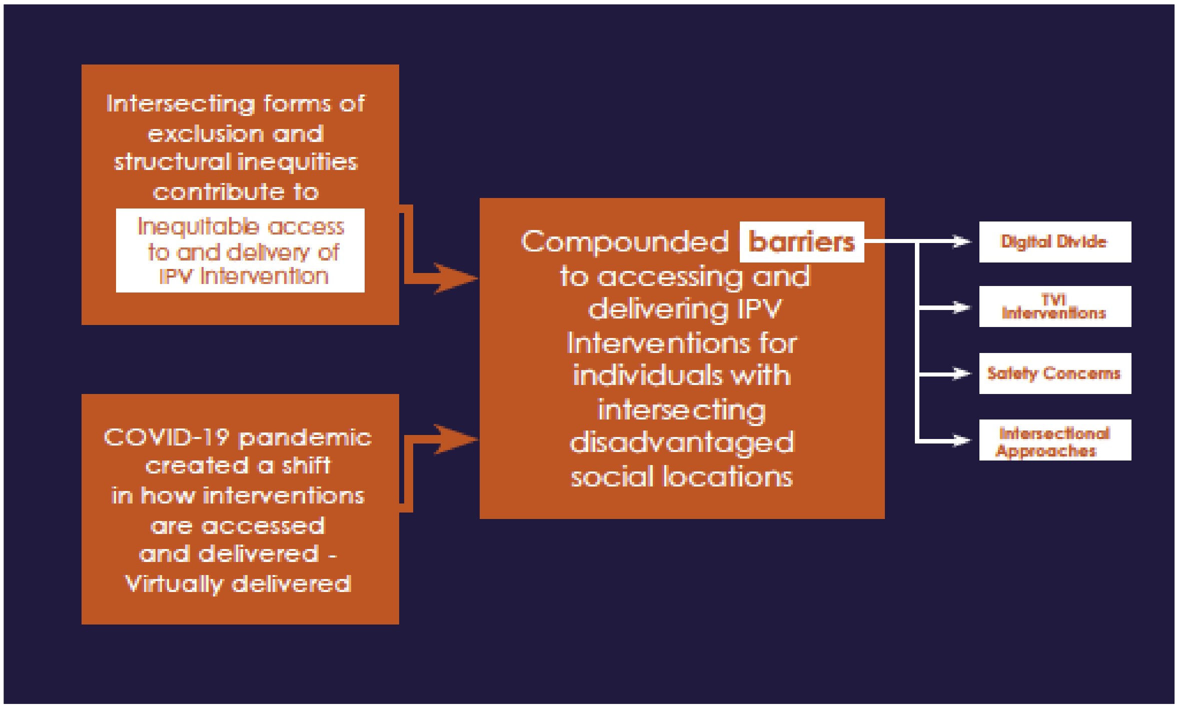
> look at how do we hire providers who can provide virtual interventions in their mother tongue. [P18]

Service providers in this study emphasized the importance of providing culturally safe, trauma-informed, client-centered, and contextually specific interventions to a diverse group of individuals affected by IPV during the pandemic and beyond.

Discussion

Our study examined from the perspective of service providers how trauma-focused virtual IPV interventions can be safe, equitable, and accessible for range of diverse individuals affected by IPV, particularly for those who are socially disadvantaged. Findings in our study show that the concepts of equity and safety are more complex for individuals affected by IPV, and the barriers they face in accessing IPV interventions and services during a pandemic were further compounded. In summary, the COVID-19 pandemic exacerbated pre-existing inequities within the anti-violence sector that serve individuals affected by IPV. The pandemic further complicated the ability for these individuals to feel physically and emotionally safe, exacerbated vulnerabilities experienced by underserved populations, and intensified the barriers they face in seeking help and accessing safe and equitable interventions virtually (see Fig. 4.1).

Fig. 4.1: The compounded effects of social exclusion, structural inequities and the impact of the global pandemic exacerbated barriers faced by individuals affected by IPV in accessing support services and interventions.



As previously highlighted, the anti-violence sector was weakened by lack of sustainable funding and resources and thus unprepared to accommodate the sudden influx of IPV support needs from a wide range of individuals during the pandemic. With many organizations at capacity prior to the pandemic and with increasing demand during the pandemic, organizations will require additional funding to increase service capacity to address the increase even after the pandemic is resolved. For instance, any wait time for counselling interventions presents considerable challenges for people who have experienced complex trauma and who are struggling to cope, and longer wait times are even more detrimental to the healing process. Similarly, researchers in the US also reported that the pandemic exacerbated pre-existing inequities and gaps in services within the anti-violence sector [87], including limited resources that could not support the needs of increased demand and needs of individuals affected by IPV seeking support during the pandemic [87]. In response to the increased demand faced by the anti-violence sector across Canada during the pandemic, the federal government provided $50 million to women's shelters, sexual-assault centers, and other organizations providing support and services to women experiencing violence [38]. An additional $350 million was then provided for community organizations serving individuals experiencing violence [38]. Although organizations within the sector appreciate this support, some anti-violence workers highlight "it will take more to overcome the legacy of years of underfunding in the sector" [38]. Service providers in our study also shared their hope for continued sustainable funding for the anti-violence sector. In addition to these funding related barriers, providers in our study also highlighted the lack of coordination and collaboration within and across sectors making it even more difficult for individuals affected by IPV to reach for or access support services and resources. It is essential for organizations that serve IPV survivors to form alliances within and across different sectors to better serve these vulnerable members of the population.

During the pandemic, individuals affected by IPV also had to navigate accessing care and treatment through virtual modalities. Recent studies have highlighted the multiple barriers that vulnerable and socially disadvantaged individuals experience with virtual delivery of interventions. Recent research highlights the consequences of inequitable access to virtual care, characterized as the 'digital divide' [86]. Service providers in our study described multiple barriers to accessing digital technologies experienced by underserved populations, who are at a greater risk of IPV during the pandemic. Interview participants noted these barriers exist for individuals residing in rural and remote communities, individuals experiencing homelessness, Indigenous peoples, immigrants and refugees, individuals with disabilities as well as those experiencing financial strain. These findings support recent studies which report individuals who reside in rural settings with limited access to internet, those who cannot afford technology and individuals with disability are facing further disparities during this new shift to virtual delivery of interventions and services [56, 88, 89]. Access to stable and reliable internet services and Wi-Fi connection devices remain a challenge for many Canadians [90]. Thus, there is an urgent need to tackle the digital divide by funding broadband infrastructure and increasing digital literacy for a wide range of diverse individuals affected by IPV. Further research is needed to examine how digital exclusion is experienced by diverse population groups, and across intersecting factors of gender, sex, age, geography, disability, race, ethnicity and culture.

Furthermore, service providers in our study highlighted the challenges their clients faced in accessing virtually delivered services remotely throughout the pandemic, emphasizing the lack of safe and private space to attend virtual sessions. This is in line with recent literature that report the stay-at-home orders in the early months of the pandemic have exasperated the safety concerns for individuals affected by IPV and their ability to safely access interventions in person or virtually [64]. Some common concerns shared by service providers in our study and in other academic reports include an abusive partner may overhear their conversations with a provider, or may not allow them to speak in private, or some abusers may use control and monitoring measures such as recording phone calls that could put these individuals at greater risk if they seek help virtually [64]. This complicated the experiences of individuals affected by IPV immensely: it increased their risk of experiencing more frequent and more severe abuse, while hindering them from safely accessing for support services. Thus, our study findings suggest safety planning can potentially be a way to protect clients' safety when accessing services virtually. Safety planning is defined as a dialogic process that informs and supports individuals at risk of IPV by identifying behaviors they can adopt to increase safety and decrease exposure to violence for themselves and their family [91]. Pre-pandemic safety planning has been commonly used in response to or in order to prevent experiences of IPV [36]. However, there is still limited evidence of its effectiveness in pandemic context when public health restrictions are in place.

For individuals affected by IPV, the concept of safety in itself is also a complex phenomenon. In addition to safety from direct experience of abuse, diverse individuals affected by IPV also require cultural safety that will ensure the available resources are meaningful to their needs. For example, providers in our study identified gaps in culturally safe approaches that address the service essentials of individuals with intersecting social disadvantages who are affected by IPV. Other studies also report racialized populations face barriers to accessing virtually delivered interventions due to a lack of culturally acceptable and appropriate virtual tools [24]. Sabri et al., [92] made similar observations in a study they conducted with immigrant IPV survivors in the US, and they added this population group was "less comfortable and less able to engage effectively with virtual resources" due to the lack of culturally safe approaches. Therefore, ensuring physical, emotional, and cultural safety for individuals affected by IPV in virtually delivered interventions is key.

Service providers in this study also highlighted their clients' need to feel safe from re-traumatization when they are receiving trauma-focused interventions virtually. The prevalence and profound health impacts of trauma and violence have been well documented in the literature [93, 94]. Although providers in our study indicated they provide comprehensive trauma-focused interventions to their clients, it was clear from their responses that a more holistic trauma-and-violence informed approach is needed to better serve underserved populations in Alberta. Trauma- and violence-informed (TVI) approaches build on trauma-informed approaches and bring attention to the broader social conditions impacting people's health; ongoing violence, including institutional violence; discrimination and harmful approaches embedded systems, structures and social norms [95, 96]. Thus, TVI approaches centre on understanding the context in which peoples' challenges are experienced and recognize how this intersects with IPV, structural violence, inequity and trauma; including trauma attributed to the devastating effects of colonialism and racism. Structural violence refers to how societies, including their institutions and policies, are organized in ways that cause harm to some people [28]. Therefore, TVI approaches work to create safe and accessible services for people impacted by trauma and violence by focusing on the experiences of trauma holistically, preventing re-traumatization, and empowering individuals affected by IPV [69]. As a result, TVI interventions are key to addressing the mental health and other needs of individuals affected by IPV from diverse population groups.

As previously stated, the intersecting barriers faced by diverse individuals affected by IPV in accessing safe, and equitable virtually delivered interventions result from structural inequities that shape experiences with discrimination, exclusion, and mistreatment. Our findings show that during the COVID-19 pandemic, individuals with heighted vulnerabilities who were affected by IPV had to cope with complex trauma and more frequent and severe violence, while also navigating issues of systemic discrimination and inequality preventing them from accessing trauma-focused IPV interventions or services. Similarly, other researchers in Canada explained the pandemic increased the existing gaps in availability of services for underserved populations while also intensifying experiences of racism and discrimination [97]. These findings are in line with similar reports from countries in the northern hemisphere [24, 87, 92, 97]. Researchers claim the pandemic brought into light the "historic, systemic, and structural inequalities at the intersection of racial and ethnic minority status, occupation, and class." [97, 98]. As a result, some scholars recommend that we view the current global crisis as a syndemic [97, 98]. The concept of syndemics (the interaction or cooperation of two or more epidemics) acknowledge the existence of epidemics and pandemics in the context of pre-existing social and health conditions [99]. Such a viewpoint would go beyond outlining the barriers faced by underserved individuals affected by IPV during a single global crisis towards illuminating the underlying sources of these intersecting forms of inequities [97, 98]. That is to explain why these individuals are more vulnerable in the first place [97, 98]. Therefore, addressing barriers to accessing safe and equitable virtually delivered IPV-related interventions will require unpacking and confronting the root causes of these barriers in the first place.

To summarize, the delivery of safe and equitable IPV-related interventions will necessitate consistent and collaborative effort from governing bodies, organizations and service providers serving individuals affected by IPV. At a systemic level, addressing racism and discrimination requires an understanding of the root causes of inequity. Some examples of such initiative include developing policies that are guided by a decolonizing and anti-racism lens; and meaningfully engaging diverse voices and perspectives from Indigenous communities, and other racialized populations to ensure equity [97]. At the same time, it is essential for the federal and provincial governments to promote sustainable funding to address the digital divide and assure greater funding for the anti-violence sector to employ providers from diverse backgrounds who can relate to the clients' cultural needs, hire language interpreters, and provide training opportunities for delivering trauma- and violence-informed (TVI) interventions. Providers in our study also shared their recommendations for mitigating the social and economic inequities their clients face in seeking for and accessing virtually delivered interventions. The providers emphasized the need for community and stakeholder involvement in the design and implementation of virtually delivered interventions, respecting local values, and addressing the core needs of clients to ensure the interventions are equitable and accessible by all. Scholars also recommend the virtual delivery of interventions to be mindful of the values and needs of the individuals affected by IPV, conducted respectfully and in collaboration with local community-based organizations, and connect to local resources [57, 100]. Sherwin et al., [100] specifically stated, "if virtual care is to remain the focus of how care is delivered at scale, now is the time to define the value proposition for [clients], systems, payors and regulators."

Strengths and limitations

Our study has some strengths and limitations. To our knowledge, this paper is the first to report on the determinants of safe, and equitable interventions for IPV survivors in Alberta, Canada. Second, our findings add valuable information to the growing body of literature on the complex and multi-dimensional issues faced by individuals affected by IPV in seeking for and virtually accessing IPV-related interventions and services during a pandemic. Despite these strengths, there are a few limitations to this study. Although data saturation was reached in this study, most of the included participants were providers at a managerial position, thus we are missing first-hand experiences of frontline providers in this sector; therefore, some other dimensions of the phenomenon may have been overlooked. In addition, the experiences of individuals affected by IPV with accessing virtually delivered interventions was reported from the perspective of service providers, thus their clients' voices are not included in this paper. However, for the next phase of our research, our team is engaging individuals affected by IPV in a photovoice project to better understand their experiences, challenges and barriers with accessing virtually delivered interventions and services during the COVID-19 pandemic. Finally, our study only focused on how the virtual delivery of interventions affected individuals experiencing IPV, at-risk of IPV, or survivors of, IPV but it did not address the experiences of perpetrators seeking or accessing virtually delivered interventions for support.

Conclusion

The current global pandemic significantly contributed to the increased rates and severity of IPV experienced by diverse individuals, and it further illuminated pre-existing social exclusions and inequities faced by underserved population groups. For these individuals, accessing and using IPV-related interventions safely has become more complex as a result of the digital divide characterized by inequitable access to safe virtual platforms because they are being controlled by their abusers, struggling with unstable or unavailable internet connections, unable to afford the required devices to receive support virtually and/or due to the lack of culturally safe resources [24, 63, 64]. As a result, these barriers have adversely impacted help-seeking among underserved individuals affected by IPV during the pandemic. Therefore, it is important to develop policy measures to narrow the digital divide by allocating funds for increased access to digital technologies and reliable internet for underserved populations. It is also crucial to ensure sustainable funding for anti-violence organizations to provide culturally appropriate, holistic, trauma-and-violence-informed, and affordable virtually delivered IPV interventions.

Moreover, our findings show that determining the factors which constitute a safe, equitable, and accessible virtually delivered intervention for these population groups is much more complex and will require a collaborative commitment from multiple levels of the social, health and political systems. It will be difficult to assure equitable and safe access to these interventions without addressing underlying factors of systemic discrimination and social exclusion that intersect on the axes of gender, race, ethnicity, ability, and geographical location.

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Chapter 5 - A Virtual Photovoice Project Capturing the Perspectives and Experiences of IPV Survivors in Determining Safe, Accessible, and Equitable IPV Interventions

Background

Globally, relative to men, women are disproportionately affected by intimate partner violence (IPV). In Canada, one in three women experience IPV and other forms of gender-based violence [1], and, in 2019 Canadian police reports showed that 30% of all violence reported to police forces was IPV while 80% of the 107,810 people aged 15 and over who experienced IPV were women [2]. Other Canadian data shows that a woman is killed by an abusive partner on average every six days [3], and, in 2020 alone, 160 women and girls were killed through violence [1]. In these IPV cases, 91% of the perpetrators were individuals who identified as male [1]. Similarly, in Canada, women experience significantly higher rates of physical abuse (23% of women versus 17% of men), sexual abuse (12% versus 2%, respectively), and psychological abuse (43% versus 35%, respectively) [4].

The risk of experiencing IPV is also highest for women from underserved populations (immigrants, refugees, ethnically or racially diverse populations, official language minorities, LGBTQ2S+ communities, individuals with disabilities, homeless populations, sex trade workers, and individuals with low socioeconomic status) [1]. For example, 55% of women with disabilities reported experiencing some form of IPV in their lifetime (after the age of 15), compared with 37% of women without disabilities [5]. Those individuals with intersecting underserved identities are at even higher risk of experiencing IPV than are those with none or only one. For instance, almost 7 in 10 (71%) women with disabilities who are also from the

LGBTQ2S+ communities have experienced some form of IPV since the age of 15 [5]. Racialized women face similar rates of violence [6].

Despite their diversity, women from underserved populations commonly face a complex set of barriers in seeking and accessing IPV interventions due to systemic oppression and structural violence [7-10]. Systemic oppression refers to the conscious or unconscious and normalized ways in which dominant groups use power to marginalize and disempower other groups based on perceived differences in order to maintain status and privilege [11]. Forms of oppression include ableism, classism, colonization, heterosexism, Islamophobia, racism, sexism, and transphobia [11, 12]. Structural violence refers to how societies, including their institutions and policies, are organized in ways that are discriminatory and cause harm to underserved populations [13].

In Canada, women face gender inequality and lower access to employment with livable wages than do men [1]. For example, women constitute the majority of minimum-/low-wage and part-time workers in the country, and 1 in 5 racialized women live in poverty compared with only 1 in 20 non-racialized women [7, 14]. Furthermore, studies have shown that women with disabilities, women who identify as LGBTQ2S+, and indigenous women are more likely to experience homelessness due to systemic discrimination [15-17]. Moreover, underserved people bear a disproportionate burden of stress, illness, and health inequities compared to privileged members of the society. Therefore, for underserved women, systemic oppression and structural violence are fundamental risk factors for experiencing IPV [14].

Simultaneously, as a result of these systemic oppressions and structural violence, underserved women affected by IPV face discrimination and stigma related to help-seeking, cultural barriers to accessing appropriate IPV interventions, and racist interactions with the police and the court system [6-9, 14, 18-20]. For example, in Canada, one in five women have reported experiencing racism and culturally insensitive and inferior quality of care when seeking help from the healthcare systems and social sectors [7]. Scholars have described instances where service providers fail to provide culturally appropriate health interventions and care for patients and may also “perpetuate the racialization of [the women’s] cultures and religions as inferior, primitive and barbaric,” further disempowering them [9]. Moreover, over-involvement of law enforcement in low-income and racialized neighborhoods, which includes increased use of force, mass incarceration of racialized men, and police brutality, has discouraged women in these neighborhoods from accessing and seeking help from formal support systems [9]. These women may feel fearful about seeking help from the justice system because they lack trust in the system, they are afraid of being blamed by the police for the violence, and they are worried about the involvement of child protection services and having their children taken away, and immigrant women are concerned about their partners’ deportation [9, 19, 21-24].

In recent years, in light of these structural and systemic vulnerabilities faced by underserved women, there has been a strong push to change the way in which interventions (i.e., mental health counseling, medical care, social services, and legal services) are delivered to women from these populations [25-29]. Scholars have advocated for care, treatment, and interventions that are culturally safe and that promote a culture of safety, empowerment, and healing when assistance or support is provided to individuals affected by IPV [30]. These practices have been incorporated into the delivery of trauma-focused interventions for individuals affected by IPV. Trauma-focused interventions are specific approaches to therapy that recognize and emphasize “how the traumatic experience [such as IPV] impacts an individual’s mental, behavioral, emotional, physical, and spiritual well-being” [31]. This approach to care has been promoted globally within the anti-violence sector, including interventions that inform, guide, and help individuals to access a range of IPV-related services and support [32].

The COVID-19 pandemic has created an unprecedented shift in how interventions for care and treatment related to health have been delivered, compounding pre-existing inequities, especially for women from underserved populations [33]. As a result, there has been a rapid shift towards virtual delivery of trauma-focused IPV interventions in order to limit unnecessary in-person interactions and to prevent the spread of the COVID-19 virus. This shift, although necessary and beneficial to many, has exacerbated the gap in intervention delivery and the ability to reach a diverse range of population groups. For example, some women might not have access to safe virtual platforms, because they are being controlled by their abusers [34], they are struggling with unstable or unavailable internet connections, or they are unable to afford the devices required to receive virtual interventions [18, 35-39]. In addition, since the beginning of the pandemic, women experiencing IPV have shared concerns related to safety in accessing virtual IPV interventions from home [40, 41].

Additional barriers to the effective uptake of virtual trauma-focused IPV interventions for these women have included discomfort with receiving treatments typically provided face to face, over the phone, or by video chat and with the potential lack of human connection in virtual settings [37]. Trauma-focused IPV interventions are driven by relationship, trust, and safety [42]; however, scholars have cautioned against the loss of human connection and difficulties in re-building trust among clients in the virtual setting [43, 44]. In a study conducted by the authors of this paper, service providers within the anti-violence sector spoke about the missed opportunities to build relationships and trust with their clients – which are central to healing trauma and recovery – in the virtual delivery of IPV interventions [42]. This has raised an important question about how trauma-focused IPV interventions can be delivered and safely accessed within the virtual environment.

Therefore, the furthering of knowledge in this area is fundamental to facilitating safe, culturally applicable, accessible, and equitable approaches to delivering virtual trauma-focused IPV interventions. This delivery could reduce disparities in accessing culturally safe interventions by increasing access to culturally and linguistically competent providers for a wide range of diverse populations [45]. Equity in the virtual delivery of IPV interventions involves fairness and justice in the availability and distribution of these interventions to a wide range of population groups and addresses practices that systematically marginalize and stigmatize entire population groups [13]. Safety in the virtual delivery of IPV interventions encompass the physical, emotional, and cultural safety of the individual accessing services via videoconferencing, by telephone, or online. These include having a structured place where the individuals' physical and emotional safety is respected and where they feel empowered "to seek, share, and obtain information, access services, express themselves, enhance psychosocial wellbeing, and more fully realize their rights" [46]. Accessibility includes the ability to attain affordable, client-centered, culturally appropriate IPV interventions virtually [47].

A recent qualitative study, addressing the challenges experienced by service providers with delivering virtual trauma-focused IPV interventions during the pandemic, emphasized the importance of providing culturally safe, equitable, client-centered, and contextually specific interventions to a diverse group of individuals affected by IPV during the pandemic and beyond [32]. However, IPV survivors' perspectives on the equity, safety, and accessibility of virtual IPV interventions are underrepresented in the current literature; and survivors' strategies for navigating these interventions have been inadequately studied. Therefore, applying a feminist intersectional lens, this photovoice project aims to explain, from the perspectives of IPV survivors, how virtually delivered IPV interventions can be made safe, accessible, and equitable for diverse individuals affected by IPV.

Study Approach

This paper describes the findings from a photovoice project which was conducted as part of a case study analysis to examine the delivery of safe, accessible and equitable virtual trauma-focused IPV interventions during the COVID-19 pandemic in Alberta, Canada. The case study analysis method [48] used an embedded single case study design with two units of analysis: (1) the perspectives and experiences of service providers, gathered through semi-structured interviews and (2) the perspectives and experiences of women affected by IPV, gathered using a photovoice methodology. The photovoice project was guided by the following research question: *How can virtually delivered IPV interventions be safe, equitable and accessible by a wide range of diverse women affected by IPV?* The study protocol was reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta (REB # Pro00101547).

The theoretical underpinning of this study was intersectional feminist theory, which explains how multiple systems of oppression and intersectional disadvantages put women from underserved population groups at a greater disadvantage than the rest of the population [49, 50]. Intersectionality underscores how social categories, including but not limited to race, class, ability, gender, and sexuality, interact to shape IPV experiences. That is, individuals facing these forms of oppression face challenges that may or may not be adequately addressed with mainstream IPV interventions [22, 51, 52]. Therefore, access to and delivery of safe and equitable virtual IPV interventions should be framed within an intersectional lens that examines how race, ethnicity, socioeconomic status, cultural acceptability, language, and geography intersect to influence these factors. Additionally, this research is grounded in respecting, understanding, and empowering study participants and using their experiences and stories as valid sources of knowledge [53-55].

Overview of Photovoice

Photovoice is a visual research methodology that draws on the principles of the community-based participatory research (CBPR) method, in which participants (1) capture their experiences in photographs and narratives, (2) engage in critical reflections and dialogue around these experiences, and (3) develop solutions and recommendations for policy and practice [55-59]. Photovoice was initially developed by Wang and Burris [56], employing theoretical foundations from feminist theory, critical consciousness, and a community-based approach [55, 59-61]. Central to these three theoretical bases is the importance of ensuring participant voices are heard and underserved individuals are empowered [59, 62, 63].

The structure of a photovoice research technique involves gathering participants' photos and narratives to create a powerful medium for translating knowledge that the participants collectively produce into action [64]. That is, participants take photographs of anything significant to them related to the study objectives and then discuss those images in groups, with the researchers, or both [60]. Next, the participants decide who and what to include in their data and develop action items or recommendations to influence policy and practice [60]. Drawing on an intersectional feminist perspective, this process minimizes the power imbalance between the researcher and the participants and maximizes the participants' control of the data and how it is interpreted [62, 64, 65].

Photovoice has been identified as an appropriate qualitative approach for addressing sensitive and complex issues [57]. The method allows individuals to share their experiences and perspectives more openly who could otherwise be reluctant to do so in an interview [57]. Additionally, this method is inclusive and more accessible for individuals facing language barriers when expressing their experiences [57]. Beyond this, compared with other data-generating techniques, photovoice can better capture complex ideas, experiences, and feelings through metaphors, thus producing richer and more nuanced forms of data [62]. Furthermore, the metaphors used in photovoice can act as buffers when participants must discuss challenging and difficult experiences [57].

Moreover, several studies have identified the effectiveness of photovoice as a research methodology with individuals who have experienced IPV [55, 60, 66-68]. At the individual level, photovoice has been impactful in healing trauma for survivors of IPV [55, 60, 66-68]. This approach provides participants with a medium to explore, express, and reflect on the challenges and barriers they face in their lives through photography and narratives [60]. This method allows these individuals to engage in self-respect, self-compassion, and positive self-regard, promoting hope; all these factors are key in healing trauma [55, 68]. At the relationship level, these survivors can gain social support through discussion sessions, known to provide emotional, social, and communal healing and which can prevent violence from re-entering the interviewees' lives [55, 60, 66-68]. In this vein, Christensen [68] indicated that group discussions among individuals who share similar experiences in photovoice research can create processes similar to group therapy, where the group members experience and exchange social and emotional support.

At the community and societal levels, the images within a photovoice project evoke emotions and feelings from viewers that are vital in "generating knowledge for change" [62].

Additionally, photovoice helps educate communities about the issues faced by individuals affected by IPV and helps the participants to identify and strengthen resources and engage in advocacy to respond to barriers and challenges they face [55, 60]. In this study, photovoice allowed participants to share the barriers and concerns related to safety which hindered their ability to access virtual IPV interventions during the pandemic, identified more complex systemic barriers they have been facing, and provided insightful recommendations for policy and practice.

Data Collection Approach

Recruitment of Survivors

Recruitment of participants was based on purposive sampling. Women IPV survivors who fit the following inclusion criteria were recruited: (1) must have been of a consenting age, (2) must not have been residing with an abusive partner, and (3) must have left the abusive relationship at least six months prior to participation in the study or who was receiving support for IPV-related experiences of trauma. These criteria were important to ensure the participants were safe and would not be re-traumatized by the content of the study. Participants were recruited through pre-established relationships with two Alberta-based anti-violence organizations: Sagesse Domestic Violence Prevention Society [69], and the Islamic Family and Social Services Association (IFSSA) [70]. Sagesse runs a peer support group and mentorship program for women who have experienced or are at risk of IPV or women involved in sex work [69]. The Islamic Family and Social Services Association (IFSSA) is a community organization working to bring community-based services directly to communities to help create healthy families and communities in Edmonton [70]. Additionally, IFSSA provides programs and services such as counseling and group sessions for individuals affected by violence.

Initially, eleven IPV survivors showed interest in participating, and nine started participating in this study. However, three dropped out due to their inability to commit to the number of photovoice sessions (see below). Thus, six participants completed the project.

Virtual Photovoice Procedure

The photovoice project was carried out within a four-month time frame. This work included hosting a total of two group sessions (2–3 individuals per group) and two individual sessions. To ensure the process was trauma-focused and survivor-centered one-on-one sessions were hosted with women who were not comfortable participating in group sessions (n=2). Guided by similar study designs [57, 58, 62], the photovoice project included four sessions (Table 5.1), and all the sessions were hosted virtually via Zoom [71].

Table 5.1: Structure of Photovoice Project Sessions

Session (Length)	**Procedure**	**Outcome**
Session 1 (2 hours)	Introductions, orientation to the research project, photovoice training, ethics training including ownership of the photographs and associated copyright issues, and consent form completion. A 30-minute professional photography lesson on how to create mood and express emotions using photography. Training on how to take metaphorical photos representing participants' experiences.	Researcher built rapport with the participants. The participants got to know each other.
Session 2 (2–3 hours)	Participants shared photographs that represent their lived experiences with	In-depth critical reflections and development of narratives.

	accessing safe and equitable IPV interventions. Participated in reflective discussions.	
Session 3 (3 hours)	Participants engaged in data analysis. Develop policy and practice recommendations to strengthen community resources to overcome the challenges faced by individuals affected by IPV in accessing IPV-related interventions.	Participants and researcher co-identified and confirmed emerging codes from the photos and discussions. Participants identified recommendations for policy and practice.
Session 4 (2-3 hours)	Confirm and/or edit policy and practice recommendations. Prioritize policy and practice recommendations. Brainstorm and discuss approaches for photo exhibit.	Identified the high priority policy and practice recommendations. Decided to create publicly available website to share (exhibit) their photos, narratives and recommendations.

Participants were given two weeks from the orientation (first session) to take photographs representing their experiences with seeking virtually delivered interventions during the COVID-19 pandemic. Participants took as many photographs as they wanted, however, they were asked to present their top three choices during the second session. They decided what to photograph, where to take the photo, and how much to share [58, 59]. Participants sent their photos to the researchers via secure emails at least one hour before the second session. During this session, a Zoom meeting, the researcher shared the photos with the participants using the screen-sharing function. First, the participants were asked to reflect on and share their thoughts on their own photographs using the following four "empowerment-based trigger questions" [58, 72]:

- What is happening in the photo?
- How does it make you feel?
- What do you think about this photo?
- What can be done about it?

The same questions were used to facilitate group discussions [58]. For individual sessions, a deeper discussion of these questions was held between the researcher and the participant. During the third session, the participants were led in the identification of emerging codes and concepts, and explored the meaning of these common concepts [58]. During the second half of this session, participants identified recommendations for policy and practice based on the common concepts identified. This conversation was prompted by the following questions [58, 72]:

- What would you like service providers to learn about your issues and concerns?
- What would you like policy makers to learn about your issues and concerns?
- What would you like service providers to do differently?
- What would you like to see change in policies?

During the fourth session, participants reviewed and confirmed all the recommendations. Subsequently, the participants prioritized these policy and practice recommendations based on their levels of importance. For this priority-setting process, a Google Form with the final versions of the recommendations was shared with the participants so they could rate these items on a scale of 0 to 10. Additionally, the participants were also asked to indicate their top three choices. This prioritization process was completed individually and anonymously to ensure each participant's voice and choices were recognized. Finally, the findings of this prioritization exercise were used to identify the most highly rated policy and practice recommendations.

During the fourth session, the participants also discussed and chose the ways in which they wanted to share their photos and narratives. All the participants chose the virtual exhibit approach, meaning a publicly available website is being developed. Additionally, each participant gave their consent regarding ways they would like to release their photos and narratives.

Analysis

Throughout the various sessions and phases of this project, the primary researcher (WG) guided participants through an iterative, qualitative thematic analysis to identify and confirm codes, and the coding process continued until group consensus was reached [58]. Next, the primary researcher (WG) collated and categorized the codes from all the sessions. Two researchers (SM and WG) worked together to identify and refine overarching themes from these categories. Subsequently, these themes were validated by the participants. Notably, the researcher (WG) approached this data with certain preconceived notions based on her personal experiences and theoretical perspectives. However, she practiced self-reflection and engaged in debriefing sessions with her thesis supervisor (SM) to ensure she remained open to new concepts emerging naturally from the data.

Findings

Six participants submitted a total of 16 photos and narratives. The demographic information of the participants is described in Table 5.2. Generally, all the participants had used technology to virtually access IPV interventions during the pandemic, including counseling services, group therapy sessions, legal services, and medical services. However, two of the participants indicated they had not been able to virtually access all the interventions they needed during the COVID-19 stay-at-home orders.

The findings of the study are summarized in two cross-cutting themes with two and three sub-themes, respectively. The first theme discusses the structural and systemic barriers faced by participants in accessing IPV interventions before and during the COVID-19 pandemic. The second theme outlines the complexities in navigating safety when accessing virtual IPV interventions.

Table 5.2: Photovoice Participants' Demographic Information

Demographics	**Number of Participants**
Age	
31-40	1
41-50	3
51-60	1
61+	1
Ethnic background	
White	2
Asian – Indian	2
Hispanic	1
Prefer not to say	1
Geographical location	
Urban	5
Rural – Undisclosed	1
Education	
Highschool	2
College Certificate	1
Bachelor's degree	2
No response	1
Disability	
Yes	2
No	3
No response	1

1. Complex Barriers to Accessing IPV Interventions

While participants were asked to describe their experiences accessing virtual IPV interventions, they wanted to first discuss the structural and systemic challenges that they face when accessing IPV interventions (in-person or virtual). These challenges were discussed in the contexts of (1) pre-existing structural and systemic barriers resulting in unmet needs of women affected by IPV; and (2) the impact of the COVID-19 pandemic which introduced new barriers to accessing virtual IPV-related interventions and further exacerbated the pre-existing challenges.

1.1 Pre-existing structural and systemic barriers resulting in unmet needs of individuals affected by IPV

The participants indicated that for years they had been dealing with long wait times to reach and access IPV interventions, and inability to access consistent and effective trauma-focused counseling services or to access experienced IPV counselors. One participant described her experiences with long wait times and inconsistent counseling as follows:

> There is always a wait list to access counseling services…There is a lack of continuity and there is limited access to experienced counselors who know how to deal with women experiencing violence. For example, the staff at the counseling agencies are constantly changing, so I cannot get continued support. The need for consistent, effective and continued counseling services and support is needed. (P4)

Beyond this, some participants indicated a lack of knowledge on how to respond to IPV disclosure within some health care settings. One participant shared the following experience:

> Years ago, when I did not speak fluent English, I reached out to my family doctor, who spoke my language, and he listened. However, he did not give me resources or

> information on how to reach out for help for domestic violence. He said, 'I am a doctor, I can't help you much in that case . . . I can only refer you to a psychiatrist.' Also, he said, 'If you leave your husband where would you go? Shelter?!' The doctor did not know that shelter for women was safe. There is [a] stereotype about shelters . . . people think it is dirty, there are drugs, and [it] leads to severe homelessness. [Thus], he discouraged me from leaving because he thought I [would not] be safe if I leave. (P5)

Another one also shared how she felt dismissed and unsupported when she reached out to her health care provider for help with experiencing IPV as following:

> The medical system because, again, many people and many doctors might not understand what you're going through, and they might think that maybe it's just stress or maybe it's just anxiety. I remember going to the doctor [and] it was a male. . . . I remember telling him what I was feeling, he minimized or dismissed [me] because he was saying it's just anxiety. And he gave me a bottle of pills for depression. And I was like, seriously? I'm telling you how I'm feeling. And, yes, it might be stress, it might be anxiety, but I'm telling you why, how I feel, and what I need [trauma support with experiencing IPV]. (P3)

Underserved women dealing with multiple forms of oppression also face additional challenges that are unique to their social realities and contexts. For example, immigrants and refugees deal with language barriers, a lack of sufficient information on how and where to access relevant interventions, and issues with their immigration statuses. The following quotes represent some of these challenges:

> It was difficult for me to leave the abusive relationship. One of the reasons was because I was new to the country and did not have permanent residency papers. My ex told me that

> if I [left] him, I would be deported, and he [would] keep my child away from me . . . I had a visa, but it was temporary. [Therefore], I could not access a lot of support [services]. (P3)

> I did not know about shelter or other similar services. If I [had known], I would have accessed them quicker. I did not know because I was an immigrant. (P1)

Furthermore, geographical barriers to accessing support services were highlighted. One participant seeking IPV interventions from a rural location shared the challenges she faced in accessing reliable trauma-focused counseling services in her area and how these challenges were further complicated by the shift to virtual delivery during the pandemic. The following photo and narrative summarize her experience:

Such a long, lonely road to travel to escape the violence with nowhere to hide. I lived in a rural residence where there was no internet to access services which made it difficult to seek counsel or support services. The existing counseling services were ineffective, sporadic, inconsistent, and had no continuity. For example, I had to talk to a different person every time I reached out for help, but there was so much disconnect in the counseling service provided. The counselors kept changing, and there was a disconnect in my therapy. I was not allowed to have a computer at home, it was not allowed by my abuser. Finally, I learned and adopted to use only my phone to access virtual services by only calling in to a Zoom meeting. With a lack of continuity because there is a limit to counseling sessions and especially limited access to experienced counselors who know how to deal with women experiencing domestic abuse and violence. Staff at counseling agencies are constantly changing, even during active series of a lot of sessions, getting much needed continued support is challenging. (P4)

1.2 The impact of the COVID-19 pandemic in accessing virtual IPV interventions

The participants identified several barriers they faced when accessing IPV interventions during the COVID-19 pandemic. These include an inability to use a keyboard due to disability, low digital or technology literacy, a financial inability to purchase devices or afford an internet connection, a lack of privacy when accessing virtual services, and a lack of time to reach for help. Most of the participants also highlighted long wait times and an inability to reach support services over the phone including long holds and having to call multiple times. Some participant quotes illustrating these challenges are shown below:

> Initially, I had to deal with issues in accessing services virtually because I did not have access to a computer or a reliable internet in a rural setting, but I learned to adapt by using my phone to access services virtually. (P4)

> [T]hey should work [on] making [the] Internet more accessible to other people because if now everything is going to be online, [they should] make it cheaper. I can afford it now, but I know at that point [2020], I could not afford it. And I know [that] right now, some people . . . might not be able to afford [those interventions] even when they have to. Not they want to; they have to because they want to access some services, or they have to access something, and they have to call, or they have to be [in] an [online] session… [H]ow are you expecting people to access [the Internet] if they cannot afford it or they don't know how to afford it? …I think the government should regulate [this service] and make it more accessible to them. (P3)

> Therapy sessions do require some privacy; even with your headphones, you won't get . . . quiet . . . there'll be kids running around, [and] there'll be people coming. And with the weather, if it's winter, it's severe winter [you can't go outside]. (P1)

Overall, the participants shared a range of challenges they faced when accessing virtual IPV interventions during the pandemic. The major challenge they faced was related to the digital divide.

2. Navigating Safety when Accessing Virtual IPV Interventions

The participants discussed the concept of safety within the contexts of (1) identifying safe physical spaces to access virtual interventions, (2) highlighting the discrepancies within the system in delivering culturally safe trauma-focused IPV interventions, and (3) reorienting the anti-violence system towards culturally safe and trauma-focused approaches using examples of positive experiences and specific recommendations for change.

2.1 Identifying safe physical spaces to access IPV interventions

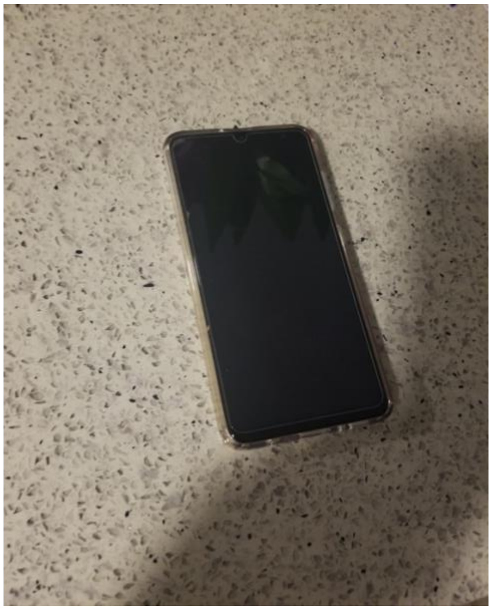
During the pandemic, participants indicated that they had not felt safe accessing virtual IPV interventions at home when perpetrators of the violence were close by. As a result, they had to find creative ways to safely access these interventions. For example, one participant indicated that she used to go to her car to reach out for help and to access services, as described here:

> I used my car as a safe space to go out of the house to use my phone and find information. [I had] no friends to talk to, so I had to find information and support myself online. [That] was my only solace: . . . going out and talking to someone. Searching [for] services and support through Google and making calls in my car to access services. (P1)

Another participant shared the following creative approach she used to access IPV interventions safely:

> To get creative, I [would] take my child to the park or the grocery store. And [there,] I [would] start checking online [for] the [information I needed]. I [would] write down what I need on a [piece of] paper. But it was difficult. (P3)

However, the participants also emphasized the dangerous reality of their abusive partners' accessing and controlling the women's devices and search histories. One participant stated that "if your spouse is checking on you or he has a tracker on your phone, for instance, even your conversations with your relatives will be tracked" (P1). Another participant shared a photo of a cell phone and the following narrative as an example of how she navigated such a challenge:



> When I first started to seek help . . . to leave my ex-husband, I didn't have a cell phone, he won't allow me to have one. I had to use his cell phone, and he listen[ed] to everything. The landline was connected to his email, so he [could] see who called, and he [could] hear the voicemails [through] his email. But using his computer, I was able to go on Facebook and find friends from my community. Also, I Googled . . . 'support services' and saw the information for [an organization that provides culturally applicable all-inclusive services from food support and networking to counseling services], and I reached out to them. [My ex] saw my search history and contact[ed] . . . [the organization], but he did not know the type of help I was reaching out for. He thought I was looking for friends from [my] community—that kept me safe from his retaliation. (P5)

Similarly, other participants shared the sense of safety when seeking help via social media. That is, even if their abusers saw their internet search histories, the abusers would assume they were only browsing social media or connecting with friends. Another woman added, "[I reached out to groups on Facebook] because usually, if you're on Facebook, you can just scroll really fast, and they [referring to the abuser] might not know what you [are] checking" (P3).

However, navigating IPV interventions and supports online and through social media channels is shaped by a person's digital and language literacy. As described by one participant:

> There is a lot of information and support on Google and [in] Facebook groups. People can exchange knowledge, information [and] advice on Facebook groups. However, there are women who can't speak English, can't use technology, . . . can't access phones and computers, etcetera, and it would be difficult for these women to reach [out] for help. (P5)

This participant further highlighted the complex set of barriers new immigrants experiencing IPV face in seeking or accessing IPV interventions as follows:

> Some men lock their wives in their homes, and these women do not speak the [local] language, [and] they may not have [a] phone, so they have no access. [The abusers] put recorders at home, so it is not safe to use [a] phone [or] computer at home because [they use] his device[s]. Some live with [their] in-laws, and the women are always controlled by [their abusers] and [their families]. (P5)

When possible, the participants suggested accessing services in public spaces or using publicly available resources like libraries or schools to prevent their abusive partners from learning what they were doing. However, during the lockdowns, libraries and schools were closed to the public. As a result, some participants suggested that during pandemic stay-at-home orders, libraries should remain open because they are places where diverse people with various challenges can access support or specific interventions for IPV, and this can be potentially life-saving.

2.2 Systemic and structural inequities contribute to the delivery of unsafe IPV interventions

Participants highlighted that the anti-violence sector and medical system lack adequate trauma-focused, culturally safe and client-centered care. One participant took a photo of an eye to show that she had been a spectator in her own life as the various institutionalized systems took over her life but did not address her needs:

We are watching everything around us, the system can decide about our future, we are more a spectator than the protagonist of own story. No one was asking me what I want, what I need . . . they were only telling me what to do. For example, my therapist did not understand me, did not take into account my experience, my background, and my realities. Service providers need to listen to us with empathy; we may not have gone to school, but we have lived it! I was overwhelmed, and I did not know whether to speak or not. (P3)

Similarly, the following quote from another participant also highlights similar challenges:

> Some professionals miss things and jump to conclusions and diagnosis before fully understanding the person and what they have been though and go through. There is a lack of feeling from these providers, relating to what the person is feeling. They have the knowledge and education but not the feeling of what we go through. (P5)

The participants further identified ways in which various systems meant to support individuals affected by IPV were re-traumatizing and not culturally safe. They shared, when they reached for help their experiences were not validated, they felt misunderstood, and were discriminated against due to their social identities. One woman shared a negative experience with seeking support when her abuser threatened her life:

> I reached out to victim services, and I explained the fact that I was being threatened. My life was being threatened. And they literally dismissed it by saying, 'We're sorry, but we need more reports, police reports, stating that he abused you' . . . [I shared with them that he broke my finger and they said] 'sorry to hear about that. But we need a police report, or you need to have bruises on you or evidence.' Seriously? You want me to be all bruised up before you can empathize and sympathize or even reach out to help or advise? It was difficult. And [then] they shut me down by saying, 'We just apologize for all this that happened, but that's [all we can do] with the threats.' And this is recorded threats and very, very serious threats. And I felt so let down. I felt so alone, and I felt like nobody care[d]. They dismissed it. Maybe I should dismiss it [too] and just move forward. (P2)

This woman was not alone in her experiences of dismissal or lack of support with IPV or with being re-traumatized by seeking help, issues especially prevalent within legal spaces. For example, other women shared similar experiences, such as the following:

> For police, if you don't show up almost dying and with bruises and a broken arm, . . . they dismiss you, or they might not believe you. And even judges, they start . . . How [do] you say it? Revictimizing the person. [They say things like,] 'You didn't leave him before. You didn't [do] anything'. Over and over again. And it's like, we have our reasons. And also, it's not that easy. (P3)

> When domestic abuse is mentioned in the escape process [or] during divorce proceedings, the facts are simply minimized [and] shunned, thus allowing the abuser to continue with more abuse. (P4)

For these women, seeking and accessing IPV-related interventions entailed navigating numerous complex systems without any guidance and dealing with pushback, external abuse, and re-traumatization. One woman shared the following photo and narrative to express her experiences dealing with these complex systems:

I have had to deal with various systems and organizations in the process of freeing myself from abuse. In this process, I have been further traumatized by the legal system, and I have not been able to access consistent, effective, [or] continued support from the social support services (e.g., counseling, social work, etc.) . . . It is not easy to be heard by the various systems put in place to help survivors like me! So where is the system? Where is my help, protection, safety, and peace coming from? This is our court system? Where is our justice? What can I do to be heard? It is like [sinking] into . . . quicksand. Something needs to change. (P4)

Another participant also shared the following experience:

> When I finally said, ‘enough is enough’ and left him, the legal and social services were not so supportive. I felt just as controlled [by] and invisible [within] the system. [That is,] the system is exacerbating the system of abuse. I felt like my life was not mine because different people within the system were controlling me. I could not decide anything about my family [or] my child because child services were involved. I was so distraught; I did not know what to do. I was impacted [by] confusing ideas and [felt] emotions. People

> [were] telling me what to do . . . but all I wanted was to go home and be safe. I was re-traumatized by the system. (P3)

These challenges were further complicated for women with intersecting social disadvantages. For example, immigrant women who experienced violence shared their experiences with having to navigate complex systems and discrimination. Two women described their experiences as such:

> When I [have] reached out to social services, I have been denied access. I was shut down because they said they [couldn't] hear my accent, or I was told 'I speak loud[ly],' and when I advocate[d] for myself, I was told [that] I 'am disrespectful.' (P5)

> Immigration systems . . . say, 'We cannot complete your case until the family law system makes a decision'. But the family law court might say, 'We cannot give you a decision about custody because immigration hasn't decided your status.' I think, especially for immigrant women, there are multifactor issues about the system. Not only the legal system. It's a lot of the systems. (P3)

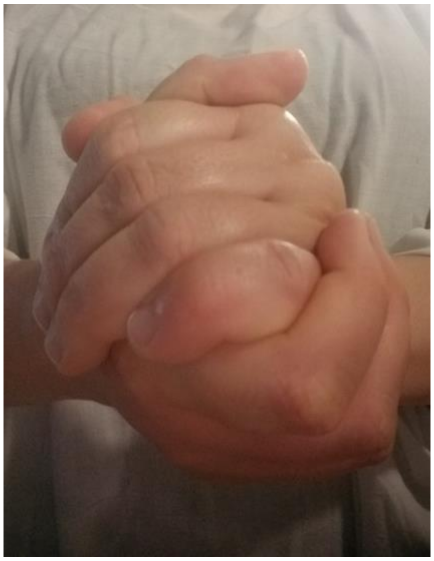
Thus, the negative and harmful experiences encountered by participants shaped their perception of the quality of virtual IPV interventions. There was a general distrust of all interventions and supports (in-person or virtual) in respecting their needs and preferences.

2.3 Re-orienting the system towards providing safe and equitable IPV interventions

Few participants shared examples of positive interactions with some organizations within the anti-violence sector, which included experiences of client-centered, culturally safe, and trauma-focused approaches they had received. Thus, these examples can be used as a blueprint to reorient the system toward safety for diverse individuals affected by IPV. For instance, one of the participants shared her experiences, as follows:

> My experience at this counseling agency was positive: I was able to share my experiences, I got validation, I felt heard, and we talked about how to get out of the relationship safely. (P4)

Another participant took a photo of a hand being held by another hand and added a narrative describing her experience with receiving positive support services:



During the pandemic my main support system were [identifies two organizations that provide culturally specific services to immigrants and refugees]. I was able to reach out through email during the pandemic and they were responsive and helped me in ways that were relevant to my needs. [One of these organizations] was always available or would get back to me within a day of reaching out. [The organization] was the main support system, they continue to provide me with free counseling services and advise from a social worker that I can count on. My social worker makes me feel like a family - she has good listening skills and makes me feel heard. She always gives good advice and provides me with all kinds help I need (e.g., call other organizations/services for me). During this time, I felt supported and less anxious - they made me feel calm. From this organization I receive the advice I need, and I always feel heard. The fact that [the organization] provides culturally specific and person-centered support makes a difference. It felt like I had a supportive hand. I continue to receive support from them until now (counseling, social work, advise). Without them I do not think I could have had access to the services I needed, it is difficult to access the systems without knowing someone who works in the system. Leaving takes courage, because you do not know what will happened next, without [the organization] my leaving/escaping would have been very very tough. With them on my side, I feel like I have someone I can count on. (P5)

Contrary to the previously described negative interactions with the legal system, one participant shared a positive interaction, as follows:

> Legal aid was supportive—I was heard, [and] I felt that they wanted to help me and opened doors for me. However, the ability to convey exactly what you need and what you

> are asking for makes a difference. Compared to experiences back home, I think there is [a] sense of support from the system here. I believe the system is fair. (P1)

Therefore, for these participants, accessing and receiving safe, and equitable IPV interventions required organizations' quick responsiveness to clients' needs, affordability of services provided, feeling heard, feeling supported and understood, and feeling valued.

Policy and Practice Recommendations

As previously described, the participants developed and prioritized policy and practice recommendations. The five top priority recommendations have been summarized in Table 5.3 and the full list of recommendations is available in Appendix C. These recommendations centered around various stakeholders' (governments, service providers, legal representatives, medical providers, etc.) responsibilities to ensure inclusion, equitable access to resources, and commitment to healing individual and historical trauma. It is important to note that during this process, the participants unanimously chose the following practice recommendation as the top priority:

> There is a need to provide more training and resources to service providers (police, judges, lawyers, counselors, social workers, health care providers) on how to provide trauma-informed services to individuals experiencing violence.

Table 5.3: Policy and Practice Recommendations Listed from High Priority to Lower Priority

Policy Recommendations	1. Impose mandatory training on the forms of violence, and on how to provide trauma-informed support to individuals affected by violence to policy makers, government workers (especially lawyers, prosecutors, judges), and medical care providers.
	2. Allocate more funds towards (a) strengthening the anti-violence sector to provide affordable, timely, reliable, trauma-informed, client-centered and culturally applicable services (e.g., counseling services, access to social workers); and (b) providing affordable and reliable internet access for underserved populations.
	3. Allocate funds towards providing affordable access to housing, income support, access to affordable vocational training, and access to affordable driving lessons, access to medical care needs (dentist, prescriptions, eye care, etc.,) and driving license regardless of immigration status.
	4. Ensure income equality for all regardless of immigration status.
	5. Existing laws, legislations, and policies regarding violence must be reviewed by diverse individuals affected by violence. Going forward, these stakeholders (diverse individuals affected by violence) must be engaged in the development, implementation and evaluations of policies, legislations and laws addressing issues related to violence.
Practice Recommendations	1. There is a need to provide more training and resources to service providers (police, judges, lawyers, counselors, social workers, health care providers) on how to provide trauma-informed services to individuals experiencing violence. Trainings should include contents on the forms of violence (psychological, emotional. financial, etc.), impact of violence, the realities of historical and generational trauma, understanding the traits and tactics of perpetrators, and how to provide the necessary support in an empathetic and trauma-informed ways.
	2. Provide emergency services in different languages (e.g., call 911 and say Hindi and you will be transferred to someone who speaks Hindi).
	3. Have advocates or social workers support survivors through the legal processes (e.g., divorce, custody), and to ensure they are provided with all necessary information (e.g., settling finances) during divorce proceedings.
	4. Provide fair and timely services/responses. This includes reduced wait times and quick access to counselors.
	5. Ensure continuity and consistency in the counseling services provided (i.e., access to the same trauma-focused therapist with abuse experience for prolonged treatments (such as CBT) for effective counseling.

Discussion

The COVID-19 pandemic has exacerbated pre-existing inequities rooted in systemic oppression and structural violence. At the same time, it added a new set of challenges, shifting support systems to virtual delivery. The participants in this study explained that most of the barriers and challenges they had faced in safely accessing IPV interventions were not specific to virtual settings but rather pre-existing structural barriers and systemic challenges that were further exacerbated during the pandemic. The participants identified long waitlists, a lack of access to specialized trauma-focused counseling services, and inconsistent counseling services as pre-existing structural barriers to accessing and receiving IPV interventions, issues magnified during the pandemic. Similarly, other studies have shown that during the pandemic, despite the increased need for trauma-focused counseling services among individuals affected by IPV, these interventions have not been easily accessible [41, 73]. Furthermore, participants in this study mentioned language barriers, insufficient information for immigrants and refugees, geographical limitations, and financial obstacles as challenges faced by underserved women experiencing violence. Similar challenges faced by underserved populations have also been reported in recent academic literature [1].

Additionally, women affected by IPV have faced challenges in accessing virtual IPV interventions during the pandemic for a range of reasons. These include the digital divide and barriers to having safe physical spaces where they could access IPV interventions virtually. Similarly, recent studies have reported that women affected by violence have faced difficulties in accessing safe spaces where they could seek help virtually during the pandemic [41, 74, 75]. In this study, the use of social media was identified as a relatively safer way to access virtual IPV interventions. Similarly, recent studies have also reported that social media was the most used safe approach to accessing support by individuals affected by IPV during the pandemic [74, 76]. However, the ability to access and use the devices and the technology required to use social media is limited for some underserved women.

Studies have shown that health care settings could provide important opportunities and safe spaces for individuals affected by IPV to safely access IPV interventions, because abusive partners are less likely to question a phone call with a physician or a visit to the doctor's office [10, 77]. However, the current study highlighted a lack of health care providers' knowledge on providing resources and support to individuals affected by IPV within health care settings. Therefore, it is key to provide training and resources for health care providers to ensure that they are aware of response procedures and IPV-related resources in communities, so they are prepared to support individuals experiencing IPV seeking for help [78]. For example, healthcare settings could incorporate IPV education and resources into the workflows of their clinics [33]. For instance, Advocacy for Women and Kids in Emergencies (AWAKE), a Boston-based, comprehensive, hospital-based IPV advocacy program, has effectively provided support to individuals affected by IPV seeking help in healthcare settings [33, 77]. This program provides healing-centered care through healthcare provider training and direct support for IPV survivors [33]. Additionally, some scholars recommend cross-sector collaborations and partnerships between the healthcare sector and other anti-violence sectors to better support women affected by IPV [33].

However, ensuring safety in accessing and using virtual interventions for individuals affected by IPV is multifaceted. Even if they could overcome the challenges of digital divide and could access safe physical spaces, they might not be able to access interventions that are culturally or emotionally safe. These individuals face structural inequities rooted in systemic oppression in the forms of racism, ableism, classism, colonization, heterosexism, Islamophobia, sexism, and transphobia from service providers [11, 12] . Moreover, individuals with intersecting identities often experience multiple forms of oppression. As a result, such people who are affected by IPV face complex sets of challenges in navigating various anti-violence services and systems. Participants in this study highlighted the lack of trauma-focused and culturally safe interventions by emphasizing their experiences with discrimination, invalidation of their experiences, and re-traumatization within multiple interconnected and complex systems established to protect and serve them, ranging from the social sector to the judicial system.

Similarly, a recent report by Women's Shelters Canada [1] highlighted the challenges faced by individuals affected by IPV within the judicial system. In this report, the authors explained a lack of awareness regarding forms of violence experienced by IPV survivors. For example, police reports often place greater emphasis on the experiences of those suffering physical violence than of those experiencing other forms of violence. Additionally, our findings showed that there is a difference in how individuals affected by IPV seek help based on their identities and contexts. This concept was explained as follows:

> Survivors of [IPV] look to justice and legal systems from different perspectives. Some, often those who are already the privileged, turn to those systems assuming they will provide justice. They are often disappointed. Others, often those who have been marginalized, reject those systems, assuming they will cause further harm. Their fears are often proved correct [1].

The participants in this study unanimously echoed this statement, discussing the lack of compassion or empathy and the re-traumatization they had experienced within the judicial system.

Thus, in recent years, experts have suggested that there is a need to build on the delivery of trauma-focused interventions and strengthen the delivery of 'trauma- and violence-informed' (TVI) practices and policies, particularly for underserved individuals [1, 79]. Trauma- and violence-informed (TVI) approaches aim to "minimize re-traumatization for people who have previously experienced violence, support people currently experiencing violence and draw attention to structural violence" [26]. However, again, the challenges faced by these individuals are rooted in a complex set of reasons, ranging from resource scarcity to funding shortages to systems of oppression. For instance, despite promoting an understanding of how to provide TVI practices, the anti-violence sector has not provided timely or consistent TVI services to individuals affected by IPV due to funding and resource constraints [32]. These issues have resulted in long waitlists and high staff turnover, producing inconsistent and ineffective counseling services. Thus, the system requires increased funding to strengthen the anti-violence sector and to establish policies to guarantee and protect continued funding [41]. In 2021, the Canadian federal government made a $600 million investment to address violence against women and gender-based violence (VAW/GBV) [1]. Additionally, the government invested $400 million to confront various data gaps, especially regarding gender, racism, and unequal power relations, to improve evidence-based decision making [1]. Although this commitment has made significant stride toward tackling an important issue, far more investment is needed to dismantle the systems of oppression and the structural challenges faced by individuals affected by IPV and the anti-violence sector [1]. In this vein, the Women's Shelter of Canada recently responded to these budgetary commitments, explaining that this process could take

> …billions, not millions [of dollars]. We need ways to systematically ensure participation and collaboration from VAW/GBV survivors, gender-justice sector experts, and anti-

> VAW/GBV advocates—upholding the principle of ‘nothing about me, without me.’ We must allow evidence generated that honors the narratives from Indigenous survivors, LGBTQI2S+ survivors, and from Black and racialized survivors of VAW/GBV —data gathering those centers on safety, healing, and justice [1].

The overarching challenge in this area is that there is less emphasis on strengthening structural and systemic solutions than on individual solutions [12]. As a result, women affected by IPV are expected to know how to navigate the complex systems, from legal to health to social services, on their own. That is, these women are expected to decipher and safely access virtual or in-person IPV interventions, and they are expected to “possess the capabilities to protect themselves from potential intended and unintended harm that might occur during the process” [80]. This relieves decision makers from their responsibilities to serve, guide and protect these women [80]. Additionally, certain scholars have mentioned that “systemic issues require systemic responses. But they are also importantly rooted in individual experiences, and these personal experiences must inform our efforts to make change” [1]. To this end this study aimed to assess, from the perspectives of IPV survivors, how virtually delivered IPV interventions can be safe, equitable and accessible by a wide range of diverse women. The participants explained empathy, validation, affordability, and cultural safety are the key traits of a safe, equitable, and accessible virtual IPV intervention. Furthermore, based on the recommendations from these participants, there is a clear need for the anti-violence sector, judicial system, and medical system to provide a more holistic TVI interventions virtually or in-person.

To better address the complex challenges faced by these women, there is a need for improved collaboration and coordination between various systems and sectors, such as victim services, social services, legal services, mental health services, and health care settings, to increase safe access to IPV interventions [1]. Moreover, there is a need for intersectional analysis which assesses how converging disadvantaged social locations impact underserved women's access to opportunities, how social, economic, political and legal environment contribute to their experiences of discrimination, and how policies, services and laws that impact on one aspect of their lives are inextricably also linked to others [81, 82]. At a societal level, it is important to understand and address structural violence by providing underserved women equal and fair access to economic, and social services (e.g., housing, employment, health care, digital technologies) [82]. It is also key to battle and deconstruct the systems of oppression. For this to be achieved, everyone involved must understand their roles in deciphering how to magnify underserved, oppressed voices at the systemic and institutional levels. Thus, it is key to engage underserved populations in policy development, implementation, and evaluation. Moreover, it is vital to have representation of underserved populations in various levels of institutional structures from frontline service provision to leadership positions in charge of funding allocations.

Strengths and Limitations

This study included both strengths and limitations. To the researchers' knowledge, this is the first study using a virtually implemented photovoice project engaging survivors of IPV. Additionally, this study analyzed how systemic oppression based on gender, class, and race prevents delivering and accessing safe, and equitable virtual IPV interventions. Finally, the study provided survivor-developed and -prioritized policy and practice recommendations that promote equitable, and survivor-centred IPV interventions and supports.

At the same time, this study has certain limitations. The first challenge was participant recruitment and retention. The time commitment expected from participants in a photovoice project is high, so some interested survivors were unable to participate due to their busy schedules. As a result, some important insights may have been missed. Second, this study recruited survivors who had virtually accessed IPV intervention during the pandemic. Therefore, certain challenges faced by women who were unable to access virtual support services were not represented. Finally, some of the participants were not comfortable with participating in group settings. For this reason, following a trauma-focused approach and ensuring participant comfort, the team hosted one-on-one sessions between the participants and researchers instead. This approach may have compromised some integrity of a traditional photovoice methodology. However, the validity and reliability of the study output was ensured through checking and rechecking participant responses and providing multiple opportunities for participant validation.

Conclusion

Although the shift to virtual delivery of IPV interventions during the COVID-19 pandemic has been necessary and beneficial, some underserved women affected by IPV have encountered several barriers in accessing and using these interventions. These women need timely, consistent, inclusive, culturally appropriate, and client-centered support services that respect their individual needs based on their lived experiences. However, they, especially those with intersecting identities, have been facing various challenges in accessing culturally safe and client-centered IPV interventions since before these services transitioned to virtual delivery during the pandemic. These challenges are rooted in systems of oppression, and thus a larger commitment is needed from all stakeholders to dismantle the systems of oppression that are at the root of inequity and inaccessibility of safe IPV interventions.

Lessons Learned and Implications for Future Photovoice Research

Engaging IPV survivors in a photovoice study can be challenging for a range of reasons. As previously highlighted the level of commitment expected from participants is high, thus a higher buy in from the potential participants is required. The researchers in this study followed the principles of CBPR approaches by ensuring flexibility to work with participants' availability and comfort levels, creating welcoming environment, providing the option to meet in-person or virtually, and ensuring respectful interactions. However, participant retention remained a challenge. The researcher facilitating the group sessions (WG) noticed the retention was higher/better within participant groups who share similar life experiences and cultural background as herself. This could indicate that these participants felt a sense of connection with the researcher which contributed to their levels of commitment in the study. Therefore, it is key to involve researchers and facilitators with similar backgrounds, contexts and identities as the participants in a photovoice study.

Being part of this study, as a participant or as a researcher, carried some psychological risks. However, the researchers made sure that the safety and comfort of participants take precedence over research goals. For example, the researcher made sure to check-in with participants as a group and individually to make sure they were comfortable during the sessions, she made sure they get breaks as needed, and she followed up with participants after each session to make sure they were emotionally safe, or to see if they needed help. Additionally, contact information for professional mental health and crisis intervention services were available to participants. The participants were also able to talk about problems in their lives with a respectful, nonjudgmental listener (the researcher and/or other group members). Therefore, when conducting photovoice projects with IPV survivors it is essential for researchers to put additional time and effort towards ensuring participants' safety and comfort.

At the same time, the disturbing discussions of violence and abuse were emotionally and psychologically draining and at times triggering to the researcher (WG). However, working with experienced thesis supervisor and seeking phycological support helped. Therefore, it is key for researchers to also be aware of how they may be impacted by the contents of the study findings and better prepare in addressing their mental health concerns.

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Chapter 6 – Analyzing Embedded Single Case Study Evidence

Explanation Building

Case studies examine the ‘why’ and/or the ‘how’ questions of a phenomenon. In this study, the case encompassed factors that constitute safe, equitable, and accessible virtually delivered interventions for a wide range of diverse women affected by IPV within the contexts of structural inequities and the COVID-19 pandemic.

As a first step, a REA was conducted, which guided the development of a theoretical proposition (Fig. 6.1) that informed the design of the embedded single case study with two units of analysis (Chapter 3). The theoretical proposition suggested the following:

a) Intersecting forms of exclusion and the contextual factors related to the COVID-19 pandemic compound barriers to accessing safe and equitable virtual IPV interventions for diverse women from underserved populations. This part of the theoretical proposition addressed ‘why women from underserved populations face challenges in accessing safe, equitable, and accessible virtual IPV interventions.’

b) To reach the desired outcome of safe, equitable, and accessible virtual IPV interventions, it is important to set priority areas of action for policy and practice identified by the knowledge users (individuals affected by IPV). This part of the theoretical proposition addressed ‘how virtual IPV interventions can be safe, equitable, and accessible for diverse women from underserved populations.’

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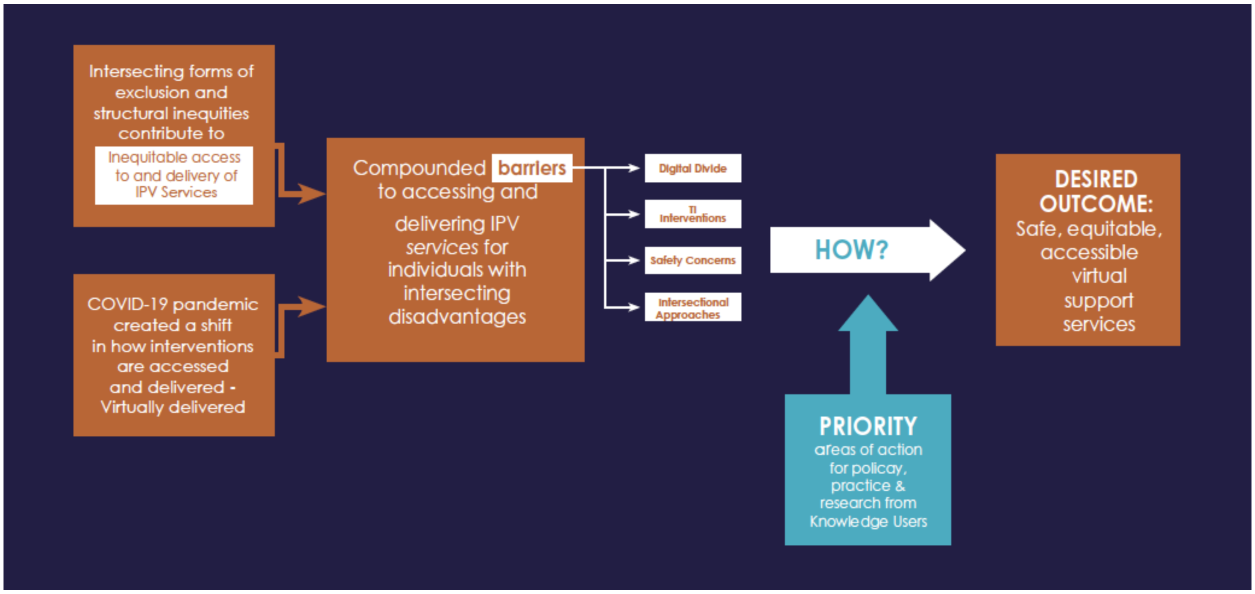
Fig. 6.1: Theoretical Proposition

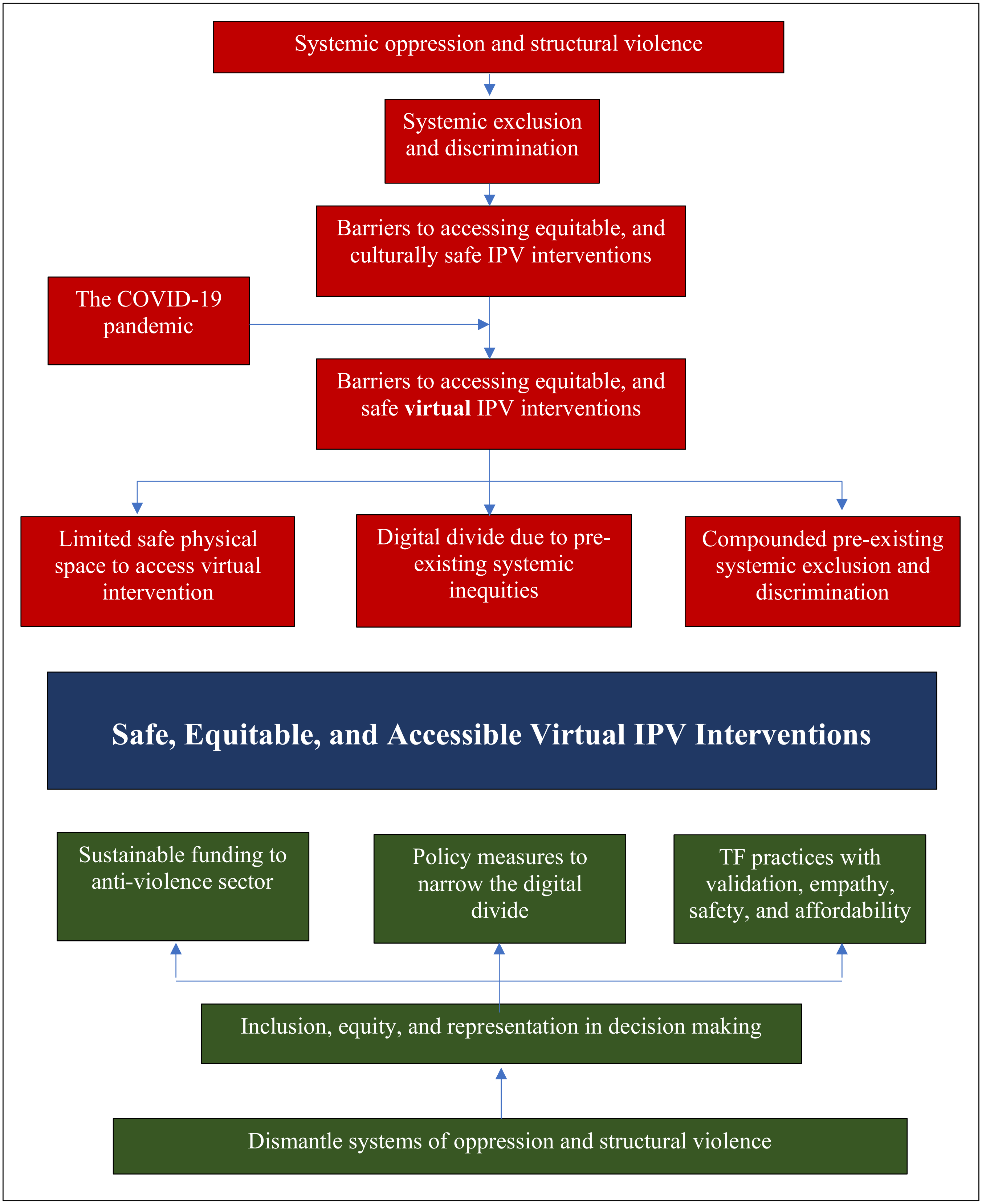


The findings from the semi-structured interviews with service providers (unit of analysis 1) and photos and narratives from survivors who participated in the photovoice project (unit of analysis 2) supported the argument that systemic exclusion rooted in oppression and structural violence is the main challenge faced by underserved women in accessing safe and equitable virtual IPV interventions. Forms of structural and systemic inequity predate the pandemic and have been experienced when receiving care in the virtual environment during the pandemic. In addition, the COVID-19 pandemic brought its own challenges in the form of the digital divide and has further exacerbated pre-existing systemic and structural challenges (e.g., long wait lists, delay in accessing specialized IPV interventions, lack of culturally safe virtual interventions). When these findings were compared with the theoretical proposition (Fig. 6.1) using the case study explanation-building technique (Chapter 3), it was recognized that the findings only partially supported the proposed theory. Therefore, a revised theoretical proposition (Fig. 6.2) was developed that outlines the following:

a) The main challenge faced by underserved women in accessing safe and equitable IPV intervention virtually or in person is related to systemic oppression and structural violence. Although the COVID-19-pandemic-related concern of digital divide is a byproduct of these pre-existing systemic inequities and exclusions, the pandemic also added a barrier to having safe physical space in accessing virtual IPV interventions. This explains why virtually delivered IPV interventions have not been accessible, safe nor equitable for many women during the pandemic. These concepts are represented in red in Fig. 6.2.

b) To ensure that virtual IPV interventions are accessible, safe, and equitable; practicing empathy and cultural safety, validating the stories of clients, and ensuring virtual interventions are affordable are key considerations. Furthermore, it is important to mandate allocation of increased funds towards strengthening the anti-violence sector and the delivery of holistic trauma-focused interventions that minimize re-traumatization for people who have previously experienced violence, support people currently experiencing violence and draw attention to structural violence [2, 3]. Finally, it is essential to address the underlying root issues – systemic oppression and structural violence – that intersect on the axes of gender, race, ethnicity, ability, and geographic location. These concepts are represented in green in Fig. 6.2.

Fig. 6.2 Revised Theoretical Proposition



Finally, when a study aims to explain a phenomenon by answering research questions that address 'how' and 'why', then the outcome may not be precisely measurable due to the complex nature of the causal sequences [1]. This is especially true for studies whose explanations reflect some theoretically significant propositions in which the causal sequence shows important insights for policy recommendations and social science theory building [1], such as the current study. Therefore, it is not possible to draw a generalizable conclusion from findings of this single case study, especially given that it required theoretical revisions. Moreover, in examining other plausible rival explanations, it was recognized that the outcome could be different if (a) women who never accessed virtual intervention were recruited, (b) a larger participant group of women from other races, ethnicities, cultural backgrounds, and age groups were included, and (c) this process was conducted through Indigenous ways of knowing and being. Additionally, the role of cultural norms and ideologies in the decision to seek and access virtual IPV interventions was not revealed in this study.

Therefore, further research is needed to examine how digital exclusion is experienced by diverse population groups and across intersecting factors of gender, sex, age, geography, disability, race, ethnicity, and culture. Yin [1] recommends the revised theoretical proposition be applied to additional cases as part of a multiple-case study. Thus, the revised theoretical proposition in this study could be tested using a multiple-case study approach in IPV survivors from different populations in the future.

Re-Defining Trauma-Focused Interventions

It is important to clarify that, the understanding and definition of trauma-focused interventions[3] used in this study encompasses trauma-informed approaches[4] and practices. However, these two terms are sometimes discussed as different concepts in the literature. Moreover, after completing the semi-structured interviews with service providers and the photovoice project with survivors of IPV, an emphasis was placed on the need for delivery of holistic trauma-and-violence-informed (TVI) approaches[5]. As a result, the understanding of how these terms should be used shifted as the researcher's knowledge evolved throughout the three phases. Therefore, it is important for any research and initiative that aim to address the concepts of equity and accessibility for individuals affected by IPV to focus on holistic approaches that address the root causes and systemic issues, that is using TVI approaches and intersectional analysis. Accordingly, we recommend the incorporation of TVI approaches into the definition and practice of trauma-focused interventions.

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[3] Trauma-Focused Interventions: are specific approaches to therapy that recognize and emphasize how the traumatic experience impacts an individual's mental, behavioral, emotional, physical, and spiritual well-being.

[4] Trauma-Informed Approaches: practices that promote a culture of safety, empowerment, and healing when providing any assistance or support to individuals affected by IPV. These assistance and support include social support, healthcare support and legal support.

[5] Trauma-and-Violence Informed Approaches: build on trauma-informed approaches and aim to minimize re-traumatization for people who have previously experienced violence, support people currently experiencing violence and draw attention to structural violence.

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Chapter 7 - Conclusion

Globally, the COVID-19 pandemic has increased the frequency and severity of IPV experienced by women and resulted in experiences of complex trauma. The pandemic has also exacerbated pre-existing systemic inequities and negatively impacted the structures and systems that provide support for individuals affected by IPV. For example, the rapid transition to virtual delivery of trauma-focused interventions posed additional access barriers for some individuals affected by IPV. This PhD dissertation demonstrated the complexity of delivering safe, equitable, and accessible virtual trauma-focused interventions for diverse individuals affected by IPV during the pandemic.

The findings from the rapid evidence assessment (REA), semi-structured interviews with service providers, and photovoice project with IPV survivors highlighted the digital divide as a key component of inequity when virtually accessing IPV interventions. However, participants in this study, both service providers and IPV survivors, underlined preexisting systemic inequalities, and the fear of re-traumatization by institutions has prevented some people from seeking and accessing help since long before the COVID-19 pandemic. These systemic barriers include experiences of racism, stigma, discrimination, language barriers, and gaps in culturally safe approaches to address the service essential to individuals who are affected by IPV. During the pandemic, such systemic and structural inequities have been further compounded, compromising the emotional and physical safety of individuals seeking and accessing IPV interventions virtually.

At the same time, for many years, the anti-violence sector has been dealing with the lack of a core sustainable funding structure, inequitable access to government funding, policy changes, and high staff turnover. Consequently, these issues have increased pressure on the sector and increased the unmet needs of individuals affected by IPV. These complex set of challenges and intersecting barriers experienced by the individuals and the anti-violence sector are a result of systemic oppression and structural violence. However, this study demonstrated that existing trauma-focused virtual interventions do not account for the broader systemic and structural barriers that affect the delivery of safe, accessible, and equitable interventions to diverse individuals affected by IPV.

Therefore, this research provided key policy and practice recommendations to address these barriers. First, it is crucial to ensure sustainable funding for anti-violence organizations to provide culturally appropriate, holistic, trauma-and-violence-informed, and affordable virtually delivered IPV interventions. In turn, this funding could be allocated for hiring service providers who reflect the populations they serve. This practice could encourage service providers to apply equity, diversity, and inclusion lens to those they serve. Additionally, such efforts would provide training and resources for healthcare providers to ensure that they are aware of response procedures and IPV-related resources in communities. Furthermore, this study revealed that it is essential for organizations interacting with individuals affected by IPV to form alliances within and across different sectors to better serve them.

Second, it is important to develop policy measures to narrow the digital divide. This includes allocating funds for increased access to digital technologies and reliable internet for underserved populations. Moreover, virtual tool developers must be mindful of inequities in digital access among intended users and must make their virtual tools more inclusive, secure, and safe for individuals affected by IPV. Beyond this, there is a need for community and stakeholder involvement in the design and implementation of virtually delivered interventions, respect for local values, and consideration of the core needs of clients. The latter would ensure that such interventions were culturally safe, equitable and accessible for all. Additionally, the perspectives and voices of individuals affected by IPV are crucial in the design, safety features, content, and applicability of the virtual support tools.

At a societal level, it is important to understand, confront, and dismantle the root causes of the systemic and structural barriers to accessing safe and equitable virtual IPV interventions, in other words, the systems of oppression and structural violence. This process involves magnifying underserved and oppressed voices at the systemic and institutional levels; engaging underserved populations in policy development, implementation, and evaluation; ensuring representation of diverse voices in decisions regarding funding allocations; and representing diverse populations in leadership positions. In conclusion, virtually delivered IPV interventions can be safe, equitable, and accessible to a diverse population by (1) providing affordable access to digital technologies and internet to individuals affected by IPV, (2) meaningfully and holistically addressing experiences of historical and contextual trauma, (3) preventing re-traumatization when providing support services, and (4) centering, honoring, and validating individual lived experiences of individuals affected by IPV.

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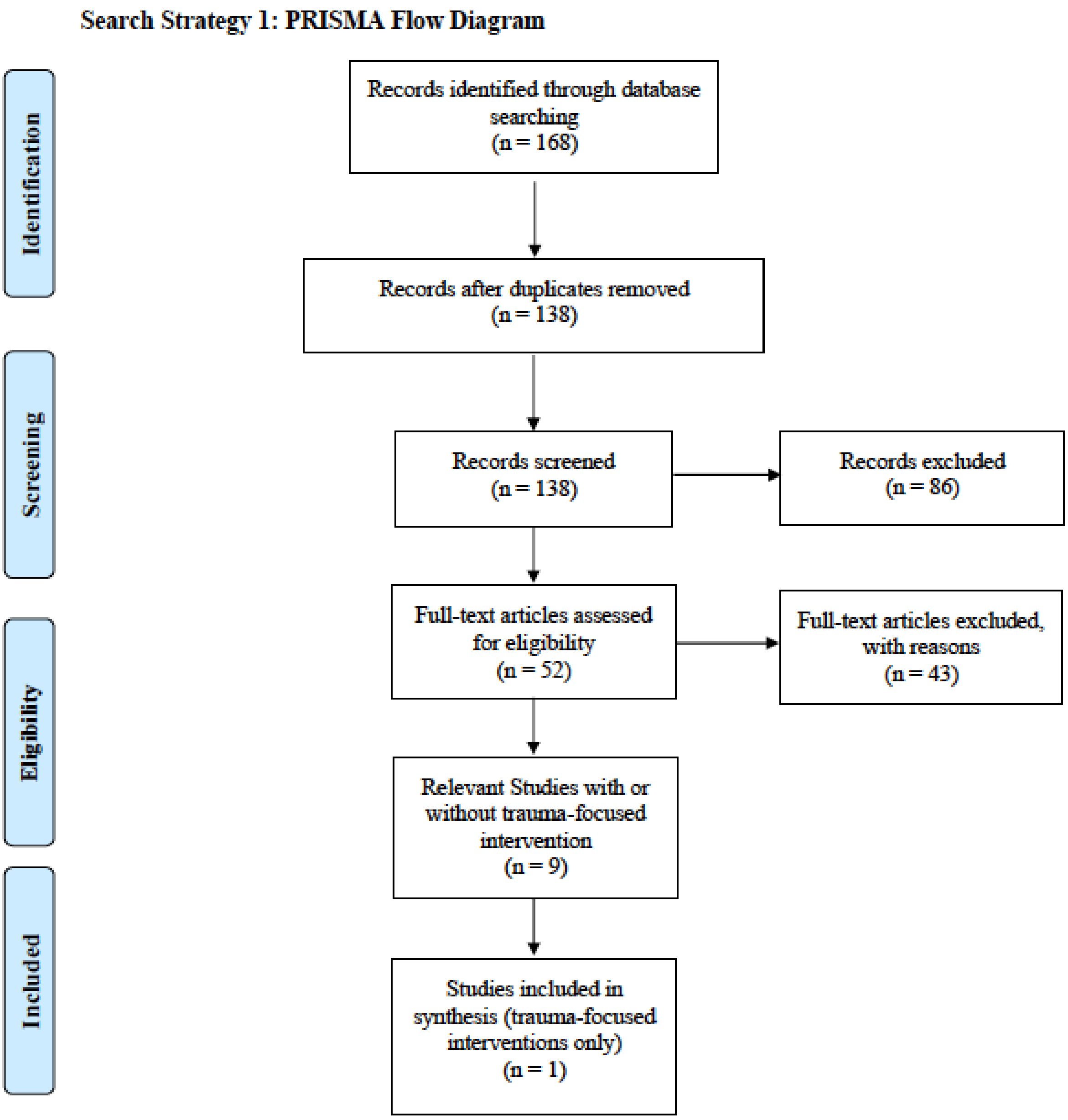
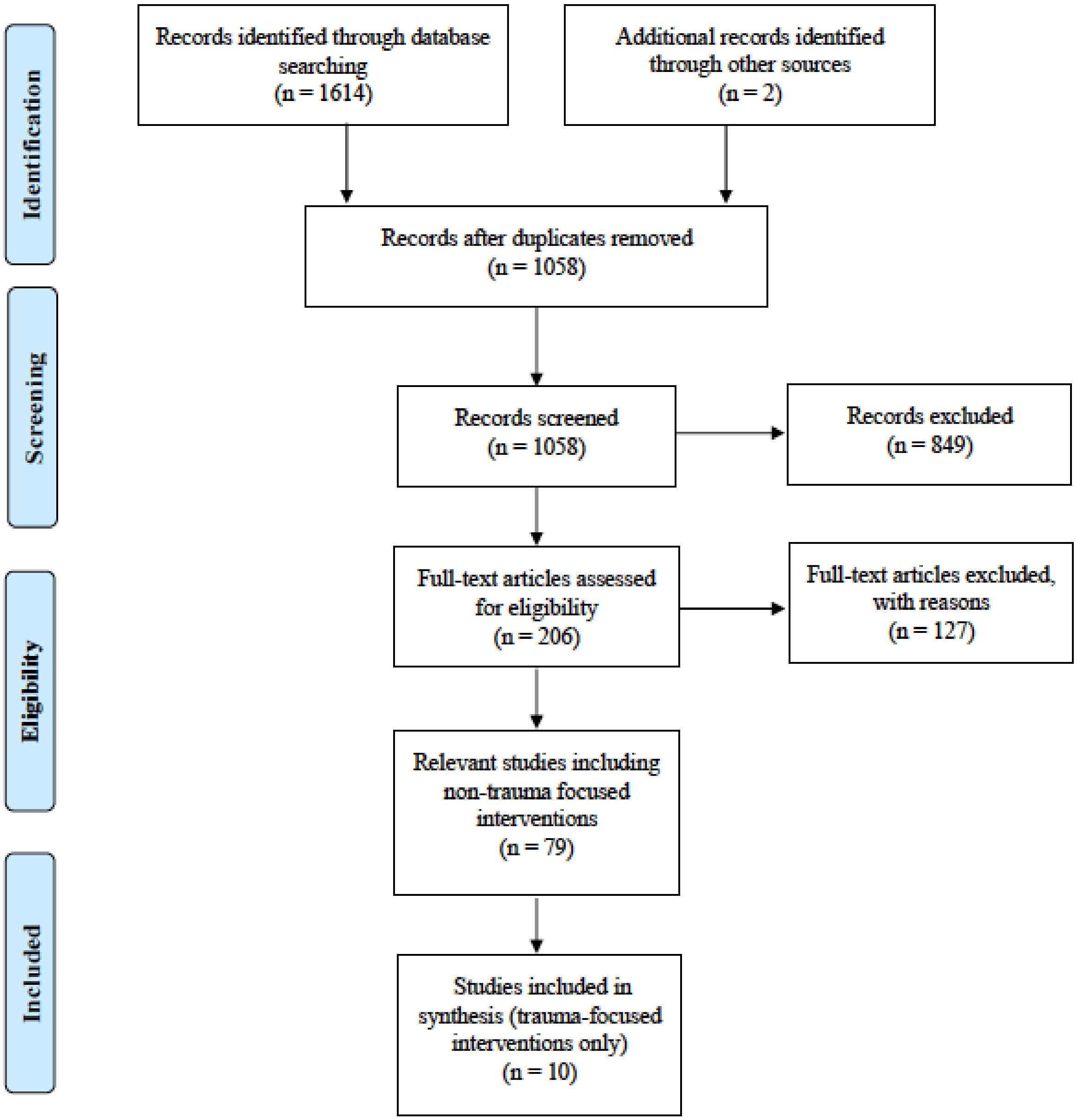
Appendix A: PRISMA Flow Diagrams

PRISMA Flow Diagram for Search Strategy 1



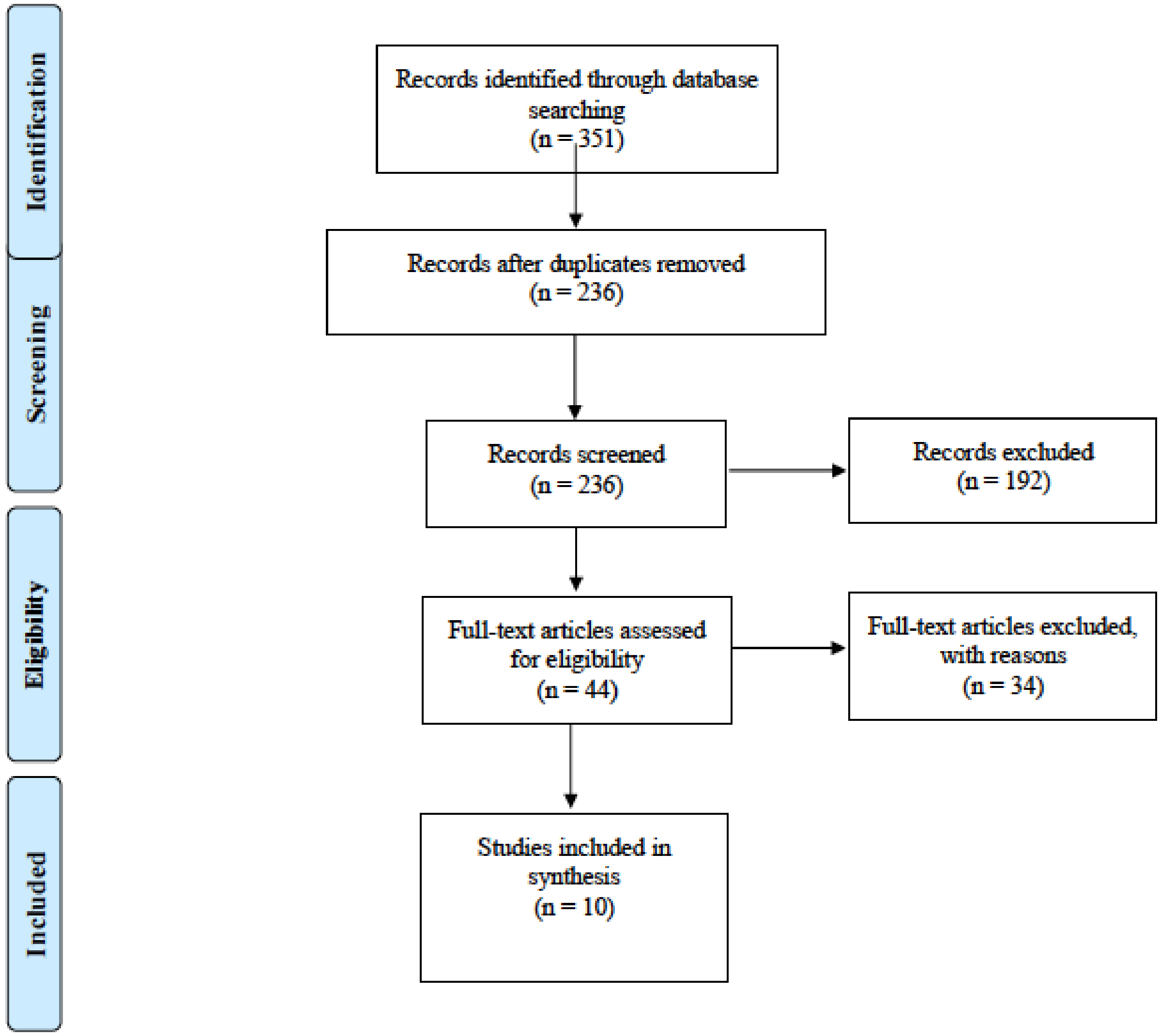
PRISMA Flow Diagram for Search Strategy 2



Search Strategy 2: PRISMA Flow Diagram

PRISMA Flow Diagram for Search Strategy 3

Search Strategy 3: PRISMA Flow Diagram



Appendix B: Extraction Table for Rapid Evidence Assessment

Author(s)	**Date of Publication**	**Title**	**Type of Publication**	**Population Studied and Country**	**Setting (e.g., Primary Care, community)**	**Virtual Care Intervention/Technology Implemented to Address Domestic Violence and/or Intimate Partner Violence**	**Outcomes Measured and Results (what do the authors include about the a) *acceptability*, b) *feasibility*, and c) *effectiveness* of the intervention)**	**Equity Considerations (i.e., gender-responsive approaches to trauma, sub-population differences; inclusion of vulnerable population groups)**	**Challenges or Barriers to Implementing Virtual Care to Address Domestic Violence**
Anderson, Krause, Krause, Welter, McClelland, et al.	2019	Web-Based and mHealth Interventions for Intimate Partner Violence Victimization Prevention: A Systematic Review	Systematic Review	Population of study were adults or youth in romantic relationship (including sex workers, same-sex couples, pregnant and prenatal mothers, perpetrators and victims).The authors did not provide the complete list of countries, however, they indicated that 23 studies were conducted in USA and only one was from low- or middle-income country (Cambodia).	Outpatient medical Psychology/therapy Academic/research Community organization	Yes, the systematic review was focused on mHealth interventions for IPV. The authors provide their findings as following: "The most commonly identified mHealth components were web-based educational content that was not responsive to user input (e.g., self-paced, click-through tutorials; and interventions where the outcome was dependent on use of computer hardware (e.g., tablet-based screening that automatically flagged a health-care provider)....two studies developed or tested a proprietary or made-for-purpose prevention app (including one proof-of concept study with no field testing), and no studies used major social media/communication platforms (e.g., Facebook, Instagram, and WhatsApp) to deliver their respective interventions. The remaining studies programmed web- or hardware-accessible platforms (e.g., e-mail) without developing new software (or else did not describe the platform)"	The authors state the following: "Feasibility and acceptability were found to be generally high where assessed (23% of studies, n= 7). There was limited evidence around whether mHealth interventions better addressed population needs compared to conventional interventions. mHealth tools for IPV prevention are especially acceptable in health-care settings, on mobile phone platforms, or when connecting victims to health care. Despite enthusiasm in pilot projects, evidence for efficacy compared to conventional IPV prevention approaches is limited. A major strength of mHealth IPV prevention programming is the ability to tailor interventions to individual victim needs without extensive human resource expenditure by providers." (pg. 1). In general, mHealth interventions are acceptable and feasible in terms of ensuring anonymity, easy access to resources and ability to provide personalized service.	The authors used equity lenses to assess their findings. They reported that interventions that were "victim oriented" was focused only on women (no other genders included), 77% of the interventions indicated they were exclusively delivered in English and only one was delivered in Spanish. Three studies included pregnant women, and three considered cultural adaptation for the included minority women. One study was from low-income country (Cambodia).	The authors indicated that barriers were not clearly described in the included studies. However, they highlight "unacceptable platforms, especially if participants have to download software or learn how to use new hardware" (pg. 10) are potential barriers to implementing mHealth. That being said, dropout rates in mHealth interventions are lower than in-person interventions. This was explained as people are more comfortable to disclose their circumstances virtually better than in-person.

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						(pg. 4-5). Three interventions included CBT (2 studies delivered CBT through telehealth video and one through web-based system).			
Bloom, Glass, Case, Wright, Nolte & Parsons	2014	Feasibility of an Online Safety Planning Intervention for Rural and Urban Pregnant Abused Women	Evaluation Study	Pregnant mothers at risk of DV in rural and urban area	Community	The researchers used and evaluated a tailored version of the Internet-based safety decision aid. This tool was initially developed with input from IPV survivors, domestic violence advocates, and IPV experts. This tool provides personalized "safety plan, including assessment of women's safety behaviors, a priority-setting activity, and risk assessment" (pg. 2).	The program was more accessible to urban mothers compared to rural. The authors attribute this to "isolation and/or concerns about privacy, anonymity, or confidentiality may also have increased rural women's reluctance to identify friends or family as safe contacts or to use less private options, such as a computer at a family member's or friend's house, library, or a public health department" (pg. 7).	The study focused on vulnerable population (pregnant mothers, rural pregnant mothers). The tool also includes a feature that is specific for mothers in same sex relationships. However, the authors also highlight that this tool is not accessible to women who are not computer literate or lack Internet or safe computer access, and those who do not know English. That being said, such tools could also be	Barrier in accessibility in terms of access to internet or devices (computer, mobile).

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								"attractive to women of color is critically important, given that abused pregnant racial minorities are less likely to access help from the formal systems where they might receive safety planning" (pg. 8).	
Brignone & Edleson	2019	The Dating and Domestic Violence App Rubric: Synthesizing Clinical Best Practices and Digital Health App Standards for Relationship Violence Prevention Smartphone Apps	Evaluation Study	N/A	N/A	This review specifically assessed smartphone apps for dating and domestic violence. In general, the authors indicate that there is important requirement for an app to be eligible to serve DV population the: the app's ability to address the safety of users (e.g. put into consideration that the perpetrator may have access to the victim's smartphone). The authors rated all the included apps as low-quality, middle quality and high-quality in terms of performance as apps and their performance as interventions for dating and DV.	The authors indicated that most of the apps included in the study were difficult to find on App store reducing their visibility and accessibility. Also, many of the apps have limited scope (target), i.e. female victims with male perpetrator. In terms of App efficacy, the authors highlight "because smartphone apps do not undergo a formal vetting process before release, the health- or safety-related quality of their content is not guaranteed" (pg. 8). Apps that provide collaborative measures and that are interactive have better health benefits and are used more frequently, thus are rated higher. Examples of these apps are LifeFree, ASK, Youth Pages. On the other spectrum, there are Apps that were not properly developed such as iHope and WIC which tend to be more harmful to survivors by proving advice contrary to evidence-based practice. These apps include "victim-blaming language and recommendations to seek couples counseling or anger	The authors highlighted gender-gap in interventions currently available through an app (female victim focused). Additionally, they addressed the issue of applicability of intervention content based on the different contexts of users. In this case, apps such as Circle of 6 and Circle of 6 U, LiveFree and Youth Pages were identified as being mindful of "their users, their users' context, the desired outcomes of the intervention and the appropriateness of their theory of change to an app-based platform" (pg. 10).	User attrition was identified as a potential challenge to implementing app-based DV interventions. The authors state, "app-based and other eHealth interventions are likely to be most effective when used to supplement or facilitate (rather than replace) professional care, a concept known as supportive accountability" (pg. 8). In terms of technical quality, the authors state, "smartphone industry norms predict regular hardware updates and frequent software updates; these may change the display of user interfaces programmed prior to the update and the nature of interfaces with which users expect to interact. As a result, apps that are not regularly updated may experience flaws in their display and outdated interfaces that may no longer be natural to users. These issues affect apps (such as Daisy and Over the Line) that in all other ways are considered high quality

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							management" (pg. 9). Therefore, the authors recommend that "app consumers, especially those recommending apps to other potential users, must be meticulous about which apps they recommend" (pg. 9). In terms of App security, some app features such as push notifications, and GPS can put victims at higher risk because the perpetrator can track, access, or view the lock screen of the victim's phone. "For this reason, app features such as passwords, hidden panels, no-cost accessibility and the user's ability to disable push notifications, location access, and other features are critically important" (pg. 9).		by this review" (pg. 9). Also, most apps do not store user data with adequate security provisions, which is potentially harmful to the users.
Constantino, Braxter, Ren, Burroughs, Doswell, Wu, ... & Greene	2015	Comparing Online with Face-to-Face HELPP Intervention in Women Experiencing Intimate Partner Violence	RCT	Female survivors of IPV (who are not living with perpetrator) in Pittsburgh, Pennsylvania, USA	Participant Home (computer)	The intervention group received online version of the HELPP (Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred) intervention. The intervention consisted of six modules: (1) Personal Thoughts, Emotions, and Behavior; (2) Interpersonal Relationships and Healing in Telling; (3) Health in HELPP; (4) Education on Safety in HELPP; (5) Legal Matters in HELPP; and (6) Community and the A-B-Cs of Empowerment. These models were delivered through email weekly.	The researchers used the WHO ecological model to assess research outcome. At the personal level they measured for anxiety and depression; at the interpersonal level they measured for anger and personal support; and at the community level they measured for social support and employment. "The HELPP intervention (1) decreased anxiety, depression, anger, and (2) increased personal and social support in the Online group. The HELPP information and intervention was shown to be feasible, acceptable, and effective among IPV survivors compared with participants in the [control] group" (pg. 430).	The researchers enrolled only female survivors (45% Asian, 32% White, and 23% Black). All survivors had protection order against their perpetrators. The survivors had to speak and read English and own a computer with internet connection to be able to participate in this study. Thus, it may not have been accessible to people from lower socioeconomic status or those with language barrier.	The authors did not discuss challenges or barriers to implementation; however, they identified some limitations of the study which include: (1) due to the short duration of the intervention (6 wks.) they could not be sure how sustainable the outcomes could be; and (2) they indicate having a follow-up would have provided better understanding of how long the outcomes could last.

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El Morr & Layal	2020	Effectiveness of ICT-based intimate partner violence interventions: a systematic review	Systematic Review	Women who experienced intimate partner violence or domestic violence. Majority of studies were from USA (n=20) followed by Canada (n=3), New Zealand (n=1) and Australia (n=1)	Different settings (community, primary care clinic, hospital, university, social services facilities, and legal services facilities)	These researchers reviewed studies that used Information and Communication Technologies (ICT) to provide care and services to women experiencing IPV or DV. They included all types of potential interventions (awareness, screening, prevention, mental health treatment). Six of the 25 included studies used online tools to address the mental health of women experiencing IPV or DV. Within these studies five studies measured depression, three studies measured anxiety and two measured stress. One study in particular addressed the treatment of IPV-related trauma through video conferencing, and measured PTSD outcomes (Note this study is already included in our analysis: Hassija and Gray). The other type of studies included are those that provide empowerment and support for women such as self-efficacy and safety decision aids (n=3). These studies focused on women creating a safety and/or action plan in the event of a future partner abuse incident and two of them also provided additional local resources.	The authors indicated that although all mental health intervention studies reported improvements compared to control, they highlighted there was lack of "homogeneity among the studies' outcome measurements and the sample sizes, the control groups used (if any), the type of interventions, and the study recruitment space." They concluded that these RCT studies are not generalizable due to lower sample size and did not include women from diverse populations. For the empowerment and support studies, the authors indicate that these interventions were more effective: "In one study, 90% of the participating women who used ICT reported leaving their abusive partner within the year, and in another study 64% of the participating women reported the intention to make changes in regard to their IPV within 30 days to 6 months. In terms of decision-making and self-efficacy, two studies reported that more than 78% of the participants acquired general skills through the ICT-based interventions, and two other studies reported that participants gained decision-making skills through the ICT-based interventions. Additionally, using their new skills, women experienced lower decisional conflicts and had an overall	This review focused on women experiencing DV or IPV, thus was not inclusive of all genders. This review focused on women experiencing DV or IPV, thus was not inclusive of all genders. The authors also highlight that given the devices required for the interventions (i.e. computer, tablets, phones) are costly for some individuals, these interventions may not be inclusive of those with lower-socioeconomic statuses. Additionally, they indicated given using these interventions would also require basic knowledge of technology, it may not be inclusive of those without basic IT literacy. In terms of diversity of the included participants, the authors claim that immigrant and Indigenous women were not included in these studies. The authors also note that women with disabilities were not included in these studies, and minimal literature was available on ICT intervention accessibility for the population.	The authors highlight this as an actual limitation of the included studies. They indicate that studies do not discuss challenges and barriers to implementing ICT. The authors, however, bring up an important point regarding safety and ethics. They state, "Ethical challenges related to the safety of women increase when women are sharing cell/smart phones with perpetrators; in such contexts special considerations should be taken care of, including "safety by design" [109]." (Pg. 8)

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							less difficult time deciding on their actions." (pg. 7)		
Hassija & Gray	2011	The Effectiveness and Feasibility of Videoconferencing Technology to Provide Evidence-Based Treatment to Rural Domestic Violence and Sexual Assault Populations	Primary Research	Rural survivors of domestic violence and sexual assault in Wyoming USA	Rural domestic violence and rape crisis centers (Wyoming Trauma Telehealth Treatment Clinic (WTTTC))	Female survivors (n=15) of domestic violence and sexual assault were given four sessions of trauma-focused treatment using remote videoconferencing	The authors indicate that the provision of trauma-focused treatment to DV and SA survivors is effective and acceptable because the survivors' showed "large reductions on measures of PTSD and depression symptom severity following treatment via videoconferencing" (pg. 1). Also, the participants reported "high degree of satisfaction with videoconferencing-administered services" (pg. 1).	Participants in this study were all female and 80% were white residing in rural Wyoming. Additional information on their socioeconomic, education, employment, etc. status was not provided. Thus, it is not clear if an equity lens was applied in delivering the trauma-focused treatment.	The authors did not specifically discuss implementation barriers; however, they were only able to enroll 15/39 participants into the full study because "clients [were] unable to commit to an extended course of therapy by virtue of relocation, unyielding work schedules, etc." (pg. 3). Which could be considered as a challenge when providing such care to rural residents. Also, the authors highlight that virtual delivery of trauma focused treatment may not be safe for suicidal survivors because of "unclear ability to manage such crises distally" (pg. 5).

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Hegarty, Tarzia, Valpied, Murray, Humphreys, Taft, ... & Glass	2019	An online healthy relationship tool and safety decision aid for women experiencing intimate partner violence (I-DECIDE): a randomized controlled trial	RCT	Women (16-50 yrs. old) in IPV relationships, with safe access to computer/internet and understood English. In Australia	Wherever participants could find safe access to computer/internet	Online interactive healthy relationship tool and safety decision aid (I-DECIDE)	"The intervention website consisted of modules on healthy relationships, abuse and safety, and relationship priority setting, and a tailored action plan. The control website was a static intimate partner violence information website" (pg. 301). The hypothesized outcome was that the I-DECIDE program would increase self-efficacy and improve depression, fear, and helpful actions. However, results show that the intervention was not effective in comparison with the control group. That being said, the participants in both study arms improved their scores for self-efficacy, depression, and fear of partner over time and had better perceptions of support. The authors state, "evidence to date suggests that in the general population, online interactive intimate partner violence interventions are no more effective than static intimate partner violence websites in reducing women's exposure to violence or victimization, improving mental health symptoms, or strengthening self-efficacy. However, these interventions are acceptable to women and can be safely used. There is a small amount of evidence that online decision aids can reduce decisional conflict, but how useful this outcome is for women remains to be elucidated. Further research is urgently needed into meaningful outcomes and helpful components in online intimate partner violence trials" (pg. 302).	This intervention did not apply equity lens to enrolling participants, the participants were women, with access to safe computer and/or internet, and understood English.	Challenges and barriers to implementation were not discussed.

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Hill, Zachor, Jones, Talis, Zelazny & Miller	2019	Trauma-Informed Personalized Scripts to Address Partner Violence and Reproductive Coercion: Preliminary Findings from an Implementation Randomized Controlled Trial	RCT	English-speaking females, ages 16–29 years) in Chicago, Illinoi, USA	Family Practice clinic	The virtual care was provided using an interactive app that facilitated discussion between provider and client. Study participants were randomized either into a Trauma-Informed Personalized Scripts (TIPS)-Plus or TIPS-Basic. Both study arms received an app prompted tailored provider scripts, and those in the (TIPS)-Plus received psychoeducational messages in addition. The app randomized individual participant either study arm, "then presented questions about the patient's sexual/reproductive health and experiences with IPV and RC; her responses triggered a series of specialized scripts. These scripts would prompt the provider to discuss specific topics, such as fear, safety, harm reduction strategies, and universal education about IPV/RC, without necessitating disclosure during the visit; only the scripts, not the patient's specific responses, were shown to the provider. Patients assigned to TIPS-Plus also received psychoeducational feedback on healthy/unhealthy relationships while answering questions on the tablet-based app. The messages were embedded into the app and tailored to their responses" (pg. 2).	To be clear this study aimed to assess the effectiveness of the app in prompting discussion between provider and client on sensitive topics such as IPV. In that sense, the researchers did not find statistically significant difference in disclosure of IPV by participants in either study arm. They indicate, "the lack of significant findings points to the extraordinary barriers patients have to overcome to initiate a conversation about harmful partner behaviors, including fear of judgment by providers, fear of retribution by a partner, and societal stigma more generally" (pg. 870). However, they note that their research can contribute to "the larger evidence base on how to utilize apps to provide patients with personalized, tailored, health education messages" (pg. 872).	Participants were all young female (16 - 29 years old); 70% were white and all spoke English.	Barriers and challenges with implementation were not discussed

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Jones, Shealy, Reid-Quiñones, Moreland, Davidson, López, ... & de Arellano	2014	Guidelines for Establishing a Telemental Health Program to Provide Evidence-Based Therapy for Trauma-Exposed Children and Families	Other	Youth and Families exposed to trauma, South Carolina, USA	Not specifically discussed, but this paper is more focused on providing guidelines for how to setup evidence-based trauma-focused telemental health.	Guidelines on how to setup, use and deliver trauma focused, cognitive-behavioral therapy (TF-CBT) via telemental health videoconferencing technology through an existing community outreach program is discussed in this paper.	There is no discussion of outcomes because this is a guideline. However, it may be important to include here the recommended guidelines and the background of the community outreach program that participated in this program development and delivery. "The Community Outreach Program-Esperanza (COPE) is a community-based program in South Carolina that provides evidence-based, trauma-focused assessment, therapeutic interventions, and referral for youth ages 4–18 and families who have experienced a range of traumatic events" (pg. 3). COPE serves a range of underserved communities, however, was not able to reach some families who live far from the center. Therefore, they introduced encrypted, confidential videoconferencing technology to serve more people in need. Based on the experience of COPE in delivering remote trauma focused care, the authors provided the following guidelines for setting up telehealth services: (1) Make sure to establish and/or utilize partnership with communities in need; (2) Ensure to have a clear understanding of all expectations from all parties of the partnership; (3) Ensure to have the necessary technological and equipment setup; (4) Ensure to have the	COPE the community agency that provided the virtual care focuses its services to underserved populations (ethnic minorities, individuals residing in rural/remote areas, and economically disadvantaged populations). This agency "attempts to address cultural barriers by offering culturally-modified, evidence-based trauma treatments, led by bilingual/bicultural clinicians, for Hispanic children and families" (pg. 4). The authors also cite the literature to recommend "clinicians be aware of the family's views of trauma and potential cultural constructs, such as acculturation and ethnic identity, which may impact the treatment process." (pg. 4).	Challenges and barriers were not discussed because this was not an implementation study.

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							necessary videoconferencing software; (5) "The physical space of the satellite clinic in which services are conducted should mimic a therapy room as much as possible" (pg. 8); (6) Setup a clinical administration system where referrals are processed or have a plan how referrals and other admin related issues are processed; (7) Know how to cover startup costs (govt fund, grants, etc.) and how service reimbursements work in your state (province); (8) Therapists should do the necessary preparations and possible modifications to deliver the treatment virtually; (9) Ensure the content is culturally-relevant to target population.		
McFarlane, Malecha, Gist, Watson, Batten, Hall &Smith	2004	Increasing the safety-promoting behaviors of abused women	RCT	English or Spanish speaking women that qualified for a protection order against a partner. Texas, USA.	Wherever participants could find safe access to a phone	Safety-promoting behaviour checklist provided over the course of 6 phone calls, with follow-up calls at 3, 6, 12, and 18 months post-intervention.	The authors state that the intervention was efficacious in that the number of safety-promoting behaviours in the treatment group was greater than in the control group, an effect which was consistent throughout the duration of the study. The participants in the treatment group also increased the number of safety-promoting behaviors that they performed, and the behaviors remained stable through the study.	The behaviour checklist was provided in both English and Spanish, and African American, Latino, and White participants were fairly evenly represented across both control and treatment groups.	Challenges and barriers were not discussed.

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Moeini	2006	Development And Evaluation of aMobile-Based Weighted Wellbeing Scoring Function For Trauma Affected Communities	Dissertation	English-speaking participants residing in Pittsburgh, Pennsylvania, USA	Free Health Center	This is a dissertation with multiple phases and lots of technical steps (app design, development and application). For the purposes of our project, we will extract data related to the Trauma focused intervention delivered through an app. The author tailored and evaluated an app-based trauma-focused intervention specifically for the needs of communities in which trauma and violence.	The author mainly measured the efficacy of the app by testing the usability and user satisfaction, and the participants rated the final product with high satisfaction. The author concludes that "has helped to initiate projects which will help to address the area of TACs with novel implementations of various mobile based tools" (pg. 93).	All participants spoke English; thus language barrier was not addressed. The participants were representative of male and female genders, of various age group (18 - over 55), with various levels of education (GED to PhD). All participants owned a smart phone and 88% use it daily.	Barriers and challenges with implementation were not discussed because this study was only in the prototype phase. It was not implemented in a community or other setting for larger use.
Moring, Dondanville , Fina, Hassija, Chard, Monson et al.	2020	Cognitive Processing Therapy for Posttraumatic Stress Disorder via Telehealth: Practical Considerations During the COVID-19 Pandemic	Narrative or Literature Review	N/A	N/A	In this paper, the authors specifically discuss the utilization of telehealth in providing therapy. They define telehealth as "behavioral health services that are delivered via communication technologies, such as telephone and clinical video teleconferencing" (pg. 2). The focus of this paper is the use of video conferencing.	The authors indicate that the effectiveness of CPT stays consistent with in-person delivery when it is provided through telehealth. This method was specifically tested for effectiveness and feasibility on DV and sexual assault survivors (n=15) in 2011, results of this uncontrolled RCT indicate that CPT delivered through telehealth was able to reduce symptoms of PTSD and depression in the survivors of DV and SA. The authors conclude "the existing research shows that telehealth can be used effectively to deliver CPT to a diverse range of trauma survivors" (pg. 3). However, for the current Covid-19 context, they provide specific guidelines on how to implement CPT via telehealth. In terms of acceptability, the authors indicate that evidence regarding acceptability of telehealth by clients is limited, however, compared to other modalities of delivering virtual care telephone	Equity considerations were not discussed in detail this paper.	Some barriers to implementing telehealth include technological issues such as unstable or unreliable video streaming. Specific to CPT however, the authors highlight "telehealth can create other challenges due to factors that may be apparent during an in-person visit that may be easy to miss in telehealth sessions" (pg. 7).

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							care seems to be more acceptable.		
Nguyen-Fang, Frazier, Greer, Meredith, Howard & Paulsen	2016	Testing the efficacy of three brief web-based interventions for reducing distress among interpersonal violence survivors	RCT	Undergraduate students with and without a history of IPV at a large Midwestern university, USA	Wherever participants access their personal computers	The authors developed 3 web-based interventions based on the concept of present control (PC) to reduce perceived stress. The original PC intervention was tested previously, and 2 new versions were developed and tested in comparison. The original PC intervention involved educational modules describing areas in which participants do and do not have control. The enhanced PC intervention has the same modules as the original with the addition of systematic and detailed PC exercises. The PC + mindfulness intervention also has the original PC modules plus mindfulness exercises to reduce rumination.	The effect of all 3 interventions on participants with a history of IPV resulted in significant reductions in distress and perceived stress measures. The enhanced PC intervention had the most significant effect on outcome measures for IPV participants. The authors state that although the effect sizes were in the small to medium range, likely due to the number of participants, all 3 interventions have shown to be efficacious in reducing distress, stress, and worry in participants with a history of IPV. This effect weaker for participants without a history of IPV.	The participants were predominantly female (63%) and white (79%).	Challenges and barriers were not discussed.

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Paul, Hassija & Clapp	2012	Technological Advances in the Treatment of Trauma: A Review of Promising Practices	Narrative or Literature Review	N/A	N/A	This paper provides overview of the three most common technologies that are used to provide trauma focused treatments (videoconferencing, e-Health, virtual reality) specifically for PTSD.	(1) Videoconferencing: The authors state, "empirical investigations of videoconferencing have generated initial support for the technology as a feasible and effective means to provide psychological services to diverse client populations" (pg. 899) specific to trauma focused care. These include provision of Telepsychiatry, Individual Psychotherapy and Group-Based Psychotherapy. The authors add, studies indicate that videoconferences are acceptable by clients and have same retention rate as in person treatment. These studies are focused on delivery of videoconferencing in remote communities. (2) e-Health: the fact that 80% of population in USA have access to Internet and search for health-related information online, the authors assume that e-Health is an effective approach to also delivering trauma-focused treatments for people suffering with PTSD. They add, e-Health interventions have been shown to be effective with respect to symptom reduction in RCTs. (3) Virtual Reality: "appear acceptable to clinicians and patients, and evidence effectiveness in populations that are historically difficult to treat. The existing data are inconclusive as to whether VR-assisted interventions provide	The authors state, "videoconference technology affords not only convenience but also a means to specialized mental health services for underserved and rural populations" (pg. 903). Similarly, they indicate that e-Health services can be used to provide treatment to those who would not otherwise receive it. However, the authors do not consider other vulnerable populations in their discussion. Although these services are possibly accessible to rural communities, they are not taking in to consideration cultural needs, language barrier, affordability and access to internet by other underserved communities. The authors also support this concept by indicating, "further empirical evaluations are greatly needed in this area, including the use of broader, more generalizable participant populations" (pg. 907).	In terms of videoconferencing challenges were mentioned in regards to the impact of distal services on the therapeutic alliance, confidentiality, and patient safety, thus the authors recommend adherence to ethical guidelines, conducting comprehensive intake procedures to assure appropriateness for treatment, and ensuring patients and providers access to on-site mental health providers and security staff (pg. 903). Additionally, technical issues were mentioned as possible challenges. In the case of e-Health, "many concerns have arisen about e-Health, including logistical (e.g., attrition, under engagement) and ethical (e.g., health disparities, user-identity assurance, privacy, crisis management) issues" (pg. 907).

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							additional benefit beyond established exposure-based therapies for PTSD" (pg. 912). Additionally, the authors highlight that virtual realities are supposed to supplement not replace traditional approaches.		
Ragavan & Bair-Merritt	2020	Thrive: A Novel Health Education Mobile Application for Mothers Who Have Experienced Intimate Partner Violence	Evaluation Research	The researchers/app developers are based in the USA	Not discussed	This article describes "the development and formative evaluation of a trauma-informed, user-friendly Smartphone based mobile application (app) to address the unmet health needs and improve the well-being of mothers who have experienced IPV. A multidisciplinary team of IPV experts developed the app (called Thrive) in partnership with software developers. Thrive includes three sections: Myself (maternal self-care, stress coping skills), My Child (stress signs in children, talking to children about IPV, mother–child dyadic communication), and My Life (hospital- and community-based resources)" (pg. 160).	The app was evaluated through feedback from IPV survivors, social workers, IPV advocates, and health care providers. These users reported that the app is user friendly, informative, trauma informed, and a potential alternative to handouts. Based on the initial feedback the authors indicate that the app is acceptable. Some survivors even indicated that the app could have been helpful for when they were in the abusive relationship. The app also includes some safety features such as password protection, quick exit button and the name and design of the app is not indicative of IPV support (disguised well). However, the researchers plan to update the app (Thrive) based on additional user feedback, disseminate it to IPV survivors around the country and evaluate it using a longitudinal outcome evaluation. Thus, they did not provide more detail on its effectiveness and	The app was developed in collaboration with key stakeholders including IPV survivors, these stakeholders requested that the app be "be tailored to the local community, be relevant for a diverse audience, and include multiple media types" (pg. 161) and thus the pilot app was designed per the requests and needs of these stakeholders. However, details of socio-cultural and socioeconomic backgrounds of these stakeholders was not provided.	Challenges and barriers were not discussed.

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							feasibility. The users also recommended that the app "be more interactive, allowing users to create goals, talk with other IPV survivors, and personalize the resource section. Participants also suggested providing multiple options for audio portions, so users can choose a voice they find most calming" (pg 161). This is potentially key information in terms of knowing what IPV survivors need from a virtually provided care.		
Rempel, Donelle, Hall & Rodger	2019	Intimate partner violence: a review of online interventions	Scoping Review	This review included studies conducted in the USA; New Zealand and Canada. Target groups were mothers and their children, pregnant women, rural women, and college students who have experienced IPV (currently experiencing IPV and survivors). Participants who have access to internet.	The setting was not specifically discussed, however, given mothers who have access to internet were the participants in the study, it must be community setting.	Included studies focused on Smart phone App -or computer-based decision support safety aids (please see additional notes for more information on how the authors assessed and reported their findings). Specifically studies used the following forms of intervention: 1. Computerized safety decision aid (three studies); 2. Online Survey; 3. Email interaction with a nurse; 4. LEAF: A privacy-conscious social network-based intervention tool for IPV survivors; 5. Internet-based or app-based safety planning (two studies); 7. Trauma-focused treatment via videoconferences; 8. Confidential online	The authors reported their results in terms of the *Reclaiming Self theory* Framework, which is an important framework but not relevant to our study. Therefore, the outcomes of each included intervention will be discussed here. (1) Computerized safety decision aids were described as useful and private by the participants. (2) The online survey does not seem like an intervention because researchers only collected data on frequency of IPV and awareness of victimization or perpetration behaviors. (3) Email between nurses and survivors included concepts of safety, job-, school-, health-, and parenting-related issues, and the authors indicate that such	The included papers were inclusive of rural residents, and pregnant mothers. However, although this level of assessment may not have been within the scope of this scoping review, the equity considerations in terms of language-barrier, technological access, socioeconomic barrier (unable to afford internet access, phones, computers) and cultural-relevance were not discussed. Also, all the included studies are from high-income countries. That being said, Anderson et al (2019) (study extracted below) reported that 90% of people residing in USA have access to internet. Additionally, the included interventions included only	Challenges and barriers were not discussed.

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						sessions; 9. Online HELPP (Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred) intervention	an approach is feasible and acceptable by survivors of IPV. (4) The findings of LEAF (A privacy-conscious social network-based intervention tool for IPV survivors) were not discussed. (5) The internet-based safety planning intervention was considered safe and accessible (74% of participants completed the sessions with "no adverse events" (pg. 7). (6) The app-based safety planning intervention was considered acceptable, and feasible based on participants' feedback. The app app provides personalized information about abusive dating relationships and appropriate resources in a private, safe, and nonjudgmental manner. (7) The evidence-based trauma-focused treatment was provided via videoconference to rural survivors of domestic violence and sexual assault. "Participants received at least four treatment sessions) treatment via videoconferencing-based technology at crisis centers." (pg. 7). the delivery of treatment via videoconferencing was considered effective in this study. (8) The online-based HELPP (Health, Education on Safety, and Legal Support and Resources in IPV Participant Preferred) intervention was effective in reducing anxiety	women (excluding other genders).	

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							and depression and increasing social support in survivors of IPV.		
Stewart, Orengo-Aguayo, Cohen, Mannarino & de Arellano	2017	A Pilot Study of Trauma-Focused Cognitive–Behavioral Therapy Delivered via Telehealth Technology	Primary Research	Children and youth (7-16 years old) referred to a trauma treatment center in SE USA	Home or local school	Trauma-focused cognitive–behavioral therapy (TF-CBT) was delivered to underserved trauma-exposed youth via telehealth technology (i.e., via one-on one videoconferencing).	This was a pilot test with n=15 participants, however, the preliminary results indicate that participants showed clinically significant reduction in PTSD symptoms and the dropout rate was zero. Therefore, the authors conclude that the delivery of TF-intervention via video conferencing is promising. The videoconferencing software, Vidyo, was used to remotely deliver care in this study.	The participants profile looks like the following: "93.3% female, 46.7% Hispanic, 40.0% African American, and 13.3% Caucasian. Five participants lived in a rural location (distance to clinic 40–110 miles) and 10 participants lived in underserved urban locations. Five youth had an index trauma of sexual abuse, one had an index trauma of physical abuse, three experienced the traumatic loss of a loved one, two witnessed the armed robbery of a family member, one witnessed the physical abuse of a sibling, and three experienced multiple traumas. All children met criteria for PTSD" (pg. 326). Before this study, the participants had barriers in accessing care due to language barrier, lack of transportation, caregiver work schedule and rural settings; these barriers were mitigated by the remote delivery of care. The treatment was provided in two languages: English and Spanish. In addition, the researchers ensured that logistical, perceptual, and cultural barriers including	The authors mention some technical challenges with the telehealth equipment (e.g. login problem) and delays due to WIFI problems.

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								"ethnocultural beliefs and attitudes related to mental health treatment" (pg. 6) were addressed during the interventions.	
Stewart, Orengo-Aguayo, Young, Wallace, Cohen, Mannarino & de Arellano	2020	Feasibility and Effectiveness of a Telehealth Service Delivery Model for Treating Childhood Posttraumatic Stress: A Community-Based, Open Pilot Trial of Trauma-Focused Cognitive–Behavioral Therapy	Primary Research	Children and adolescents aged 7 to 18 struggling with PTSD as a result of physical abuse, sexual abuse, witnessing domestic or community violence, violent or unexpected death of a loved one in South Carolina, USA	Medical Center	Telepsychotherapy a type of e mental health or telehealth was delivered to trauma exposed children and youth (n=70).	The authors indicate, "88.6% completed a full course of TF-CBT and 96.8% of these treatment completers no longer met diagnostic criteria for a trauma-related disorder at posttreatment. Results demonstrated clinically meaningful symptom change posttreatment, with large effect sizes evident for both youth and caregiver-reported reduction in posttraumatic stress disorder symptoms. The results observed in this pilot evaluation are promising and provide preliminary evidence of the feasibility and effectiveness of this novel treatment format" (pg. 274-275).	The children and youth were identified as being from an underserved population of South Carolina. Additionally, a wider range of diverse subgroups were included (58.6% Hispanic, 30.0% African American; 34.3% of children and 57.1% of parents requesting Spanish-language materials and services) (pg. 284-285). The treatment was also available in two languages (English and Spanish).	The intervention was successfully implemented and barriers or challenges were not discussed, however, this is a pilot study with small sample.

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Valentine, Donofry, Broman, Smith, Rauch, & Sexton	2019	Comparing PTSD treatment retention among survivors of military sexual trauma utilizing clinical video technology and in-person approaches	Primary Research	Military Sexual Assault Survivors, USA	Veteran Medical Center and Homes of survivors	Trauma focused Treatment (Prolonged Exposure or Cognitive Processing Therapy) was delivered via clinical video technology to military sexual trauma survivors struggling with PTSD. These survivors were given a choice to enroll in remote delivery (clinical video technology) or in person therapy.	Overall, full completion rate was similar between in-person delivery and video delivery. However, "these results suggest survivors of Military Sexual Trauma were less likely to receive a minimum adequate dose of trauma-focused treatment and that early attrition was particularly salient when care was delivered remotely via Clinical Video Technology" (pg. 5).	The participants were mostly female (74%) and 69% identified as white.	The authors state, "attrition speed was greater for veterans in Clinical Video Technology-delivered treatment, with veterans in this group markedly more likely to attrite quite early in care. The attrition patterns observed tended to coincide with interventions such as early imaginal exposure and written trauma accounts. This is an unfortunate time for patients to dropout, as they may be experiencing temporary symptom exacerbation, which may reduce their likelihood of reengaging in treatment in the future and may negatively impact treatment expectancy. It may be helpful for CVT clinicians to assess for motivation to return at the end of each session and have specific discussion about retention throughout the course of treatment" (pg. 7).
Villegas-Gold	2018	Developing a Prototype of an Internet-based Decision Aid to Assist Student Survivors of Sexual Assault at Colleges and Universities with Making Informed Choices about Seeking Care and Pursuing Justice in Real-time	Primary Research	Sexual Assault Survivors (students) at Arizona State University, USA	Arizona State University	This is a PhD dissertation where the researcher developed and designed a prototype of an internet-based, trauma-informed decision aid specifically tailored to assist students at Arizona State University who experience sexual. The virtual decision aid supports survivors with making informed choices about reporting and seeking care, advocacy,	Based on the preliminary results of the pilot test the authors conclude, "1. It is feasible to adapt decision aids for use with the target population, and 2. While aspects of the tool can be improved during the next phases of redrafting and redesign, members of the target population find it to be acceptable, comprehensible, and usable" (pg. 3).	The participants were female University students, and the researcher developed the project with feminist approach in mind. However, additional considerations regarding equity were not discussed.	Given this was a prototype test, the authors indicate that "survivors' voices may have been underrepresented due to sampling issues" (pg. 127). Also, it is difficult to comment on implementation challenges because this prototype was not implemented for larger use.

Author(s)	Date of Publication	Title	Type of Publication	Population Studied and Country	Setting (e.g., Primary Care, community)	Virtual Care Intervention/Technology Implemented to Address Domestic Violence and/or Intimate Partner Violence	Outcomes Measured and Results (what do the authors include about the a) ***acceptability***, b) ***feasibility***, and c) ***effectiveness*** of the intervention)	Equity Considerations (i.e., gender-responsive approaches to trauma, sub-population differences; inclusion of vulnerable population groups)	Challenges or Barriers to Implementing Virtual Care to Address Domestic Violence
						and support on and off campus.			
Warshaw, Sullivan & Rivera	2013	A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors	Systematic Review	Diverse groups in USA (African American, White, Latina, Asian)	Different settings (shelter, community, Primary care).	No, however, all the interventions discussed in this paper are trauma-based treatments tailored for IPV survivors. These include Cognitive Trauma Therapy for Battered Women (CTT-BW); HOPE: Helping to Overcome PTSD through Empowerment; a trauma focused intervention for abused Korean Women residing in shelters; trauma focused treatment that was tailored specifically for African American women, Latina women, suicidal women, and low-income pregnant mothers. Some of these were also culturally tailored for the women.	The results show that each intervention has a positive outcome in terms of lowering signs of PTSD and depression. However, authors of this systematic review indicate that these findings should be interpreted with caution because there were methodological limitations in the included studies (small participant number, higher dropout rates) and the intervention delivery also varied from one study to another (e.g. some were group based, some were individual based). The studies that tailored the intervention to specific cultural groups had higher attrition rate, but the authors again caution in interpretation of this data by point out that other factors such as homelessness or other factors could have been confounders to attrition rates. Therefore, all around the authors recommend caution be taken when discussing effectiveness of the	Equity considerations are at the center of this review. Studies included were inclusive of various underserved population in USA (African American, Asian, Latina, low-income, suicidal, drug addicted). However, the authors note the following: "While a number of the interventions reviewed in this paper included diverse groups of participants and culturally tailored interventions, approaches to trauma recovery that are based on the values and healing traditions of particular communities that not only may be more relevant for those communities but which offer approaches that touch on domains affected by trauma not addressed by existing evidence-based practices." (pg. 16)	Not applicable, because this study is not focused on virtual care delivery.

Author(s)	Date of Publication	Title	Type of Publication	Population Studied and Country	Setting (e.g., Primary Care, community)	Virtual Care Intervention/Technology Implemented to Address Domestic Violence and/or Intimate Partner Violence	Outcomes Measured and Results (what do the authors include about the a) *acceptability*, b) *feasibility*, and c) *effectiveness* of the intervention)	Equity Considerations (i.e., gender-responsive approaches to trauma, sub-population differences; inclusion of vulnerable population groups)	Challenges or Barriers to Implementing Virtual Care to Address Domestic Violence
							intervention. Feasibility and acceptability are not discussed but this review did not discuss remotely (virtually) delivered interventions.		

Appendix C: Full List of Policy and Practice Recommendations from High Priority to Lower Priority

Policy Recommendation	**Practice Recommendation**
Impose mandatory training on the forms of violence, and on how to provide trauma-informed support to individuals affected by violence to policy makers, government workers (especially lawyers, prosecutors, judges), and medical care providers.	There is a need to provide more training and resources to service providers (police, judges, lawyers, counselors, social workers, health care providers) on how to provide trauma-informed services to individuals experiencing violence. Training should include contents on understanding the different forms of violence (psychological, emotional. financial, technology, etc.), impact of violence, the realities of historical and generational trauma, understanding the traits and tactics of perpetrators, and how to provide the necessary support in an empathetic and trauma-informed manner.
Allocate more funds towards (a) strengthening the anti-violence sector to provide affordable, timely, reliable, trauma-informed, client-centered and culturally applicable services (e.g., counseling services, access to social workers); and (b) providing affordable and reliable internet access for underserved populations.	Provide emergency services in different languages (e.g., call 911 and say Hindi and you will be transferred to someone who speaks Hindi), and ensure service providers are trained in how to provide culturally appropriate services.
Allocate funds towards providing affordable access to housing, income support, access to affordable vocational training, and access to affordable driving lessons, access to medical care needs (dentist, prescriptions, eye care, etc.) and driving license regardless of immigration status.	Have advocates or social workers support survivors through the legal processes (e.g., divorce, custody), and to ensure they are provided with all necessary information (e.g., settling finances) during divorce proceedings.
Ensure income equality for all regardless of immigration status.	Provide fair and timely services/responses. This includes reduced wait times and quick access to counselors.
Existing laws, legislations, and policies regarding violence must be reviewed by diverse individuals affected by violence. Going forward, these stakeholders (diverse individuals affected by violence) must be engaged in the development, implementation and evaluations of policies, legislations and laws addressing issues related to violence.	Ensure continuity and consistency in the counseling services provided (i.e., access to the same trauma-informed therapist with abuse experience for prolonged treatments such as CBT) for effective counseling.

During separations and divorce proceedings both parties must be obligated to provide mandatory paperwork, documents and other relevant information in a timely basis. For example, in the court system there is a need for Disclosure Enforcement Program (DEP), just like the MEP program (Maintenance Enforcement Program).	Law enforcement agencies should provide women with follow-up protection after an emergency police order expires.
There needs to be a mandatory psychological assessment of both parties in divorce, and custody hearings when violence is involved (even threats). The results of these assessments should be used in decisions regarding custody hearings in order to protect children from exposure to further psychological and emotional violence from a violent parent.	Law enforcement and legal service providers should avoid jargon when talking about the legal cases (i.e., explain it to the survivors in layperson's terms).
Mandate quotas to ensure a diversity of service providers.	Provide survivor centered services in which diverse individuals that have experienced violence are trained to support others experiencing or at risk of experiencing IPV.
	Most anti-violence services should be offered in different languages and must be culturally appropriate. Also, organizations should display the languages in which their services are offered, so people would know in advance.

Recommendations to Strengthen Public Engagement and Awareness in Addressing and Preventing IPV – High to Low Priority

Preventive measures by teaching children and youth in K-12 schools about healthy relationships and engage parents/family/caregivers in these educational activities.
Engage religious leaders in violence prevention activities because they are key stakeholders with high social capital and capacity to change the cultures of society to effectively address experiences and perpetration of IPV. This means they should be informed of how to talk to women who may approach them with experiences of violence and where to guide them to go. Also, they should be informed of how to provide support and resources for perpetrators.
Develop and implement public campaigns on violence prevention targeting various stakeholders and in different languages. For example, provide publicly available violence prevention initiatives educating and engaging men on violence prevention such as *White Ribbon Campaign*[6], and *A Man Respects a Woman*[7] – in different languages.
Engage many different community groups and grassroots organizations to host discussions about various forms of violence and solutions - what to do about it. Encourage networking among these organizations and communities to talk about social issues related to systemic violence, to share advice and resources, and to discuss available support services.
Provide information more broadly on where and how to get support services when women are experiencing IPV. For example, send emails to all parents in schools about what family violence looks like, and how to reach out for help; broadcast information on how

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[6] The *White Ribbon Campaign* aims to engage men as allies of women and agents of change by challenge traditional notions of masculinity through providing training, programs, and research around public attitudes and media campaigns.
Full description of the imitative can be found in Crooks, C., Jaffe, P., Dunlop, C., Kerry, A., Houston, B., Exner-Cortens, D., & Wells, L. (n.d.). Primary prevention of violence against women and girls: Current knowledge about program effectiveness. *Centre for Research & Education on Violence Against Women & Children*

[7] *A Man Respects a Woman* aims to reduce sexual violence and cohesive behaviors in men by using a social marketing campaign and theater presentation addressing socialization issues and male peer-to-peer education.
Full description of the initiative can be found in Claussen, C., Wells, L., & Esina, E. (2019). *Moving beyond programs: How non-programmatic interventions can be used to engage and mobilize men in violence prevention and gender equality*. Calgary, AB: The University of Calgary, Shift: The Project to End Domestic Violence.

to safely access services on the radio/TV; send messages as AMBER Alert to the public (preferably in multiple languages); have neighborhood safe houses where women can escape to for a short period of time.
Distribute information on how to safely access services in common locations that women visit: For example, in the laundry room of apartment buildings, grocery stores (especially ethnic stores), at bus stops, daycare and schools, women's bathrooms in public spaces, at chain stores such as Walmart provide a poster at the front desks where cashiers are.
Legal information and police records of violence perpetrators (e.g., the Interpersonal Violence Disclosure Protocol (Clare's Law) Act) should be publicly available - nationally.
Provide support resources (e.g., fliers) for men (e.g., in men's bathrooms in both public places and in restaurants/bars/etc.).