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Women's Experiences of the Intervention for Health Enhancement After Leaving (iHEAL)

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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WOMEN'S EXPERIENCES OF THE INTERVENTION FOR HEALTH
ENHANCEMENT AFTER LEAVING (*i*HEAL)

(Spine title: Women's Experiences of the *i*HEAL)

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by

Rachel Ann Colquhoun

Graduate Program in Nursing

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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THE UNIVERSITY OF WESTERN ONTARIO
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ABSTRACT

Despite the high rates of service use across sectors, there is increasing evidence that women exposed to intimate partner violence have unmet care needs and face barriers in accessing health and other services. The purpose of this study was to explore women's experiences of taking part in a primary health care intervention for adult women who had recently left an abusive intimate partner with a particular focus on how women's varied social locations affect their experiences. The qualitative content analysis grounded in an intersectional perspective that is presented here is part of a larger feasibility study of the "Intervention for Health Enhancement After Leaving" [iHEAL] in Ontario. Three themes were identified: 1) *Spinning in Circles*, reflected women's experiences of blame and barriers as they actively sought help to deal with abuse and its consequences, 2) *Finding my Footing*, suggests that women experienced shifting needs in their attempt to deal with the effects of violence and found the intervention to be collaborative and individualized support, and, 3) *Moving Forward* describes a shift in knowledge, skills, and connections that positioned women to move forward with their lives. The findings suggest that, among women who have recently left an abusive partner, women are actively help-seeking but finding a poor service-fit with need as they transition out of a violent relationship.

Women universally reported that the relationship with the interventionist was critical to developing knowledge, skill and connections to resources in order to aid their healing and help with their ability to move forward. The iHEAL is a promising intervention that has the potential to positively impact women's health and quality of life after leaving.

Key Words: intimate partner violence, women's health, intervention, fit of service, women's experiences

CO-AUTHORSHIP STATEMENT

Rachel Colquhoun completed the following work under the supervision of Dr. Marilyn Ford-Gilboe and Dr. Colleen Varcoe. Drs. Ford-Gilboe and Varcoe will be co-authors of any publication resulting from this work.

DEDICATION

This thesis is dedicated to all persons who experience intimate partner violence and forms of gender-based oppression around the world. Specifically, this thesis is dedicated to the women who participated within the Intervention for Health Enhancement After Leaving [*i*HEAL] who entrusted me with their experiences. This thesis is dedicated to all persons and professionals seeking to advocate for issues of social justice and who actively seek to create change for women who experience violence.

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To the members of the *iHEAL* research team across the country, thank you for your time, energy and investment in this promising intervention for women who experience violence.

I would also like to thank my family, especially my parents, Elizabeth and Geoff Pede, my sister and brother, Danielle and Aaron Robb (Molly), and all my friends, for their constant encouragement and support.

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CHAPTER I

INTRODUCTION

Intimate partner violence (IPV) is internationally recognized as a legitimate human rights concern and a significant threat to women's health and well-being (Ellsberg & Heise, 2005). IPV is a pattern of physical, sexual and/or emotional violence in the context of coercive control by an intimate partner (Tjaden & Thoennes, 2000) and disproportionately affects women (Campbell & Kendall-Tackett, 2005). Globally, IPV is the most prevalent form of gender-based violence (Heise & Garcia-Moreno, 2002). According to the 2009 Canadian General Social Survey (GSS), 6.4% of women with a current intimate partner reported being physically or sexually assaulted by their partner at least once during the previous five years, although lifetime rates are high at 23% (Clark & DuMont, 2003). IPV is a global health and social problem that leads to health, social and economic disadvantages for women and their children. In Canada, women who are younger, living on low incomes, disabled, and/or who identify as Aboriginal and/or racialized, are at greatest risk of IPV (Clark & DuMont, 2003; GSS, 2009). Articulations of patriarchy and legacies of colonialism and racism (Sokoloff & Pratt, 2005) also increase risk of IPV. There is good evidence to suggest that women's risk of IPV increases around the time of separation from an abusive partner (Smith, 2006). Furthermore, these structural factors, which lead to differences in women's risk of IPV, also reduce women's options for addressing the violence in their lives.

Determinants of health are the societal and political structures and conditions that shape the health of communities, individuals and populations (Raphael, 2009). Since IPV and its consequences are preventable, these experiences can be thought of as important causes of *health inequities* – systematic, unfair, and avoidable differences in the health of

population subgroups which arise from social, economic, demographic and/or geographic differences between them (Whitehead & Dahlgren, 2006). From a structural perspective, health promotion is a comprehensive social and political process which focuses on changing social, environmental, and economic conditions that impact health (World Health Organization [WHO], 2000; 2002). Thus, achieving health is not simply a matter of enabling people to take more responsibility for their health; it is about naming injustice and taking action to address social and economic inequity (Anderson, 2000; 2002) at the individual and population levels. This approach has potential to improve the health and lives of women who have experienced IPV, yet comprehensive interventions that address the health consequences of IPV and the conditions that lead to poor health have not been developed and tested.

The purpose of this thesis was to explore women's experiences of taking part in a primary health care intervention for adult women who had recently left an abusive intimate partner. To provide a context for this study, it is important to first understand the structural risk factors for IPV, and the process by which exposure to violence results in long-term negative health effects and patterns of service use among women who have left an abusive partner. A brief overview of the literature follows, which addresses: 1) the sociopolitical context of intimate partner violence; 2) the process of leaving; 3) the health consequences of IPV; and, 4) service use among women who have experienced IPV.

The Sociopolitical Context of Intimate Partner Violence

In the past three decades, three different perspectives have been used to conceptualize violence against women based on whether the focus is on individuals, couples or dyads, or society (Bograd, 1988; Gelles, 1993). Stark and Flitcraft (1991)

labelled these three perspectives the interpersonal model, the family violence model, and the gender-politics model. Interpersonal Models dominated early work on violence and focused on individual and interpersonal relationships; these views emphasized the psychology of the victim and perpetrator and their interrelationships (Varcoe, 1996; 2009). These models highlight behaviour of individuals and do not attempt to incorporate conceptualizations of coercive control. Second, Family Violence Models focus attention on either couples or families and seek to explain the causes of violence in social relations within couples and families. These perspectives tend to be gender-neutral, treat power inequities as only one factor among many, and explain violence primarily as resulting from external stresses and the breakdown of the family (Stanko, 1988).

In contrast, Gender-Political Models, which include feminist perspectives, tend to explain violence as arising from the social context and contribute an analysis of the influence of gender and power relations to theorizing violence (Yllö, 1993). Consistent with this view, Johnson (1995) identified intimate partner terrorism (IPT) as a particularly severe form of violence which is most strongly associated with negative health consequences; IPT is almost always directed toward a woman by a male partner and the primary motivation for such violence is to maintain power and control (Johnson, 1995). This gender-specific pattern of deliberate, repeated physical and/or sexual assault within the context of coercive control has also been called “battering” (Humphreys & Campbell, 2004). Davies, Ford-Gilboe, and Hammerton (2009) discuss IPV in the context of gender role expectations that serve to reinforce male privilege and further oppress women and the intentional, methodical way that men can continue to exert dominance over their female partners. From this perspective, the experience of violence is seen as being

influenced profoundly by the intersections of multiple social locations of privilege and oppression. Intersectionality is useful to point to ways in which social location, multiple and complex identity categories, such as gender, race/ethnicity, class, age, able-bodiedness, and sexual orientation interact to shape individual life experiences (Hulko, 2002). Thus, IPV is not confined to interpersonal relationships but is sanctioned by broader social, cultural, and political structures that systematically oppress women (Mason et al., 2008). Violence and its impact on women's lives must be understood within the context of a wider culture that encompasses the violence of racism, poverty, and other forms of inequity (Varcoe, 2009).

Intimate partner violence is widely acknowledged as a critical health issue for women worldwide. However, relatively little is known about its prevalence in diverse contexts (Guruge & Khanlou, 2004; Sorenson, 1996). Global rates of IPV vary widely due to differing definitions, as well as varying approaches to data collection and research (Heise & Garcia-Moreno, 2002; Ellsberg et al., 2008). Global lifetime IPV prevalence rates vary from 15%-71% with estimates in most sites ranging from 30% to 60% (Garcia-Moreno et al., 2006). Clark and Du Mont (2003) estimate that up to 23% of Canadians are affected by IPV in their lifetimes. Based on a systematic review of prevalence studies, Alhabib, Nur and Jones (2010) suggest that no racial or socio-economic group is immune and that IPV has reached epidemic proportions in many societies. In addition to unique forms of IPV, some studies have found cross-cultural differences in how severe abuse is defined (Mason et al., 2008). Indeed, the highest rates of IPV are reported in countries in which gender inequities are ubiquitous (Ackerson & Subramanian, 2008). Although some studies attempt to capture rates of sexual and to a lesser extent emotional abuse,

definitions of abuse used in these studies tended to prioritize physical violence (Clark & Du Mont, 2003). Given that these studies tend to focus primarily on physical violence, the prevalence rates derived from them are believed to under-report the actual extent and severity of IPV.

The Process of Leaving

Many women eventually separate from an abusive intimate partner and face a multitude of ongoing challenges after leaving (Campbell & Soeken, 1999). Although IPV transcends social location, women with fewer resources are more likely to become trapped in an abusive relationship because they have fewer options for addressing the violence available to them (Campbell, Woods, Chouaf & Parker, 2000). Leaving is more of a process than a singular event (Rothery, Tutty & Weaver, 1999; Landenburger, 1998) and can be both physically and emotionally exhausting (Wuest & Merritt-Gray, 1999). Ongoing abuse and harassment, economic and social stresses, the 'costs' of getting informal and professional help, and demands of living with chronic and continuing health problems have been found to intrude on women's abilities to take control of their lives for as long as 20 years after leaving (Ford-Gilboe, Wuest & Merritt-Gray, 2005; Wuest, Ford-Gilboe, Merritt-Gray & Berman, 2003). Access to economic resources is crucial to women's abilities to sustain separation from an abusive partner (Anderson & Saunders, 2003) and to improve their quality of life. The inequitable distribution and availability of the social resources that promote and sustain the health of individuals and communities (e.g. working conditions, health services, early childhood development, housing, income, education, and food security) is shaped largely by social locations such as class, race, and gender, as well as structural oppression including racism, classism, and sexism

(Hankivsky, Cormier, & de Marich, 2009; Raphael, 2009). Women's access to the resources that are needed to address IPV and the health consequences of IPV may be shaped by multiple, intersecting social locations and experiences of systemic oppression.

The Health Consequences of Intimate Partner Violence

The substantial mental and physical health consequences of IPV for women should be of great concern to health care providers, health promoters, and policy makers. A WHO study on women's health and domestic violence confirmed significant associations between lifetime experiences of partner violence and self-reported poor health (Ellsberg & Heise, 2005). These long lasting physical and mental health consequences for women are well documented in the literature (Afifi et al., 2009; Campbell, 2002; Ford-Gilboe et al., 2009; Rivara et al., 2007; Wuest et al., 2010; Zlotnick, Johnson & Kohr, 2006). Such problems may be acute or chronic and arise from injuries, often untreated and/or unhealed, and women's physical and psychological responses to trauma (Plichta, 2004; Wuest et al., 2009). Additionally, the duration and type of violence are positively correlated with the severity of health problems experienced (Peterson, Moracco, Goldstein & Clark, 2004). The negative health consequences women experience as a result of IPV are often disabling in nature, impair women's abilities to carry out activities of daily living and, ultimately, affect their quality of life (Cohen & Maclean, 2004; Coker, Smith, & Fadden, 2005; Rees et al., 2011). Evidence suggests that the health problems women experience as a result of IPV persist long after the violence ends (Ansara & Hindin, 2011).

Intimate partner violence has severe and sometimes lethal consequences for women (Bachman & Saltzman, 1995; Campbell, 2002). These consequences include

physical injury, stress-related health effects, mental health effects, abuse during pregnancy, and the physical effects of forced sexual intercourse (Kendall-Tackett & Campbell, 2005; WHO, 2006). The high incidence of head injuries as a result of IPV can lead to chronic neurological problems (Kwako et al., 2011; Banks, 2007). Chronic pain is a prevalent health effect of IPV for women and may be experienced in varied ways, including headaches; back problems, as well as swollen and painful joints (Wuest et al., 2009; Wuest et al., 2010). In addition to causing injury, IPV increases long-term risks for stress-related health effects, even after the abuse has ended. In fact, physical health effects may be related to trauma-related alterations in neurophysiology (Kendall-Tackett & Campbell, 2005). Compared to their non-abused counterparts, cardiovascular disease and hypertension are more prevalent among women who have experienced IPV (Tollestrup, Sklar, & Frost, 1999). This suggests that women who experience violence may be at heightened risk for cardiovascular disease and warrant clinical attention (Scott-Storey, Wuest & Ford-Gilboe, 2009). Women who experience IPV may also self-report considerably higher rates of gastrointestinal symptoms and diagnosed functional gastrointestinal disorders associated with chronic stress (Campbell et al., 2008).

Beyond these direct physical effects, the traumatic experience of abuse can result in enduring chronic psychological stress that is believed to have long-term negative mental health consequences (Kendall-Tackett, 2005; Plichta, 2004). Depression and post-traumatic stress disorder (PTSD) are the most prevalent mental health sequelae of IPV, with women often experiencing both conditions (Zlotnick, Johnson, & Kohr, 2006). Chronic psychological stress can accumulate and compound over time to produce significant and long-term physiological changes within the body (Black, 2011). The long

term physical and mental effects of IPV-related traumatic stress have been linked to neuro-endocrine changes, altered immune activity, psychological responses (Woods, 2000; Woods, Kozachik, & Hall, 2010) and epigenetic changes that reflect accelerated cellular aging (Humphreys, Epel, Copper, Lin & Blackburn, 2012). In fact, a history of child abuse and other forms of trauma may further compound the health consequences of IPV (Kimerling et al., 2007) as a result of cumulative trauma (Scott-Storey, 2011). IPV trauma may also lead to increased health risk behaviours such as smoking, substance use, or risk factors for HIV and/or sexually transmitted infections that contribute further to health problems (Weaver & Resnick, 2004). Thus, cumulative violence and trauma impact the social determinants of health and compromise health and well-being (Humphreys, Parker, & Campbell, 2001). Ultimately, these health consequences can translate into higher rates of health care use and a lower quality of life.

Service Use among Women who have Experienced Intimate Partner Violence

Women who have experienced IPV-related trauma are high users of services in many sectors (Kendall-Tackett & Campbell, 2005; Rivara et al., 2007), but particularly so in health care (Bonomi, Anderson & Rivara, & Thompson, 2009). For example, Sharps et al. (2001) found that only four percent of women who were murdered by intimate partners accessed domestic violence services, but 56% had seen a health care provider at least once the previous year. In fact, women experiencing IPV are three times more likely than non-abused women to seek care in emergency departments (Peterson, Moracco, Goldstein, & Clark, 2004). These findings are consistent with previous analyses of the Violence Against Women Survey, a Canadian population based study (Ratner, 1993; Varcoe et al., 2011). Thus, women who have experienced IPV come into contact with

health-care providers more frequently than their non-abused counterparts (Rivara et al., 2007). However, there is increasing evidence that women exposed to IPV have unmet care needs and face barriers in accessing health and other services (Ford-Gilboe et al., 2009; Stam, Ford-Gilboe, & Regan, in review).

IPV results in tremendous personal, social and economic costs (WHO, 2006), which continue even after women have separated physically from their abusive partners (Varcoe et al., 2011). Wisner et al. (1999) estimates that the health care costs linked to women with histories of IPV, compared to those who had not experienced abuse were 92% higher, with mental health services accounting for the majority of the excess cost. Likewise, Rivara et al. (2007) found that women who had experienced IPV used mental health services 2.5 times more frequently than non-abused women, resulting in increased costs to the health care system. In an analysis of data from the Women's Health Effects Study, Varcoe, Hankivsky, Ford-Gilboe and colleagues (2011) estimated the public and private health care costs attributable to IPV for a sample of Canadian women who had separated from an abusive partner for an average of 20 months were \$4,969 higher than for women in the general population; 90% of these costs were related to hospital and emergency services use. In addition to the health consequences of violence, it has been estimated by the WHO (2000) that 5–20% of healthy years of life are lost in women aged 15 to 44 affected by IPV. Furthermore, according to the Centres for Disease Control (2003), survivors of IPV lose nearly 8 million paid work days every year and health related costs exceed 5.8 billion dollars annually. These costs include nearly \$4.1 billion in the direct costs of medical and mental health care and nearly \$1.8 billion in the indirect costs of lost productivity (CDC, 2003). A Canadian study following women who had

separated from an abusive partner longitudinally, reported that a conservative, partial estimate of the annual costs of IPV is 6.9 billion dollars per year (Varcoe et al., 2011).

Despite growing interest within the health care sector to improve the care of women who have experienced IPV, the phenomenon of violence has only recently been included in the education of health care professionals, leaving the vast majority of health care providers ill-equipped to recognize and respond to IPV in ways that are sensitive to the complexity of women's experiences and respectful of women's safety and choices (Ford-Gilboe, Wuest, Varcoe, & Merritt-Gray, 2006; Wathen et al., 2009). Although health care professionals are well positioned to support women who have experienced IPV, the dominant response to date within health care settings has focused on screening and/or identification of IPV and subsequent referral of women to domestic violence services (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011). Shelters, crisis lines, women's centres, and elements of the justice system offer essential support to women leaving abusive relationships, yet few health-specific supports are available to women during this transition (Ford-Gilboe et al., 2006). More comprehensive health interventions, including those designed to support women in improving their health and quality of life over time, have not been integrated into the health care system (Wathen & MacMillan, 2003). This is a significant gap, particularly for women who are attempting to change their lives, since poor mental health was found to be the most significant predictor of women's ability to sustain short term separation from an abusive partner (Alhalal, Ford-Gilboe, Kerr, & Davies, 2012).

Few interventions exist to help promote healing for survivors of IPV, with the majority of interventions directly or indirectly focused on helping women leave their

partner (Sitaker, 2008). Despite this fact, women actively seek both formal and informal supports in an attempt to overcome the effects of violence (Barrett & St. Pierre, 2011). Although women attempt to access services, there are multiple socio-demographic barriers related to their social locations that create help-seeking challenges. Research demonstrates that women often face multiple structural barriers such as costs of accessing services, transportation, system bureaucracy and services functioning in silos, over and above negative interactions with service providers, in accessing services, which are often compounded by social location (Barrett & St. Pierre, 2011; Ford-Gilboe, Hammerton, Burnett, Wuest, & Varcoe, 2009). In addition, qualitative accounts of women's experiences with both health care and social services often describe their interactions as negative and unsupportive, leaving them feeling judged and disrespected (Barrett & St. Piere, 2011; Gerbert et al., 1997; 1999; Goodman, Dutton, Weinfurt & Cook, 2003). Ultimately, interactions with "the system" lead to many women continuing to feel oppressed despite leaving the abusive partner (Wuest et al., 2010), resulting in unmet care needs (Plichta, 2007). It is essential to move understanding of the effectiveness of interventions for women who have left an abusive partner beyond a singular focus on quantitative outcomes. It is equally important to understand who benefits from interventions and why. Women experience IPV in different ways and have varying needs after leaving (Hamel, 2009; Pennington-Zoellner, 2009). As a result, this thesis focused on women's personal experiences of an intervention designed to improve women's health and quality of life and how they understand intervention processes and outcomes in the context of their everyday lives.

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CHAPTER II

MANUSCRIPT

Women who have left a violent intimate partner must contend with significant losses of financial and material supports, in addition to multiple ongoing health challenges (Anderson & Saunders, 2003). Intimate partner violence results in substantial, negative long-term physical and mental health outcomes for women (Campbell, 2002), which significantly impact their ability to carry out basic activities of daily living (Cohen & Maclean, 2004). Given the negative health consequences of IPV, women with a history of abuse tend to have frequent contact with health care professionals (Coker et al., 2000). Research demonstrates that abused women use a disproportionately greater amount of services across sectors than non-abused women (Farley & Patsalides, 2001; Coker et al., 2000), yet have unmet care needs and face barriers in accessing healthcare and other services (Vives-Cases et al., 2011; Wu, Huff & Bhandari, 2010).

To date, few tested interventions exist which seek to prevent IPV or address its consequences (Wathen & MacMillan, 2003; Ramsay et al., 2009) and there is a lack of evidenced-based strategies to aid women who have separated from an abusive partner rebuild their health and lives (Ford-Gilboe et al., 2009). Although women's perspectives of their health needs and preferences are essential for informing the development of interventions to address IPV and its consequences, few studies have taken women's perspectives into account when developing or testing such interventions. Furthermore, survivors of IPV are not a homogenous group of women; they experience IPV in different ways and have varying needs after leaving (Hamel, 2009). A social determinant of health perspective is useful in designing interventions that incorporate an understanding of

women's diversity, and that foster continuity of relationships across service sectors to help women navigate complex systems (Ford-Gilboe, Wuest, Varcoe, Merritt-Gray, 2006). Understanding how women's varied social locations and access to resources impact both intervention processes and outcomes is needed as a basis for developing effective, evidenced-based interventions for diverse groups of women. The purposes of this study were to explore women's experiences of participating in a complex, primary health care intervention, called the "Intervention for Health Enhancement After Leaving [iHEAL]" developed for adult women who have recently separated from an abusive partner. A particular focus of this study was on understanding how women's varied social locations affect their experiences. The qualitative findings presented here are part of a larger feasibility study of the *iHEAL* conducted with a sample of 29 women living in Southwestern Ontario, Canada between June 2010 and February 2012.

Literature Review

Despite greater recognition of IPV as a major public health problem (Garcia-Moreno & Watts, 2011) and evidence that women exposed to IPV are higher users of health care services than those who have not experienced IPV (McFarlane, Groff, O'Brien & Watson, 2006; Rivara et al., 2007; Varcoe et al., 2011), little effort has been directed toward developing interventions aimed at reducing the consequences of IPV, compared to the quantity of research on universal screening or safety planning interventions. Overwhelmingly, health research has focused primarily on screening for IPV and referral to domestic violence agencies, although evidence of effectiveness in reducing violence or improving health is lacking (MacMillan et al., 2009; Ramsey et al., 2009). The development and testing of interventions to support women who have

experienced IPV has been identified as a priority for research (Barner & Carney, 2011; Roberts & Roberts, 2005). A number of systematic reviews (Feder et al., 2009; Wathen & MacMillan, 2003; Nelson, Nygen, McInerney & Klein, 2004; Ramsey et al., 2009) have concluded that the evidence supporting specific interventions for abused women is weak, especially for interventions provided in health care settings, or those to which health care providers could refer women (Jack et al., 2012).

Based on a recent systematic review (Ramsay et al., 2009), there is emerging evidence that certain advocacy interventions for women who have experienced IPV lead to improvements in quality of life, safety actions, social support, access to services, and a reduction in violence. For example, in a randomized controlled trial conducted in the United States, a brief, 8 week advocacy intervention delivered by psychology students to women who were leaving a shelter was found to be effective in helping women access resources immediately post-intervention and improved women's social support and quality of life longer-term (3 years post-intervention), but did not result in changes in depression (Bybee & Sullivan, 2005; Sullivan & Bybee, 1999; 2002). Consistent with these findings, in a second RCT of a 12-week advocacy intervention delivered by social workers to 200 pregnant women in Hong Kong, Tiwari (2010) found improvements in the quality of women's relationships, but no effects on the level of depressive symptoms or women's quality of life. This research supports the potential benefits of advocacy support for women, who have experienced violence, and validates the knowledge and expertise that lay advocates and social service workers provide within a larger system of services, but suggests advocacy is not sufficient to address all of the issues women face after separation from an abusive partner, particularly their health concerns.

There is emerging evidence regarding the positive impacts of specific types of counseling, case management, or support interventions delivered by Registered Nurses (McFarlane, Groff, O'Brien & Watson, 2006; Jack et al., 2012, Tiwari et al., 2005) or social workers (Kiely, El-Mohandes, El-Korazaty & Gantz, 2010; Tiwari et al., 2010) in reducing IPV and improving other outcomes in specific groups. For example, in a randomized controlled trial of a brief empowerment intervention delivered by Registered Nurses to 110 abused, pregnant women in Hong Kong who presented for antenatal care, Tiwari et al. (2005) found that the empowerment intervention delivered by a Registered Nurse consisting of advice in the areas of safety, choice making and problem solving was effective in improving women's physical health and in reducing role limitations due to physical and emotional health problems, psychological abuse and minor physical violence and levels of postnatal depression. While further research is needed, these findings suggest that interventions delivered by health care professionals in health care settings may play a unique role in improving the health and safety of women who have experienced IPV.

A meta-analysis of 25 qualitative studies demonstrated that women who have experienced IPV desire health professionals who are nonjudgmental, non-directive, individually focused, and have a holistic understanding of the complexity of intimate partner violence (Feder, Hutson, Ramsay & Taket, 2006). Although women have identified what they need from health care providers, in testing the effectiveness of IPV interventions, researchers have tended to focus primarily on quantitative changes in primary outcomes, with much less attention given to the processes of change which explain intervention effects or to women's experiences of the intervention. To a limited

extent, women's perspectives of acceptability, safety and harms have been sought in studies of IPV screening (e.g. Koziol-McLain, Giddings, Rameka, & Fyfe, 2008; Koziol-McLain et al., 2010; MacMillan et al., 2009), but, with a few exceptions (Taft et al., 2009; 2011; Hegarty et al., 2010), their experiences of taking part in IPV interventions have seldom been explored in-depth using qualitative interviews. These types of findings are needed to fully understand how complex interventions work, who benefits and why, and to suggest how interventions may be refined so that impacts are maximized.

Although the health consequences of IPV are extensive and their impacts on women's lives have been well documented, few interventions have been developed to address these issues. Neither symptom management, nor referrals for health care are well addressed by domestic violence services and these areas often require expertise that nurses can provide (Ford-Gilboe, Wuest, Varcoe, & Merritt-Gray, 2006). Nurse delivered, theory-based primary health care interventions have been shown to be effective with other populations (Philips, 2008; Rolling & Brosi, 2010), including low-income single mothers and their families, a population which has been found to experience high rates of lifetime adversities and trauma, including IPV (Samuels-Dennis et al., 2010). For example, Browne, Byrne, Roberts, Gafni, and Whittaker (2001) developed a complex, one year, public health nursing case-management intervention, *When the Bough Breaks*, to help single mothers on social assistance return to work. The intervention did not specifically address IPV, but included health promotion by public health nurses during home visits, employment retraining, and subsidized after-school recreation or child care. In a randomized controlled trial (N=756), this complex health promotion intervention was found to be more effective than self-directed care in increasing exits from social

assistance and subsequently saved costs (Markle-Reid, Browne, Roberts, Gafni, & Byrne, 2002). Similarly, the Nurse-Family Partnership (NFP; Olds, Sadler & Kitzman, 2007), a complex, evidence-based home visitation program for low income, first time mothers, has demonstrated long-term improvements in maternal prenatal health, greater informal social supports and formal access to community services for women and improvements in child health in several controlled trials (Olds et al., 2002). Interestingly, in a comparative study conducted using both paraprofessionals and nurses to deliver the NFP, paraprofessional visiting produced small effects that rarely reached statistical significance, whereas nurse visiting had significant effects on many child and maternal outcomes (Olds et al., 1997; 2002). Given research demonstrating that the NFP is not as effective if IPV is occurring and not specifically addressed (Eckenrode et al., 2000), new interventions designed to identify and support women who are dealing with IPV have been integrated into the NFP and are currently being tested in a multi-site randomized controlled trial (Jack et al., 2012). These findings underscore the importance of developing and testing interventions to specifically target and address women's needs within a context of abuse. In particular, interventions that address the complex health and social issues that women face during the transition out of an abusive relationship need to be developed and tested.

Intervention for Health Enhancement After Leaving [*i*HEAL]

The Intervention for Health Enhancement After Leaving (*i*HEAL) is an innovative complex, trauma informed, primary health care intervention for women who have separated from an abusive partner, which was developed by Marilyn Ford-Gilboe, Marilyn Merritt-Gray, Colleen Varcoe and Judy Wuest (2011). It is based primarily on

their previous research on health promotion in families after leaving an abusive partner (Wuest, Ford-Gilboe, Merritt-Gray, Berman, 2003; Wuest, Merritt-Gray, Ford-Gilboe, 2004) and health effects of IPV (Varcoe, Hankivsky, Ford-Gilboe, Wuest & Wilk, 2011; Wuest et al., 2009). The *iHEAL* is informed by a set of philosophical assumptions and the theory of Strengthening Capacity to Limit Intrusion (SCLI) that together provide a broad frame of reference for understanding women's gendered experiences (Ford-Gilboe, Merritt-Gray, Varcoe, Wuest, 2011). The *iHEAL* represents a clinical application of the SCLI theory (Figure 1) which captures conceptually what women do to survive, promote their health and well-being, and move on with their lives after leaving an abusive partner.

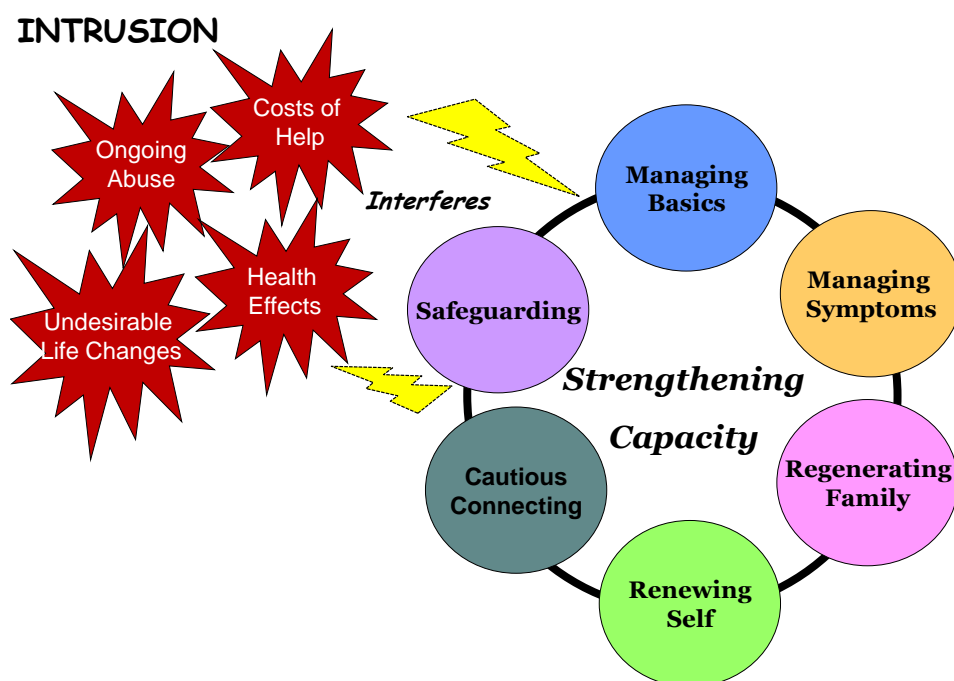


Figure 1. Theory of Strengthening Capacity to Limit Intrusion. Adapted from "A theory-based primary health care intervention for women who have left abusive partners, by M. Ford-Gilboe, M. Merritt-Gray, C. Varcoe, & J. Wuest, 2011, *Advances in Nursing Science*, 34(3), 198-214.

In the SCLI theory, intrusion, the central problem, is unwanted interference in everyday life arising from abuse and its consequences, that demands attention, diverts attention away from family priorities, and limits choice regarding moving on (Ford-Gilboe, Wuest, Merritt-Gray, 2005). Women face four types of intrusive challenges after leaving (i.e. ongoing abuse, chronic health problems, life changes in supports and living arrangements, and the costs of obtaining help). To survive in the context of intrusion, women develop skills and knowledge and build stability by taking risks to strengthen capacity for the future using six processes that reflect their priorities for moving on with their lives. Over time, reduced intrusion leads to enhanced personal control, enabling women to more proactively address long-term priorities, resulting in improvements in their health and quality of life (Ford-Gilboe et al., 2011).

The goal of the theory-driven *iHEAL* is to improve women's health and quality of life after leaving an abusive partner by: (a) reducing intrusion and (b) enhancing women's capacity (knowledge, skills, and resources) to limit intrusion (Ford-Gilboe et al., 2011). The *iHEAL* is a short-term (6-month), complex, intervention for women who are past the initial crisis of leaving, and who are working through the transition of creating a life separate from their abusive partners. It is delivered in 12-14 visits by a Registered Nurse and social service worker with specialized expertise in violence and trauma, such as a DV outreach worker or social worker, working in partnership in the context of a larger team and in collaboration with the woman. The intervention is guided by 10 principles (Table 1) which provide a broad framework for *how* the *iHEAL* should be delivered and follows a 3-phase relational process: Getting In Sync (Phase 1), Working Together (Phase 2), and Moving On (Phase 3). In the working

together phase, the interventionist and woman work through six components (i.e. Managing the basics, Safeguarding, Rebuilding Security, Managing Symptoms, Renewing Self, Regenerating Family) (Table 2), derived from women’s priorities Table 1.

“Intervention for Health Enhancement After Leaving” Principles. Adapted from “A theory-based primary health care intervention for women who have left abusive partners, by M. Ford-Gilboe, M. Merritt-Gray, C. Varcoe, & J. Wuest, 2011, *Advances in Nursing Science*, 34(3), 198-214.

| Principle | Focus |
|---------------------------|--|
| Safety First | Women’s emotional and physical safety will be promoted in all interactions. |
| Health as Priority | Women’s physical, mental, emotional, and spiritual health will be prioritized. |
| Woman-Centered | Women will direct the pace, what is given priority, and who is involved. |
| Strengths-Based | Women’s strengths and capacities will be recognized, drawn upon and further developed. |
| Learning from Other Women | Women’s own experiences of leaving an abusive partner and those of other women, as reflected in the theory of Strengthening Capacity to Limit Intrusion, will be a key source of knowledge to help them reflect on, reframe and name their experiences, concerns and priorities. |
| Woman in Context | Attention will be focused on each woman in the context of her family and network close relationships as she defines them. |
| Calculated Risks | Women will be supported to assess, judge and take calculated risks necessary for moving forward. |
| “Costs” Limited | The costs of getting help, including from the interventionists, will be assessed and limited. |
| Active System Navigation | Women will be helped to seek and obtain support from community resources and services, and to deal with the barriers she |

encounters.

| | |
|----------|---|
| Advocacy | The interventionists will work to reduce intrusion from community services and to advocate for improved system responses to women who are situated in varied contexts of social inequity. |
|----------|---|

identified in the SCLI theory, with the timing and order being based on the woman's priorities and preferences.

The context of women's lives after leaving is central to understanding health. However, existing studies of the health consequences of IPV have not consistently accounted for variation in women's health according to their life circumstances. The *iHEAL* offers alternative ways of understanding and addressing issues most important to women using a collaborative and strengths-based approach (Ford Gilboe et al., 2011). Two pilot studies examining the feasibility and initial efficacy of the *iHEAL* were recently completed in Ontario (N=29) and New Brunswick (N=52). Results of these studies are forthcoming and will provide powerful insights used to refine the *iHEAL* before conducting a more rigorous, multisite trial of this new primary health care intervention (Ford-Gilboe et al., 2011).

Table 2

“Intervention for Health Enhancement After Leaving” Components. Adapted from “A theory-based primary health care intervention for women who have left abusive partners, by M. Ford-Gilboe, M. Merritt-Gray, C. Varcoe, & J. Wuest, 2011, *Advances in Nursing Science*, 34(3), 198-214.

| | |
|--------------|--|
| Safeguarding | Assisting the woman to limiting her exposure and that of her family to people or circumstances that threaten their physical and emotional safety by assessing her sense of safety and developing strategies to manage risks and build her sense of security. |
|--------------|--|

| | |
|---------------------|--|
| Managing Basics | Assisting the woman to secure and build economic, material and personal energy resources needed to establish and sustain herself separate from the abuser over time. |
| Managing Symptoms | Supporting the woman to identify her most intrusive symptoms and health problems and to build confidence in preventing and managing symptoms, both through self-care strategies and support from health professionals. |
| Cautious Connecting | Supporting the woman to enhance her instrumental support, sense of belonging and social connection by evaluating the costs and optimizing the benefits of current and potential relationships with peers, extended family, social networks or formal service agencies. |
| Renewing Self | Helping the woman to turn inward and focus on personal restoration, making meaning of their past, and working toward a more personally fulfilling future. |
| Regenerating Family | Supporting the woman in constructing and modifying the family “storyline”, finding functional ways to work together to meet every day needs in a predictable way through rules, routines and new roles, and purposefully developing new constructive ways of getting along as a family unit or team. |

In summary, the research to date demonstrates the need for interventions to move beyond traditional models of addressing IPV and its health effects, yet few such interventions exist. The *iHEAL* is an innovative, trauma informed, primary health care intervention that addresses a gap in services after leaving. If women’s health improves as a result of access to appropriate and effective health care, they may experience strengthened capacities, allowing them to improve their quality of life. Yet, little is known about the experience of women transitioning out of an abusive relationship within the context of a health care intervention. Furthermore, Sandelowski (2004) argues that in intervention research, primacy is often given to the development of evidenced-based strategies with little to no attention being paid to participant views or client preferences. It is crucial that health professionals seek to understand social structures within the health care system that create and perpetuate conditions for disempowerment and health

inequities. A thorough understanding of this process may aid in the development of nursing practice, research, and policy that promotes health equity and healing for women who have experienced IPV.

Theoretical Framework

This feminist study is guided by an Intersectional perspective. Feminist scholarship has moved the field of gender-based violence beyond previous individual and family based models, arguing persuasively that IPV emerges out of the social context of peoples' lives. This perspective avoids the creation of simplistic views of IPV (Guruge & Khanlou, 2004) and instead, emphasizes that gender-based violence and its consequences need to be understood within the context of patriarchy and a wider culture that encompasses the violence of racism, poverty, and other forms of inequity (Varcoe, 2009). Intersectionality, a branch of third wave feminist theory emphasizes how multiple categories of identity and social locations intersect multiplicatively to produce systems of power, oppression, and privilege that shape women's everyday lives in fluid and contested ways (Crenshaw, 1994; Mosher, 1998; McCall, 2005). As a theoretical approach, Intersectionality grew out of feminist concerns with the limits of privileging gender over other social locations; as such, it can be used as an analytical tool to correct the omissions and distortions in analysis caused by failures to investigate the structures of power, race, class, ethnicity, sexuality and nationality (Varcoe, Hankivsky, & Morrow, 2007; Reid, Ponc, Hara, Kaweesi & LeDrew, 2011). In this study, I drew on an Intersectional perspective to analyze women's experience of inequities in addressing IPV and its health consequences as they reflected on their experiences of taking part in the *iHEAL* because this perspective recognizes as important the intersection of multiple

social locations, including gender and other forms of systemic discrimination that affect health outcomes and abilities to access health services (Hankivsky & Christoffersen, 2008). The understanding gained from this type of analysis may generate understandings of how women who are differently located experience the *iHEAL* to ensure that it is appropriate for diverse groups of women. Furthermore, this may lead to the development of interventions that address structures that permit and perpetuate violence (Varcoe, 2009) rather than simply those which focus on individuals. Drawing on Intersectional approaches to study the impacts of IPV produces more complex and finely nuanced understandings, and, thus, provide an enhanced platform for policy, practice, and further research.

Purpose of the Study

The purpose of this critical feminist study was to explore women's experiences of participating in a complex, health promotion intervention for adult women who have recently separated from an abusive intimate partner (*iHEAL*), with particular attention given to how women's varied social locations affected both the processes and outcomes of the *iHEAL* intervention.

Method

This study presents a qualitative analysis of data from a larger, longitudinal mixed-methods study undertaken to examine the feasibility and initial efficacy of the *iHEAL* in Ontario. The role of qualitative approaches in assessing the effectiveness and appropriateness of health and social interventions is now recognized (Sandelowski, 2004). Within critical feminist research, pragmatic methodological decisions are given primacy as knowledge production is perceived as a social process (Ramazanoğlu &

Holland, 2002) in which power relations are inherent. This study was conducted in a way that was consistent with the principles of feminist research which also coincided with the foundational principles of the *iHEAL*. Specifically, this study was conducted with focus on valuing and giving voice to women's diverse experiences, while promoting choice and control. Lather (1998; 2001) argues that emancipatory research calls for empowering approaches where both the researcher and participants become the agents of change.

Design

A community sample of 29 adult women who lived in a mid-size city and surrounding area, and had separated from an abusive partner up to 3 years previously, was recruited for the larger Ontario feasibility study using advertisements and posters placed in community settings and service agencies. Women who were interested in completing the *iHEAL* were screened for eligibility and, if eligible, additional information about the study was provided and verbal informed consent was obtained. Contact information was collected to enable follow up, and a code number was assigned to ensure confidentiality. Women were interviewed three times: before starting the intervention (baseline), immediately post-intervention and 6 months later. The majority of the women worked directly with a Registered Nurse interventionist, while a DV advocate functioned primarily in a case consultant role during this study. Interviews were conducted in a community location where women felt comfortable, after first establishing a safety plan. Written informed consent was obtained (Appendix A) and reaffirmed before each interview. Each interview included standard self-report measures to assess changes in health, intrusion and capacities. Open-ended questions which sought women's perspectives about their experiences of the *iHEAL* were incorporated into the interview

post-intervention and 6 months later (Appendix B). Of the 29 women who enrolled in the study, 25 completed the *iHEAL*, 24 were interviewed immediately post-intervention, and 22 completed the 6 month follow up interview. The qualitative analysis presented here draws on data mainly from women's post-intervention and 6 month follow up interviews selectively.

Participant Profile

The 24 women who completed post-intervention interviews reported that the abuse they had experienced from their former partners lasted for, on average, 7 years and that they had separated from their partners 17.7 months prior to when they first entered the study (range 3.5 to 36 months). While 56.5% of women reported ongoing harassment from their partner, the remainder reported no contact. Overall, 30% of the women in the study had used a shelter within the past year and many had previously accessed a variety of services across sectors. Women were, on average, 38 years old (range 18-72 years) with the majority (66.7%) having dependent children. Five women self-identified as members of a visible minority group. Only 25% of the women were employed; 66.7% reported living on social assistance within the past six months, and 35% of women had accessed the food bank within the past month, demonstrating considerable economic disadvantage. Many of these women were beginning the application process for government disability benefits in order to increase their monthly earnings. Overall, the women reported poor health, screening in at baseline with clinically significant levels of post-traumatic stress on the Davidson Trauma Scale (Davidson et al., 1997) and depressive symptoms on the CES-D (Comstock & Helsing, 1976; Radloff, 1977). Women also reported high levels of chronic fatigue, difficulty sleeping, and feeling sad.

Almost 30% of women lost 30 or more days of work or usual activities in the past six months due to chronic pain. Finally, overall 54% of women visited a family doctor and 42% of women visited another general practitioner within the past month. Although half of the women in this study reported access to a primary health care provider, many continued to use emergency services or walk-in clinics to manage their health problems.

Data Collection and Analysis

Consistent with the feminist orientation of this study, the qualitative portion of the study interviews were conducted in an interactive, dialogic manner that required self-disclosure on the part of the researcher, encouraging reciprocity (DeVault & Gross, 2011; Hesse-Biber, 2007). A semi-structured interview guide was used with flexibility, to engage in a dialogue with women in a collaborative manner. I had the privilege of interviewing women three times over the course of the study which provided an opportunity for consistency, promoted trust and enhanced dialogue (Lather, 1993; 2007). Consistent with the recommendations by Loftland & Loftland (1995), with the woman's permission, qualitative portions of the interviews were audio-recorded and transcribed verbatim by a transcriptionist. All identifying information was removed from transcripts to protect participant confidentiality (DiCicco-Bloom & Crabtree, 2006). Pseudonyms are used in this report to further protect women's identities. In addition, I took field notes after each interview in an effort to further situate the data and attempt to capture context. This interactive process provided a dialectical framework within which to present findings and check descriptive and analytical validity (Yuval-Davis, 2006).

Data analysis took place concurrently with data collection with the ultimate aim of becoming immersed in the data (Polit & Beck, 2004) and allowing for emerging

analysis to inform subsequent interviews (Tesch, 1990). This is consistent with a conventional content analysis method (Downe-Wamboldt, 1992; Hsieh & Shannon, 2005). Pre-conceived categories of data coding were avoided (Konracki & Wellman, 2002), instead allowing the categories and names of categories to be identified from the data using an inductive approach. Coding was focused on both manifest content, that is visible, obvious components, and latent content, that is interpretation of the underlying meaning of the text (Graneheim & Lundman, 2004). In addition, copious field notes and memos of impressions and insights on individual transcripts were made throughout the process of analysis to encourage self-reflexivity (Heaton, 2004). As this process continued, a structured coding scheme was developed in consultation with committee members. After initial coding of transcripts, the coding scheme subsequently evolved to capture new ideas as the analysis proceeded. Although the majority of interviews were independently coded by me, early in the process, some interviews were independently coded by me and my thesis supervisor in order to ensure congruency. In committee meetings, we reviewed the coding of the transcripts to discuss and reach agreement on the coding and to refine codes and operational definitions as needed (Fonteyn et al., 2008).

Coded data were sorted by coding category using NVIVO 9 and data in each category were examined for what they indicated about the concept it represented. Through comparison, data were used to confirm, expand, refine, or question the conceptual categories in an iterative process in collaboration with the research team. A conceptual map was helpful during this stage of analysis (Schilling, 2006) and was utilized in data analysis meetings. Trustworthiness was promoted through activities such as prolonged engagement and member checks in the research process and persistent

observation with data collection over time through participation in the larger provincial pilot study. In addition, ongoing meetings and debriefing with committee members provided an opportunity for triangulation of various data sources, comparing case summaries, examining negative case analyses and individual case summaries through various tools in order to promote reliability (Lindoln & Guba, 1985).

An Intersectional lens can be used as an analytical tool to correct the omissions and distortions in analysis caused by failures to investigate the structures of power, gender, race, class, ethnicity, sexuality and nationality (Hawkesworth, 2006). In order to understand how social location impacts women's experiences of the *iHEAL*, a specific layer of coding which addresses varied locations was developed by the research team. Intersectionality is compatible with a wide range of research methods making an easy link between the qualitative analysis reported here and the larger project. An Intersectional lens helped to map the ways in which gender, power and inequity are created and maintained through institutional practices and structural processes (Berger & Guidroz, 2009). Thus, Intersectionality guided the process of interpretation to elucidate both obvious and hidden meanings by coding for social location and its impact on women's experience with *iHEAL*.

Results

The results of the qualitative content analysis presented here are presented in three sections: 1) Spinning in Circles; 2) Finding my Footing; 3) Moving Forward. This language may create the perception of a linear, ordered trajectory. In fact, there is some time ordering of these three processes, but they also overlapped and most often occurred

simultaneously. Collectively, they reflect key elements of women's experiences of the *iHEAL*.

Spinning in Circles: the Exhausting Process of Help-Seeking

The health effects of violence were significant and led to multiple challenges for women after leaving their abusive partners. Although women were questioned regarding their experience of the *iHEAL* intervention, they consistently framed their experience through the lens of their previous help-seeking and service use, providing necessary context for their experience of the *iHEAL*. Women demonstrated persistence in seeking out services, yet they consistently experienced multiple barriers. In addition, women often experienced poor fit between these services and their needs. Ultimately, this process proved exhausting and the multiple barriers compounded the challenges they faced. As a result of these negative experiences, women consistently came into the *iHEAL* with no to low expectations of what they might gain, and viewed their *iHEAL* experience through the filter of their frustrations with their previous service use.

Barriers and Blame

Prior to the *iHEAL*, women actively sought out and attempted to utilize many resources across sectors. Many women did benefit from access to shelter, Domestic Violence (DV), or counselling services, but as they attempted to move forward with their lives, what was offered was often not sufficient to meet needs. In fact, many described their experiences as frustrating and unhelpful. Specifically, Victoria was a successful financial planner who remained immobilized due to the health effects of violence and a lack of appropriate support despite accessing a variety of services:

I had tried my EAP program several times, like marriage counselling, individual counselling, and...all I got was statistics. I didn't continue with the last bout of counselling because I didn't feel that it was giving me anything that I needed, I was still that one legged duck spinning around in a circle.

This experience was not specific to the mid-sized, urban, Canadian city where this intervention took place. Many women in the study were mobile and had lived in multiple, varied contexts. Overall, women often experienced poor service fit which ultimately led to unmet need. Natalie, for example, demonstrated persistence in trying to access services in every city where she re-located despite her recurring, negative experiences. Natalie sought help from five different domestic violence services in three cities but, because the services did not match with her needs, she “walked out in the middle of a session” and, in each of the other instances, “only went for one session and never went back.” Women continued to attempt to get what they needed, but this challenging process came at great expense. In fact, many women spoke at length as though they were “fighting against” the system and exposed multiple barriers. These barriers were both at the level of individual service providers and the structural level.

Many women experienced specific difficulties accessing supports and receiving consistent care. Although just over half of the women in this study had access to a primary health care provider, many women did not find these interactions helpful and, as a result, accessed walk in clinics or emergency departments to manage their health problems. Specifically, patriarchal values within healthcare created disempowering conditions which, ultimately, hindered relationships and prevented women from accessing care. For example, Avery, an older woman whose main source of income was

disability benefits, lived in constant fear of not having what she needed to survive on a day to day basis. Avery's consistent frustration with her physician, who she saw as patronizing and of touch with her needs, reveals the deeply gendered process and power inequities exist in women's interactions with the health care system:

[What helps] is not medications, okay, here little girl, go home, take these pills and go home. That doesn't help...

Often women who were more marginalized expressed a feeling of powerlessness when dealing with physicians which interfered with their ability to advocate for themselves, resulting in unmet health needs.

Women experienced multiple barriers to accessing services, such as safety concerns, transportation, lack of affordable child care, limitations around the amount of service to which they were entitled, or financial instability. Avery further described how she confronted multiple bureaucratic barriers when she sought help at a specific program:

...I went down there one time and they said "Oh you got the wrong date" and I said "No, I wrote it down from what she was saying on the phone." It was bad enough going all the way down there, trying to find parking and you don't know who is around you. Then you get that, bad reception and nobody to even talk to you. At the time I thought, no, I don't need that!

Judgement or attitudes of care providers impacted women's ability to connect with and trust services. Many women reported dissatisfaction with services as a result of these interactions. These frustrations with service providers were echoed by Talia, a young Aboriginal woman who confronted multiple layers of bureaucracy with social services when attempting to acquire a bus pass. In fact, many women described

difficulties when interacting with systems that default to “blame the victim” whether intentional or not. Miranda, a single mother of two, was living on Ontario Works (OW), felt that she had experienced injustice at the hands of the housing system:

I left where we were living, and went to a [shelter] with my children. I went back to my townhouse to get some stuff. And my ex came and kicked off, ripped off the bathroom door where we had locked ourselves in, my children and I, and just basically destroyed the whole house. There were holes in the walls from him, and doors off the hinges. I have police reports; I mean he got arrested from that. Now, I have to pay over \$2000 to fix what he destroyed in my house, while he beat me up. And I’ve called housing, I’ve said, “look I have a police report number for you, like he was charged, he plead guilty, he was convicted...and you’re going to expect me to pay for this or I can’t get housing?” Clearly, I didn’t let the man in, he kicked down the door. It’s frustrating, so frustrating. That’s not the way the system should function, blaming the victim.

Danielle recounted a similar experience dealing with police and victim services after her ex-partner physically assaulted her by breaking into and damaging her home while she was sleeping. She explained her reasons for remaining silent, rather than fighting back:

If this happened again I would not have called the police, I really wouldn’t have, because of how they made me feel. Like I would have just shut up and just took it really. They didn’t realize, they did more damage than anything, so that’s kind of a scary thought. That people are out there that just don’t say anything, will not do

anything, because of what [they are] going to get with the system. Next time, I wouldn't have done anything.

Many women reported that silence would be their chosen response rather than continuing their attempts to access support after experiences with the system. As a result of learning that they can't trust the system to be helpful, many differently located women became reluctant to seek help or didn't expect much from services they did access. Both of these conditions left women with limited support at a time when they need it.

Women who experienced multiple forms of oppression, such as poverty, racism, disability, ageism and so on, found their access to resources to be particularly limited, in part, due to the costs of services, such as counselling, and lack of affordable childcare and/or transportation to access these services. For example, women with access to a helpful counsellor or free community service were limited by of number of appointments offered or the fact that only group sessions were available due to financial constraints. Furthermore, although some services were located within the accessible downtown core, women cited safety concerns as a barrier to seeking help. Women's paid and unpaid work left little time to sort through complex systems, and few had the luxury of paid time off to attend services. In fact, many women expressed feeling stigma associated with asking for help; they feared the involvement of the system because they anticipated being judged or were embarrassed about their circumstances. Even when women successfully accessed services, those services were often inadequate or inappropriate, leaving women feeling frustrated. Thus, for many women, the process of help-seeking proved to be both a frustrating and unhelpful experience.

The Exhausting Process of Help Seeking

Without consistent support, many women found it challenging and exhausting to try and overcome bureaucratic constraints and receive quality care or support from services across sectors, and this increased stress, compounding pre-existing health problems and threatening women's often fragile functioning. Avery eloquently described her experience of "re-victimization":

It's like the woman is being re-abused by the system, constantly, you know, it's just the not knowing. It's like your husband treating you like, "Oh, well, I'm taking your money away from you. And I'm not going to let you know anything that's going on from one day to the next." And it can change --We don't need to be re-abused again because it just pulls you right back there... We don't even have a voice, period. Then we start getting our voice back and it doesn't help us... We get slapped right back there by the system.

This woman is highlighting her attempt to access resources from the health care system in order to support her living independently as she suffers from the health effects of violence compounded by chronic disease and the aging process. Despite countless attempts to contact service providers and their managers and government officials such as the Minister of Health and Long-Term Care, an inability to successfully advocate for herself greatly impacted her quality of life and hindered her healing process due to a constant worry of not having what she needed to survive on a day-to-day basis.

Despite significant health problems and needs for treatment and symptom management, many women focused on ensuring proper care for their children at the expense of their own health. When finances were strained, many women took medication every other day, or as often as possible, or simply went without, despite significant needs.

Beth, a single mother of two children who had fled an extremely dangerous partner, had entered the witness protection program, and was living in constant fear, with limited supports. Although previously employed in a successful professional capacity, Beth was unable to maintain full time employment due to the profound physical and mental health effects of the violence she experienced; in the context of poor health, she found the three hour commute to work exhausting. She talked about the extreme difficulty her family faced transitioning out of that violent relationship without support:

It was a shock to the system...It's probably hard for a lot of women in my position to actually ask for help, or even to know what you need. You know because it's just so overwhelming...I knew we were just surviving, everybody has emotional needs. Especially the children, it's been a big challenge getting help.

Beth used an empty bronchodilator inhaler to treat her asthma because she could not afford to refill her prescription. Ultimately, she ended up on life support in intensive care. This is problematic because in addition to external barriers, it was challenging for some women to seek help due to chaotic lives and unfamiliarity with services.

Overall, although women were attempting to seek help and access services, they faced multiple barriers to help-seeking, resulting in unmet needs. In fact, although many women did access some service, they experienced a poor fit, or were unable to get enough of what they needed. Part of women's exhaustion with help-seeking included traveling to a variety of agencies and overcoming barriers. This process proved to be exhausting for women and despite their persistence, many women did not find the support they needed to ease their transition out of an abusive relationship. The inability to obtain services that met women's unique needs made it difficult for them to move

forward and, as a result of these experiences almost all women had limited expectations of *iHEAL* and its ability to impact their lives.

Finding my Footing: Addressing Women's Shifting Needs

The majority of women expressed their dissatisfaction with “cookie-cutter” services that were available to them as a result of leaving an abusive relationship; these programs tended to treat women in an impersonal way, rather than responding to their particular needs and tended to reinforce the dominant assumption that leaving an abusive relationship solves “the problem”. During the transition after leaving, many women found that they experienced shifting needs in their attempt to deal with the effects of violence. Women consistently described the *iHEAL* as collaborative and individualized support, provided according to their specific needs. Due to the high degree of emotional safety and trust that developed with the interventionists, women were able to create a space for healing by focusing on themselves. Goal directed and purposeful dialogue encouraged the women to address intrusion and build capacity. Strategies developed as a result of working with the interventionist promoted women’s independence and built long-term supports. Interventionists were able to work outside of the system and yet still have access to its resources in order to help women access resources to aid the transition.

Finding Services that Fit with Shifting Needs

As women transitioned out of the violent relationship, their support needs also changed. With the realization that the abuse was no longer central, women discussed how access to DV and counselling services were not as helpful as they once had been. Many identified that there was a gap in the types of support they needed longer-term. In particular, women consistently expressed discontent with traditional “*how do you feel*”

counselling services because they did not offer practical support to help them build the resources they needed to move beyond the violence. Talia reflected on the initial transition of leaving, and talked about how she needed more practical help and support to build resources that meet her unique longer-term needs:

Counselling is like, you know, just counselling, it's not anything else. It's not more resources or advocating. It was just going over feelings, you know. *iHEAL* was more resourceful and talked about your health and what you want to do as a person now that you have left that situation. You're starting life over, and what other resources in the community can help me move forward.

Miranda, a single mother of two, echoed these frustrations with traditional DV services:

[*iHEAL* is] based on what you want, what the woman wants. It's no cookie cutter. It's based on what you want to do with your life and where you want to go after leaving the abusive situation. Because shelters are good places - When you're there they may help you find a place to live, but after that, you're on your own. Where do you go from there?

While women valued shelters and DV services, they also highlighted that these services paid little attention to women's needs beyond the crisis of leaving.

Many women found it extremely difficult to begin to re-build their lives after leaving the relationship and felt overwhelmed by multiple forms of intrusion. Avery who felt she was "stronger than a lot of [women]" despite her physical limitations, found it extremely challenging to address the financial instability, lack of transportation, physical and mental health problems, and safety issues and lived in a constant fear that her ex-partner would return. Despite her training as a therapist, she found that as her needs

changed, she was unable to find appropriate support. She, and many women, highlighted the ability of the *iHEAL* to address her multiple, changing needs after leaving with a unique, individualized approach. As a result, the majority of women felt that the *iHEAL* was a much better service fit to address their shifting needs during this stage of attempting to get their feet on the ground.

Making a Connection

iHEAL was consistently described by women as collaborative, individualized support provided according to their specific needs. Women were surprised by the trust they developed as a result of working together with the interventionist. Interventionists were reported to be non-judgemental in their approach to active listening and strategizing with women. When interventionists followed through with helpful referrals or contacts, suggestions, strategies or access to information, women were more likely to engage in further dialogue and continued to develop trust. Katie had attempted to use multiple services and was struggling with both the legal and judicial systems in an attempt to convict her ex-partner. She was also working part-time with a local DV service and finishing her social work degree. Although she highly valued DV services, she remained mistrustful of some service providers:

What surprised me is the relationship, the trust I have for the interventionist. I was not expecting to be able to trust, or to be able to open up to somebody that way. I've been very guarded of my feelings for the past few years because I've had to protect myself from so many things. So meeting with someone one- on-one who will take the time, and who actually listens to you and doesn't try to stop you from talking, who actually understands what you're saying is huge. I didn't expect

to be able to talk to somebody as openly as I have, and to feel as supported as I have, I wasn't expecting that.

Even women who expressed the most difficulty with the intervention felt a level of connection with the interventionist. In fact, the women often used familial language to describe the relationship with the interventionist, expressing a high degree of emotional safety and connectedness. Rochelle had an extremely challenging relationship with her mother and ended up living on the streets after leaving home. She described her experience working with the interventionist like having the trust and support of a sister:

It was kind of like she was my big sister. I was able to talk to her about certain things and I felt comfortable. So I think the confidentiality, knowing that whatever I said in the house, wasn't going to be talked about everywhere, and it took a couple of days to build this bond, trust for her. So I knew she wasn't going to run off and tell another social worker, you know what I mean, like point your finger 'you should not do that.

Rochelle reinforced the importance of confidentiality and the non-judgemental attitude of care providers which created acceptance and trust. She had previously been prevented from a fresh start in a new city due to the actions of a social service worker divulging information to a new service provider, which led to a mistrust of "the system".

Another common trend amongst women was referring to the interventionist as being *like a friend*. Natalie was the youngest woman in the study and had an extensive history with counselling but connected with her interventionist in a way that was unique:

Any counsellor I've been to is like, oh poor you, poor you. That whole survivor way of counselling. It was like they were catering to you...And they are just

battering you up so you would talk to them. Plus on top of it they would judge you a little bit. And I just wanted to talk about it with a friend instead of a counsellor. [The nurse] was much more of a friend to me than a counsellor.

These examples illustrate that the woman-centered approach of the intervention created a space for shared power and a comfort level with an authentic care provider that engaged women into the process of collaborative goal-setting to address their multiple needs. This consistent connection with the interventionist in conjunction with the unique structured flexibility of the intervention permitted the women to engage in the process of working towards overcoming the effects of the abusive relationship.

Space for Healing

Focusing on the self was an aspect of the intervention that many women found both crucial and incredibly challenging. The *iHEAL* provided time and space for women to address their own priorities, including how to care for themselves. As previously noted, many women reported that their experiences with counselling or DV services focused more on the abuse and ex-partner. Many women found this to be problematic in many ways. For example, Danielle was struggling to co-parent with her ex-partner and maintain consistency for her daughter and boundaries for herself. In contrast to her previous experiences with counselling, she found the focus of *iHEAL* to be much broader than simply focusing on “him.”

In fact, many women needed encouragement from the interventionist to take time for themselves. Most mothers found this task extremely difficult as their priority was often their children and the practical needs of their families. *iHEAL* provided a unique opportunity by creating a safe space for women to address their own emotions and

personal needs. Elizabeth argued that although it was challenging to focus on her own needs, she viewed this as integral to the healing process. Elizabeth was so busy meeting the daily practical needs of her family that she struggled to address her own health problems and needs. Furthermore, the support of a consistent care provider created a safe space to address her concerns that often related back to experiences of violence:

Honestly, I figured it was going to bring up stuff right, but I didn't expect it was going to make me heal better than counselling...because I talk like that with my counsellor. I talk like that with my Mom. But nobody focuses on me. Everybody focuses on the family and what he did. [The interventionist] made me realize my strengths, and my goals, and what I can do for self-care. Nobody ever tells me to take care of myself like that. So once I started doing that, then it really worked.

The goal-directed discussion and purposeful dialogue engaged the women to address their individual concerns. These conversations with the interventionists were crucial for not only addressing intrusive factors but also for building the women's capacities. This also reinforced the message that women were "worth it" in contrast to the negative messages given to them by their ex-partners. Although some women reported that completing modules was challenging due to difficulty with the "homework/school aspect" of the modules or perceived lack of time, the majority thoroughly enjoyed the intervention in its entirety. For example, Stephanie previously had struggled in school and at times found the homework daunting. She described a need to trust the interventionist before she could engage in this eye-opening process:

I got a lot out that I wouldn't normally be able to get out anywhere else. [iHEAL] had the questions and the modules that needed to be worked through but there was

always leeway. And the conversations and the eye opening things that came out of working through those was huge too, because it gave me a purpose. You know, there was work that needed to be done...and I found that having that purpose really helped focus me and put me in the frame of mind that I needed to be in order to help heal myself.

Many women suggested that, rather than ending after 6 months, the intervention could have been flexible and tapered off according to women's specific needs. Although the women had the encouragement and support of the interventionist, they were responsible for their own work and the direction of the intervention. The interventionist was there at times to give women a push, or to hold them accountable, but this was not done judgmentally or punitively. Women worked with the interventionist collaboratively but took responsibility and ownership over the intervention and for the changes in their lives. Thus, for many women, including Rochelle, this connection with the interventionist did not create dependence but, in fact, gave them ownership of their future and ultimately their life:

She would listen to me or she would give me feedback, but it was up to me. She wasn't there to tell me what to do or to guide me through certain situations. I mean she was there to guide me through situations, but I was the one that needed to do the work.

Elizabeth echoed these thoughts of feeling more independent after the conclusion of

iHEAL:

I don't need [the relationship with the interventionist]. No, no, I don't need it. I miss her, because she's a wonderful woman. But she definitely gave me the tools to go on.

Working From the Outside In

Interventionists had the luxury of working outside the restrictive nature of the health care system while, at the same time, having access to its resources. Despite not being connected to a formal system or program, the *iHEAL* interventionists were able to access multiple resources due to their expertise and connections. In this pilot study, the interventionists were mainly Registered Nurses with a unique skill set, knowledge and ability to assess women's needs, plan and implement accordingly. Furthermore, interventionists' credentials and connectedness to the system facilitated their ability to make referrals and assisted with advocating for client needs within the various systems. When asked what she found helpful about *iHEAL*, Beth reported that one of the best parts was the ability of the interventionist to follow through with connections to community agencies:

The referrals in general. When you asked the nurse for help, she did it. Like anything that she said she would do, she did. Yeah, she followed through. And so in some ways she went above and beyond.

In this case, the interventionist ensured connection and access to a primary care provider, access to affordable medications, connections to local services, access to a local gym, referrals to programs for her children and overall, on-going emotional support. The ability of the interventionist to follow up and make supportive connections within the community with women reinforced women's trust in a care provider.

Miranda reported that often life after leaving her relationship seemed bleak. She was left attempting to work with multiple services that functioned in silos. In collaboration with the interventionist, she was able to hold a meeting with all services, where she regained power by facilitating and advocating for her needs. These vital connections to resources were important to provide continuous support and for her, this ultimately represented a hope for the future:

I think the best part is the confidence I have gained from this. Being able to know what resources are available out there and being able to get the help. That's huge. Because not having that and going through this, you feel lost and hopeless, I actually have hope now.

As previously noted, women identified many barriers that prevented them from accessing services and some expressed safety concerns related to the location of services or fear of the ex-partner. Women also discussed the public transportation barriers, both financial and time constraints, especially when attempting to travel with small children.

Interventionists tailored the *iHEAL* to women's needs and were extremely flexible in negotiating with women about when and where they would meet. Interventionists earned women's trust by meeting in parks, community centres, libraries and even at the curb on the side of the road - wherever and whenever the women felt comfortable. Women quickly developed trust with the interventionist and often opened up their homes for meetings. This type of flexibility not only decreased barriers to participation but helped to reinforce the woman's control and worth. Liza's comments illustrate that the intervention was women-centered and that the interventionist was critical to the process of reducing barriers to address women's diverse needs after leaving:

[the interventionist] exceeded any expectations I might have had: psychologically, emotionally, spiritually, physically, everything. With the *iHEAL* I felt like I wasn't just on the list for the nurse and that she wasn't in a hurry. And that was the great thing because it depended on me. And if I couldn't make it one day because of my [gastrointestinal problems] she was fine, and she worked completely with me. She made it really easy. I felt like her priority. A lot of times, I couldn't go and meet her somewhere and she would come here which was amazing, because I probably wouldn't have met with her otherwise.

Moving Forward: Shifting Gears

Immediately following the completion of the *iHEAL*, women consistently reported positive personal changes which they attributed to their participation in the intervention. Women, and others in their lives, recognized that they had changed in important ways, particularly related to their confidence, awareness of self, sense of worth, mental health, and knowledge of resources. Women's shift in knowledge, skills, and connections they developed as a result of participating in *iHEAL* equipped and encouraged them to move forward with their lives. Furthermore, this personal growth and healing resulted in women's desire to help and advocate for others.

Ready to Move

Women felt that, through the process of working with the interventionist they were able to realize that either they possessed the skills and abilities to move forward or, they were able to identify gaps and strategize to move forward by developing skills. Elizabeth felt that the knowledge she gained contributed to this outcome. She had been

separated from her partner for more than a year and initially did not believe she would see positive changes as a result of the *iHEAL*:

The intervention was very eye opening. I didn't realize how much risk I was in, even though he had been gone for so long. It was very supportive...And I feel much stronger now that I've done it. [The nurse] made me realize that I had all the stuff I needed. I didn't have the confidence in myself or the self-knowledge that I thought I had until after.

Similarly, Olivia was extremely skeptical of the intervention and overly critical of the interventionist due to her previous interactions with care providers. Although she had bad experiences with professionals, she felt that she was stronger and "got to know who I am as a person and what I deserve". Many of these powerful changes in confidence and strength were sustained at 6 months follow up.

Women made significant strides not only in self-confidence, but also in their confidence in their ability to access resources in the community and to make supportive, long-term connections. Women were not only connected to these resources and were making positive changes in their own lives, but were willing to step out and help others in similar circumstances. For example, many of the women enjoyed access to the modules and the information after the intervention ended; some women even passed on materials to other women in similar circumstances to educate them and share the knowledge they had gained as a result of the *iHEAL*. By the end of the intervention, many women were feeling confident enough to begin to actually engage in social justice or advocacy work. Kelly, a senior citizen, became passionate about speaking out for elderly women and relayed a desire to share her experiences with others as a result of this intervention:

I certainly feel more confident that I can do things, that I never thought I would be doing for the rest of my life, to be honest. I've kind of come from being very inward, and I'm going forward now. And I want to do a lot more things with the rest of my life...for seniors, in my instance, and women, senior women. Next to single moms, they're up there! And who cares? They need a voice!

Despite many positive changes women experienced as a result of completing the *iHEAL*, at the end of the intervention, many women continued to struggle with poverty and financial instability, were living on social assistance, and still accessing food banks. The knowledge that women gained about how to connect and move forward often coincided with a decision to further their education or employability training in order to improve their lives. Many were willing to accept short-term hardships for long-term gain, demonstrating an orientation towards future planning and skillfully accessing resources to do so. Liza, a woman who was immobilized by health effects of violence when she entered the study, was almost unrecognizable at the six-month follow up interview:

I'm not the same person. Like when you first met me, I spent most of my days lying on the sofa with the heating pad... My plan right now, and I'm still struggling to do it, is to finish my grade 12 and that's not going to happen for a few months. There's a [program] coming up in June that I am going to be speaking at ...But the goal is to end up with my social work diploma. I've got a five year plan now, kind of. But I'll have to stay here, and if I stay here and if I go on OSAP, my rent drops down to 85 dollars. I'll just have to be at food banks for the next five years and I'm really, really suffering financially, but oh well. I can't do anything about money right now, I just can't.

This financial barrier was present in the majority of women's lives and a huge obstacle to their ability to move forward. Despite this, women were working hard to overcome this obstacle and create a better life for themselves and their family.

Personal Growth and Healing

Interventionists assisted women by equipping them with tools to respond to intrusive factors or by helping women to realize they already possessed the skill and ability necessary to move forward. The process of focusing on the self provided women with time and resources needed to actively work on their own health and healing. Despite significant positive changes in overall health, the majority of women did not initially expect the intervention to impact their health and tended to view health from a traditional absence of illness perspective. Many women expected a “physical nurse, but not a mental health nurse” and were encouraged by the more holistic approach to health. In fact, the interventionist often addressed health untraditionally and almost seamlessly throughout the entire course of the intervention. For example, as nurse interventionists worked with the women collaboratively, they were able to assess women's needs and strategically incorporate grounding techniques into routine safety planning to reduce anxiety.

Many women expressed concerns regarding their health care provider, or lack thereof. As a result, women often drew on support from the Registered Nurse interventionist to help them advocate for better fit between health services and their particular needs. They reported that nurses wrote letters on their behalf and, when necessary, attended appointments to assist with self-advocacy. Liza shared an example of her own resourcefulness after demonstrating an ability to self-advocate for her needs with a physician:

I'm still struggling with my health a bit, but I've got med[ication]s for it now because [the interventionist] came with me to my doctor twice to help me self-advocate. Because I was having troubles doing that and [the *iHEAL*] made all the difference. And I don't know if it's because he listened to her or because her being there enabled me to self-advocate, or both. But it did make all the difference. Every now and then I'd kind of get stuck because I am intimidated by the white suit, and I'd look at her and then I could carry on... So yeah, I've got meds for the first time in two and a half years. And worst case scenario, [the physician] doesn't know I don't see [the interventionist] anymore. I've got it in the back of my head that he thinks she's around right? So in my mind I've got a backup still, and he thinks I do too. He doesn't need to know right?

This reflects how women's gains in confidence and knowledge of the complex systems helped them navigate services independently and resourcefully.

Despite the complexity of physical health problems, many women were more concerned with mental health or emotional symptoms. Specifically, Kelly was hospitalized for cardiovascular problems and ended up in the intensive care on life support due to respiratory distress; despite the positive changes to her physical health, in her reflections about the *iHEAL*, she focussed primarily on shifts in her mental health:

Well in 6 months, I had some physical changes that were good. But the mental changes! I feel like, you know I'm a person. I'm going to contribute. I'm worthwhile and I'm going to sally forth with the throng.

For many women, a positive outcome of the intervention was the fact that they were supported to obtain access to a high quality, consistent, primary care provider. Many

were referred to nurse practitioners or physicians through Community Health Centres or Family Health Teams. After the completion of the intervention, many women are still living with the negative physical health effects of violence, but women also expressed positive changes in mental health. Although Elizabeth was still experiencing high levels of chronic pain, she reported positive changes to her health:

I just feel so much better after. And I didn't want it to stop. I just feel more whole.

I don't know. Just yeah, I feel healed after everything. Healing looks like peace.

Yeah, peace and I feel calm. Yeah, she made me realize that I had all the stuff I needed.

Talia revealed that she was six months sober as a result of engaging with the interventionist and was making strides in her health. Although, she too was living with chronic back pain that affected her employability, she was eager to move forward:

Working with [the interventionist] was a really good experience overall, just helping me to become stronger and more positive in everyday life. And I have to say, it was probably one of the best experiences I've had, like *life giving*. It has empowered my life, to move forward and not to take no for an answer from anybody and not, you know, put up with abuse or violence from anybody.

These experiences of healing enabled women to continue moving forward.

However, it was not only women who were aware of this healing process; other professionals who interacted with the women from the outside recognized the positive changes. Danielle reported that although she felt like she was making progress, her family members and health care providers noticed she was "all around happier" with life after

the completion of the intervention. These examples powerfully illustrate the impacts of the *iHEAL* and its ability to impact women's health and quality of life.

Discussion

The purpose of this study was to explore women's experiences of participating in a complex, primary health care intervention, called the "Intervention for Health Enhancement After Leaving [*iHEAL*]" developed for adult women who have recently separated from an abusive partner. A particular focus of this study was on understanding how women's varied social locations affect their experiences of the intervention. The findings of this study contribute insights about women's experiences of the *iHEAL* to consider with outcome data from the larger feasibility study in order to further refine and develop of the *iHEAL*. Overall, women reported overwhelmingly high levels of acceptability, integrity, and helpfulness of the intervention. Women universally reported that the woman-centered approach of the interventionist and the development of knowledge, skills and connection to resources facilitated access to the social determinants of health to address their ongoing needs after leaving.

Contrary to the assumption that separation from the abusive partner eventually resolves the most significant problems that women face, including health problems, both improvements and deterioration in specific health outcomes have been documented in the few longitudinal studies in which health consequences of IPV have been examined (Campbell, Sullivan, & Davidson, 1995; Mertin & Mohr, 2001; Woods, 2000). The health consequences of IPV are well-known and documented within the literature (Adkins & Kamp Dush, 2011; Campbell, 2002; Ford-Gilboe et al., 2009; Rivara et al., 2007; Wuest et al., 2009). However few interventions have been developed and tested to

address the health effects of violence (Ford-Gilboe et al., 2011; Wathen & MacMillan, 2003). With few exceptions, most emerging IPV interventions within the health care system emphasize safety planning or empowerment (Tiwari, 2005; Ford-Gilboe et al., 2011) around the time of disclosure (Jack et al., 2012).

It is important to develop and rigorously test interventions for women who experience intimate partner violence in order to understand how best to help women address the health effects of violence after leaving. Within healthcare, a push towards evidence-based practice is intended to result in the informed use of the best evidence and as a result create more effective treatments (Trinder, 2000), but this model often limits the integration of qualitative findings. Perspectives of women participating in interventions for women who experience IPV are lacking within the literature and despite positive outcomes reported, little is known about women's experiences within interventions that seek to address their needs. Sandelowski (2004) argues that qualitative health research is important in creating best practices. Incorporating the strengths of both qualitative findings and quantitative outcomes is crucial in developing and refining interventions for women who have recently left an abusive partner. Furthermore, the use of an Intersectional analysis aids in the creation of transformative knowledge by considering social location and women's diverse experiences. As such, incorporating women's feedback described in this analysis into the larger feasibility study will provide an important basis for further refinement of the *iHEAL*.

The findings of this study also suggest that the delivery of the *iHEAL* was consistent with the foundational principles and philosophical assumptions that guided its creation. Women most frequently described this intervention as women-centered or as an

opportunity to focus on the self. This strengths-based process enabled women to focus on their health as a priority and work towards healing. As a result of this practice model, many women reported huge gains in their personal and family health. Although the *iHEAL* was not intended to be trauma therapy, the changes women noted as a result of taking part in the *iHEAL* are consistent with successful stabilization of their lives after leaving. Herman (1997) describes trauma recovery as unfolding in three broad stages: 1) establishing client safety and stabilization, 2) remembering, exploring and mourning past trauma, 3) reconnection. Stage-oriented treatment was conceptualized based on extensive clinical experience demonstrated that many survivors of severe abuse require initial and often lengthy periods to develop fundamental skills before they can explore or process traumatic events (Centre for Mental Health and Addictions, 2009). Consistent with this perspective, as women took control and as the chaos in their lives diminished, they began to focus on themselves and demonstrated both skills and connection to resources in order to assist with access to the social determinants of health. Furthermore, the gender-sensitive conceptualization of trauma demonstrated within the *iHEAL* accounts for women's experiences of childhood abuse and partner abuse as traumatic experiences that are motivated and supported by entrenched beliefs about socially ascribed roles, responsibilities and locations of individuals due to their perceived gender role (Samuels-Dennis, Bailey, & Ford-Gilboe, 2011). This finding suggests that stabilization work undertaken within the *iHEAL* can be enacted by Registered Nurses with additional training, and may be a powerful strategy for assisting women to heal from the effects of trauma.

Barriers to accessing and using services are not well understood within the literature (Rodriguez, Valentine, Son, & Muhammad, 2009). Overall, women reported that their prior help-seeking experiences were a difficult and exhausting process. This finding reinforces previous research (Barrett & St. Pierre, 2011; Plitcha, 2007; Brownridge, 2008; Wilson et al., 2007; Runner, Yoshihama & Novick, 2009; Bui, 2003; Wachholz & Miedema, 2000) highlighting the multiple barriers that women who have experienced IPV face during the process of help-seeking. The more forms of oppression a woman experienced, such as poverty, racialization, and disability, the more constrained were her 'choices.' A woman's level of income was a particular powerful factor which shaped her choices. Income is the most consistent social determinant of health and among women who have experienced IPV, low income is a powerful determinant of decisions to stay or leave their partners and ability to maintain separation (Anderson & Saunders, 2003). Although previous research demonstrates that women who earn higher incomes, or who are more financially independent, are more likely to seek help (Henning & Klesges, 2002; Kim & Gray, 2008), this study demonstrates that women with considerable economic disadvantage are also active help-seekers. This finding is consistent with Barrett & St. Pierre's (2011) analysis of data from the 1999 Canadian General Social Survey (GSS) in which the majority of women who had experienced IPV were found to use both formal and informal services and a variety of help-seeking strategies to address the impacts of violence.

Women reported a gap in the ability of the *iHEAL* to address their financial security. Although the *iHEAL* provided practical support for accessing basic resources, an area which is often not addressed in health interventions, it demonstrated little impact

on women's economic disadvantage at the 6 months follow up. In addition to support in accessing the basics, more focussed attention may need to be given to working with women to address women's economic barriers within the intervention. The *Advancing Career Counseling and Employment Support for Survivors (ACCESS)* is a five session, group intervention developed to restore women's educational, occupational and economic opportunities after leaving a violent relationship (Chronister et al., 2009). Early testing of this intervention demonstrated impacts on vocational self-efficacy (Chronister & McWhirter, 2006; Chronister et al., 2009) and qualitative accounts suggest increased self-esteem, motivation as well as impacts on women's vocational knowledge and self-efficacy (Chronister et al., 2009). A randomized controlled trial of *ACCESS* (N=73; Chronister & Davidson, 2010) demonstrated significant improvements in women's career-search self-efficacy and a reduction in perceived career barriers at 8 weeks follow up. However, despite women's perceptions of future perceived financial supports, no concrete economic changes were reported. This suggests that the economic problems experienced by women during the transition out of an abusive relationship may be difficult to change, particularly in the absence of structural changes to support women's efforts to improve their economic security.

Systemic structures can depersonalize people and create multiple and complex challenges for women who experience IPV (Wilson et al., 2007). Through a relational practice model, interventionists skillfully created the conditions for empowerment that helped women find resources and provided practical assistance, resulting in increased control and greater access to the social determinants of health. Shedding the dominant medical paradigm, Nursing has begun to articulate values that emphasize the human to

human process of caring (Gadow 1988, Leininger, 1988, Watson, 1988, Neil & Watts 1991, Crowley, 1994, Hartrick, 1997). Relational practice focuses on this experience and evolution of connections between clients and nurses (Hartrick, 1997; Doane & Varcoe, 2007). As Paterson & Zderad (1976) contend, Nursing is an experience lived between people in a shared context. Within the *iHEAL*, interventionists had the luxury of working outside the restrictive nature of the system while at the same time having access to its resources. Both the intervention and the interventionist were extremely flexible and this decreased participation barriers for women. The holistic nature of the intervention and the collaborative, individualized plan gave the interventionists permission to practice relationally in almost an ideal practice model. Perhaps the *iHEAL* points to what is possible within nursing practice utilizing a unique philosophy of providing care to women who have experienced IPV.

Active system navigation is presented within *iHEAL* as a foundational principle. In contrast to a more passive approach of providing information and educational pamphlets to inform women's choices, this active process of system navigation helped equip women to seek and obtain support from community resources and services themselves in order to reduce intrusion (Ford-Gilboe, Merritt-Gray, Varcoe & Wuest, 2011). This process included strategizing with women and supporting problem-solving to strengthen women's capacity. This strength-based approach of coaching women to advocate for their needs and promote health long-term provides a unique way of approaching system navigation.

Interventionists worked collaboratively, in relationship with women, to decrease the barriers women face when help-seeking after leaving a violent relationship. Although

some systemic structures are difficult to change (ie. geographical location of services, difficulties with transportation, policy), within the short-term time frame of the *iHEAL*, interventionists were successful in assisting women to decrease barriers to service access and use, in both direct and indirect ways and this was highly valued by women. Previous research has shown that, among women who are transitioning out of an abusive relationship, advocacy work is effective in helping women navigate social and/or housing systems, and in enhancing access to services and social support (Ramsey et al., 2009; Sullivan & Bybee, 2002). This study extends this body of literature by reinforcing the value to women of also focussing on navigation of the health care and social service systems within a larger system navigation model. In Ontario, individual medical practices in primary care, large multi-site hospital systems, municipally operated public health departments and neighborhood-based small community support organizations all are structured and operated primarily as independent entities (Ontario Association of Community Care Access Centres, 2005). This creates a complex system for those attempting to access resources within the healthcare system to address the health effects of violence. At the policy level, this study suggests a distinctive role for Registered Nurses which extends beyond identification of women who have experienced IPV, safety planning and referral to domestic violence services. Registered Nurses have the expertise to help women address the health effects of violence and access social determinants of health in ways that complement and extend domestic violence services.

Strengths and Limitations

Although this study drew mainly on post-intervention data and selectively on data from the six-month follow up interviews to reinforce findings, further analysis of these

data would be helpful in capturing women's experiences of iHEAL and its impacts over time. In moving forward with refinement of the iHEAL, consideration should be given to analyzing women's interview data from both the Ontario and New Brunswick pilot studies concurrently as a means of developing more in-depth understanding of women's diverse experiences. Convenience sampling, which was used for the larger primary study, can be helpful when trying to identify 'hidden' or marginalized populations which are reluctant to be identified due to concerns about privacy, safety, and stigma (Petersen & Valdez, 2005). However, variation in women's social locations was limited in the study sample. Only three Aboriginal women and one newcomer woman participated in the iHEAL. Furthermore, in contrast to a population sample, the majority of women in this study experienced considerable economic disadvantage. However, this pattern is expected as abuse erodes women's economic resources over time (WHO, 2006). Although intersectional analysis involves considering multiple social locations, rather than limiting or essentializing analysis to categorical considerations of race or gender, limited variation in women socioeconomic positions made such an analysis more challenging. There may be particular features of the sample and/or context in which the iHEAL which was delivered and tested which limit generalizability of the findings. Further testing of this intervention needs to carefully consider how these factors shape intervention processes and outcomes.

Structured interviews were used in the data collection and this can be helpful in minimizing missing data, as well as ensuring that language, literacy, and comprehension issues are adequately addressed (Polit & Back, 2008). Although the semi-structured interviews were conducted as a dialogue between researcher and participant, women may

have reported information due to a desire to appease the researcher. In addition, the researcher's interpretation of the participants' experiences may have been constrained by pre-conceived assumptions related to personal privilege and social location within society (Patton, 2001). A reflexive stance was undertaken to ensure credibility and to encourage self-awareness and self-questioning, in an effort to be attentive and conscious of the experiences and values I brought to the study and how these may have shaped the findings.

Conclusion

Intimate partner violence is a complex health and social problem which is shaped by multiple and intersecting personal, social and systemic factors. Interventions that seek to reduce IPV and its consequences must take the complexity of women's experiences of IPV and help-seeking into account if they are to be effective. The *iHEAL* is an innovative, trauma informed, primary health care intervention that addresses a gap in health services for women after leaving a violent relationship. Women's support for the *iHEAL* overall, was overwhelming and although they provided suggestions for changes to the process or implementation of the intervention itself, there was a consensus as to the program acceptability. Although *iHEAL* was designed to be a short-term intervention, many women reported that it helped them move forward to begin addressing their shifting needs for health and healing after leaving a violent relationship.

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CHAPTER III

IMPLICATIONS FOR NURSING

The purpose of this study was to explore women's experiences of participating in a complex, health promotion intervention for adult women who have recently separated from an abusive intimate partner (*iHEAL*), with particular attention given to how women's varied social locations affected both the processes and outcomes of the intervention. In this study, women actively sought help to overcome the impacts of violence after leaving a violent intimate partner. The findings of this study highlight the complexities of help-seeking for women living in socially and/or economically marginalized conditions. Despite their persistence in attempting to access services, many women experienced multiple barriers to system access, power imbalances and inequitable conditions that limited access to supportive care. As a result, many women found the process of help-seeking to be exhausting, compounding health effects and leading to experiences of re-victimization. Thus, women entered the *iHEAL* with no-low expectations of what they might gain as a result of these prior help-seeking experiences. In spite of this context, the *iHEAL* was continuously described by women as collaborative, individualized support. Dissatisfied with "cookie-cutter" services, participants found the women-centered approach and opportunity to focus on themselves to be crucial in improving their health. Registered Nurse interventionists with a unique skill set, knowledge and ability to assess women's needs, plan, and implement accordingly, were able to address health in a collaborative and seamless manner throughout the intervention. As a result of working with an interventionist, women consistently reported positive life changes post-intervention. Women made significant

strides not only in self-confidence, but also in the confidence to access resources in the community and make supportive, long-term connections. This study demonstrated that the support provided to women during the *iHEAL* may have equipped them and may have provided the encouragement for women to move forward with their lives.

It is critical to recognize the ways in which both nurses and nursing education can improve the care of women who have recently left an abusive intimate partner. Nurses can play an important role in lobbying for changes to Canadian health policies that would improve women's ability to access services that fit their needs. Furthermore, it is crucial to advocate for a social determinants of health framework incorporating an intersectional analysis of both health and social policies in order to create more equitable conditions for women who have left abusive relationships. Moreover, through new research, nurses can further our understanding of the complex needs of women who have recently left an abusive partner. In this chapter, the implications of this study's findings are described for: 1) nursing practice; 2) nursing education; 3) health policy; and, 4) nursing research.

Implications for Nursing Practice

As the findings of this study suggest, women who have experienced IPV persistently attempt to seek help through formal access to services. Within the literature, there is a current and ongoing debate about the relative value of health care professionals compared with lay advocate support to improve the health and well-being of women and children who experience violence (Taft et al., 2009). This study contributes to this body of literature, suggesting a key role for health care providers in the provision of care for women who experience violence beyond the traditional roles of safety planning and passive system navigation. Further work in this area is needed to understand how to

collaboratively integrate the expertise of Registered Nurses and domestic violence workers in order to minimize cost and maximize outcomes for women who experience violence.

Women who experience IPV are overrepresented in many outpatient settings and in primary care (Plichta, 2007). It is estimated that one third of women will disclose IPV to their health care provider (Hegarty & Taft, 2001). Thus, it is critical to ensure that health care providers are equipped to explore issues of IPV with women in a supportive, empowering, and non-judgmental manner (Barrett & St. Pierre, 2011). A recent systematic review demonstrated that there is insufficient evidence to justify implementing discrete screening programs (Feder et al., 2009). This finding is consistent with current Canadian research (MacMillan et al., 2009). However, a recent update from the Institute of Medicine recommends routine screening and counseling, involving elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner and counselling to address current safety and health concerns (Institute of Medicine, 2012). In order to implement successful screening interventions in health care, the availability of effective treatment or supportive services for women who disclose abuse is mandatory (Hegarty et al., 2010; Feder et al., 2009). Therefore, there is an urgent need for rigorous testing of specific interventions and services for women following the identification of IPV (Hegarty et al., 2010) so that health care providers are equipped to appropriately respond to women who disclose IPV.

Many women in this study experienced multiple barriers, preventing access to a consistent, quality health care provider. Even women with access to care providers continued to utilize walk-in clinics or emergency rooms, which may increase health care

costs. While health care practitioners are widely encouraged to assume a role in supporting abused women, women's preferences regarding effective interventions have seldom been sought (Taft, Hegarty & Feder, 2006). Although Feder et al. (2006) found that women who had experienced IPV valued health care practitioners' ability to listen to their experiences without judgment, to validate their experiences, and to acknowledge the complex, far-reaching impacts of IPV on many areas of their lives, many women do not have positive encounters with health care providers (Barrett & St. Piere, 2011; Goodman, Dutton, Weinfurt & Cook, 2003). The *iHEAL* interventionists were consistently described by women as collaborative, individualized support which was tailored to their specific needs. Women developed trust with care providers that was unique and impactful. This relational practice model aided women to build capacity and reduce intrusion after leaving. Further research is necessary to fully understand this process of empowerment and its implications for nursing practice. Further testing of *iHEAL* is also important to understand if its effectiveness across diverse contexts, including rural areas in which services may be more limited.

Nurses have a moral imperative to care and advocate for those who experience health and health service inequities resulting from intersecting social locations and systemic discrimination, especially women who have recently left an abusive partner who also contend with abuse histories and the health consequences of IPV (Canadian Nurses Association, 2008). Falk-Rafael (2005) argues that nurses, who practice at the intersection of public policy and personal lives, are ideally situated and morally obligated to include political advocacy and efforts to influence health public policy into their practice.

The *iHEAL* has potential to help advance understanding of how nurses and social service workers with specialized expertise in violence and trauma, such as DV outreach workers or social workers, can support women who have experienced IPV over time, using a model that draws on a relational practice. In other cross-sectional studies of women who have experienced IPV, social support has been positively associated with general health status (Coker, Watkins, Smith & Brandt, 2009), a reduction in symptoms of physical and psychological distress while in shelter (Humphreys, Lee, Neylan, & Marmer, 2001; Wang & McKinney, 1997) and lower levels of depression 6 months post-shelter (Campbell, Kub, Belknap & Templin, 1997). This study demonstrated that women who participated in a short-term, trauma-informed, primary health care intervention for women who experienced IPV after leaving an intimate partner had self-reported positive changes and improvements to quality of life. Although further research is needed to refine the intervention (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011) and incorporate women's feedback, this intervention may be an important contribution to helping women after the acute stages of leaving a violent relationship. Future research to demonstrate more rigorously, within a randomized controlled trial, the impacts of this intervention is currently in the early planning stages.

Implications for Nursing Education

The *iHEAL* has the potential to significantly advance understanding of how Registered Nurses and social service workers with specialized expertise in violence and trauma, such as DV outreach workers or social workers, can support women who have experienced IPV over time, using a model that draws on a relational practice. Doane (2002) argues that the teaching of behavioral communication skills may interfere with

the learning of humanistic nursing practice, with primacy given to formulaic interpretations of interpersonal communication rather than a more interpretive approach. Nursing school curricula in Ontario tend to give primacy to the development of therapeutic communication skills within a methods approach (Doane, 2004). The Revised Therapeutic Nurse-Client Relationship practice standard promoted by the College of Nurses' of Ontario (CNO, 2006) is overly prescriptive and methodical when attempting to educate nurses on the value of relational practice. Doane (2004) suggests that incorporating a "non-method" pedagogy of interpretive inquiry may create opportunities for nursing students to experience the transformative power of relationships and allow students to gain confidence in their capacity to be with people in ways that are authentic and meaningful. Although relational practice does not follow a prescribed method or tool, the structure that guides relational practice is a thoughtful process of interpretive, critical inquiry (Hartrick-Doane & Varcoe, 2005). This may support students in developing their overall ability to enact humanistic, relational nursing. The *iHEAL* offers key insights for students into a practically enacted relational practice model of nursing care. This may provide students with a unique learning opportunity into the enactment of the abstract principles of relational practice.

Implications for Health Policy

The context of women's lives after leaving is central to understanding their health. From a determinants of health perspective (Whitehead & Dahlgren, 2006), women's health is shaped by multiple and intersecting social locations. Many women experience circumstances that have the potential to erode their financial resources over time (Ford-Gilboe, Wuest, Varcoe & Merritt-Gray, 2006). Despite positive changes to both health

and life after leaving a violent relationship, many women continued to struggle with financial instability. Although there is some promising intervention work demonstrating advances in economic stability (Chronister et al., 2009; Davidson et al., 2010; Kim et al., 2009), more rigorous research is needed. In fact, the stress associated with financial problems may lead to or exacerbate health problems (Carlson, McNutt, Choi, & Rose, 2002; Sutherland, Sullivan, & Bybee, 2001). Because marginalized or disadvantaged women may possess fewer material resources to access services, it is imperative that the federal and provincial governments provide adequate budgetary support to the provinces to ensure that these crucial services remain accessible to the women most in need (Barrett & St. Pierre, 2011).

Consistent with this finding, the World Health Organization (2006) recently identified economic resources as key to eradicating violence against women and called for research that explores the causal associations between economic inequality, weak safety nets, unemployment and poverty. Programs and policies that help women acquire economic resources may be important supports for health, yet women face many barriers to finding and obtaining good jobs post-leaving, particularly if they have dependent children (Swanberg & Logan, 2005). This is a current opportunity for improvement to the *iHEAL* as many women faced financial instability in spite of positive health impacts and improvements in quality of life.

Nursing organizations must continue to advocate for an intersectional framework of health to be implement in current and future health accords within a federal and provincial context. The Echo Women's Health Framework is a good example of an intersectional approach, created by an Ontario government agency, advocating for

improved health and health services for women in Ontario (Echo, 2011). However, this funding has recently been discontinued leaving further gaps in the promotion of health and health services for women in Canada. Nurses must continue to advocate for the needs of women to decision-makers in order to address the health needs of women who experience IPV.

Implications for Nursing Research

More research is needed in Canada to explore women's experiencing of participating in a unique health intervention for women who have experienced IPV and/or who have separated from an abusive partner. With few exceptions, (Tiwari et al., 2005; Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011) most emerging IPV interventions within health care are time limited and emphasize brief safety planning or empowerment around the time of disclosure (Jack et al., 2012). There is strong rationale for developing and testing interventions for women who experience IPV and for embedding this research within a primary health care framework (Hegarty et al., 2010). However, a recent systematic review of intervention studies for women who experience IPV (Ramsay et al., 2009) demonstrated a clear absence of qualitative studies examining what women think should be included within an intervention for intimate partner violence. This study seeks to expand the evidence based with respect to qualitative evaluation of interventions and their effectiveness and acceptability for women who experience IPV. Although this study presents an important methodological contribution to further address this major gap in nursing knowledge, there is more work necessary. There is some work focusing on the experiences of immigrant women that have documented barriers to service use after leaving (Bui, 2003; Wachholz & Miedema, 2000) but there are few rigorous intervention

studies that include women of colour (Lee, Thompson & Mechanic, 2002). There are huge gaps in the literature evaluating women of colour or international women and their experiences participating in interventions to support women who have left violent relationships. Due to the sampling limitations of this study, only one immigrant woman completed the intervention. More research is necessary in order to understand the needs of diverse women from various social locations to ensure the *iHEAL* is both effective and appropriate to meet their needs.

There are limited data available on the help-seeking initiatives of battered Aboriginal women living in Canada (Barrett & St. Pierre, 2011) and their experiences with interventions to address IPV. Only three women in this study self-reported their Aboriginal status. Brownridge (2008) reports that, due to the unique, historical context of oppression and trauma faced by Aboriginal peoples (e.g., colonization, residential schools, geographic/social isolation), help-seeking among Aboriginal women may be severely compromised. Moreover, research demonstrates that help-seeking behaviour may be impacted by mistrust and lack of confidence in service providers (Thibodeau & Peigan, 2007) and other structural barriers (Paterson, 2009) related to social location (Barrett & St. Pierre, 2011). Although contemporary research has attempted to incorporate a more thorough understanding of the complexities of women's experiences, the majority of efforts have primarily considered the issues of race, income, and age in categorical ways. Our understanding of other socio-demographic factors, and the manner in which they intersect with other aspects of women's identities, is limited.

As feminist scholars and activists continue to counter deficit-based public discourses of violence against women, which all too often create disempowering

conditions for women who experience violence, the continued development of a strengths-based analysis of women's help seeking is particularly vital (Barrett & St. Pierre, 2011). The findings of the present study make a valuable contribution to such an analysis incorporating a critical feminist framework. Intersectionality examines how varying social locations impact health and health service inequities between and among women who experience IPV. A more thorough understanding of the unmet need and poor service fit and the impact of this on health over time is essential to understanding the diverse needs of women who have left a violent relationship and how to develop interventions that are supportive to women, within their diverse contexts. Perhaps future research in the area of developing and testing interventions to address the health effects of violence for women who experience IPV should incorporate participatory action methodology. This empowering approach to research collaborates with women who have left an abusive partner to inform the research process. A more in-depth understanding of women's diverse experiences may result and led to more effective strategies to help women after leaving.

Conclusion

Registered Nurses can play a vital role in meeting the diverse needs of women who have recently left an abusive partner. The *iHEAL* has the potential to significantly advance understanding of how nurses and social service workers with specialized expertise in violence and trauma can work collaboratively to provide a better service fit for women who experience IPV. Women's feedback about interventions that seek to address their needs after leaving is critical to developing supportive services for women transitioning out of a violent relationship. Nurses and nursing organizations must

continue to lobby key leaders and decision makers for health policy changes to improve equitable access to services that fit the needs of all Canadians. Finally, it is important that nurses engage in future research that furthers our understanding of the diverse needs of women who experience the intersectional impacts of IPV and its health consequences.

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APPENDIX A

**Pilot Testing the Intervention for Health Enhancement After Leaving (i-HEAL)****Letter of Information**

You are being asked to take part in a research study to test a new health invention for women who have recently separated from an abusive partner. This health intervention is called i-HEAL. We want to learn whether this intervention helps women to manage challenges and have a better quality of life after leaving. We also want to learn what women like and do not like about the intervention so that it can be improved. We hope that the information in this letter will help you to decide whether to take part.

What will I have to do if I choose to take part?

If you agree to take part, a Registered Nurse and/or domestic violence advocate will meet with you 12 to 14 times (i.e. every 1-2 weeks) over a 6 month period. Meetings will take place in your home or other private location that you choose. During these meetings, the nurse and/or advocate will talk with you about the issues that typically *intrude* or make it difficult for women to move on after separating from an abusive partner. These include: intrusive health problems and finding time to care for yourself, keeping safe and dealing with your ex-partner, getting the basics to provide for the family, making sense of the abuse experience, developing new ways of getting along together, rebuilding social relationships and dealing with the ‘system’, such as social services or family court. You will select the issues you would like to address from a “menu”. You and the nurse or advocate will explore how much the issue intrudes on your life. Together, you will discuss what has worked or not worked in dealing with this issue, what has worked for

other women, and what might work for you. If you wish, the nurse and/or advocate will help you locate information, and community services to help you try new ways of managing these issues.

In addition to completing the 6 month intervention, you will be interviewed by a research assistant 3 times: before you start the intervention, right after you complete it and 6 months later. Each interview will take 60-90 minutes to complete. You will be asked questions about your health and quality of life, your family and relationships, your experiences of abuse, your finances and your use of services and your views about taking part in the intervention. The interview will take place in your home or other private location that you choose (e.g. research office, library or other community location). A research assistant will also contact you 3 months after the intervention to update your address and telephone number.

Are there any risks or discomforts?

The risks of taking part in this study are small. You may become upset by some questions if you recall painful experiences of abuse. If you become upset, support will be provided. If you wish, we will give you information to help you find counselling or other support services. We know that some women who have recently left abusive partners are at-risk of harm from their ex-partners. We will ask you about the level of safety risk you are facing from your ex-partner and make a safety plan to use when we contact you. We will update this plan each time we contact you and ask for your ongoing consent each time.

What are the benefits of taking part?

By taking part in this study, you may gain information, confidence and skills to help you manage health, social, safety, family and economic challenges in your life. Some women find that talking about their situation helps them to understand their life or health. It is possible that your health and quality of life may improve. You may also learn about useful community services and how to access them. Taking part in this study may help health care and domestic violence agencies develop more helpful ways of supporting women who have recently separated from an abusive partner.

Do I have to take part?

Participation in this study is voluntary. You may refuse to take part, refuse to answer any questions, or withdraw from the study at any time.

What happens to the information I tell you?

The information you provide is confidential. A code number, rather than your name, will be used to identify the information you provide. Your answers to questions asked during the assessments will be recorded by a research assistant on a computer assisted data entry program. In the interview that takes place 6 months after the intervention ends, your answers to several questions will be audio-taped and transcribed. The nurse and advocate will also record the activities completed at each meeting in a personal study record. If you wish, we will provide a copy of any of these materials for your use. Your background information will be recorded in writing on a contact form.

Your information will be stored in a locked cabinet or file in a secure location. Only the research team will have access to these files. Your name and other identifying information will be kept separate from your answers to the study questions and your study record. Even if you drop out of the study, the information you have provided will be kept and may be used in this and other related studies. At the end of the study, we will keep your contact information in the event that we are able to do a follow-up study in the future.

What we learn in this study will be shared in research journals, magazines, newspapers, and public talks. Neither your name nor identifying information will be used. If you would like a summary of what we learn at the end of this study, one will be provided to you.

If you tell us about any current abuse of children, we must, by law, report this to the local child protection agency. Before reporting, we will discuss this with you.

How are the costs of participating handled?

No fees will be paid for taking part in the intervention meetings with the nurse and advocate. If you need to travel or have childcare to take part in the intervention sessions or interviews, we will also help pay these costs.

Other information about this study

If you have any questions about the study, please call Joanne Hammerton, the Research Coordinator at _____ or toll free at _____, or Dr. Marilyn Ford-Gilboe, the Principal Investigator at _____ extension _____. If you have any concerns about the conduct of this study or your rights as a research participant, please contact Office of Research Ethics, The University of Western Ontario, at _____ or Office of Research Services, The University of British Columbia, at _____.

This letter is for you to keep. If it is not safe for you to keep this letter, the interviewer will keep it on file for you at the study office.

CONSENT FORM

I have read the letter of information, have had the study explained to me and I agree to take part. All of my questions have been answered to my satisfaction.

Date

Research Participant Signature

Printed Name

Signature of Person Obtaining Informed Consent

APPENDIX B

SECTION 6: EXPERIENCES OF TAKING PART IN THE IHEAL

Before we finish up, I would like to ask you a few questions about what it has been like for you to take part in the iHEAL. With your permission, I would like to tape record this section of the interview so that we have a clear record of what you have said. As we discussed, we will use the audiotape to make a typed copy of your answers. We will review this written copy to help us understand how to improve the iHEAL. We will destroy the audiotape after the written copy of your answers has been made.

Do I have your permission to audiotape your answers to these questions? YES NO (if no, record answers in writing)

Interview Questions

1. As you know, we would like to know from you what it has been like for you to take part in this intervention. I am wondering if you can tell me overall what it has been like?
2. How did the experience compare with what you thought it would be like when you first started it?
3. What has been the best part? the most challenging part?
4. What, if anything, would you say has changed in your life as a result of taking part in this study?
5. What would you suggest that we do differently?
6. Finally, what would you say to other women about the intervention experience?

Thank you for participating in this interview. Your input will help us to better understand how the intervention might help women who have left abusive relationships.

We will need to contact you again for an interview in 6 months. We will also contact you in 3 months to check in. Would you be able to give us some names of people who might know where you are in case you move?

(INTERVIEWER: UPDATE CONTACT SHEET; CONDUCT DEBRIEFING)

Approximate time needed to complete open-ended questions: _____

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