CARE, CONTROL AND CONNECTION: HEALTH-CARE EXPERIENCES OF WOMEN IN ABUSIVE INTIMATE RELATIONSHIPS

by

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Abstract

Violence against women in intimate relationships has been recognised as a serious public health concern. Formal health-care responses to this issue have been implemented across the industrialised world. Few evaluations of these responses explore their impacts on women's health or lives, and the perspectives of abused women on different health-care responses are rarely reported in the academic literature. The purpose of this qualitative study was to describe the health-care experiences of abused women and to generate substantive theory on the essential components of an effective health-care response to violence against women. This study generated an emergent grounded theory based on in-depth individual and group interviews with women who experienced abuse in their intimate relationships (n = 16). The findings of this study suggest that women actively strive to recover the health that they have lost through experiencing abuse in their relationships. If abused women's strategies to regain health are supported by health-care providers, this process is facilitated. Specifically, the women in this study identified three significant components of such enabling health-care experiences: *caring*, *sharing control*, and *connecting*. Conversely, if these strategies are not supported, aspects of abusive relationship experiences may inadvertently be reproduced in health-care experiences, leading to a further loss of health. Thus, changes in the structures of the health-care system could either facilitate of impede improvements in the responses of individual health-care providers and institutions to women experiencing violence. Theory emerging from this study can be used to inform the development of models in health care to address violence against women, as well as to evaluate the impact of existing programs.

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I begin with a poem written by a wise, young woman I met while completing my thesis.

She taught me that to fix the bad in life, you need to focus on the good.

Breathe

find your peace within.
be happy in your works.
instead of focusing on the bad in life, focus on the good, and make it better.
smile and be positive about what you have.
remember you have it because of you.
you are smiling,
shaman lady.
healer of the sick, mender of the broken.
it's okay if you don't play music well,
you can do other things better.
read.
practice...practice.
read books about kids and magic.
remember who you love and more importantly remember who loves you.
remember why they love you.
remember the great creator,
who made you and loves you and would only want you to smile.
don't forget that when life is hard, it's hard to remember that it doesn't really matter
the ocean is much more intense and large.
flowing and consistent.
be like the ocean.
not a puddle, stagnant and immobile.
be like a tree.
strong and quiet.
be like the wind.
powerful and cleansing.
be like fire.
warm and creative.
life happens for its reasons,
and if you're strong with the properties of the physical universe,
mental strength will follow.
when you are ready to go, the ocean will swallow you and keep you safe in its belly.
love yourself for you love the ocean, the earth, the wind, the fire.
stay focused.
each smiles and hugs you close.
don't forget the beautiful colours of a sunset.
and the kisses sent through the wind.
find your peace within.
rejoice with unlimited strength.
you are young with many years to practice.
take your time,

but stay focused.
don't stress about times of silence.
they're there because something else is talking.
listen
with a mind beyond words.
love everyone because everyone wore diapers at one point.
and when others refuse to love back,
understand that they haven't made the diaper connection yet.
give them time and they will.
everyone has a different past.
a different way of dealing with things.
it's all part of the process.
keep smiling.
stretch.
take care of your body.
drink water.
eat when you're hungry.
rest when you're tired.
laugh when it's funny.
hug when it's needed.
listen when it's quiet.
breathe when it hurts.
remember it'll be okay.
it doesn't matter.
the ocean is much older than you and it is wonderful, balanced.
some love it .
some don't.
but it always stays the same.
live your life the way that makes you happy.
it will come easy.
follow your belly,
the butterflies mean something.
follow your own advice.
keep singing.
keep dancing.
the earth belongs to you.
and everyone else
share it.
meditate.
simplicity is easy.
easy to survey.
to know.
to be.
Breathe.

- Naomi Audia

CHAPTER 1

Introduction

Background

When Member of Parliament Margaret Mitchell (Vancouver East) stood in the House of Commons in 1982, cited recent estimates that 1 in every 10 women experiences violence in her intimate relationship each year, and suggested that her colleagues might want to do something about it, the ranks of her elected counterparts erupted with laughter and derision [1]. Now, thirty years later, violence against women in relationships is generally viewed as a serious issue worthy of public concern and attention. Initial estimates of the incidence of the problem have been supported through additional research and it is now widely acknowledged that one in every three women will experience abuse in an intimate relationship at some point in their lives [1-7]. Violence against women in relationships[1] has been defined as:

> A pattern of intentionally coercive and violent behavior toward an individual with whom there is or has been an intimate relationship. These behaviors can be used to establish control of an individual and can include physical and sexual abuse; psychological abuse with verbal intimidation, progressive social isolation, or deprivation; and economic control. [8]

Efforts to address the problem initially focused on providing shelter for women and criminal sanctions against abusers [9]. Responses within the health-care system emerged as it became increasingly apparent that violence in relationships can have significant

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[1] The terms 'violence against women in relationships' and 'woman abuse' are used interchangeably in this study to highlight both the seriousness and the broad range of the experience and to recognise that abuse is experienced primarily by women. The former term will also, at times, be shortened to 'violence against women'. The word 'relationship' in this thesis will denote women's *intimate* relationships, unless otherwise specified.

impacts on women's health, and abused women comprise a significant percentage of patients in health settings [10]. Formal calls for action in health care in response to accumulating evidence that revealed that the needs of many abused women were not being adequately addressed in the health-care system, and emerging evidence that some women were experiencing further harmful effects as a result of their health-care encounters [11-16].

Programs to address woman abuse are now proliferating throughout health-care systems across the industrialised world. Screening models (identification of violence through direct questioning) dominate formal health-care responses, although a growing number of programs are moving towards advocacy models (empowering abused women through respect and support for their decisions) [15]. Despite increasing action to address the problem, the impact of health-care responses on the lives and health of women experiencing abuse remains mostly unexamined [16]. What research there is indicates that simply identifying cases of woman abuse does not necessarily lead to positive interventions and outcomes for women [17]. In fact, some women in abusive relationships have reported that experiences of being identified as abused in health-care settings have increased the risk of abuse in their relationships [18] and negatively affected their health [19]. Research points to the need to investigate additional, more complex phenomena, including the patient-provider relationship to better understand the determinants of successful interventions for abused women [20, 21]. Understanding the relationship between response strategies undertaken in the health-care system and women's short- and long-term health outcomes is fundamental to creating appropriate health-care responses for abused women [22, 23].

Purpose of the Study

This study was designed to inform health-care practice and programming for woman abuse by giving women in abusive relationships the opportunity to describe the perceived impact of health-care encounters on their health and lives. Thus, the objectives of this study were to:

a) examine abused women's descriptions of their health-care experiences to identify key components of health-care encounters that they perceive to have been important influences (positive and negative) on their health and well-being;

b) describe the process by which women in abusive intimate relationships perceive these key components of their health-care encounters to have affected their health and well-being; and

c) generate hypotheses about why and how these components influence the health and well-being of women in abusive relationships to help inform and evaluate health-care responses to woman abuse.

Research Setting

This study was conducted in the Lower Mainland of British Columbia, Canada. This location is well suited to this study for several reasons. First, this region is home to several formal health-care programs to address violence against women in relationships. The theoretical underpinnings of these programs span the range of health-care responses described in the literature, from screening models to advocacy or empowerment-based programming. At the same time, many health settings and providers are not directly linked to formal health-care programming responses to woman abuse. Thus, abused women who seek health-care in the region can experience an array of health-care responses. As well, because many people come to Vancouver and the surrounding areas from rural and isolated areas in the province, it was possible to incorporate the perspectives of women who had accessed health-care in a range of geographical settings.

The study described here posed questions that dovetailed with those being asked by local service providers examining the intersections between violence and health. The Health Subcommittee of the Vancouver Coordination Committee on Violence Against Women in Relationships was dedicated to understanding the health-care experiences of women in abusive intimate relationships to offer direction to the health-care system. Findings of this research, and those of the Health Subcommittee, have been integrated to offer guidance to local health-care providers, programmers and policymakers.

Conclusion

Numerous people asked me during the course of this research if woman abuse was a depressing subject to be studying. To the contrary, what I heard from the women who participated in this study increased my optimism that violence against women could be effectively addressed, and enhanced my belief that the health-care system can play an important role in doing so. All of the participants in this study had escaped their abusive relationship and described their experiences of healing and finding joy again in life. As well, while it was not the norm, many of the women did have some positive, helpful experiences within the health-care system that played a role in the recovery of their health and control over their lives. My hope is that others in health care can learn from, and base formal responses upon, the important components of positive health-care encounters identified herein, while also working to change the structures of health care to further facilitate effective health-care responses to woman abuse.

CHAPTER 2

Review of the Literature

Introduction

The purpose of this literature review is to assess the current state of knowledge about the health-care system's response to violence against women in relationships and to determine where research is most needed to further develop knowledge and practice in this area. Relevant descriptive and empirical literature was identified through manual and computer database searches, using MEDLINE (1966 – 2002), Social Sciences Citation Index (1986 – 2002), and Academic Search Premier (1975 – 2002). Computer searches were limited to works written in English and began with the use of the keywords: health or healthcare AND violence against women, domestic violence, family violence, woman abuse, partner abuse or spouse abuse.

Over 2000 articles were located on the intersections between violence and health, with the vast majority concerned with the impact of relationship violence on women's health. A smaller, but growing, body of literature that examines implications for health-care practice form the basis of this literature review. Influential works not captured in the computer databases were identified from the citations listed in those articles retrieved and included in the review. While the bulk of the review focused on work published in journals aimed at health-care providers and health researchers, relevant articles and books from other areas that address this topic were also included; these additional resources came primarily from the social sciences and feminist literature. Reports in the "grey" literature (e.g., policy backgrounders, presentations, evaluations, dissertations, and manuals) were also located, often by directly contacting people, programs or organisations named in journal articles or who presented at local conferences. The majority of these are from Canadian sources. In total, over 200 relevant papers and other kinds of literature were examined closely to understand the health-care responses to violence against women in relationships, and determine where research is most needed to further both knowledge and practice.

Scope and Definition of Violence Against Women in Relationships

The rate at which violence against women is reported to occur in a population, how the issue is defined, and the labels used to name it, are all interdependent. Recent historical context and current understanding of labels, definition parameters, theories of underlying causes, and rates of woman abuse are discussed below.

Naming the Problem

The abuse of women has existed in Western societies for centuries, perhaps even millenia, and has come under public scrutiny at other times in history [24, 25]. The issue was largely invisible in public discourse throughout much of the twentieth century, however, until feminist activists began to "name it" in the 1960's [1, 26]. Early labels and definitions, such as 'wife battering' and 'wife beating', focused on severe acts of physical violence that could be considered criminal behaviour inside legally recognised relationships. Due in part to the galvanising of public censure, it became possible in 1968 to get a divorce on the basis of physical cruelty [1]. These early definitions did not capture the reality or entirety of women's experiences, however, so definitions expanded to also include psychological abuse and acts of coercive sex [26, 27]. In 1983, it became possible for a husband to be charged in Canadian courts with sexually assaulting his wife [1]. Definitions also were expanded to include abuse in common-law and dating relationships. Labels used to name the issue likewise expanded to include terms such as 'domestic violence', 'wife abuse', 'spousal abuse', 'violence against women in relationships', 'male violence against women', 'family violence', 'woman abuse', and 'intimate partner violence'.

While different labels are often used interchangeably, they imply variations in definition, specifically regarding the nature and cause of the abuse [19, 24]. The use of the word 'violence' highlights the serious, and often criminal, aspects of the experience, whereas 'abuse' suggests a larger spectrum of experiences, including emotional, verbal, and mental aspects of abuse that are not currently considered a crime in most parts of the world[2]. The words 'intimate partner' or 'spouse' or 'family' capture that the abuse is experienced within an intimate relationship, but obscures the fact that it is women who are overwhelmingly the targets of the violence [29]. The array of labels used to name this issue underscores different views on the reasons violence against women happens in our society.

The Cause(s) of Woman Abuse

The underlying cause of violence against women has been an issue of much debate. Feminist activists who lobbied to have the issue taken seriously did so from the standpoint that violence against women is both a product of the inequality between men and women, and a tool used to maintain and perpetuate this inequality [30, 31]. As violence against women gained public attention, other theories were postulated to explain it. These theories often looked to individuals or family units as the source of the problem, rather than the larger society [9, 32]. Some theories suggest that men are abusive because they are aberrant or pathological. Others look to women as the source

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[2] Spain recently took the landmark step of designating psychological violence a crime [28].

of the problem or focus on why she does not leave her abuser. These include theories of women's 'masochism', 'traumatic bonding', or 'learned helplessness' [24, 32, 33]. These individualistic theories are challenged by research revealing that prior to the onset of abuse, abused and non-abused women do not differ [30] and that abusive men are no more likely to exhibit psychosis than men in the general population [34, 35]. While these theories continue to be promoted, they are generally considered to be victim-blaming, and narrowly focused on the aberrance of a few 'sick' men rather than recognising the abuse as part of a predominant pattern of behaviour supported by 'normal' societal gender roles [24, 27, 32, 36-38].

Violence against women in relationships is now generally attributed in the health-care literature to the lesser status and subordinate position of women in society in relation to men [11, 39-48]. As Hanvey and Kinnon wrote in *The Health Care Sector's Response to Woman Abuse:*

> The abuse of women by their partners therefore must be understood as being determined in part by the broad social and economic context of women's lives. Women do not share full equality with men. Women do not enjoy the economic freedoms of men. [49]

Violence against women in relationships is also viewed as one facet of a global picture of gender oppression that includes rape and sexual coercion, forced sexual initiation, sexual abuse of girls, trafficking, forced prostitution, exploitation of labour, debt bondage, violence against prostitutes, rape in war, sex-selective abortion, female infanticide, deliberate neglect of girls, and female genital mutilation [50, 51].

The Problem of Abused Men

The issue of men being abused by women is raised in the literature, often to suggest that gender is not an important factor in abuse [52]. When tools are used such as the Conflicts

Tactics Scale, which assesses the frequency of physically aggressive tactics experienced or engaged in by each partner during 'marital conflicts', researchers often conclude that women are as abusive as men and that 'mutual battering' or 'reciprocal aggression' typify abusive relationships [34, 41, 53]. The utility of such scales is called into question, however, for their lack of inclusion of the motive behind, or impact of, violent behaviours [1, 41, 54]. When this larger context is included, it is evident that women rarely initiate violence, women's aggression is mostly retaliatory or self-defensive and that the violence experienced by women, as well as its impacts, is far more severe than that experienced by men [1, 27, 41, 53-55]. According to Canadian police reports for 1999, 523 women died at the hands of their husbands or common-law partners [56]. This number is five times higher than the number of men who suffered physical injury or death at the hands of their female partners [47].

The claim by women's advocates that no abused men exist is, according to one researcher, as much an exaggeration as the claim that women are as violent as men [57]. Linda MacLeod, a prominent researcher in this area, suggests that the omission of male victims from discourses of abuse may be an understandable reaction to the repeated use of their existence to discredit the validity, importance, and magnitude of the problem of violence against women in relationships [27]. Many authors agree that while men who are abused should not be ignored, neither should the fact that it is mostly women who suffer violence in their relationships [1, 27, 39]. Ninety to ninety-five percent of the victims of abuse are women [8, 24, 58]. It also has been asserted that men are generally in a position to have greater financial security, better jobs, less responsibility for children, and greater credibility in society, and thus require less support in cases of abuse [27].

However, although this study focuses on women in abusive relationships, it is with the hope that abused men will also benefit from its findings.

Intersecting Oppressions

As feminism evolved to include the participation and perspectives of a greater diversity of women, it became more widely recognised that gender is only one basis of inequality at play in abusive relationships. Other forms of inequality intersect with gender to shape the experiences of women in abusive relationships [37, 59-61]. This view insists that it is not enough to say that women of all backgrounds experience violence, or to attempt to identify 'higher risk' groups of women; we must also understand the ways in which different inequalities intersect in women's lives to compound their experiences of violence [59-61].

Women with physical disabilities, approximately 15% of the women in Canada [62], may face greater risk of being abused because of their dependence on their partners and increased isolation [37, 47, 63-67]. Young women are at a higher risk of violence and of being killed [34, 56, 68, 69]. This may be due to the downplaying of the seriousness of abuse in relationships between younger women and their partners [70] when research reports that abuse can begin as early as in elementary school dating relationships [1]. There has been much debate over whether poverty increases a woman's risk of being abused [8]. While being poor has been found to be positively correlated with the likelihood of being in an abusive relationship [71], lifetime prevalence rates of women of different socio-economic status are similar [72]. This has been interpreted to mean that women of all socio-economic strata are at risk of experiencing abuse in their relationships, while poverty can increase difficulties escaping the abuse [23, 37, 48, 72, 73].

Rates of violence in the intimate relationships of First Nations and Inuit women have been found to be higher than the Canadian average [47]. Relationship abuse may be exacerbated for these women by economic factors, a history of colonisation, and a cultural legacy of mistreatment and abuses that arose in past decades through educational practices [74]. Abuse for all 'racialised'[3] women can be compounded when disclosure may bring on assumptions that 'certain cultures are more inherently violent', stigmatisation of interracial relationships, culturally inappropriate responses, or additional discrimination or violence against racialised communities [23, 24, 37, 61, 74, 76-84]. Immigrant and refugee women may face greater barriers to escaping abuse due to isolation on the basis of language or culture, and to their dependent status on their partners as a result of immigration legislation and their marginalised place in the workforce [73, 76, 80, 82, 84]. Women who live in rural communities also face similar effects due to isolation and increased community pressure to not speak out about abuse [27, 78, 81].

Women in same-sex relationships also experience abuse at the hands of their partners [79, 83, 85], which is interpreted as support for the theory that abuse stems from power and control, and not simply gender [86]. Lesbians, bisexual, queer, transsexual and transgendered women can face increased difficulties obtaining support in the social context of homophobia and heterosexism [37, 85, 87, 88].

A Pattern of Power and Control

It is now generally agreed that violence against women in relationships perpetuates inequality through a range of abusive behaviours, all designed to exert power and control

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[3] 'Racialisation' is the phenomenon in which the term 'race' is used to refer generally only to people who are not white. While the experiences of 'racialised' women are clearly varied and unique, it is asserted that what they do share is the experience of assumptions being made about them on the basis of their skin

over a woman by her partner [1, 7, 37, 39, 40, 43, 47, 49, 60, 89-91]. This pattern is an enduring, traumatic, and complex experience that isolates and controls women, whether or not it includes physical or sexual violence [7, 90-92]. The Canadian *Violence Against Women Survey*, which conducted telephone interviews with 12,300 women over the age of 18 about their relationships, reinforced that four behaviours comprised the exercise of dominance over a woman in her relationship: jealousy of social contact with other men; limited contact with family and friends; whereabouts monitored; and access to finances limited [2, 54]. Scales have been developed that aim to measure abuse as a pattern of power and control that may be, but is not necessarily, punctuated by physical or sexual assault. The Women's Experiences with Battering (WEB) scale measures loss of power and control, entrapment and disempowerment [92]. However, research on the incidence and prevalence of woman abuse in populations generally remains focused on the frequency and severity of discrete acts of physical assault, rather than on complex, enduring conditions of which these acts are only one part [92].

Rates of Woman Abuse

Research on rates of woman abuse has played a vital role in establishing the seriousness of the issue. The announcement in the early 1980's that approximately 1 in 10 women experience abuse each year helped spur public attention to the issue [27]. The continued focus on establishing rates has been criticised, however, for depersonalising the issue and detracting from a true understanding of the problem [27]. While it is now generally accepted that one in three women will experience abuse in an intimate relationship at some point in their lives, definitively counting abuse has been hampered by differences in definition, definitions that compartmentalise different aspects of abuse, assume a

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colour, hair colour and texture, and facial features [37, 75, 76].

'hierarchy of seriousness', and do not necessarily reflect the reality of women's experiences [27, 48, 93]. As well, women reject stigmatising labels and may name experiences as abusive only in retrospect [26, 27]. What is known about the rates at which violence against women in relationships occurs in the population is summarised below.

In Canada, several population-based studies have been conducted on the rates of violence against women in relationships. DeKeseredy and MacLeod spoke to women and men in university and colleges across Canada, learning that abuse in dating relationships can begin as early as elementary school. Seven percent of female university or college students reported being intentionally physically hurt by their elementary school dating partners, and 3.6% of male students reported committing these acts. Twenty-three percent of women said that they had been intentionally emotionally hurt by their elementary school partners, while 18.6% of men admitted to having perpetrated this behaviour. Four percent of women reported that they were physically forced to engage in sexual acts in dating relationships, and 1.5% of men admitted to forcing sexual acts in elementary school dating relationships [1].

The study also reveals that abuse continues throughout the later years. In college or university dating relationships, 22.3% of the women surveyed reported being physical assaulted in the past year, and 13.7% of men conceded to assaulting their partners. Thirty-five percent of the women reported being physically assaulted at some time in their adult lives, and 17.8% of men admitted to using force against a female partner since high school. Seventy-four percent of men reported being psychologically abusive in the past 12 months, and 79.1% of females reported such victimisation [1].

Similar rates of abuse in adult intimate relationships are noted in the national, population-based *Violence Against Women Survey* conducted in 1993 by Statistics Canada. Twenty-nine percent of the women in this study reported experiencing physical abuse at some time in their adult lives, and 35% of the "ever-married" women had experienced controlling or emotionally abusive behaviour [2]. Johnson extrapolated these figures to the population, estimating that over 2.6 million Canadian women have experienced physical or sexual assault [6]. In British Columbia (BC), the *Violence Against Women Survey* found the highest lifetime prevalence rate of abuse in Canada, with 36% of BC women reporting having been physically or sexually assaulted by their partners at some time in their lives [2].

A significant number of women in Canada experience relationship abuse each year. A population-based survey in a Canadian urban centre (Edmonton) found that 10.6% of women reported having experienced physical abuse in the past year, and 13.1% experienced psychological abuse [5]. In an average year in Canada, it is estimated that about 200,000 women are threatened, slapped, kicked, punched, choked, beaten, or sexually assaulted by their partners [6]. According to police reports for 1999, 523 women in Canada died at the hands of their husbands or common-law partners [56]. Every year, it is estimated that more than 40,000 BC women are physically injured as a result of violence [23].

Similar rates of violence against women in relationships are reported world-wide. Lifetime prevalence rates of 10% to 50%, and past-year prevalence rates from 6% to 14% have been found in population-based surveys from around the world [3, 4, 7, 94-97]. Although little research has included same-sex relationships, a review of the research that has been conducted finds lifetime prevalence rates for abuse between 25% and 35%, comparable to heterosexual populations [88].

Health Impacts

Research shows that abused women have poorer health than women not experiencing abuse [34, 54, 98]. The health implications of violence against women, like the violence itself, can take a myriad of forms. The most apparent may be acute physical injuries from which disability can result. Abuse in intimate relationships can also affect women's basic bodily functioning, mental health, reproductive and sexual health, and the health of their children. These health effects can, at times, be fatal.

Physical Injury and Disability

Violence against women in relationships has been found to be the single most common cause of injury to women [98]. Physical violence can result in bruises, lacerations, abrasions, burns, sprains, fractured bones, broken teeth, choking, head injuries, and internal abdominal injuries [53, 99-102]. Injuries can range from minor to life threatening and may include injuries from firearms or other weapons. Injuries sustained through abuse are more likely to be to the chest, neck and facial areas compared with injuries unrelated to abuse [103]. Chronic pain at the site of previous injuries is common for women who have experienced abuse [100, 104]. Long-term or permanent disability, such as hearing loss, visual impairment, disfigurement, brain damage, or paralysis can result from injury [95, 99]. Women may die as a result of acute physical trauma; 40% to 60% percent of murders of North American women are perpetrated by their intimate partners [105, 106]. Despite efforts to mitigate the harms done to women by their intimate partners, these numbers are not decreasing. In Canada in 2001, homicides of women by their spouses increased for the first time in six years [107].

Somatic and Psychosomatic Complaints

Women in abusive relationships experience a wide range of varied, vague symptoms for which it can be difficult for health-care providers to find physical cause. Women experience problems sleeping, including insomnia, nightmares or repetitive dreams [5, 95, 99]. They can also develop disorders related to eating and digesting food, including loss of appetite, anorexia, bulimia, nausea, vomiting, diarrhoea, constipation, irritable bowel syndrome, gastrointestinal illness and spastic colon [99, 100, 108-111]. As a result of abuse, women can also have chronic and recurring symptoms including fainting, seizures, hypertension, chest pain, muscle tension, headaches, backaches, palpitations, and hyperventilation [53, 99, 100, 103].

Substance Use

Abused women are more likely to use alcohol or drugs than women not experiencing abuse [5, 48, 51, 54, 100, 103, 108, 112]. Research exploring the temporal nature of this relationship has revealed that the use of alcohol or drugs usually began after the onset of abuse, which suggests that women are self-medicating against the effects of the abuse [113]. Abused women also are more likely than non-abused women to smoke [95] and to be prescribed medication [5, 30, 54, 103]. Women express fears of addiction to prescription medication or a loss of alertness increasing their risk for more abuse [114].

Effects on Pregnancy and Children

Women in abusive relationships are more likely to have less prenatal care, an unhealthy diet during pregnancy, poor fetal weight gain, blunt injury to the abdomen, fetal injury and death, miscarriage, pre-term birth, and decreased or low birth weight babies [68, 99, 115, 116]. However, the mechanisms through which abuse in relationships affects pregnancy outcomes are not entirely understood. The use of tobacco, alcohol and drugs can have an impact on the pre-natal development of abused women's infants [117, 118].

Children whose mothers experience abuse also face significant harm, including also being abused [113, 119], and the emotional and developmental sequelae of witnessing violence [34, 120].

Reproductive and Sexual Complications

Because the terms of sexual relations can be difficult to negotiate by women in abusive relationships, and many women are sexually assaulted by their abusive partners, they face an increased risk of contracting sexually transmitted diseases, including HIV/AIDS, and of having unwanted pregnancies [51, 95, 99, 100, 121, 122]. Other gynaecological symptoms of abuse include chronic pelvic, abdominal or vaginal pain, vaginal bleeding or infection, fibroids, pain with intercourse, urinary tract infections, pre-menstrual syndrome, and dysmenorrhoea [99, 100, 108, 123]. Again, the pathways through which this happens are not entirely understood. Violence against women in relationships has been also reported in an exploratory study to increase a woman's risk of pre-invasive and invasive cervical cancer [77]. The mechanism through which this happens is unknown, but the stress of being in an abusive relationship and the transmission of human papillomavirus through sexual assault are offered as possible factors [77].

Psychological Impact

Experiencing abuse in an intimate relationship can have a significant impact on a woman's psychological well-being. Studies reveal that women who have endured violent relationships are four to five times more likely to require psychiatric treatment [113]. Women often report the psychological sequelae of abuse to be worse than the physical impacts [45, 72, 95, 124]. Psychological impact is not determined by the severity nor frequency of physical assault [6, 51]; rather, exposure to dominance is the strongest determinant of psychopathology, as well as threats of harm, sexual abuse, and emotional abuse [54].

As a result of abuse, women can experience depression, anxiety, post-traumatic stress disorder, fear, feelings of shame and guilt, lowered self-esteem, rage, dissociation, compulsive or addictive patterns, borderline personality, and aggressive and antisocial behaviour [48, 53, 54, 95, 98-100, 125]. At the same time, researchers have argued that some of these labels – such as borderline personality or antisocial behaviour – serve to pathologise and dismiss women in abusive relationships, and to obscure that the abuse is the problem, not the woman [36, 126-128]. Women in abusive relationships are also more likely to engage in self-harming behaviour and to contemplate and attempt suicide [30, 48, 95, 125, 129, 130].

Exacerbation of Health Issues by Abusive Partners

As a compounding effect, an abusive partner may interfere with a woman's ability to care for herself, seek health care, or adhere to proposed treatment regimens. Abusive partners may make it difficult for women to care for chronic medical conditions such as diabetes, asthma, angina, and pain [98]. Power and control may manifest as an abusive partner preventing a woman from seeking health care until she is very ill [131], or from seeking prenatal care before the third trimester [132], remaining by her side unceasingly during her hospital stay, exerting control over medical decisions, and insisting on premature release from hospital [98, 114]. An abusive partner may also describe a woman as mentally ill and a danger to herself as a strategy to maintain control over her [133].

Effects of Leaving

While being in an abusive relationship can affect women's health, trying to leave may not always alleviate the impacts. One-quarter of women who have left their abusers still experience physical violence [33], and threats of violence have been found to be higher for women who have left their abusers than those who stay [134]. Women report ongoing danger and fear for their own safety and that of their children [135]. Child custody and access procedures can also provide abusive men opportunities to continue to harass, monitor, and intimidate women who have left them [135-137]. The risk of injury and death rises dramatically once a woman tries to end her relationship with her abuser [2, 24]. An examination of statistics gathered between 1974 and 1992 indicates that the rate of wives killed by husbands was six times higher for those women who had separated from their husbands than for those who had not [6].

Worldwide, gender-based violence accounts for as much death and ill-health amongst women aged 15-44 as cancer, and is a greater cause of ill-health in women of this age group than malaria and traffic accidents combined [71]. Thus, it is not surprising that women in abusive relationships comprise a significant percentage of patients in health-care settings.

Abused Women in Health Settings

Research reveals that women in abusive relationships utilise medical services more frequently than women who are not abused [53, 103, 129, 130, 138]. Abused women interviewed in the *Violence Against Women Survey* saw medical professionals about three times more often than non-abused women [5]. In addition to seeking treatment for traumatic injuries, women in abusive relationships seek health care for a range of medical, gynaecological, psychiatric, and unspecified disorders [129]. Studies show that women experiencing abuse are more likely than their non-abused counterparts to utilise emergency room services, "drop in" health-care centres, chronic pain clinics, public or community health nursing services, primary care, psychiatric care, psychological care and in-patient hospital care [103, 138-141]. One study found that women continue to require health services at elevated levels in the years following the termination of their abusive relationships [129].

Rates of Abuse in Patient Populations

Research has been conducted to determine rates of abuse among female patients in a variety of health-care settings. Attempts to establish specific rates of abuse in different health settings encounter similar difficulties as prevalence studies of woman abuse in the general population. It is difficult to compare rates among health settings due to differences in samples and data collection methods. Studies in health settings reveal, however, that one-quarter to one-half of women in a health setting will have experienced abuse in an intimate relationship at some time in their lives, with even higher rates among women seeking psychiatric treatment.

In 1976, in what was perhaps the first woman abuse prevalence study in a health setting, Anne Flitcraft, a medical student, and Evan Stark, a social worker, began to explore violence against women as a cause of injuries presented in the emergency department. By analysing the medical records of 481 women who sought care for injuries over the period of one month, they discovered that 25% of the women had experienced abuse by a partner at some time in their lives [30]. Research in other emergency departments has since confirmed lifetime prevalence rates between 25% and 35% [101, 142, 143]. In two of these studies, between 2% and 3% of women sought care for direct physical sequelae of abuse [101, 142].

Rates found in ambulatory and primary care settings appear similar, though they also vary based on methods and definitions employed. In a United States (US) ambulatory clinic, 40% of 406 women reported having experienced emotional or physical abuse by a partner, 7% were currently in abusive relationships, and 3% had forced sex within the past year [144]. Of 394 women seen in a family practice clinic in a medium-sized Midwestern US community, 22.7% had been physically assaulted by their partners within the previous year. The lifetime rate of physical abuse in this setting was 38.8% [145]. Approximately 15% of female patients at a suburban family practice clinic at a tertiary university hospital reported having sustained injury or being fearful of their partners as a result of their partners' physical aggression in the past year [146]. In two primary care clinics in South Dakota, 48% of 218 women reported verbal abuse, 44% minor physical abuse, and 28% severe physical abuse [147]. Of 1207 women recruited from 13 general practices in an East London borough, 41% reported at some time in their lives experiencing physical violence from their male partners, 46% having been threatened, and 74% experiencing some form of controlling behaviour. Fifteen percent of these women experienced abuse during pregnancy, and for a quarter of these women, the abuse was worse during pregnancy [148].

In a Gynaecologic and Obstetric Emergency Clinic in Britain, 40.1% of 452 female patients during one month gave a history of abuse; of those that did, one-half were currently in an abusive relationship [149]. Rates of abuse during pregnancy, determined in a number of settings, are found to vary between 3.9% and 19%, depending on sample, methods, and parameters of abuse [115, 117, 150-155]. While some researchers suggest that pregnancy is a time of increased risk for abuse, analysis of the *Violence Against Women Survey* data suggests that links between abuse and pregnancy are spurious [54]. While women may not be more likely to be abused when they are pregnant, women experiencing abuse may be more likely to require and seek health care during pregnancy [34].

In several studies of the prevalence of abuse in psychiatric populations, between half and three-quarters of women had experienced abuse at some point in their lives [98, 156-160]. These findings may underscore the immense psychological impact of abuse on women's health.

Woman Abuse Experiences of Health-Care Providers

In health settings, it is not only patients who may be experiencing abuse in their intimate relationships [161]. Health-care providers also report experiencing woman abuse. In a convenience sample of 275 nurses in three practice sites (public health, hospital, and private practice), 31% of nurses reported abuse of themselves or family members [162]. In a sample of nurses in the BC Women's Hospital, 37% of nurses reported experiencing abuse in their intimate relationships [163]. The Women Physicians Health Study, a US nationally distributed questionnaire, found 3.7% of female physicians reported having experienced abuse in their intimate relationships [164].

Economic Costs

The costs associated with the health impacts of woman abuse also have been subject to research. In a comparison of health plans in the US, abused women generated about 92% more costs per year than non-battered women, with mental health services accounting for most of the increased costs [165]. It is estimated that, in the US, violence against women causes 21,000 hospitalisations annually, accounting for 99,800 days of hospitalisation, 28,700 emergency department visits, and 39,000 physician visits [166]. Estimated medical expenses in the US for one woman experiencing abuse per year are $1,633 [167]. The overall measurable costs related to health and well-being in Canada, including medical, dental, and workplace costs, as well as short- and long-term physical and mental health effects, but not including hospital admissions, amounts to about $1.5 billion per year [168].

Rates of Detection

Despite the significant proportions of abused women accessing health services, research reveals that only a small percentage of women who experience abuse are subsequently identified as such by health-care providers [44, 69, 115, 169-172]. A number of studies reviewed women's charts in emergency, primary care and obstetrical settings and found that in cases that were "highly indicative" of physical abuse by an intimate partner, treatment and discharge diagnoses rarely indicated the possibility of woman abuse [30, 44, 68, 126, 142, 173].

Health-Care Responses to Woman Abuse

Most research articles call for the health-care system to address the issue of woman abuse, and many professional associations, and government and non-governmental organisations have declared violence against women a priority health issue [3, 12, 14, 23, 49, 174-183]. However, there is a paucity of evidence regarding what health-care responses would be best to pursue in order to reduce the health impacts of woman abuse.

Earliest Formal Responses

Initial health-care responses to woman abuse were survivor-informed and advocacy-based. As part of their pioneering research in the late 1970's and early 1980's, Stark and Flitcraft created a working group of colleagues across the US who were also working to improve the health-care response to women in abusive relationships [15]. A key member of this group was Courtney Esposito, a woman abuse survivor who worked in a New Jersey shelter for abused women. In 1983, she teamed up with Ronald Chez, an obstetrician/gynaecologist, to begin educating physicians about woman abuse. They wrote a health-care manual on violence against women that became widely used, and helped the American College of Obstetricians and Gynaecologists create guidelines for responding to woman abuse [15].

Three years later, in 1986, Sue Hadley, while completing a master's degree in public health and volunteering at a hotline for abused women, began the first formal hospital-based program to respond to woman abuse. The program, entitled "WomanKind," is located in the Fairview Health System in Minneapolis and provides case management advocacy services for abused women combined with education and consultation for providers [15]. The program is intended to empower battered women to make positive decisions to discover their own strength to live violence-free. The advocacy component of the program aims to help abused women rediscover a sense of self, build hope, reduce isolation, develop strength and direction, and acknowledge small steps toward change or safety [91]. Later that same year, Advocacy for Women and Kids in Emergency Situations (AWAKE) was started at the Boston Children's Hospital by Susan Schechter, a well-known feminist activist and researcher who recognised that abused children often have abused mothers, and further demonstrating that ongoing advocacy services could be provided in health settings for abused women [1, 15].

In Canada, the late 1980's and early 1990's saw a proliferation of discussions regarding protocols and guidelines in the medical and nursing literature [49] and new curricula were developed for Canadian health care professionals [184]. The health sector began to play an important role in raising awareness of violence against women in relationships as a health issue [42]. As had been the process in other systems (e.g., the legal system), the upsurge of interest amongst health-care professionals meant that programming for violence against women became less influenced by women who had experienced abuse and community women's advocates [1]; written literature became the primary source of information on interventions available for use by health-care personnel [184]. Research findings that abused women comprise a significant proportion of patient populations, but are rarely identified as such, appear to have shaped much of the second wave of the health-care system response to woman abuse.

Screening for Woman Abuse

Elements of the initial health-care responses – identification and referral – became the primary focus of most formal health-care responses to woman abuse in the 1990's [185]. "Screening" for violence against women in relationships is based on the assumption that health-care providers cannot help women unless they know about the abuse [186] and, because there is no specific "presentation" that is indicative of abuse, the best way to learn about abuse is through direct questioning of all women in a health setting [8, 148]. Health-care providers generally receive between one and three hours of training, which is designed to explain how to ask one or more direct questions about abuse in patients' current or former relationships [40, 132, 187]. While questions generally focus on physical or sexual violence, they sometimes also enquire about fear of, or threats by, a partner [188]. If women answer 'yes' to any of the questions, health-care providers are trained to provide simple messages of support and give referrals, either to in-house social workers or to outside community resources [40]. Other principles of screening include: asking a woman in privacy, not using her family members as translators, and asking in a compassionate and non-judgemental way [189]. Screening programs, endorsed by many health professional associations [178, 179, 190, 191], have proliferated and are now commonplace [185, 192-194].

Evaluation of Screening Programs

Evaluations of screening programs generally focus on rates of screening questions asked, disclosures of abuse made, and referrals given [23, 195]. No studies were located that determined the impact of screening on the lives or health of women experiencing abuse in their relationships. While claims are commonly made in the literature that screening can significantly reduce morbidity and mortality and improve the health and lives of women experiencing abuse [194, 196, 197], it appears that no empirical evidence exists to support such assertions [16, 22, 23, 171, 198-201].

The proportion of women being asked direct questions about abuse by health-care providers has been determined in many different health settings. In settings where screening is a recommended guideline, routine inquiry is infrequent; research finding have shown that 7% to 15% of women are actually asked about abuse in settings where routine enquiry is policy [71, 144, 202, 203]. In settings in which screening protocols are in place and training has taken place to teach health-care providers to ask screening questions, reported screening rates rise to between 20% and 35% [23, 90, 170, 189]. One study measured the rate of screening over a three-month period and found that, without sustained training, the screening rate decreased to baseline levels [170]. This raises questions as to whether this type of practice can legitimately be considered as "screening". Screening, by definition, means that all patients in a population, regardless of their symptoms (or the lack of any symptoms), are assessed for the health issue under question [204]. Asking "screening" questions of only a small percentage of the patient population is more akin to "case finding" [204]. There is some evidence that the implementation of screening protocols enhances the likelihood of identifying abused women [16].

Identification rates in screening programs remain lower than estimated rates of abuse in the population, however, and many studies fail to take into account disclosure and identification of abuse that can occur without screening. In addition, it is not always clear in the reporting of these studies whether it is women who are currently in abusive relationships that are being identified, or those who have ever been in an abusive relationship. One of the first, and most widely cited studies pertaining to screening approaches, found that the identification rates of abused women in an inner city US hospital increased from 5.6% to 30% with a training program [69]. However, rates fell again to 7.7% after one year [205]. Such a dramatic rise in identification rates does not appear to have been replicated. It has been suggested that the high rate of identification in this initial study might be attributable to health-care providers asking questions about abuse only of women who were seeking care for physical trauma, rather of all female patients in a particular setting [206]. In fact, most studies in various health settings report lower rates of identification through screening.

In one emergency department, 0.3% of women were identified as abused through screening [207]. In another emergency department, 3% of women identified as seeking health care for injuries related to abuse, and 51% of women as having experienced abuse at some time in their lives [208]. In a Vancouver post-partum setting, 1.5% of women were identified as experiencing physical abuse from, or fear of, their current or former partner during their pregnancy [209]. Five percent of women in 12 US community health centres were confirmed through screening as 'having a domestic violence episode' [170]. Six percent of patients in a Vancouver emergency department answered that abuse or violence was a problem in their lives, though this was not limited to abuse experienced in intimate relationships [206]. Public health nurses found a 9% identification rate with the implementation of a screening protocol for women experiencing abuse, although this number was not statistically significantly different from pre-protocol identification [210]. The only study to employ randomised control groups found no increase in identification in primary care clinics with a screening intervention. In each of the five control and comparison settings, 3% of the female patient population were identified as abused [90].

Research has also determined rates of interventions provided when women disclose abuse through screening. With screening, the administration of safety assessments, referrals, information, advice or counselling is found to increase [16, 144, 170, 210]. However, studies also find that up to one-half of women identified as abused report that no interventions were subsequently provided [144, 211].

Researchers evaluating screening programs almost unanimously conclude that screening is an effective intervention for woman abuse. A few, however, lament the discovery that the majority of health-care providers are not asking screening questions, and that the majority of women are not disclosing even when asked [144, 211]. This has led to a significant body of research focusing on the 'barriers to screening'.

Barriers to Screening

Barriers to screening generally focus on the individuals involved: health-care providers and abused women [212]. Primary research and review articles report that barriers to asking screening questions for health-care providers are: lack of education regarding woman abuse, lack of time, own histories of abuse, fear of offending the patient, non-disclosure by women, frustration when women do not follow advice, and lack of effective interventions to offer women when they do disclose [21, 33, 73, 144, 161, 162, 171, 186, 194, 195, 205, 211, 213-219]. Research indicates that few health-care providers are screening and many are opposed to it because they do not feel it is appropriate or effective [20, 171, 203, 219]. Physicians in one study reported shifting their practice away from screening after seeing women leave their practice, never to return, after being screened [21].

Attempts to overcome these barriers to screening have focused on convincing health-care providers that the majority of women do not mind being asked direct questions about abuse [40, 220]. Other authors urge practitioners to ignore that most women are not disclosing in response to screening, and suggest that asking a direct question is itself an intervention [20, 189, 200, 209]. Health-care providers who do not ask screening questions are exhorted to do so, and it is suggested that they may even be negligent if they do not [188, 209, 220]. It has also been suggested in the literature that health-care providers be monitored for adherence to screening protocols and provided incentives, including rewards for screening or penalties for not screening, such as warnings and even eventual termination of their employment [170, 189, 195, 209].

Patient-related barriers to screening also have been the subject of research. While some abused women report that they would be "glad" if a health-care professional took an interest in their situation [1, 40], many also express fears and concerns about being identified as abused through screening as it is practised [95, 148, 152, 185, 221, 222]. More than one-half of women surveyed in several studies report having denied abuse when asked [222-224]. In a number of studies that explored the reasons women do not disclose abuse in health-care settings, women generally name fears about what the health-care provider might do (or not do) in response. Women report not discussing abuse with health-care providers due to a perceived lack of time or interest on the part of the health-care provider, including when they felt their providers did not care, were uncomfortable discussing the issue, did not listen, and treated only their physical symptoms. Women also report fear of losing control, including: having the violence escalate by a health-care provider speaking to the abusive partner, being labelled, blamed for the abuse, having confidentiality breached, their children apprehended, police involved, or being pushed into leaving when they are not in a position to do so due to family or social obligations or economic dependency [114, 144, 222-225]. Some women identify the potential for their immigration status to be jeopardised as a barrier to disclosing abuse [226]. While some authors appear to suggest that these concerns are unfounded and imply that abused women must be identified if they are to receive good care [223], research also shows that women are cautious for good reason. As outlined in the next section, women report many negative experiences in health-care settings, including, and at times especially, when they have been identified as abused.

Re-evaluating Screening

Questions are now being raised in the research literature about the efficacy and possible negative impacts of screening [16, 17, 40, 148, 189, 215]. A recent meta-analysis of the quantitative research evaluating screening concludes that "other than increased referral to outside agencies, little evidence exists for changes in important outcomes such as decreased exposure to violence" [16]. According to other researchers, however, "Rates of referrals to outside agencies are not a convincing proxy for important outcomes such as quality of life or mental health status" [39]. No studies were located that directly assessed the impact of screening on women's health or lives. However, a critical examination of the literature indicates that we should not assume that the identification of abuse will lead to positive interventions or outcomes [17] or that screening protocols meet the basic criterion of 'do no harm' [224, 227].

McNutt and colleagues asked questions about experiences with screening to 80 female patients seen at an urban family practice and 91 women from four urban domestic violence programs. Fifty-three percent of the abused respondents reported previous negative experiences, including insensitive or dehumanising doctors, and health-care providers who did not provide assistance or information once the issue of abuse was raised [222]. An analysis of the *Violence Against Women Survey* reveals that, of the women who did talk to a doctor about an incident of sexual or physical assault, only one in six found the doctor to be especially helpful [23]. Eighty-one percent of abused women in another study reported experiences in an Emergency Department that were neither helpful nor informative. The women perceived staff members to be concerned only with their physical injury, and women felt that their experiences were minimised, confidentiality was not respected, and that they were treated rudely, humiliated, and laughed at after being identified as abused [131].

A phenomenological study with four abused women who had multiple hospital admissions for injuries from violence reports several themes regarding their experiences: a) disengagement and loss of status (e.g., a sense of rejection once women had been labelled as a "domestic violence case"; being made to feel they deserved it, judged, and given no practical support); b) disempowerment and lack of control (e.g., being called a 'bloody idiot', lack of encouragement for them to participate in their own care, coldness, lack of empathy, treatment that heightened their fear, embarrassment, humiliation, degradation, depression and further isolation); c) stigma and social isolation (e.g., being made to feel humiliated and unworthy of being a patient); and d) being misunderstood (e.g., when women felt they were being blamed instead of their abuser) [228]. In a nation-wide survey of 1000 abused women in the US, 39% reported receiving help from medical personnel, and 9% of these women reported that the health-care encounter had increased the violence in their relationships [18].

As well, through screening and identification of abuse, women may experience a compounding of other forms of discrimination they already face. Research in health settings reveals that poor or racialised women are more likely to be asked questions about abuse, making many women feel that they are being targeted due to discriminatory assumptions about their culture, race, or socio-economic background [60, 131, 189, 216, 217, 229, 230]. Research reveals that abused women's use of alcohol or drugs can also negatively influence the way health-care providers interact with these women [131, 211].

The extent to which identification of abuse through screening meets the acceptable criteria of health screening programs in general also has been questioned. Guidelines for instituting screening programs include: Has the effectiveness of the program been demonstrated in a randomised clinical trial? Are efficacious treatments available? Does the burden of suffering warrant screening? Is there a good screening test? Does the program reach those who could benefit? [204]. It is generally agreed that the burden of suffering warrants addressing the issue and that women experiencing abuse could be reached in health settings [201]. However, the lack of evidence regarding its benefit to women, widespread resistance to it by abused women and health-care providers, and the possibility of it leading to a cascade of negative interventions are raising doubts about the acceptability of screening for woman abuse [16, 17, 40, 148, 195, 201, 215, 221].

Concerns are also being raised about the impact of screening programs on staff. Health-care providers have expressed apprehension that one to three hours of training do not adequately prepare them for addressing woman abuse [17]. As well, health professionals' personal experiences of relationship abuse may be neglected by screening programs [40, 189]. Stark and Flitcraft, two of the pioneers of the health-care response to woman abuse, express worry about the direction that the health-care system has taken, and that, ironically, screening is not apt to facilitate patients and health-care providers discussing abuse or women getting appropriate care [98]. They insist that another role for health professionals is needed. While little research has elucidated what this role might be, there are some clues in the literature.

'Re-framing' Screening

Research reveals that some health-care providers who originally adopted screening have since shifted their response to woman abuse away from a focus on identification and disclosure and towards building trusting relationships with their patients. In a grounded theory study, 13 obstetrician/gynaecologists, practising in a large metropolitan area in the south-western US, reported starting out screening, but then found themselves in a "double-bind". While none of the doctors believed that screening worked, they were worried that not screening their patients for abuse meant that they were doing nothing to help women in abusive relationships. Their resolution of this dilemma came through shifting their practice towards focusing on building trusting relationships with their female patients. Instead of trying to "fix" the problem of abuse, they concentrated on supporting their patients [21]. Many of the 45 physicians (emergency, obstetrician/gynaecologist and primary care) included in a study conducted in the San Francisco Bay Area also reported stopping or refusing to conduct universal screening protocols. Instead, these physicians chose to focus on compassionate, non-judgemental communication with their patients, without pressuring for disclosure, to build respectful physician-patient relationships [20].

When women in abusive relationships are asked open-ended questions about what helps them to discuss abuse with their health-care provider, they also shift the focus from disclosure and identification toward the importance of good patient-provider relationships. In one study, researchers conducted interviews with 49 clients of a hospital-based program, Hospitals Helping Abuse and Violence End Now (H.A.V.E.N.) at the Massachusetts General Hospital, to learn what compels women towards disclosure and what constitutes helpful provider responses. The following factors were found to be important to women: a good relationship with a health-care provider, providers' perceived knowledge and understanding of partner abuse, care and interest in helping the patient, being asked about the abuse (though patients preferred not to be asked verbally from a list of questions), not being pressured to disclose, attention to confidentiality, the woman's readiness for disclosure, provider awareness of abuse as a possibility, and the availability of printed materials about violence against women in relationships. Components of supportive responses to disclosures of abuse were reported to include providers that were non-judgemental, respectful, made addressing the abuse a priority, believed the patient, made supportive statements, gave violence-related referrals, exerted no pressure to accept referrals, provided immediate connection to woman abuse services, paid attention to safety issues, gave assistance with other immediate needs such as notes, written documentation and photographs, did not ask for too many details, followed-up or remained available, and provided a range of emotional and practical support [231].

Another research study asked 21 women from three community-based mental health centres and one women's shelter what would help them disclose abuse to their health-care provider [114]. Researchers found that women were more inclined to discuss abuse if they perceived the clinician to be caring, easy to talk to, supportive, non-judgemental, and to offer follow-up. The women interviewed in this study also commented that referral to women's groups or other agencies were beneficial, but that referrals to psychologists or psychiatrists were not. Another group of researchers learned that the factors that predisposed the 51 women they interviewed to seek help in health settings were health-care professionals who exhibited compassion, awareness and respect for patients' needs to make final decisions about their situations, and worked to established a supportive patient-provider relationship [225]. In focus groups and interviews with 15 immigrant and refugee women of colour in BC who had experienced violence, it was revealed that a trusting relationship was most conducive to disclosure [76]. Positive experiences for these women were health-care providers taking time with them, listening, being respectful, and supporting their decisions to stay or leave.

The trend in expanding the scope of, or shifting the focus away from, screening also includes discussion of ideas such as safety, advocacy and support as important factors in how health-care providers can address violence against women in relationships [17, 43, 231-235]. Interestingly, as described in the next section, this line of thought is beginning to converge with many of the ideas raised in the initial health-care responses to woman abuse.

Advocacy and Empowerment Responses

Advocacy or 'empowerment' models were part of the early formal health-care responses to woman abuse, and despite the proliferation of screening programs, some programs have continued to be, or were since developed, based on these ideas. The role of health-care providers in these models is not of case finder, "fixer", or "linker" to other resources, but one of advocacy. The belief driving these models is that an abused woman is the best judge of her own situation, and the role of a health-care provider is to help empower her. This is achieved by supporting and facilitating her decision-making process through assuring confidentiality and privacy, building trust, listening non-judgementally and validating her experience [29, 39, 43, 46, 81, 91, 225, 233, 236-240]. Some of the programs based on these models include routine enquiry about abuse as one element, but not the focus, of an overall response strategy [91, 188, 193, 232], while others aim to foster good medical care for abused women whether or not abuse is identified [17, 236, 237]. Few studies were located that evaluated the impact of advocacy and empowerment focused health responses to woman abuse. What they reveal, however, provides some evidence that advocacy can help women increase safety behaviours, decrease violence, and improve health, as well as have a positive impact on the health-care providers implementing the programs.

One article reports the evaluation of a "mentor mother" advocacy model in the US, which consists of weekly social support, education, and assisted referrals to pregnant women identified as abused. Effectiveness of the advocacy intervention was measured as contact success rate, number and type of advocacy contacts, and number and type of referrals made to the first 100 women to complete the advocacy program. The mentor mother advocates were successful in contacting the abused woman 33% of the time, regardless of whether a telephone call, home visit, or in-person meeting was attempted. The average number of advocacy contacts was 9.2 (SD = 7.6) with the majority (74%) being via the telephone. The average number of referrals per woman was 8.6 (SD = 7.6) with the largest percentage (38%) being for medical services [193]. What this study does not reveal, similar to evaluation studies of screening programs, is how the contacts or referrals affected women's lives or health.

A second study reports that abused women adopt safety behaviours as a result of an advocacy intervention. An ethnically stratified group of pregnant women who answered 'yes' to an abuse assessment screen in a maternity setting, received the intervention (given 3 times during the pregnancy) which involved safety planning, a list of community resources, and offers of assistance in making telephone calls. The adoption of safety behaviours increased significantly over the course of the intervention. Safety behaviours are defined as having hidden money and an extra set of house and car keys, established a code with the rest of the family, asked a neighbour to call the police if violence begins, removed weapons, and hidden important documents, phone numbers and belongings [241]. Again the findings do not uncover the connection between the adoption of these safety behaviours and a woman's ability to be safe, become healthier, or get free from the abuse.

A third evaluation reports that empowerment-based education on woman abuse can have a positive impact on health-care providers [242]. The Woman Abuse Response Program, located at BC Women's Hospital, focuses on educating and supporting all health-care professionals to respond appropriately to the safety and health-care needs of women experiencing relationship abuse. It aims to enhance the health of women by providing an environment that supports the safety of women, including women who access health services at BC Women's Hospital, as well as women who work there. Ninety-three health-care providers were surveyed, before and after training, through anonymous open-ended questionnaires, to determine the extent that the program was supporting their needs. Responses by health-care providers were resoundingly positive.

Themes that emerged through the analysis of the surveys were that health-care providers felt: empowered through their inclusion in the development of the program; that the program helped relieve their 'helplessness' about their ability to care for abused women; reinforced in what many of them already knew about the importance of putting an abused woman at the centre of her own care; supported in their own safety and well-being through the program; and that learning to provide empowering care is best learned through empowerment training. Several health-care providers who had experienced abuse in their own intimate relationships reported feeling supported, safe, and validated through the training. A second evaluation, of the program's provincial mandate, focused on its training and community development work across BC [243]. It reported that empowerment training has a positive impact on health-care providers and community women's advocates receiving the training across the province, as well as building their capacity to work together as part of a broad community response to violence against women. While the impact on health-care providers and community advocates is an important aspect in health-care responses to woman abuse, the subsequent impacts on female patients experiencing abuse remain hidden.

An evaluation of another local program, located at Vancouver Hospital and Health Science Centre, suggests that follow-up support and counselling, referrals to women's organisations, safety information, information about legal services, and information about violence against women and health, can have a positive impact on abused women. This program is primarily based on a screening model in three different hospital sites. However, it also has a follow-up program at one of its sites which is based on an advocacy model. Twenty-five current and former clients of the follow-up advocacy services were interviewed by telephone about their experiences, of which six had been connected to the program through screening. Although cause and effect related to program impact was not established, the clients identified positive changes in their relationships, including ceasing contact with their abuser, and improvements in their relationships due to increased self-confidence and awareness. The women also reported increased safety and improvements in their physical and emotional health [189]. These findings cannot be generalised to the program as a whole, however, due to the skewed sampling. Interviewees were selected by program staff, and were among those who had chosen to continue to access its services. However, the findings do suggest the possibility of advocacy-based health-care responses having a positive impact on women and their health.

Another study found a reduction of physical and non-physical abuse as a result of an 'empowerment model' for pregnant women living in abusive relationships. The program under study provided counselling and advocacy support for women identified in antenatal clinics as experiencing abuse in their relationship, and includes development of a safety plan, information on community and legal resources, and a focus on increasing women's control over decisions and safety. The researchers used a parallel group design and adjusted for differences in baseline rates and potential confounding factors, and found that the intervention was successful in decreasing violence at 6 and 12 months post-delivery, as measured on an abuse assessment screen. The authors concluded that "future research is needed", however, "to specify further the components of successful interventions" [244].

Conclusion

While little is known about the impact on women of screening for abuse, evidence suggests that identification cannot be assumed to result in health-care responses that positively affect abused women. Empowerment and advocacy models may result in positive impacts on women experiencing abuse in their relationships, although more research is required in this area. To this end, it may be useful to undertake additional research that explains how various components of health-care encounters influence women's lives and health outcomes in the long-term. In addition, research can offer opportunities for abused women to have a say in defining what "success" should mean in terms of health-care interventions [10, 17, 174, 177, 245, 246]. New theory is needed to inform the development and evaluation of new interventions, and can help researchers and practitioners begin to move systematically towards a more effective health-care response to violence against women [22, 23].

CHAPTER 3

Methodology and Methods

Overview of the Chapter

This study examined the health-care experiences of women in abusive intimate relationships with the purpose of developing knowledge that can be used in health-care practice and program development. Chapter Three provides an overview and discussion of the methods used, including the rationale for the study approach, relevant ethical considerations, the specific research procedures followed, and issues of rigour. The utilisation of grounded theory allowed me, the researcher, to gain an understanding of the health-care experiences of women in abusive relationships. The result is a preliminary theory that describes the key components of women's experiences with the health-care system and the impact of those experiences on women's lives and health.

Rationale for a Qualitative Approach

Researchers have yet to provide a comprehensive understanding of the central components of health-care encounters that shape the experiences and health outcomes of women in abusive relationships. Most previous research in this area has been quantitative in nature, often predicated on untested assumptions about what is beneficial for abused women, and rarely examined the impact of various responses on women's lives or health. Qualitative studies have identified some aspects of *what* abused women might consider to be helpful during a health-care encounter, but have rarely moved beyond description to an understanding of *why* or *how* these components may influence the health and well-being of women in abusive relationships. It has been recognised that developing an adequate health-care response to woman abuse requires an understanding of health-care encounters from the perspective of women in abusive relationships [1, 10, 17, 174, 177, 245-247].

To understand more fully the impact of their health-care experiences a research method was needed that could incorporate the perspectives of women in abusive intimate relationships, explore potentially complex processes and structures, and use a systematic analytic process to generate hypotheses that might explain how their health-care experiences affected these women's health. Qualitative approaches are designed to uncover the nature of persons' experiences, to explore concepts and relationships that are complex and not yet clearly understood, and to generate substantive and formal theory [248-253]. Several specific qualitative approaches were considered, with grounded theory ultimately deemed most appropriate for use in this study.

Grounded Theory

Developed by Glaser and Strauss, in 1967, grounded theory systematically derives concepts and hypothetical relationships or linkages among those concepts from raw data regarding personal experiences [254]. Theory produced through this approach is "grounded" because the concepts and relational hypotheses are derived through a constant interplay between proposing concepts and linkages based on the data, and checking them against the raw data. Although this method has been adopted widely in health research, its adaptation by numerous scholars has resulted in debate regarding its proper application. Despite divergent views on the principles and practices of grounded theory [249, 251, 255], however, the main tenets are generally agreed upon:

- The aim of grounded theory is to generate or discover a theory

- Theory focuses on how individuals interact in relation to the phenomenon under study
- Theory asserts plausible relationships between concepts and sets of concepts
- Theory is derived from data acquired through fieldwork interviews, observations, and documents
- Data analysis is systematic and begins as soon as data become available
- Data analysis proceeds through identifying categories and connecting them
- Further data collection (or sampling) is based on emerging concepts
- These concepts are developed through constant comparison with additional data
- Data collection can stop when no new conceptualizations emerge
- Data analysis proceeds from "open" coding (identifying categories, properties and dimensions) through axial coding (examining conditions, strategies, and consequences) to selective coding around an emerging story line
- The resulting theory can be reported in a narrative framework or as a set of propositions [256].

Grounded theory originally developed as an alternative to "positivistic" ontologies, which suggest that: a stable, objective reality exists independent of an individual's perceptions; only observable phenomena can be validly considered knowledge; science is deductive, such that hypotheses must be derived from scientific theories then empirically tested; and researchers must be purged of their values because they may impair objectivity and undermine the validity of the knowledge produced [253].

Grounded theory, like other "post-positivist" methodologies, instead recognises multiple explanations of reality, and values people's interpretations of social experience as a legitimate source of knowledge [257-260]. Grounded theory researchers' a priori knowledge, experience, and practice can provide sensitivity to and awareness of the subtleties of meaning in data and help to formulate theory faithful to the reality of the phenomenon being investigated [261]. Guidelines for self-reflexivity help ensure that only concepts that emerge from the ensuing data enter the resulting theory [252, 260]. Grounded theory is developed using deductive *and* inductive approaches to data analysis; it is used to both generate and verify theory [262]. This occurs through an iterative process of the emergence of theory from data, then the testing and refining of the emerging theory through additional data collection and analysis [249, 263]. Theory differs from description in that it specifies concepts related by means of statements of relationship; in description alone, data may be organised according to themes but there is little, if any, interpretation of the data and no explicit relationship to a conceptual scheme [261]. The grounded theory approach is especially suited to developing theory in areas where little is known or the complexities are not thoroughly understood [261], such as in the case of abused women's health-care experiences.

Grounded theory is further conducive to considerations specific to research about violence against women in intimate relationships. The World Health Organization has suggested that researchers in the area of woman abuse have an ethical obligation to ensure that their findings will be used to further the development of policy and relevant interventions [264]. Feminist researchers and advocates agree that it is imperative to not simply document a problem, but to also commit to doing something to remedy it [1, 127, 259, 265-268]. The grounded theory approach stems from a paradigm of pragmatism [257, 269]. Thus, while grounded theory need not be used to advance practice or policy development, it does create a conceptual framework that is meant to be useful [252] and can thus form a basis for action [249, 257, 270].

Grounded theory seeks to include and account for multiple and diverse perspectives, an aim congruent with recognising that woman abuse is not a singular experience, but can intersect with multiple forms of oppression [257, 271, 272]. While "relationality", the commitment to attending to power relations between the researcher and the researched, is often under-emphasised in grounded theory [260], it can be incorporated into the research process [270, 272, 273]. This acknowledgement can provide opportunities for more "empowering" or collaborative research designs [259, 274]. Grounded theory also strives to account for structural and contextual conditions in explanatory models [269]. This makes it especially well-suited to research of violence against women which, it is generally accepted, needs to be understood in its broader social context [49, 257, 259, 275].

Ethical Considerations

It is crucial to ensure that the study of violence against women in relationships does not subject women to additional danger, abuse, or exploitation [259, 276]. The recommendations set out by the World Health Organization for conducting ethical research in the area of violence against women include ensuring that the safety of the respondents and researchers is paramount, confidentiality is respected, and the study design includes actions aimed at reducing any possible distress caused to the participants by the research [221]. Designing this research study began with a process of consultation with members of the Lower Mainland anti-violence women's community as to how best to ethically and safely conduct the research. A series of community meetings were held in the spring of 2000 with over two dozen community women's groups or services. From these meetings, a set of community ethical guidelines were developed for the project. They are:

> *Confidentiality:* An abused woman would not be contacted unless she initiated the contact. There were accounts from other research projects of women being telephoned after agreeing to be interviewed and messages being left, which jeopardised their safety, undermined their trust in the advocates who arranged the interviews, and isolated them from the organisations where continuing support was available.
>
> *Support:* An advocate with a relationship of trust with a potential participant would approach the woman about the research, be present during the interview (if the participant wanted), and be available afterward for de-briefing.
>
> *Choice:* A woman's participation would be strictly voluntary; the researcher was not to be seen as "one more person" who had a woman's "case" and was coming to work with her. It was important that the participants understood that they did not have to "spill their guts" about their relationships. What was being sought were comments about their treatment by health-care professionals -- open-ended questions were deemed desirable.
>
> *Diversity:* Diverse representation in the research was paramount. It was important to include women from a wide range of backgrounds, knowing that oppression on the basis of race, class, sexual orientation, age, ability, and so forth could be an important factor in determining how women were treated by health-care professionals.
>
> *Action:* Marginalised groups are often researched extensively and rarely see concrete results. Thus, the women who participated and their advocates needed to have input into how the findings were disseminated. It was agreed that "accessible" versions (i. e., plain language) of the reported findings would be created and distributed to interested women and community groups. If appropriate, the findings would be available for use in training health professionals, and disseminated through various news media, with caution being taken in the interpretations accorded by mainstream journalists [277].

These ethical guidelines were adopted in addition to those laid out by the University of British Columbia's Behavioural Research Ethics Review Board. Ethical approval for the proposed project was granted in April of 2000 (Ethical Review Number BO-0123). How the particular research methods adhered to the approved guidelines is described in upcoming sections.

Research Procedures

The generation of grounded theory involves several research processes operating simultaneously. Sampling, data collection, and analysis occur as part of an iterative process, rather than in a linear fashion [261]. At the outset, a range of women's experience was sought through sampling, data were collected through broad open-ended interview questions, and the analysis was conducted to inductively generate abstract concepts and linkages between them through open coding. As the research progressed, the sampling and data collection techniques became increasingly refined to test and further hone the emerging provisional theory. The fluidity and circularity of these processes ensured that the provisional hypotheses were constantly compared with the raw data and kept the resultant theory "grounded" in the stories of the research participants. In the final stages, the sampling was "discriminate", the data collection was "focused" and the analytical procedures were "selective". The process concluded when "new" conceptualisations emerged only rarely from further data collection or analysis. Each of these processes is described in more detail below.

Sampling

A total of 16 women who had experienced abuse within their intimate relationships were purposively recruited into the research sample. Purposive or theoretical sampling is a form of non-probability sampling in which all participants are selected deliberately by researchers according to the direction and theoretical needs of the study. Initially, the "open sampling" attempted to capture a breadth of women's experience. Results from the initial interviews were used to inform subsequent sampling decisions. The second stage of theoretical sampling, "relational and variational sampling", aimed to develop density within the discovered categories and to further explore the relationships between the categories. During the final sampling stage, "discriminate sampling", participants were selected to maximise opportunities to further refine and assess conceptual linkages between the categories. Thus, the sampling strategy was systematic, yet flexible, to allow for exploration of a breadth of experience, the development of an in-depth understanding of identified concepts and linkages, and for repeated testing and verification of each aspect of the emerging theoretical framework. Women were recruited into the study slowly to allow for transcription of the completed interviews, to modify the interview guide where necessary, to fully and systematically analyse resultant data before recruiting additional study participants, and to establish trust with advocates and potential research participants. I was not the first researcher to find that "it takes a substantial amount of time to establish relationships with women who have been battered and with community groups. Building trust and listening and talking to people are the most time consuming tasks" [278].

Women were recruited through advocates in the local anti-violence women's community. Advocates described the study's purpose and methods to women that they believed were in "safe places" – physically and emotionally – to participate in the project and that met the project criteria. The initial criteria for including women were that they: 1) self-defined as experiencing abuse in an intimate relationship within the past ten, but ideally, five years; 2) had encounters with the health-care system in British Columbia during the time they were experiencing abuse; 3) were comfortable sharing their experiences; 4) were currently connected with support services for women experiencing abuse; and 5) were over 18 years of age. The first criterion helped ensure health-care experiences that were recent enough to reflect current practices, and to also allow for the inclusion of women who had some time in which to reflect upon their relationship and health-care experiences. The fourth criterion helped ensure that women had resources in place to support them emotionally if necessary.

Women who were interested in participating in the research were asked to contact the researcher directly. Only one woman who expressed interest in participating in the research was not interviewed. In this case, the researcher and woman together determined, in their first telephone conversation, that she instead needed more immediate support and advocacy in dealing with the recent loss of her son through a custody and access hearing. She was provided information about legal advocacy and a custody and access support group at a local women's organisation, and given the opportunity to participate in an interview at a later date. She phoned again, two months later, to say that she was "doing much better," but would not be ready to talk about her experiences for "quite some time."

In the initial stages, every effort was made to include women with a diverse range of experiences – in their relationships, with the health-care system, and in society. As the study progressed, women were recruited on the basis of their potential to provide information that would help flesh out and test the provisional hypotheses that had emerged from the analysis of data from previous interviews. The characteristics of the study sample are described in Chapter Four and detailed in Appendix A. The 16 women interviewed comprised a diversity of ethnicities, religions, cultures, income brackets, ages, and physical abilities. One of the women had been involved in both same-sex and heterosexual relationships, but experienced abuse only from a male partner. Four of the women mentioned having experienced abuse in more than one relationship. When this was the case, the most recent relationship was generally the focus of discussion in order to reflect more current health-care practices. The duration of the abusive relationships varied between 1 and 33 years and involved co-habitation in all but one case. While all of the women lived in the Lower Mainland of British Columbia, their relationship and health-care experiences occurred in a variety of urban and rural locations throughout British Columbia. The women sought health-care from a variety of health-care providers and settings. Most of the women had both negative and positive experiences with the health-care system, with a large majority being negative, despite concerted efforts to recruit women who had positive experiences.

Data collection

Interviewing, of individuals or groups, is a valuable method for collecting data in grounded theory studies and has been described as "one of the most common and most powerful ways we use to try to understand our fellow human beings" [279]. The first six interviews were individual interviews, followed by a group interview of three women, one more individual interview, and a final group interview or "focus group", consisting of seven women. One woman, who was initially individually interviewed, also participated in the first group interview. This data collection approach demonstrated that individual interviews had the advantage of eliciting stories in great depth and complexity, and allowing the individual to control the flow of topics [279, 280]. Group interviews also had their benefits; they were more "focused" in that they evoked similar, but shorter responses, more specific to the research questions. The focus groups also provided respondents with the opportunity to build on each other's stories and to see connections and variations among their particular experiences [281, 282]. Thus, individual interviews were beneficial early in the data collection process and, as the study progressed and the ideas became more focused, group interviews were more useful [255, 282].

Interview-guide development was informed by the literature, consultation with practitioners in the field, and the emerging theory. Initial interviews were guided by open-ended questioning in the following areas: a) women's experiences of abuse in their relationships, b) health impacts of the abuse, c) health-care sought during the abuse, d) important components of those health-care experiences, e) impacts of those health-care experiences, and f) improving the health-care response to woman abuse (see Appendix B). The interview guide also included questions on socio-demographic characteristics (Appendix C). These were generally asked verbally as part of the individual interviews, and administered as a written questionnaire in the group interviews. As the interviewing process progressed, the interview questions evolved to elicit information that would help to fill in and test the emerging theory. In the final group interview, the theoretical framework that had emerged from analysing the completed interviews was presented, and respondents were invited to comment on its "fit" to their experiences, to provide additional details, and to describe any experiences that challenged or modified the theory. The discussions of the focus group supported the emergent theory and added richness and detail, but did not provide significant amounts of "new" data to challenge or advance the conceptual framework. As a result, it was determined that the analysis was approaching "theoretical saturation" [249, 251], and no additional data were collected.

The individual interviews lasted between one and five hours, the group interviews between two and three hours, and were held at a time and place negotiated with the study participants to reflect issues of safety and confidentiality. Child care was provided, if needed, and all respondents received a $20 honorarium. None of the women chose to have an advocate present at the interview, so the researcher ensured that they had someone to call or see after the interview if they wanted to debrief. Safety planning tools, information on community and legal resources, and a plan for referral were also in place. Each participant carefully reviewed and signed a consent form (Appendix D). This included the researcher's legal duty to report child abuse, which was further clarified and discussed before the interview. After strategies for confidentiality were explained, the women were given the option of having the session audio-taped. All of the women consented to have their interview audio-taped, and chose a pseudonym for use on the tape and in the reporting of the findings. The women also responded to a question about if, and how, they could be safely contacted again in the research process. The respondents were offered a signed copy of their consent form.

Prior to the interviews, the recording equipment was tested. The women were informed that at any time during the interview they could go "off the record" by pausing the tape recorder, which was situated between the researcher and the respondent. In a few instances, some women did stop the tape recorder, or requested that it be momentarily shut off by the researcher, while they discussed certain issues (generally an ongoing court case). Some women also requested that potential identifying information that had been recorded be erased from the tape. Such requests were immediately carried out by rewinding the tape to the appropriate location and re-recording. During each interview, the researcher took some notes to supplement the audio-tape and to aid the posing of questions about a particular experience later in the interview.

The respondents appeared to be able to speak openly and easily in response to the research questions. Most of the respondents came to the interview with one or two particular experiences that they wanted to share, either positive or negative, but often remembered and shared additional experiences during the interview, as well as reflecting more on all of their experiences. Occasionally, experiences were difficult to recount or difficult to hear. However, all of the interviews were characterised by a note of hope – because all of the women were currently safer and healthier than they had previously been, and felt optimistic that health-care providers might learn from their stories to create more appropriate services for other abused women. "That's why I'm here", expressed one respondent, "...my hope is that this will have an effect, will change the health-care system" (Judy, 1508-11).

Directly after each interview, all potential identifying features were removed from the audio-recording, and additional notes were made on the character and content of the interview. These notes and additional ideas that arose for strategies for further sampling and data collection were compiled in the form of "method memos." The tapes were transcribed by a third-party and reviewed for accuracy, for all but one of the interviews. In this latter case, the respondent expressed her wish that I be the only one to hear her voice on the tape, so I transcribed the audiotape according to the basic principles of transcription [283, 284]. The transcripts and tapes were identified only by code, and kept in a locked filing cabinet to which only the researcher had access. The decoder and consent forms were kept in a locked filing cabinet in a separate location. The tapes and original transcripts will be kept for five years, as per UBC policy and in case they can be further used according to the wishes of the respondents. The interviews resulted in over 500 double-spaced pages of transcription, which were conducted and analysed between May 2000 and May 2003.

Figure 3.1 Example of a method memo

Created after first interview:

Interview with Mina lasted one taped hour, plus conversation on either end. She told me afterward that, although she ended the relationship 7 years ago, the most recent way her partner got to her was through the divorce papers she just received, which say that the grounds for divorce are that *she* had an affair when he was the one who did.

I was surprised that I didn't need to ask very many questions, that Mina's story unfolded in a way that followed the interview guide quite closely.

I also realised that health-care encounters *after* the relationship is "over" are important to ask about because the health effects from the abuse may continue. As well, I think I can more concretely get at what women would like to see in health-care encounters by asking about what could have gone better in the experiences they describe as negative.

Traditional interviewing methods of remaining a "detached observer" during the interview seemed inappropriate as soon as we got started. Getting to know each other and establishing trust was an important part of the interview. I didn't feel comfortable just listening to her experiences without, at the appropriate times, also sharing some of my own and providing acknowledgement and validation of her experiences. It was interesting, though, how vulnerable I felt giving those tapes to the transcriptionist with very personal information about myself on them. Certainly a clue to how much I am asking women to do in trusting me with what they're disclosing about their life experiences.

Sampling directions: 1) Should speak to a woman who accessed health-care services because of physical injuries directly related to the abuse, as this respondent was mostly emotionally abused and accessing services for more indirect health concerns. Yet I mustn't forget that Mina's depression was due to her relationship, and her sleeping problems were due to the stress being in an abusive relationship. The links are there, but conceptions of health impacts related to abuse need to shift to capture all the complexities of long-term emotional and physical abuse. 2) Mina's experiences were almost entirely negative. Need to speak to a woman who had some positive experiences.

Analysis

In grounded theory, coding is the central analytic process by which hypotheses are generated from raw data [249, 269, 285]. Coding provides the grounding, builds the density and develops the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely resembles the reality it represents [261]. This process includes three stages: open, axial and selective coding. The boundaries between these three stages are conceptual rather than rigidly temporal. Thus, while the research moved from the initial to the final stages of the analysis process, each stage of coding built upon the previous, but also overlapped and often occurred simultaneously.

At the outset of open coding, transcripts from the first two interviews were analysed word by word, then line by line. The data were broken down into discrete parts and closely examined. Codes – abstract, conceptual labels for ideas – were applied to each new idea found in the raw data. Operational definitions were developed for each of the initial 105 conceptual codes generated. At this point in the analysis, accurately depicting an idea was less important than naming it. Initially, codes were often descriptive rather than analytical, such that they represented certain events, rather than *types* of events. Strauss and Corbin's technique of stepping back and asking questions about the data [249] helped me to see the data on a more abstract level. As the analysis continued and the ideas refined, many of the initial code names evolved to more accurately reflect the ideas they represented and codes became amalgamated under more abstract labels.

The example below depicts the process of open coding using 10 lines of data from the first interview. Codes were inserted into the digital text following the concept they depicted by using the word-processing program's "endnote" function. The transcripts are identified using the pseudonym chosen by the respective interview respondent and line-numbered to facilitate reference to a particular part of the interview.

Figure 3.2 Example of open coding

Sample of raw data from transcript of first interview:

"So, I could feel $^{\text{perception}}$ *I was going deeper and deeper* $^{\text{process}}$ *into a depression* $^{\text{health impact}}$*. I went to my family doctor* $^{\text{seeking health-care}}$ *and I told her those things* $^{\text{communication}}$ *and as soon* $^{\text{time factor}}$ *as I told her...she just gave pills for me* $^{\text{not giving options}}$*. She didn't even* $^{\text{negative}}$ *talk to me* $^{\text{communication}}$ *or she didn't refer me* $^{\text{referrals}}$ *to any resource centre or any counsellor* $^{\text{social support}}$*, nothing...I had no idea* $^{\text{knowledge}}$ *about shelter or counselling places* $^{\text{social support}}$ *in Vancouver or generally in Canada* $^{\text{immigration}}$*. So I took those pills* $^{\text{compliance}}$ *and meanwhile I got this job at [a] bank* $^{\text{employment}}$*...Starting a job at a financial institution, I had to concentrate solely but those pills* $^{\text{prescribed remedy}}$ *made me very tired and sleepy* $^{\text{health impact}}$ *and plus I knew* $^{\text{knowledge}}$*, if I take them every day I may become* $^{\text{process}}$ *dependent* $^{\text{health impact}}$ *on those pills* $^{\text{prescribed remedy}}$*"* (Mina, 159-169).

As the codes were identified and defined, deductive processes guided the theorising about how they were linked within a theoretical framework. Throughout the analysis, an ongoing record of the theory development, decision-making about purposive and theoretical sampling, shifts in the interview questions, and tentative hypotheses was kept. Theoretical memos were used to track the development of the theory and emerging hypothetical relationships.

Figure 3.3 Example of a theoretical memo

Category Development: ***Negative*** and ***Positive Health-Care Experiences***

Women appear to be distinguishing between positive and negative experiences using words and phrases like "this was good" (positive), or "I didn't like that..." (negative). For example:

"[My family doctor] really listens $^{\text{listening}}$ *and she will ask you, 'What do you want me to do?'* $^{\text{asking open-ended questions}}$. *If you have any suggestions* $^{\text{opportunity for input}}$, *she'll do it* $^{\text{supporting her choices}}$. *If you don't have any suggestion she'll tell you what your options are* $^{\text{giving options}}$ *and you can tell her* $^{\text{communication}}$ *what you want* $^{\text{choice}}$. *That's a good thing* $^{\text{positive experience}}$ *about her"* (Tahmine, 984 - 87).

Question: Are *negative* and *positive* experiences different ends of the same continuum?

During axial coding, the categories were further developed. Coding occurred around the "axis" of each category, such that the data were put back together in new ways after open coding, by making connections between the categories. Within the theoretical framework, the initial codes were modified or grouped to form broader, more abstract codes. As the codes became grouped into higher order categories, and as the links between those categories were described, the categories were also broken down again into their various components. Axial coding also served as an opportunity to verify or refute how hypothesised relationships functioned within the theoretical framework.

This process of "breaking apart" and "putting back together" the data was done quite literally. Scissors were used to dissect the hard copies of the transcripts into units of data, generally one to five lines at a time, which were sorted into file folders representing more abstract conceptualisations. This process was a deliberate strategy to "immerse myself in the data" and to provide a more tactile element to the creative process of generating theory[4].

Writing about the emergent categories also began during the initial stages of the coding. Hypotheses about potential linkages among the concepts were specified, and the

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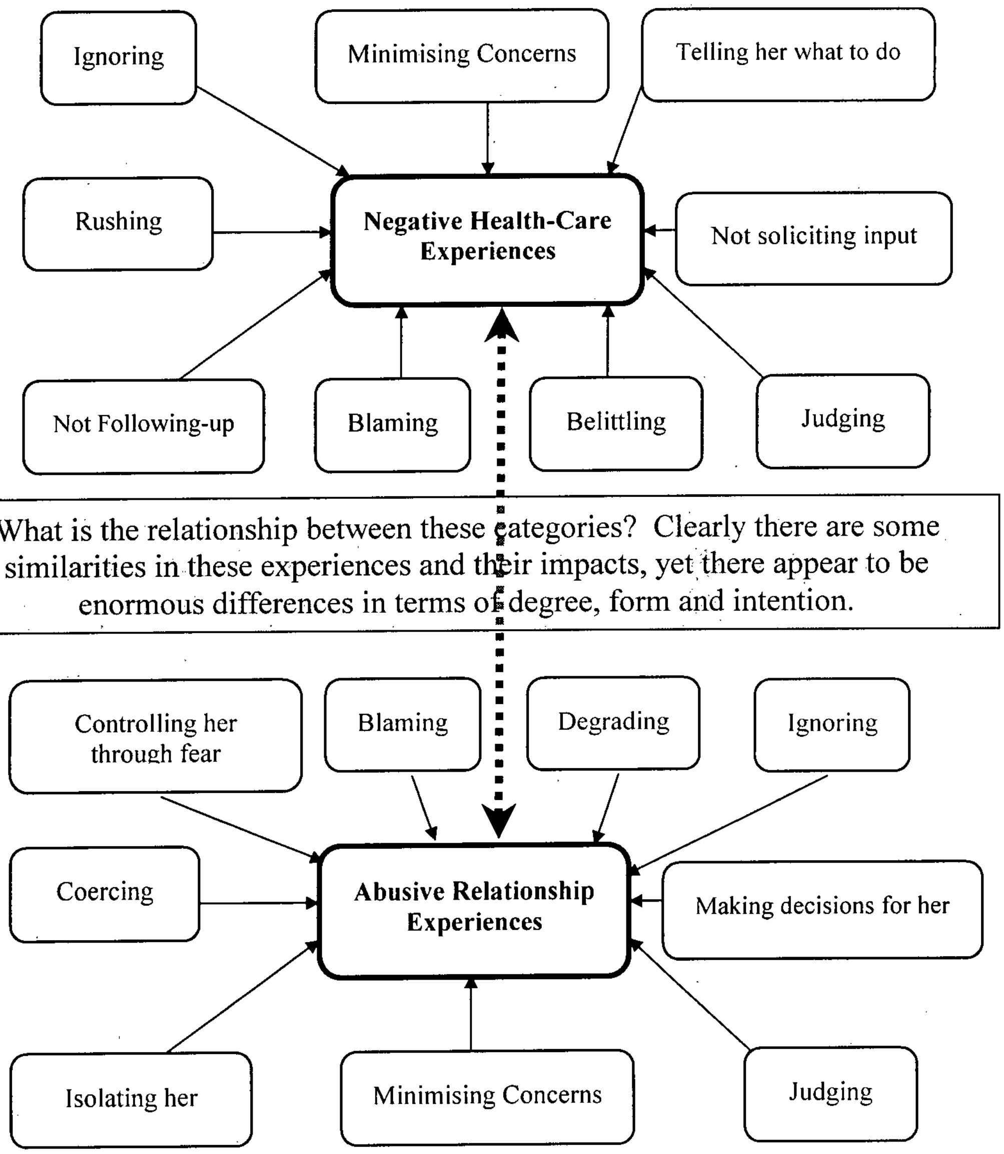
[4] The use of techniques such as "stepping back" during some periods in time and "immersing myself in the data" at others, as well as the practices of self-reflexivity and relationality, meant that my perceived distance from the research process vacillated; I sometimes thought of my role in the research in the first

categories were divided into several "properties" (e.g., more specific aspects of the categories) and "dimensions" (e.g., specific types, circumstances or conditions) of those properties. For example, the properties of *components of health-care experiences* were initially: *responsibility, voice, decision-making power,* and *social support*. *Negative* and

Figure 3.4 Example of axial coding



What is the relationship between these categories? Clearly there are some similarities in these experiences and their impacts, yet there appear to be enormous differences in terms of degree, form and intention.

---

person and sometimes in the third, as reflected in the use of both "I" and "the researcher" to refer to myself.

positive health-care experiences became dimensions of each of these properties. The properties expanded to five to include the concept of *care,* and then were refined to the final three properties of *care, control,* and *connection*, through the ongoing process of bringing the theory to a higher level of abstraction.

Table 3.1 Example of part of early theoretical framework

Category	**Properties**	**Dimensions**	
		Negative	***Positive***
Components of health-care experiences	Responsibility	Blaming	Not judging
	Voice	Ignoring	Taking concerns seriously
	Decision-Making Power	Telling her what to do	Supporting her choices
	Social Support	Not following up	Referring

As the interviews progressed, many of the initial categories also evolved to become more dynamic, recognising that many of their aspects reflected processes rather than static attributes (e.g., *health impact* became *shifting health status*). Written theory was continually being created that described the emerging theoretical framework and was constantly compared with the raw data. Just as the analysis created written theory, so the written theory drove the analysis by illuminating where questions still needed to be answered. Quotes from the women's stories were used liberally in explaining the concepts and linkages of the theory, and remain in the written theory. Many of the quotes used in describing the theory were from the first six interviews, because the analysis of these interviews formed the "guts" of the theory. Quotes from subsequent interviews were also included to better explain or illustrate a concept, add variation, or to challenge or modify the theory.

Figure 3.5 Example of written theory

Category: SHIFTING HEALTH STATUS

Shifting health status refers to perceived and real changes over time in physical and emotional well-being. For example, one woman described how "*these little things ... were just making [a] kind of decay in my body*" (Mina, 138-9). Properties include direction and magnitude of change, the forces that generate the change and the levels at which they operate, and the domains (e.g., physical, emotional) affected. The direction and magnitude of shifts in health status may be positive or negative, small or large. Individual perceptions, as well as outside forces that create change, influence the direction and magnitude of shifts in health status. The direction of a shift in health status may be towards *losing health* or *regaining health.* Health status may be shifted by *relationship abuse* or *health-care experiences*.

Question for further analysis:

What is the relationship(s) between *negative* and *positive components* of these experiences and *losing* and *regaining health*?

Selective coding involved a more abstract level of analysis in which the categories were filled-in, integrated and further validated against the data. It was during this stage that I focused on the development and explication of the core category. The core category is the "main story line" reflected repeatedly across the stories, is related to all the other categories, and forms the "core" of understanding the emergent theory [251, 261]. At first it appeared that *shifting health status* might be the core category because relationship abuse and health-care experiences both culminate in effects on women's health. In delineating these experiences and impacts, however, it became increasingly apparent that to understand the linkages between them, the strategies women themselves employed to mitigate the negative health effects needed to first be comprehended. These women were not passive, simply being affected by their relationships or health-care experiences, but were actively engaged in negotiating the circumstances they were experiencing and striving to maintain or improve their health. Selective coding involved moving between explicating the core category and relating categories at the dimensional level, validating relationships against the data, and filling in the categories. Describing and explaining *striving for health* forms the basis of the following chapter.

Issues of Rigour

The idea of what constitutes rigorous qualitative inquiry continues to be debated. The deliberation often focuses on whether qualitative methods should strive to meet quantitative notions of rigour, whether there are different conceptualisations of those quantitative notions, or whether qualitative researchers need to create new ideas of, and thus criteria for, assessing rigour in qualitative investigations [249, 253, 261, 269, 286-291]. Moreover, arguments continue about the terminology that should be used to describe issues of rigour within qualitative research [289, 291, 292]. Awareness and understanding of the nature and bases of this debate formed a backdrop for assessing the rigour with which this study was conducted. As in all good scientific studies, rigour was attended to from the outset of this investigation.

Because grounded theory is not based on positivist assumptions that there is an objective and measurable "truth", it has a different purpose that must be assessed. Wolcott described what he endeavours to approximate through qualitative inquiry: "What I seek is something else, a quality that points more to identifying critical elements and wringing plausible explanations from them, something one can pursue without becoming obsessed with finding the right or ultimate answer, the correct version, the Truth... For the present, *understanding* seems to encapsulate the idea as well as any other everyday term. ['Understanding' is] the power to make experiences intelligible by applying concepts or categories" [248]. Thus, rather than trying to speak the truth of women's experiences in health care, my concern in this study is with postulating the possibility of effects [293]. Several methods of enhancing rigour were systematically employed to enhance the "trustworthiness" of this study in developing an understanding of the health-care experiences of the participants, including: theoretical sensitivity, the constant comparative method, reflexivity, relationality, and purposive sampling.

It has been argued that all scientific findings, whether obtained through quantitative or qualitative methods, include theoretical assumptions and rigour is best assessed if these are made explicit [247, 260, 268, 288, 291, 294]. If used appropriately, researcher values, knowledge and experience can enhance theoretical sensitivity by providing insight and a greater capacity to understand [247, 252]. For example, my education, knowledge of the literature, experience and values clearly influenced me to choose a particular area of study and to conduct research that I thought would help improve the health-care response to violence against women. Knowing that the more we understand about health-care experiences, from abused women's perspectives, the better health care can be for abused women, has led me to want to conceptualise and represent those experiences as accurately as possible.

The use of the constant comparative approach in grounded theory also assists in the generation of theory faithful to the reality of the experiences under question. Because embarking on inquiry with pre-defined categories or rigidly hanging on to previously developed theories may stifle discovery, Strauss and Corbin [261] outlined a series of steps that grounded theorists can follow to help break through biases and to examine assumptions. In addition to carefully following the research procedures they prescribed, I also employed the two tools they recommended: 1) stepping back and asking questions and 2) being sceptical. Thus, all relationships between concepts that emerged from the data were regarded as provisional until repeatedly supported by the data. I worked diligently to avoid conducting "selective plausabilization", the act of finding quotes from women's stories to support pre-conceived theories, as this would neither add to scientific knowledge nor inform health-care practice in a useful way [246, 286]. For example, I was highly sceptical of any aspect of the emergent theory that resembled previously developed theory, and avoided too quickly grasping ideas just because they "felt right." "Prolonged engagement" in the field was another method enhancing the rigour of the project, as was keeping an "audit trail", which included information on the raw data, their collection and recording, method and theoretical memos, and the progression of the emerging theory [261, 286, 289].

Some qualitative researchers do not believe that Strauss and Corbin emphasised strongly enough the importance of reflexivity as a systematic procedure for minimising or understanding ways that the investigator's values enter into research [260, 274, 291]. "Reflexivity" means "to reflect upon, to examine critically, and explore analytically the nature of the research process" [257]. It also goes further than theoretical sensitivity to explicitly include attending to the effects of the relationship between the researcher and the informants as an important method for enhancing rigour [260, 292, 294]. A valuable means of self-reflexively exploring bias was obtained through repeated discussions with my supervisor, committee members, colleagues, and community advocates. Further, I presented the emerging theory at two professional conferences. Through feedback and discussion, I was able to uncover untested assumptions (see below) that were influencing the data collection or analysis and was thus able to identify incongruencies in the developing theory. I did not labour under the pretence, however, that reflexivity would allow me to identify and address all of the assumptions influencing my work [293].

By recognising many underlying assumptions, however, I was able to use them in the analytical process by asking respondents about them and exploring their foundations. Often, my assumptions and personal reactions to the respondents or the data provided excellent "jumping off points" for further investigation and understanding. For example, my respect for the women I was interviewing initially made it difficult for me to admit into the analysis aspects of the women's stories that portrayed them as anything but "good" (e.g., substance use) or showed her abusive partner to be anything but "bad" (e.g., occasionally showing affection). Having this pointed out to me, and working to generate theory grounded in all the richness and variation in the raw data, allowed me to understand that these were all important aspects of a woman trying to cope with her abusive relationship and its subsequent health impacts. The conceptualisation of abused women's lives without inclusion of these dimensions is part of what made many of these women feel guilty or deserving of the abuse, knowing they did not fit the stereotype of the "good victim". Ignoring these aspects also denies the agency and strength that can be seen in them. As well, I heard from these women that it is precisely the portrayal of abusive men as entirely bad that made it difficult for them to recognise abuse in their own relationships. As one woman described, when it was pointed out to her by a counsellor, that she "had been subjected to mental and emotional abuse:" "That was a smack in the face for me because I just did not see that at all. I thought, 'No, he's not a monster like that at all....He has some really good qualities'" (Judy, 487-491). She later said that "society has a certain look in their mind of what an abuser looks like...and what a victim looks like. And, I would never have guessed it would be me. Never" (Judy, 1646-51).

In attending to the effects of the researcher-participant relationship, many researchers argue that relations of power must also be addressed, as another important method for enhancing the rigour as well as the ethical value of the research [259, 260, 268, 290, 293]. "Relationality" is the term used to describe the attention to power relations between actors in the research process [260, 295]. In this study, I endeavoured to give this group of abused women "voice" through a variety of methods [259, 294]. The construction of the research categories were generated through their words, not mine, and their voices influenced the research process in terms of subsequent sampling and analysis [247, 294]. Through in-depth interviewing, rather than hypothesis-testing, I gave the informants the opportunity to express what was significant to them. I "privileged" the voices of these women over any presumed theoretical perspective, and allowed the theory to develop from the entirety of their stories [271, 286]. The theory development was difficult at times precisely because I struggled with abstracting too far from the words of the women I interviewed.

Feminist researchers have pointed out that the acts of transcribing and analysing interviews may be perceived as silencing research participants and attributing superiority to the voice of the researcher [293]. I was aware that I had the power to decide on the final analysis, but did my best to share that power. For example, the final focus group was part of the process of presenting the emerging theory to abused women to ensure it described their experiences. It was responses such as "that's exactly what my experiences were like, only I call them [health-care professionals] 'givers' and 'takers'" (Margaret, 295), that demonstrated my proximity to understanding. I also engaged in "member-checking" with five of the respondents, presenting findings to them for feedback and input into the latest in a series of "successive approximations" to these women's reality. By focusing on trust and reciprocity, I hoped to create the conditions that would allow them to be as honest in their feedback as possible. I also gave the respondents opportunities to provide additional thoughts or information at a later date, and to have a say in how the results would be used (see Appendix E). The respondents always had my contact information, and several women contacted me after their initial interviews to convey additional thoughts to me. I also shared transcripts of their interviews with the respondents that wanted them.

I was aware that at least one community advocate had chosen not to participate in the community consultation meetings because she felt that academic research processes are inherently exploitative. There has been much written about the challenges of researchers and community advocates working together, and strategies to undermine potential misuses of power [227, 247, 259, 265, 296]. To the extent possible, I attempted to share the power to design the research process, shape the analysis, and determine how the research would be used with both community advocates and the women who participated in the research. I have committed myself to getting the voices of these women heard by those in the health-care system who have the power to create the necessary change. At the same time, I strove to be realistic with the women who participated in the study regarding the ability of this research and researcher to affect social change, so that women were not ultimately disappointed [293]. My dissemination plan includes presenting the findings widely, at conferences, grand rounds, and through the health-research literature. I have been contracted to develop a manual for training health-care providers in British Columbia. A plain language version of the findings will be created and made available to respondents and community women's organisations.

The utilisation of appropriate sampling procedures is also crucial to the rigour of a study [261]. Purposive or theoretical sampling bases inclusion in the sample on the shared common experiences under study, and thus results in analyses that cannot claim representativeness or statistical generalisability [271]. However, those who employ this sampling technique "make this trade-off for the advantages of gaining deep detailed understanding of social process and to discover new concepts, categories and issues" [271]. The "theoretical generalisability" of the analysis remains to be assessed through further research, and by the degree to which it can be applied in a variety of contexts. This study, then, represents an initial foray into understanding the health-care experiences of women in abusive relationships.

By generating a composite picture of the health-care experiences of abused women, using their words to "ground" a framework in their experiences, and through systematic analyses of their stories and the potential effects of values and relationships on the research process, I was able to develop hypotheses about the components of health-care encounters that shape abused women's lives and health. In conclusion, the uniquely suitable methodological approach taken here allowed me to fulfil the purpose of this study.

CHAPTER 4

The Emergent Theory: Striving for Health

Overview of the Chapter

Many programs, protocols and policies have been developed within the health-care system to address the issue of violence against women; however, few are based on abused women's experiences within the health-care system. There has been little research to determine the effects of health-care experiences on women in abusive relationships. Through the use of grounded theory methods, a theoretical framework emerged for beginning to understand the significance of what women experience in health-care settings and the impact of those experiences on their health. Chapter Four introduces the findings and describes each component of the framework, which centres on the core category of *striving for health.* How the framework fits together is demonstrated through illustration of women's "disabling" and "enabling" experiences in the health-care system. In the former condition, women's strategies in striving for health are not supported and their health continues to degrade, while "enabling" experiences occur when women's strategies are supported and they are able to begin regaining their health. Aspects of the health-care context that can influence these experiences are also discussed. The chapter concludes with a summary of the hypothetical relationships generated through the grounded theory approach described in Chapter Three.

Introduction to the Findings

The 16 women who participated in this study ranged in age from 21 to 61 years of age, with a mean age of 40. Four of the participants were women of colour, two were First

Nations, and nine identified as white or Caucasian. Three of the women had immigrated to Canada as adults. Five of the women had the majority of their health-care experiences in rural BC, whereas the other 11 accessed health care mostly in urban centres. Participants' personal income in the last year of the abusive relationship ranged from less than $10,000 to over $70,000, with a mean personal income of $34,000. Education levels ranged from grade 12 to post-graduate, with most of the women having some college or university education. Six of the women had no children, whereas other women had between one and five children. The length of time spent in the abusive relationship was between 1 and 33 years, with women spending an average of nine years in the relationship.

Although each of the 16 women's stories included in this study is unique, they share several themes. Each of the women described having power exerted over them and being increasingly degraded, controlled, and isolated by their partners. All of the women experienced verbal, emotional and mental abuse, and many of them also experienced physical or sexual abuse. Within an overarching pattern of control that these women described, physical abuse was not generally considered the entirety or even the worst aspect of the abuse, but was perceived as simply another means for authority to be exerted over them.

The majority of the women who participated in this study expressed that they never thought that they would find themselves in an abusive relationship. Many of the women described entering their relationships with clear boundaries regarding the kinds of behaviour that was acceptable to them, but experiencing a process of those "lines" repeatedly being "pushed" by their partners into areas formerly conceived as unacceptable. At the same time, their investment in and commitment to the relationship grew, and it became harder for them to "just walk away". Although a few of the women recognised "red flags" early on in the relationship, most of the women described a long process leading to their realisation that they were in an abusive relationship, a realisation that was often hampered by societal definitions of abuse that focus exclusively on physical assault. As one woman said, "I didn't know I was abused, because I wasn't beaten" (Roberta, 291). Societal images of abusers as "monsters" also made it difficult for many of these women to see their relationships as abusive, when their partner was "not that bad, he does treat me well at times" (Susan, 392-3). Although all of these women now place responsibility for the abuse on their abusive partners, social norms also were seen as contributing to the problem. As Andradea expressed, "Our society conditions men to think that in order to be masculine they have to have power over women" (1158-9). Conversely, several of the women pointed out, society confers stigma on women, especially mothers, who remain or become single.

For many of the women there came a "catalysing" moment or event that helped them to see the abuse for what it was and that, while they could dampen or postpone some aspects of the abuse, nothing they did could make it stop. This event may have been seeing how the abuser treated their children, a particularly brutal verbal or physical attack, or having a friend or counsellor describe what they were seeing. After the initial shock of the realisation, the women described engaging in strategies to cope with the abuse and to try to put an end to it. While a few of the women took steps immediately to try to end the relationship, most first tried several other means of stopping the abuse, without terminating the relationship. All of these strategies, including leaving the relationship, were undertaken in the face of many challenges and were described as a constant balancing act of trying to regain their health while staying safe.

As the women in this study described abuse as much broader than physical assault, they likewise described the overall health impacts of relationship abuse as encompassing more than acute physical injury. While it is not possible in this study to determine cause and effect directly, women's descriptions of how the abuse affected their health include many of the impacts on physical health that are well documented in the literature - injuries, sexually transmitted diseases, depression, suicide attempts, alcohol and drug abuse, exacerbation of health conditions, sleep and eating disorders, unplanned pregnancy, chronic pain - as well as more indirect and less researched effects of abuse. For example, most of the women explained how their relationships affected their entire health and well being, including their ability to maintain basic immunity and energy levels. As one participant related, "I was convinced that I was going to die if I didn't get [my abusive partner] out of my life. I mean, I was convinced he was going to kill me, but that worried me less than dying from exhaustion and stress" (Luisa, 168-71). The five women who did not experience physical assault as part of their abuse experience did not appear to suffer fewer or less severe health effects. For most of the women who participated in this study, the long-term impact of living in the kind of stressful environment created by an abusive relationship was perceived as more debilitating than any acute physical injuries they sustained.

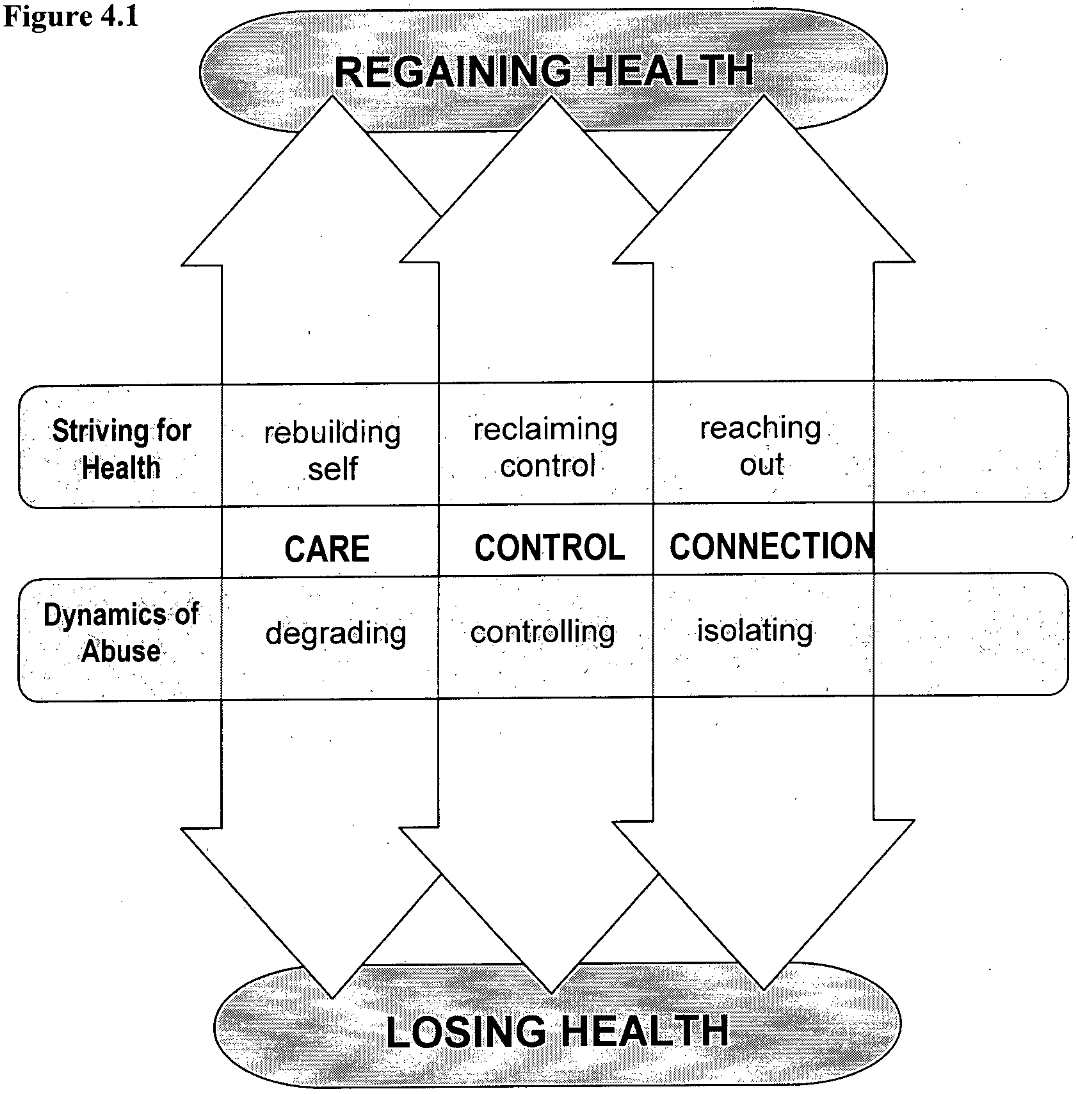
The women in this study reported seeking health care in a range of settings and from a variety of practitioners, including: emergency departments, acute-care hospitals, walk-in clinics, substance-abuse treatment facilities, mental-health facilities, sexually-transmitted disease clinics, abortion clinics, nurses, family physicians, chiropractors, naturopaths, paramedics, respirologists, haematologists, radiologists, physiotherapists, obstetrician/gynaecologists, psychologists and psychiatrists. In delineating between positive and negative health-care experiences, little differentiation was made between the *who*, *where* or *what* – such as certain types of practitioners, particular settings, or specific interventions for abuse. Instead, the women focused on *how* things happened – the character or quality of the experience. Caring interactions between the women and their health-care providers, shared control over decisions about health care, and positive connections to community supports were important qualities of successful health-care encounters. The women recognised, however, many inherent challenges to health-care providers creating such enabling interactions within the context of the health-care system. These are described later in this chapter, and further discussed in the following chapter.

The findings also negate two prevalent, yet contradictory, stereotypes of women in abusive relationships: 1) helpless and in need of rescue and 2) choosing to be in an abusive relationship. These simplistic renditions of women's complex situations appear to undermine women who are seeking health care. In this study, women were actively engaged in highly individualised and contextualised strategies to regain their safety and health while attempting to disengage from abuse. The degree to which women's strategies around safety and health are supported during their health-care encounters can determine the degree to which women can begin to regain the health previously lost through experiencing abuse in their intimate relationships.

The Theoretical Framework

In the emergent theory, the central integrative concept Striving for Health, as seen in the diagram below, encapsulates the myriad of strategies that women engage in to mitigate the loss of health experienced within their abusive relationships. Three major dynamics of abusive relationships include: (1) being given little care and attention and having one's self-worth increasingly degraded, (2) being controlled in most aspects of life, and (3) becoming increasingly isolated. Thus, women's stories of striving for health can be

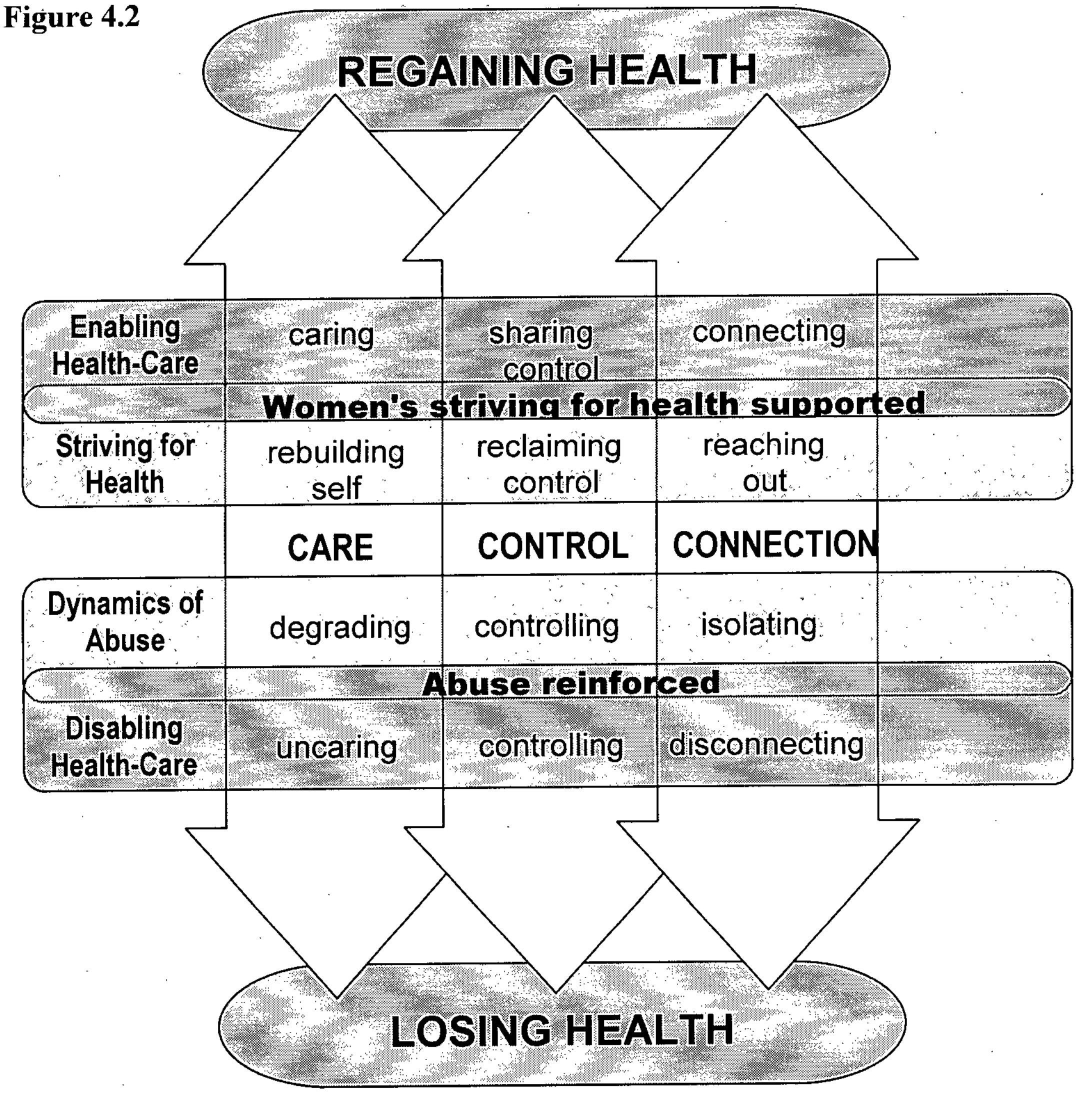
Figure 4.1



conceptualised across three domains: Care, Control and Connection. Women resist the abuse and strive to regain their health through rebuilding self, reclaiming control, and reaching out. The "tug of war" that exists between the dynamics of abusive relationships and women's strategies in striving for health, as well as their resulting impact on women's health, are illustrated in Figure 4.1.

In the second diagram, Figure 4.2, the links between women's experiences in their

Figure 4.2



abusive relationships, their strategies of resistance, *and* their experiences in health-care are illustrated. Each of the three domains (*Care, Control* and *Connection*) also captures a range of conditions, from negative to positive, which women describe as paramount in determining what kind of role a health-care experience will play in their *Shifting Health Status*. The links between women's actions and their experiences in their relationships and within the health-care system are complex, yet critical to understanding the impact that health-care experiences can have on women in abusive relationships. A simplified model of these relationships is presented here in order to highlight the most primary relationships addressed by the women in this study. *Disabling Health-Care Experiences* include conditions at the negative ends of the care, control and connection continua. *Uncaring*, *controlling*, and *disconnecting* conditions reinforce what women experience in their abusive relationships. These conditions do not support women's strategies in striving for health and contribute to women further *losing health.* In *Enabling Health-Care Experiences*, women encounter *caring, sharing control,* and *connecting,* which support their strategies, undermine the abuse in their relationships and contribute to their *regaining health.*

As each concept is introduced in the following sections, it is defined and described. Enabling and disabling health-care encounters are illustrated using examples from the participating women's stories. These portrayals of the impacts of health-care experiences on these women's lives and health demonstrate the nuances and intricacies of how these connections play out. The context in which women's experiences and actions take place is also important for understanding the connections between them. In the final section, aspects of the context of health care that facilitate or hinder health-care providers' ability to support women in striving for health are integrated into the theory. The final layer to the theory is the understanding that women may have health-care experiences that echo experiences in their abusive relationships because the health-care system mirrors the larger society in which it has been constructed, a society in which the conditions exist to allow violence against women in relationships.

The Themes of Care, Control and Connection

Care, *Control* and *Connection* refer to three key themes prevalent throughout these women's experiences within the health-care system, in abusive relationships, and in striving for health. Each of the three aspects extend along a spectrum with dimensions ranging from negative to positive. Abusive relationships provide negative experiences related to *care*, *control*, and *connection.* Women's strategies in striving for health, while unique to their individual situations, aim to move their experiences towards the positive end of each spectrum. Experiences in the health-care system can fall along the entire range. As varied as these experiences may be, if women's experiences with health care are perceived to be negative, their strategies are not supported, the abuse in their relationships can be implicitly sanctioned, and their health continues to deteriorate. If health-care experiences are perceived to be positive, women's strategies in striving for health are supported, the impact of the abusive relationship is diminished, and they are supported in their efforts to regain their health.

As defined by Webster's Dictionary, *care* means: "to feel concern; give close attention; and to look after" [297]. Within the context of this study, the concept of care exists along a continuum that extends from *Uncaring* to *Caring.* Uncaring experiences include neglect and degradation of one's self-worth. In such health-care experiences, women who participated in this study did not feel cared for or valued as human beings, nor feel consideration was being given to their needs or feelings. Instead, they felt ignored, belittled or judged. Caring describes aspects of women's health-care experiences in which they feel cared for, that their needs and feelings are being considered, and that they are looked after. Caring health-care experiences help women to rebuild their self-worth, which is constantly degraded in their abusive relationships.

Control is based on the denotation "to exercise authority over; [to] direct" [297]. In the emergent theory, the concept ranges from *Controlling* to *Sharing Control* and captures the idea that, in our society, social and political power are unequally distributed amongst groups, on the basis of such factors as gender, race, ethnicity, class, and physical or mental ability. By extension, individuals from one group are granted authority relative to individuals from other, less powerful groups. Many of the women who participated in this study observed that they generally had less power than their partners and health-care providers, especially doctors. *Controlling* describes experiences in which women feel they have few choices, as their partner or health-care provider retains control over decisions. Women do not feel that their wishes are solicited or respected, and they feel pressured into courses of action not of their choosing. *Sharing control*, on the other hand, occurs when women feel that their wishes are identified and opinions sought, that they are listened to, knowledge and options are shared, and the decisions they choose are supported. In scenarios in which control is shared, women feel that they have some control over what happens to them, that they are involved in decisions being made that affect them, and that things are not done to them, or on their behalf, without their consent. *Sharing Control* works to support women in regaining the control they have lost in their abusive relationships.

Connection is the concept of being acquainted with people who are supportive and helpful, and refers to a continuum that spans from *Disconnecting* to *Connecting*. *Disconnecting* experiences are those in which quality connections with supportive people are lost. Women become, or feel, more alone. In abusive relationships, *disconnecting* experiences lead to increasing social isolation. In health-care encounters, *disconnecting* experiences increase the likelihood that women will not be provided with useful options or information regarding connections to outside community supports and will feel less inclined to return to the health-care system for support. *Connecting*, on the positive end of the continuum, describes experiences through which a woman comes to feel less alone. Connections are made with people who support her; she feels that people are 'looking out' for her, and she has places and people to go to for assistance in the health-care system or in the broader community. *Connecting* experiences support women in reaching out to combat the isolation and the lack of support experienced within an abusive relationship.

Care, *Control* and *Connection* are interrelated. In negative health-care encounters, uncaring, controlling and disconnecting conditions can interact to create a disabling experience. For example, if a woman does not feel cared for in her health-care experience, she is less likely to feel she can discuss her experiences of abuse with her health-care providers. A lack of discussion about her experience may mean that her health-care provider has little or no information about her abusive relationship and its health impacts. Not having such information incorporated into the health-care decision-making process may lead to unhelpful treatment or advice being provided, which in turn decreases the likelihood that a woman will return to the health-care system, leaving her further disconnected from potential care and support.

In enabling experiences, *caring*, *sharing control* and *connecting* are synergistic. If a woman feels listened to and cared for, she is more likely to disclose abuse. If she is further listened to and supported, she is more likely to have knowledge of her abusive situation accounted for in health-care decisions. This means that she is more likely to receive appropriate health care, to perceive the health-care system as an avenue of support, and to become connected to more sources of information and support beyond the health-care system. *Caring*, *sharing control* and *connecting* also appear to be contingent upon each other such that, if one element is missing, the experience may not be enabling. For example, a woman may feel that she is in a caring environment and disclose abuse, only to find that she is being pressured to pursue a particular course of treatment or action. If she believes the advice to be unsafe in her situation, she may not feel she can return to the health-care system if she has not complied, leaving her disconnected from potential care and support.

Shifting Health Status

The women who participated in this study generally described their health and well-being as a process. While all of the women described the immediate physical health impacts of abuse, they also described their health in more all-encompassing terms that integrated mental, physical and emotional health. The women did not sharply demarcate between these various facets of their health. All of the women described a process of losing health as a result of being in an abusive relationship. For example, Angel said that, during the abusive relationship, she became "sicker and sicker and sicker" (236). The impact of living in an abusive relationship was perceived by all the women who participated in this study as the major negative influence on their health. Almost all of the women, however, also identified health issues they perceived to be unrelated to the abuse.

Shifting Health Status focuses on the consequences of, and connections between, women's intimate relationships and health-care experiences. Without meaning to imply an overly simplistic causal relationship, my discussion of this concept summarises the way women in this study described the connection between their experiences and their health status. The women interacted with the health-care system as part of their strategies in striving for health. Health-care experiences that help women regain health while still in their abusive relationship can assist them in gaining the supports, strength, and resources they need to get free from the abuse when they feel it is safe to do so. After safely disengaging from their abusive relationships, all of the women who participated in this study described a process of regaining their health. However, for some of the women, this process was slow, and the health impacts of abuse continued long after the relationship ended. For some women, this included witnessing the long-term effects of abuse on the health and well-being of their children.

The Core Category: Striving for Health

Striving for Health is the category at the core of understanding women's experiences in the health-care system and the resulting impacts on their health. It became increasingly clear through the course of the analysis that women are not passive recipients of abuse in their relationships or of treatment in health-care encounters. Rather, women are actors, reacting to what is happening to them and engaged in trying to do what is best for them. Thus, the impact of a health-care encounter is not simply a function of the treatment provided therein. It is instead an interaction between the treatment and a woman's strategies. Specifically, the impact of a health-care encounter on a woman is directly related to the degree to which the experience supports the woman's strategies in striving for health.

Although all the women who participated in this study indicated that getting safely out of their abusive relationship was the ultimate way to eventually regain their health, they also understood that leaving their abuser could potentially further jeopardise their health. Fear of retaliation from an abuser is a major factor, but financial dependence and lack of social support also make it difficult for women to leave abusive relationships. Thus, striving for health can mean staying in a relationship and acquiescing to a partner's control, while amassing the resources necessary to get safely away. How this is achieved can vary greatly, and women recognise that they cannot always address long-term health issues while making decisions to protect their health and safety in the short-term. Women's strategies generally lessen the immediate harm done to them while they work at rebuilding their self-worth, reclaiming control over their lives, and reaching out for social support.

Rebuilding Self

In the face of their self-worth being degraded through their relationships, the women in this study described working vigorously to regain the belief that they had worth. The women who participated in this study described a range of ways they worked to regain their self-esteem, from covertly gathering strength to openly confronting their partners about their abusive behaviour. Many of the women described fighting against being made to feel that they were "the problem", and thus to blame for the abuse. For example, one woman described how she was made to think, "If I was more patient or if I was less interfering in these areas and more supportive in these areas, and if I was sexier or smarter or played ball better...I just didn't seem to match up to the perfect image that must be in his mind because how else would he treat me in a way such that I'm falling short" (Judy, 1262-7). Thus, rebuilding self is about women working to feel that they are not "falling short", that they are fine just the way they are. For some women, this involved beginning to respond with anger to the degradation. "I became a very angry person", said Susan (310). Unfortunately, abusers often twisted this to make the women further feel that they were deserving of abuse. For example, when Judy responded to abuse with anger her partner made her feel that "we sort of deserved each other because I wasn't a very good person" (1240).

The women described strategies they engaged in to begin to re-connect with and rebuild who they were before experiencing abuse. Some women took solace and expressed themselves in their journals. For Nancy, "Doing theatre was a way of staying sane while getting out of the relationship" (297). Other women channelled their energy into, what Margaret described as, "a job that I loved and I got my identity from" (183). Other women went for bike rides, wrote poetry, made music, focused on school, and generally worked at redefining their lives in terms of their own priorities, not their partners'.

Reclaiming Control

Thinking about their own priorities and needs also signals that women are beginning to make their own decisions about their lives. For the women who participated in this study, making their own decisions meant first recognising their right to do so. As Susan described, "He's got to have power over me and have this control, or tell me what to do. I [began to think], 'How dare you? You're telling me what I should be doing? You don't own me....You have no right'" (410-3). Reclaiming control includes women making their own decisions about both small and larger issues. However, the women often "picked their battles", letting less important things "slide", to save their energy for more important decisions. Deciding not to marry or have children with their abuser were important steps in reclaiming control for several of the women. As Jessica said, "That's one reason why I wouldn't marry him because then you're stuck" (709-10). Judy explained, "I said [to him], 'I think we have issues right now to deal with and I'm postponing the wedding'...He was very upset that I'm making this decision, and I see it now that I was taking control away from him, that he didn't have control over this situation. He couldn't make me marry him" (560-7). Other women divorced their abusive husbands as part of reclaiming control. Described Angel, "Little by little, I just sort of put my life back together...If I can just get through this divorce okay, [but] I've got all the power now" (253-6). Deciding not to get married or to have children, or to end a marriage or pregnancy, were difficult decisions for all the women. As Judy said, the decision to have an abortion was extremely difficult "because my whole life I have thought that if that situation ever arose I would have the child" (224-5).

The women found that they had to be careful about their safety in challenging the power of their abusers. While reclaiming control was sometimes about openly resisting a partner's control, at other times working to get out from under the abuser's control had to be done discreetly or under the guise of making the abuser think he was getting his way. For example, Judy described some of the concessions she made to get safely out of her relationship, which included letting him blame her for the relationship not working out, and letting him leave her with many of their financial obligations: "There was a period where I thought it was possible [that] he could just go off the deep end, grab a gun from somewhere and be at home when I come home...[so] I'm quite happy to let him think it's all my fault. If he thinks I'm getting the raw end of the deal, that's good [because] essentially I'd like to live for a long time and my life is valuable to me...So you make whatever compromises or conditions you can to make sure that you can keep it that way" (2039-59). Thus, while these women were in the process of reclaiming control over their lives, it was often under the guise of conceding to their abusers' wishes to lessen the impact of the abuse.

Reaching Out

To support their efforts to rebuild self worth and reclaim control, women sought outside support from those that would appreciate them for whom they were and help support their decisions. Reaching out meant trying to connect with family, friends, police, ministers, government agencies, community resources and the health-care system. The women did this carefully, trying to determine who could be trusted to believe and support them and not increase their risk of danger. The health-care system was seen as a potential avenue of support as well as a way to connect to other resources. It was not the only place that the women sought care or support for dealing with abuse and its health impacts; however, many of them described the health-care system as an important place where they could generally access help without arousing the suspicions or wrath of their partners. Women's reasons for seeking health care and what they hoped to achieve through their interactions with the health-care system varied significantly.

The women described searching for a doctor who "really listened", or being less sure about what exactly they wanted, knowing only that they needed help and wanted to be given some options: "I could not think of anything else to do", explained Judy. "I thought I should seek outside help...I really didn't think I should be depressed so much of the time" (1470-72). Some of the women knew exactly what they hoped to find in the health-care system. Jessica described going to see her family doctor: "I didn't know what was for battered women but...I went in there saying, 'I need help now, I need counselling. Where can I go? What's available?'" (1388-94).

Other women hypothesised that they had engaged in self-harming actions in a subconscious effort to demonstrate to others that they needed help. Andradea, who engaged in self-mutilation, said her actions may have resulted from "a subconscious desire to...[say] 'Oh look, something's wrong, help me'" (519-21). Jessica described her suicidal ideation and her attempted suicide as part of an effort to demonstrate to others that she was suffering and required help: "I had a suicide attempt... I reached out. A 9-1-1 call was made" (FG[5], 15-7).

Reaching out includes building support while in an abusive relationship, as well as support after leaving it. The women described calling the police, transition shelters, community resources, friends and family for transportation away from the abuser or for a place to stay upon separation from their partners. To decrease her isolation after leaving her partner, one woman chose to move across the country to be nearer to friends. She sought assistance from her family doctor in doing so, in the form of a note which would help her to receive social assistance in the new province until she could find employment.

Many of the women expressed being well aware that the period immediately following separation from an abusive partner can be the most dangerous time for women. Extensive media reports of women who have been murdered by ex-partners and threats from, and experience with, their own partners emphasised the danger that women

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[5] Jessica is the woman who participated in both the focus group and an individual interview, as discussed in the previous chapter. Quotes taken from the focus group are indicated with 'FG'.

expected to face in trying to leave their relationships. As Judy explained, "I always knew that if I ever left him it would be ugly. There was just going to be no nice, easy, friendly way to do this...I understood that some things would definitely put him over the top" (508-18). Staying safe and regaining their health was a difficult and delicate balance to maintain, especially immediately following separation.

Building self worth, reclaiming control over their lives and reaching out for support eventually led to all of these women fully escaping their abusive relationships. For some, it was with the help of enabling experiences in the health-care system, for others it was despite disabling experiences. In summary, the following quote from Judy describes how difficult she found it was for people to know what to do to help her, and the idea that each woman has unique, intelligent strategies for dealing with the abuse and its effects: "People are aware that [abuse] goes on but not what to do. What do you do if a woman comes to you and she's been abused by her husband? You think, okay, go to the police, but in a lot of cases that could make it just worse, [so] what to do? Because I think every situation, depending on the abusive individual, is going to need a smart attack plan because everybody's different" (1930-7).

The next sections illustrate how women in this study described their experiences within the health-care system, how well those experiences supported their individual "smart attack plans", and how they perceived those experiences influenced their health. The health-care experiences described in these women's stories ranged from negative to positive. Negative health-care experiences and consequent adverse effects on women's health are described first, followed by a description of the women's enabling health-care encounters.

Disabling Experiences in Health-Care

Disabling experiences are those that detract from women's abilities to help themselves and to improve their health. Women employ many strategies in striving for health, all aimed at regaining a sense of feeling worthy of being cared for, of having control over their lives, and of making connections. Because women's strategies centre on care, control and connection, these aspects of their health-care experiences are especially important in shifting their health status. When the women described their health-care experiences as being deleterious they described not feeling cared for and having little control over decisions. When health-care encounters did not provide them with connections to other forms of social support or information about where they could find such support, they negatively evaluated the health-care experience. In the following section, care, control and connection are discussed and illustrations from the women's stories are provided to demonstrate the ways each can manifest in health-care encounters.

Uncaring

All of the women who participated in this study described encounters with the health-care system during which they did not feel cared for. The women perceived their encounter as uncaring when they felt treated like "just a number", instead of a human being with feelings and needs. The women described not having their emotions enquired about, feeling rushed, being asked about abuse in an impersonal manner, or not being properly supported upon disclosing the abuse.

Several of the women described health-care encounters in which they felt health-care providers should have recognised the signs of abuse, if they had practised in a caring way. For example, Mina described an experience after undergoing an abortion: "As soon as I woke up, I just cried and the nurse, she didn't say anything [like], 'What's wrong with you? Why are you alone?' It was very painful for me, not having any kind of support...no emotion at all. So, I asked her to phone [my husband] to see if he could come and pick me up to go home, but he refused to come. [So] they called a taxi and they sent me home in a taxi" (124-35). Mina felt that the health-care personnel at the clinic should have noticed that there was something wrong in her relationship; she was saddened when the staff sent her home without inquiring about her home life. This was a lost opportunity for Mina to discuss her abuse with a health-care provider and contributed to her reluctance to disclose in the future.

In an effort to recognise the abuse in women's lives, "screening" programs have been implemented in several health-care settings in British Columbia. Such programs ask all women admitted for any treatment about abuse in their relationships. However, the women who participated in this study suggested that, without genuine care or concern motivating the enquiry and subsequent action, screening can further contribute to women feeling that they are in an uncaring environment. For example, Judy described being asked whether she was in an abusive relationship during a visit to an emergency department. She indicated that because the query was posed in an impersonal and obligatory manner she did not feel cared about and therefore did not feel impelled to disclose her abusive situation. "The woman [at reception] was asking my name blah blah blah and who's this that brought me in ... not very kind, just like I'm just another person checking in... And I remember her asking me the question, 'Are you in an abusive relationship?', which at that point I was like, 'Of course not, I'm not'" (Judy, 97-105). She went on to say, "You have somebody sitting across from a desk with a computer, clack-clack-clack-clack on the keys and you just feel like you're spouting out this information and I might as well be saying it on a phone because that's about all the interaction you feel you're getting. So you don't really have a sense that this individual [the health-care worker] really cares about your problem, or why you're here, or what your answers are" (Judy, 1728-33). Many of the women who participated in this study considered the screening questions about abuse to be insincere and flippant, which conveyed to them that the health-care system considers abuse to be an issue that can be addressed in a simplistic manner: "If the medical system...is worried about women getting abused, this is not a "quick-service" [issue]... This is a very important issue and it has to be looked at in a professional way, not just [being asked for] your address 'and, oh by the way, have you been beaten up by your husband?'" (Tahmine, 1102-7).

Eleven of the 16 women who participated in this study discussed disclosing abuse to at least one health-care provider, and none of the disclosures described was in response to being asked a screening question. Several of the women who disclosed abuse described having decided that they were going to do so prior to arriving in the health-care setting, and stated "up front" that it was their reason for needing health care. If their initial experiences created the impression that health-care providers did not care about them, however, some women decided not to disclose at that time. When women do disclose, they may find that their subsequent experiences do not leave them feeling cared for. Jessica described one such encounter: "When you first come in, they ask you what you're there for and I said...'I've been hit by my partner, I need to be seen by a doctor'... The nurse...she just had me fill out some papers and then go and sit in the waiting room. I was left sitting in the waiting room a long time just bawling my eyes out...I couldn't stop crying... I just could have used a little support" (Jessica, 403-23, 334-53).

Uncaring health-care encounters also involve women feeling that their health concerns are minimised or dismissed by health-care providers. Many of the women described being made to feel like they were exaggerating or that they were "hypochondriacs". They also described being released home before feeling able or ready, and not being provided with helpful follow-up support. Some women in this study related encounters in which they described serious effects of abuse to their health-care providers only to be told, "Nothing is wrong with you. Just relax. Go on a vacation" (Tahmine, 1587-8). Having health concerns minimised or dismissed made these women less likely to discuss abuse with other health-care providers. Several of the women extrapolated that if health-care providers did not pay serious attention to their stated health issues, they were unlikely to attend adequately to the issue of abuse.

Controlling

Not feeling that their stated concerns are taken seriously is a major factor in women feeling that they have little input or control in their health-care encounters. Several of the women in this study recognised the power that health-care providers, especially doctors, had in the decision-making process around their health, and how relatively little power they themselves had. Said Luisa, "If I need a note to stay home from work, if I need medication, whatever I need, the doctor gets to decide. He even gets to decide if there's anything wrong with me. He even gets to say, 'Well, it's all in your head'. He has all this power" (533-6). The women generally believed that individual health-care providers are not to blame for the authority granted their professions. However, they were also significantly affected by seeing their own expertise not being recognised or included in the decision-making processes regarding their health. Aspects of their health-care encounters that made these women feel that health-care providers were retaining control, rather than sharing decisions, included: not being asked for input into decisions being made, not feeling listened to when they had a contribution to the decision-making process, feeling like decisions were made for them about their health-care or relationships, and feeling judged or blamed if their decisions differed from those of their health-care providers.

All of the women described being prescribed treatment, often medication, without ever being asked for their input into the causes or potential solutions to their health problems. For example, Mina described "...talking about my depression symptoms with my family doctor....She [didn't] even try to talk to me [or ask me] what was bothering me [or how] I feel... Just a prescription" (245-8). Several of the women expressed concern about how quickly medications are prescribed seemingly without taking into account their appropriateness for the situation or potential side effects. In an ironic twist, one woman in this study described not being able to get a prescription medication when she felt it was what could help her address her health issue. She went to her health-care provider specifically to get a prescription to help her sleep, and "[the doctor] made a point of saying that obviously [my sleeping problems don't have] a medical cause...I'm in an abusive relationship and... [I should] 'try and handle it on my own'" (Judy, 899-910). The women in this study detailed many instances in which they did not feel that their personal assessment of their health issue was incorporated into their medical treatment.

The majority of the women also described feeling pressured into undesired courses of action with respect to their treatment or relationship. For example, Tahmine described one such situation: "I had to lay there on the bed and he [the doctor] wanted to touch me inside my vagina and I couldn't, I didn't let him. I said 'No'...[but] he was insisting that he has to examine me" (258-78). She felt guilty for not letting him "do his job" and that she was being propelled towards having something done to her with which she was not comfortable. Several women also described feeling that their input was not incorporated into decisions about their relationship, and feeling blamed or judged if they wanted to make decisions that differed from those of their health-care providers. Susan described one such experience in the emergency department, after her partner had physically assaulted her: "All they were concerned about was me pressing charges. I remember countless times saying, 'If I press charges, how are you going to help me? Because he's going to come back and get me'. 'Well, you know, [the police] can put a restraining order on him', [they said]. 'Well, are they going to be able to protect me 24 hours a day?' [I asked]...And when I didn't want to [pursue a restraining order], they looked at me like, 'Well, then, you deserve it. You deserve getting hurt'" (Susan, 181-90). It is a deflating experience for women when they are made to feel that they are "doing nothing" about the abuse when, in fact, they are actively trying to stay safe and believe their partners' threats about the ramifications of police involvement. Several of the women's partners had threatened to kill them if they called the police.

The women also related feeling a loss of control through a lack of privacy or confidentiality. When health-care providers asked the women personal questions in non-private settings, the women reported feeling "vulnerable, that anybody and everybody could be listening to this information" (Judy, 1723-4). As well, when they saw their personal information being shared among health-care providers without their permission, it reinforced their perceived loss of control in the situation. When Bethany went in to find out the results of her HIV test, "the doctor had a medical student in there with her.

This was the moment when my whole life could change, I was so scared, and she had invited someone else to witness it without asking me. It felt so disrespectful" (17-9).

Feeling that their input is not asked for or incorporated into decisions, lacking control over who has access to personal information, or experiencing pressure or judgements contribute to women feeling that they have little control over what happens to them within the health-care system. Such experiences also make women less likely to discuss abuse and reluctant to return to the health-care system for help.

Disconnecting

Women's disabling experiences within the health-care system leave them feeling unable to discuss abuse with their health-care providers, reluctant to seek health care in the future, and disconnected from supports. The women in this study often felt that health-care providers did not care about them, minimised their concerns, rushed them, or did not listen to them. As a result of this treatment, the women were unlikely to disclose that they were in abusive relationships, even when directly questioned. While these women all sought health care for assistance in dealing with the health impacts of abuse, many chose not to discuss their relationships with their health-care providers as a result of experiencing uncaring or controlling health-care encounters. For example, Sarah described the result of feeling rushed on her decision to divulge the status of her relationship: "The ten minute factor is huge. There I am, I'm supposed to explain to [my doctor] the most important aspect of my life, before [they see] their next patient, who's sitting out there waiting. Why bother to even start?" (Sarah, 104-6). Another woman described deciding not to discuss her abusive relationship with her health-care provider because of the way she had seen her physician respond to her other health issues: "I remember several times thinking, I probably should tell her [about the abuse]... but somehow I just felt like she would tell me to 'buck up'...so I just never did" (Judy, 238-41). After experiencing pressure by health-care providers to take courses of action she knew could jeopardise her safety, Susan, too, decided not to reveal that she was in an abusive relationship when seeking health-care. "You start lying. [You say], 'I tripped', 'I fell down the stairs', because you just don't want to go through [that pressure]" (199-201).

No longer seeing the health-care system as an avenue of support means that women become even more isolated. "I don't go [to health care] unless there's something dreadfully wrong with me. You just don't want to be treated like you're wasting other people's time or you're wasting your time" (Judy, 2134-6). Feeling that the expertise they had about their health or relationships was not respected or included in health-care decisions also made these women less likely to seek health care in the future. Not receiving support after disclosing abuse had a similar effect. "That [kind of treatment] doesn't make it easier to take yourself to the hospital", expressed Jessica, "[knowing] that you're going to be left feeling terrible and upset [when you're] needing to have some support" (FG, 405-7). Said Susan, "It got to the point where [I was] scared to go to the hospital, even. A lot of times I remember just trying to take care of myself. I didn't want to go to the hospital. I didn't want to go through that harassment. Because I knew what was going to happen, knew that they were going to try to get me to give them his name and all this stuff. So, I'd sooner suffer at home" (191-6).

Women also feel disconnected from potential social supports when no follow-up is provided beyond a single health-care encounter. When health-care encounters provide no helpful information about community support services, the isolation experienced within abusive relationships is compounded. When women are provided with information about support services without being asked what kind of help they need or want, it generally does not add to their options. For example, as Judy described, "[My physician] did give me the name of another counsellor...and I thought, 'you know, I'm already paying for somebody that I find is good and helpful. I'm sure this other [counsellor] is equally as good,' but I just didn't feel [my doctor] was listening to me" (910-4). The women were sometimes given general information about the availability of services, but the descriptions often failed to provide sufficient and crucial details. As Susan related, "[The health-care providers] told me there were support groups out there, but they didn't tell me where or how [to access them]" (258-9). Another woman did not access counselling because she was not told it was free of charge. While the health-care experiences portrayed above may be typical of many people's experiences, these types of health-care encounters may have more significant adverse effects on women in abusive relationships.

Losing Health

Health-care experiences perceived to be uncaring, controlling and disconnecting serve to undermine women's strategies in striving for health and the participating women perceived these aspects to contribute to their loss of health. The women described negative health-care encounters as 'echoing' their experiences in their abusive relationships. In doing so, the women did not imply that they experienced abuse from their health-care providers. Rather, they described how negative health-care encounters resonated with aspects of their abusive relationships, and explained how these experiences could unintentionally provide legitimacy to the abuse, which further contributed to a loss of health.

Echoing Abuse

In abusive relationships, women experience neglect, lack of support or care, and minimisation or dismissal of their concerns. For example, in Mina's visit to an abortion clinic, no one enquired as to how she was doing and she was sent home in a taxi. What she experienced at the clinic compounded what she was already feeling in her abusive relationship. She described that in her relationship, "After awhile, I realised, [my husband] doesn't care, he doesn't have any feelings" (Mina, 35). When she underwent the abortion, she also experienced a lack of care and support from him: "He refused to go with me to the hospital and so I went on my own...After the abortion... as soon as I got home he just left home. He took his guitar out and he went to a friend's house for a party" (119-36). Because she found no emotional support in the health-care system, she described feeling even further isolated in her abusive relationship.

Feeling that their health concerns are minimised by health-care providers also has significant impacts on women who experience minimisation of their worth and concerns within their relationships. "One of the things my partner really reinforced, because that was one of my worst fears, was that I was a hypochondriac" (Judy, 2353-5). "And it [was] the same going to see the physician. [Being made to feel], 'Oh, you're just exaggerating things again', or 'You're being too sensitive about this or that'. And that's part of the problem is that you have somebody else messing with your mind now" (Judy, 2384-7).

Certain medical procedures were reminiscent of the abuse the women experienced. For example, Glenna explained how the abuse led to particular health problems, and that the treatment for those health issues could replicate the abuse: "My abuse led to substance abuse. So, the health effects continue. And there's lots of discrimination because I have Hep[atitis] C…Giving blood in the bio lab here…I was in tears. There were so many technicians there to take my blood. I left there with bruises all over me. It was horrifying. I felt totally abused again" (Glenna, 23-9). For different women, other medical procedures could elicit similar responses. When health-care providers do not determine whether women are comfortable with medical procedures, it is possible to unintentionally re-create circumstances reminiscent of previous abuse.

Unwanted sexual contact also is part of the abuse experienced by many women. Being physically examined by health-care practitioners, especially men, can be difficult for women who have experienced sexual abuse in their relationship. "One of the problems from having been abused", said Sarah, "[is that] it's given me that 'Don't touch me' kind of feeling. It goes beyond just the guy who did it" (492-4). Not being given a choice or control over the situation, and no enquiry being made as to what they are comfortable with, can echo the abuse that many women experience in their relationships. As Sam described, "I had an ectopic pregnancy and the next thing I knew I was in the hospital and my arms were tied to the bed and my legs were tied to the bed, needle in this arm, blood in that arm. And then, after that, they used me as a guinea pig for the medical students. So I've got all these medical students shoving their fingers up my vagina, and that's when… I just died that day" (Sam, 69-74). Many of the women also had little control over the use of birth control or protection against sexually transmitted diseases. However, they were still the ones who were often held responsible by their physicians. One woman explained, "I kind of got the third degree, the lecture about not using [condoms]" (Judy, 1319-20). The result of this interaction was that, "I was embarrassed, for me, that I wasn't the person that I thought I should be" (Judy, 1328-9)

A message that women frequently hear in their abusive relationships is that it is their shortcomings that are responsible for the abuse. This message can be inadvertently reiterated through disabling health-care experiences. For example, when Susan explained to her doctor that she had decided to return to her abusive relationship, the physician berated her. Susan indicated that she was striving to stay safe in the short-term. She explained that by returning to her relationship she believed that she could placate her partner's most recent violent threats about the consequences of separation. Instead of trying to understand her situation, or respecting that she might know best her partner's capacity for violence, the doctor's reaction reinforced how Susan's partner had made her feel about herself: "I was already feeling horrible. This man [my abusive partner] is making me feel horrible and stupid. And then I come out to try and get help...and I went to my doctor and he yells at me for going back [to my partner]. I know he meant well, but I just felt even more stupid" (Susan, 58-61). This kind of reaction can reinforce women's perceptions that they are to blame for the abuse they experience.

All of the women who participated in this study described becoming increasingly isolated in their abusive relationships, either through their partners' blatant exercise of control or through more subtle means, such as in Judy's case: "Our friends were essentially his friends... Initially...I had contact with my friends, but then he would say, 'Well, they're kind of quirky, you know, you don't want to hang out with them' and I just gradually lost touch with them because it was a big deal to try and see them" (32-6). For some women, this isolation was compounded by being new to the country, learning English as a foreign language, or living in a remote area. When women reach out to health-care providers, but are not provided with care, support, or follow-up resources, it has the potential to enhance their feelings of isolation and make them feel that they are "this tiny little person in this big world and nobody cares" (Judy, 1989-90).

The women described how a lack of caring and compassionate practice in the health-care system negatively affected their health. For example, Mina talked about the impact on her emotional health of an uncaring health-care encounter: "You take [that no-one seems to care] inside yourself...it makes you kind of depressed" (Mina, 564-9). Feeling judged also meant that "you become so shame-based and...so just isolated... that that's a detriment to one's health, too...not having happy social interactions" (Andradea, 582-6). "I think I was ill a lot longer because of it", recounted Judy (2191-2), of having both her abusive partner and emergency doctor dismiss her initial health concerns and insinuate that she was overstating their severity. When she saw her family physician two days later, the doctor expressed surprise that the serious nature of her symptoms had not resulted in hospitalisation. This illustrates the paradox of women waiting to seek treatment until their health condition is dire, but still encountering the myth that they excessively use the health-care system for minor concerns.

Not feeling able to discuss their abusive relationships with their health-care providers isolated the women, reinforced their perceptions of deserving the abuse, and stranded them, without an outlet for expressing their feelings. They described the impact this had on their health. Mina related, "I had so much pain inside and if I talked I could relieve this pain" (244-5). "I didn't know how to deal with it," said Andradea, "I would do some writing, some journalling, but my feelings mostly got stuffed down and I had to do it with food and so my weight went up and down all over the place" (Andradea, 503-5). Some of the women felt that their health-care providers' lack of care bordered on negligence. "There wasn't any follow-up from my doctor [after my suicide attempt]...As it was, I was already in counselling, but if I had been further suicidal it could have led to another suicide attempt" (Jessica, FG, 27-30).

Undermining Women's Strategies

In striving for health, women describe their efforts to resist the lack of care, control and connection that they experience in their relationships. When women find that their health-care encounters mirror their experiences in their abusive relationships, their loss of health is further compounded. When health-care providers do not ask women to fully explain their health concerns, what they need, and whether a treatment option is feasible within the context of their lives, they risk prescribing treatment that is unacceptable or even dangerous. For example, prescribing medications without recognising abuse as the underlying issue, or without consulting about the impact the prescription might have, could exacerbate difficulties in coping. Although a few of the women found that prescription medications helped them in their striving for health, many more found that the medications prescribed made it more difficult to recognise abuse and formulate strategies to resist it. For example, Sam related that "being medicated all the time, it keeps you in the abusive situation because you don't have the wherewithal to think 'I'm being abused'" (Sam, 107-8). Having their normal functioning altered by prescription drugs also made it difficult to deal with other aspects of their lives, such as work.

Without accounting for the context of women's lives in the treatment plan, the root cause of the illness may be obscured: "It's like putting a band-aid on the real issue. [Medication] is not going to help me because I'm continuing on in my stress, in my...relationship....[The relationship] is more the illness if you will. *That* is the area that needs to be attacked and changed, not just 'Here's some pills'" (Judy, 2256-60). As

Glenna asked, "When do you actually get well when you have all those dependencies on all these different drugs? Does it help the victim to leave the relationship? I don't think so. You're learning to manage, and harming yourself in the process" (61-3). Thus, treatments prescribed in the absence of an understanding of the context of women's lives can make it even more difficult for women to change their situation, and may exacerbate the hazards they face.

Women often find themselves unable to follow medical advice without jeopardising their safety. The women in this study conveyed that being in an abusive relationship means one does not have access to finances, control over how time is spent, or a partner who thinks that a woman deserves to attend to her health needs. Therefore, some medical advice may be unachievable or dangerous. For example, Luisa expressed: "The doctors are giving me these lists of all the things I should do, the physio, the back massage. Well, do you have the money? Do you have the time? Can you actually get [to] those things? And if you don't, you're seen as not caring, or not co-operating" (452-5). Another woman described how she was discharged with four broken ribs and told to get bed rest – an impossibility in a home in which her husband expected her to do all the housework, she had a young daughter to care for, and she was not given any follow-up support or help. "I really suffered, and my daughter suffered a lot...my life was in jeopardy, except this time not with a gun. It's with the health-care system" (Tahmine, 875-86). Susan's strategy for staying safe – to not involve the police because her partner had threatened her life if she did – was undermined by health-care providers insisting she obtain a restraining order: "If you give his name, he's going to come back for me [I told them]....I'll never forget the one time I did have a restraining order and he ended up at my house. He smashed the back window, broke in and came in, there was blood everywhere. He was screaming and shouting at me" (24-9). "It was just as I said. They weren't able to protect me. He kept coming back and back and back" (Susan, 186-7). As a result of the extenuating circumstances surrounding the abuse in their intimate relationships, some women may opt not to follow medical advice, often resulting in them being characterised as "non-compliant" by the health-care system.

When confidentiality is breached, women's strategies to regain their health while staying safe could also be undermined. One woman described an experience in which she confided in her doctor and he helped her, but then also conveyed information on her whereabouts to the abuser. "I went in and talked to my doctor [about the abuse] because [my abusive husband] was out [working], and the next day, I phoned [my doctor] and said, 'This is what has happened now and I'm going to have to get out', and he did phone the cops so they took all of [my abuser's] guns. Then [my doctor's] concern turned totally on [the abuser] and he told him where I was, what town I was in. [My doctor's] concern...was [that my abuser was] suicidal, not that he was murderous. We [my children and I] were quite sure that if we hadn't left when we did, we would have been one of these family annihilation groups" (Nancy, 135-42). The result was that her abuser stalked her and her children, keeping them all in a state of fear, and making it much more difficult to escape the abusive situation. Thus, disclosing to health-care professionals may have consequences that are worse for women than remaining silent. How health-care providers respond to information shared with them is a crucial determinant of whether women's strategies for regaining health and freedom will be effective.

Providing referrals and resources outside the health-care system is not always a helpful intervention. Referrals can sometimes put women in other contexts that are uncaring, controlling or disconnecting. Susan described her experience with a referral that she hoped would help her with the abusive relationship, but instead left her feeling more isolated and less healthy: "I actually went to social services and told them that I needed help and [the Ministry of Children and Family Development] took it upon themselves to take my son, instead of getting me the help I needed. So, when they finally had my son, and I was like, 'Well, I still need help,' [they said] 'You can't get help unless you go check yourself in for addiction'. Well my addiction only got really bad after they took my son because it was like 'I've got nothing now. I'm still getting beaten up by this idiot. You've got my son. What do I have left?'" (Susan, 110-8). It was not recognised that Susan's drug use stemmed from a strategy to keep herself and her child safer in the short-term. She explained how doing drugs with her abusive husband "would make him happy, and he wouldn't hurt me", and that "he never, ever abused my son" (Susan, 65, 106-7). Rather than helping her, she felt that the system further punished her by taking away her child.

Andradea, too, was connected with services that undermined her strategies for gaining independence from her abuser by not incorporating what she was saying about her situation into the decision-making process. She described her interaction with the welfare system after fleeing her abuser's farm: "I had been living in the city for awhile just with money that I had from the past. I had been applying for work, looking for work and did not get work. I could no longer pay my rent...I applied for welfare. Because I hadn't been working and had no pay stubs...[the welfare worker] wanted a letter from him [the abuser] saying how much money he may have supported me with. And, because he's an abusive man who wants me to live with him, not live independently of him, there's no way he would do that. He would probably rather shoot me in the head than actually do that. And I explained that to her. But she just said, 'Well I need that letter, I need that proof'. And so I was denied help when I really, really needed it" (341-52). She went on to say, "I wouldn't have gone back the last couple of times had it not been for financial reasons. It wasn't because I was naïve enough to think that 'Oh yes, it will really work out' or 'Oh, I really believe his promises'...It was just ...that I had become so isolated and I didn't have a support system anymore" (Andradea, 576-80).

Giving up on seeking health care because it is uncaring or controlling can result in further loss of health. "If you get the help that you need, you're more open or willing or more optimistic to go and seek help again," said one woman, "but if you get the wrong [help]...it's very easy to get discouraged and not to bother and just to try to handle it on your own, whether you feel capable of doing that or not" (Judy, 1892-6). The potential impact of avoiding health care was addressed by Andradea: "[Because] I have more distrust of the medical system, I would go there only [as a] very, very last resort and that might be a cost to me health-wise" (1015-7). Susan described an instance in which she avoided health care even though she had a serious injury, determining that being pressured into a certain course of action would put her in even more danger: "I remember getting broken ribs once and I didn't even go in. I just suffered it myself. I knew they had to be broken because it was so painful, but I didn't even want to go in and check...because I really didn't think they were out to *help me*, they were out to *get him*. And to *get him* was just going to *hurt me* even more" (Susan, 191-207). Thus, experiences of not being supported in the health-care system resulted in several of the women viewing it as a place where their health might be put in greater jeopardy.

The women believed that they remained in their abusive relationships for longer than they might have if they had received care, support for their decisions, follow-up or resources from the health-care system. "If maybe someone had come to see me, maybe I wouldn't have been in that situation as long. Maybe they could have said, 'Here's the card, go see so-and-so and talk to them' or 'We can get you into shelter. He doesn't need to know. We can do it when he goes away'" (Susan, 361-5). Mina reflected, "Sometimes when I look back when that abortion happened and when I cried, if the nurse [had] talked to me...if I knew there were places I could go...I may have left that relationship a long time ago instead of living in that situation for seven years and keep[ing] things inside of me. It was damaging my soul, my spirit, everything, and my physical body, but instead I stayed in that relationship....If I had somewhere [to go], or if I knew [of] some resources, I could have ended that abusive relationship long before" (358-65). Not receiving such care, support, or information, however, meant that these women's loss of health continued and was compounded.

Disabling health-care experiences reinforce what women are experiencing in their abusive relationships and fail to support their strategies in striving for health. The resultant loss of health includes emotional health impacts and their physical sequelae. In addition, women's health concerns tend to be inadequately addressed or women avoid accessing health services, even in the face of serious physical injury. In some cases, well-intentioned interventions result in escalated levels of abuse. When women's strategies are not supported, they are more likely to remain in their abusive relationships and experience the impacts of abuse for longer periods of time.

Enabling Experiences

Not all health-care experiences described by women in this study were negative. The women who participated in this study also described positive experiences in the health-care system that supported them in regaining their health. They also described how negative health-care encounters could have been made better, or how the provision of health care could be improved. Enabling health-care experiences are those in which women become more able to achieve safety and health. Because women are degraded, controlled and isolated in their relationships, experiencing the opposite in health-care encounters can have a substantial effect on supporting women's strategies in striving for health. Feeling cared for, that health-care providers are sharing control over decisions, and that their health-care experiences are connecting them to support are all aspects of enabling health-care experiences. While enabling health-care encounters are essentially the opposite of disabling ones, the crucial element is the degree to which women – specifically their individual feelings, safety concerns, strategies and circumstances – are included in their health care.

Caring

In caring health-care encounters, the women in this study perceived that their feelings and needs were given consideration and that their health concerns were taken seriously. They described experiencing non-judgemental listening, support after disclosing abuse, and follow-up after leaving a health-care setting. Caring health-care encounters did not necessarily translate into lengthy interactions or being prioritised in waiting rooms. Rather, the essence of a caring health-care encounter for some of the women was more about the concern expressed by a health-care provider. One woman expressed that it would be helpful for health-care providers "to let people know that, 'Yes, we know you're here, and we know it's going to be a long wait...but I'm keeping my eye on you, and how are you holding up?'" (Judy, 1562-4). For other women, however, not being rushed was an important part of feeling cared for. Said Margaret, "My doctor was exceptional in that she spent a lot of time with me, and never rushed me. Always looked me straight in the eye and asked me, 'What's going on? What's happening? How are you dealing with things?'" (174-7). Angel described her family physician as "just great" because "he never pushes you out of the office" (244-5).

Being listened to and taken seriously by health-care providers helps women in abusive relationships feel cared about. "Just having somebody listen to me and support me in my concerns was such a relief. I felt like a big load was lifted off my shoulders" (Judy, 506-7). Jessica described how active, non-judgemental listening determined how comfortable she felt discussing her abuse: "I saw a psychiatrist years ago, and he just sat there and listened with a bored look on his face, and I thought, 'I don't really have anything to talk about, what a waste of time.' And seeing [a counsellor since, there was instead]... a feeling of acceptance, they're going to listen to you and accept what you're saying and be non-judgemental. I felt really intimidated by my psychiatrist, that he's going to really judge me. Whereas my counsellor was there to help me" (Jessica, 130-8). Non-judgemental support also is important once a woman does share that she is in an abusive relationship. One woman, who chose to discuss her situation with her health-care provider, related: "[The doctor] didn't judge me as being stupid for having been abused or make me feel blamed for what had happened to me. She was very respectful of me....It made me feel like a human being she was interested in....The whole manner with which she dealt with me, I felt that she was compassionate and she cared....She never said, 'Oh, don't be so stupid as to go back to that', nothing like that. It was just heartfelt concern and it felt genuine" (Andradea, 254-67).

In addition to being listened to, being made to feel like a human being is about not being treated simply for physical symptoms. As Glenna described, "Positives [are] where people are there to help me, to help me get healthier. People that are listening. The caring part, the talking to me like I'm a human being, like they would the person next to me. And my specialist takes care of me – it's not just checking my pulse and listening to my heart. She's there to talk to me and see how my everyday life is, my stress, and things like that. Not just, 'Here's a prescription. See you later'" (38-43).

Caring health-care encounters are not necessarily about health-care providers just being "nice", but rather taking into consideration how different women want to be treated. For example, one woman found that she needed health-care providers to "have a clinical approach" when she was relating her story, to get the facts out without breaking down, and then required sympathy afterwards. She stressed that health-care providers "can't pigeon-hole women, because we're not pigeons. There's not one answer. Be compassionate, but know what a woman needs. Ask her how she'd rather go through it" (Roberta, 267-73). Feeling cared for also includes concern that extends beyond when a woman leaves a health-care setting. Many of the women described that knowing that they could return for follow-up appointments if their health condition deteriorated (or failed to improve) made them feel that health-care providers cared about them in the long- as well as the short-term.

Sharing Control

The women who participated in this study stressed the importance of feeling that their health-care providers were sharing control with them by including them in the decision-making process within the health-care encounter. This does not mean that health-care providers should surrender all decisions to their patients. Rather, it is about recognising that while health professionals have expertise in specific health and treatment issues, women too have expertise about their situations and better understanding of the relationship between the abuse and its subsequent health impacts. Sharing control is therefore about incorporating both forms of knowledge into health-care decisions and recognising that only women know which treatment options are appropriate for them given their situation. Sharing control is achieved through asking open-ended questions, listening, supporting decisions, and giving options rather than directive advice. Privacy and confidentiality help prevent control being taken away from women over deeply personal details of their intimate relationships.

Being asked open-ended questions provides women in abusive relationships with choices about what they are going to discuss. This is an important way that women are able to stay in control of who they are going to discuss their abuse with and when. One woman explained that the question she wished to be asked was, "'Is there anything else we can help you with?' Not...'Oh, by the way, have you been beaten up lately?'...No, you can't just confront a woman", she admonished (Tahmine, 1128-30). Not feeling "violated in any way" involved, for Andradea, being asked a question in such a way that gave "the option that if you didn't want to answer it, you didn't have to" (1089-91). The women explained that what they decided to reveal in response to open-ended questions was largely a result of how much trust they had in their health-care providers based on how they had dealt with previous health concerns.

Women in abusive relationships can exercise control over who knows about their situation when health-care encounters provide privacy and respect their confidentiality. Knowing that the person to whom they disclose is not going to take control over that information and share it with anyone else without permission is important to women in abusive relationships: "Everything is confidential. Nobody has to know. This is what a woman in [an abusive] situation wants. That this news is not travelling anywhere" (Tahmine, 1249-51). Although some of the women sought health care specifically to get their abuse documented in order to press charges against their abusers, other women expressed a fear of having a record made of their abuse because they were concerned about who had access to the information. By giving women choice in deciding whether and how the abuse is documented and by being clear about the limits of confidentiality, health-care providers can show women that they are prioritising their needs.

Being listened to and having needs ascertained and supported is an important part of women's enabling health-care experiences. Tahmine explained that the idea of including women in the decision-making process means that the health-care provider "has to listen to you and she has to see what you need, not what she thinks you need" (1000-1). Tahmine described how her family doctor does this by first asking open-ended questions, listening, supporting her decisions and, only then, describing options: "She really listens and she will ask you, 'What do you want me to do?' If you have any suggestions, she'll do it. If you don't have any suggestions, she'll tell you what your options are and you can tell her what you want. That's a good thing about her" (991-4).

Several of the women stressed the difference between having options described to them and being given directive advice. Having health-care options or community resources described by their health-care providers informed the women without setting up expectations that they follow a particular course of action. The women perceived advice as the health-care provider having predetermined a plan without consulting them. Judy expressed the importance of having options available, but acknowledged that women themselves know what may work in their circumstances: "Have resources at hand, ideas, things to think about. Because [women in abusive relationships] really will know what's best for their situation" (2030-2). Recognising that "every situation is going to be different" (Judy, 1944-5), and that health-care providers cannot possibly know all the details of a woman's situation, the women in this study urged health-care providers to support women in their decisions. Luisa explained, "We often know what we need, and we often know what's wrong. [It would be good] if there was some way for us to be more involved in that process and have more options [and] be supported [in exercising them]" (Luisa, 486-8). Several of the women stressed that because they have an "insider's" view into their own needs, what they choose to do may not make sense to outsiders, but must still be respected: "Support her no matter what. No matter what her decision is, you're respecting that decision" (Tahmine, 1283-4).

Connecting

Connecting is intricately related to caring and sharing control. If women feel cared for and included in decisions in a health-care setting, they are much more likely to view the health-care system as a place where they can discuss their abuse, find care and support and seek assistance in the future. As well, if options and information are provided regarding available community supports, isolation is minimised and women are supported in their health-seeking strategies. In some health settings (e.g., a family practice) an ongoing relationship can develop between a woman and her health-care provider, allowing a woman to determine if she can trust her health-care provider enough to confide about the abuse. In other settings (e.g., an emergency room), it is less likely that an ongoing relationship will develop between women and health-care providers. However, women describe that their experiences in a single health-care venue have the potential to influence their perceptions of the entire system. Thus, it is important that women experience enabling support in all health settings. Regardless of the venue, if a woman's concerns are taken seriously, her wishes are respected, and she is not judged, she is more likely to disclose and subsequently receive helpful information and support.

Assistance in finding and accessing community-support services is an important aspect of connecting. Free transportation to transition shelters and information about counselling and peer support groups were perceived as enabling. Information is especially useful when it is comprehensive. For example, Jessica explained, "[My doctor] gave me this number that particularly dealt with abused people...but he says, 'There is a bit of a wait' and he said, 'There is another group [available sooner]'" (258-60). Jessica's ability to obtain support was enhanced by her health-care provider's knowledge about the service he was recommending, what to expect there, and other available options.

In being given information about community support services, several of the women again emphasised the important difference between being given options and being given directive advice. Being given information about resources, without pressure to use them, allowed these women to learn more about their options, and to choose when to use them. "The staff [at the hospital] were helpful", said Judy, "because I had the number to call if I wanted counselling or I wanted somebody to talk [to] about it" (1130-1). Tahmine's suggestion to health-care providers was to "tell [a woman in an abusive relationship] all the options she has and let her know [you're] not going to tell her [she has] to go to the shelter....You just have to let [women] know what's going on, not tell them, 'Don't do this anymore', or 'Let's do this'....You can let her know what things are available that you can help her with...[and let her know], 'You don't have to do anything at this moment'" (1252-76).

Helping women to create enabling connections in their lives can occur without a health-care provider ever knowing that a woman is in an abusive relationship. Simply by supporting a woman in her health-seeking strategies, health-care providers can be helpful to women living in abusive relationships. For example, one woman sought health-care to obtain a doctor's note to say that she was ill and consequently had difficulties working. Her doctor respected her wishes, although he did not know that she was in an abusive relationship. The doctor's note allowed the woman to quit her job, move across the country to escape her abusive partner, be closer to supportive friends and to more easily collect unemployment insurance in her new province until she was able to regain her health and secure employment.

Tanya described an enabling experience during which she never disclosed the abuse and the health-care providers did not ask her about it: "When I had a baby, something happened that was very positive. Usually, after you have a baby, they kick you out of the hospital after one day. After having a baby, my baby and me were both very healthy, and they kept us for one week. And it just dawned on me that they knew what was going on, without ever letting me know. Because every time I saw the nurse, I started crying. They asked me, 'Do you have any support in the house, do you have any relatives? I said, 'I don't. It's only my husband and me. That's it'. So they kept me for one week. Until I really recovered....That's a very good thing that these doctors in the hospital did for me. I've heard so many horrible stories of people just being kicked out [of] the hospital, and I hope they would make exceptions for women who've had this experience [of abuse] -- because it can get worse." (Tanya, 3-17). The women suggested that health-care providers do not necessarily need women to disclose abuse to support them in dealing with its effects. Enabling health-care encounters aid women by supporting their efforts in regaining their health.

Regaining Health

Feeling cared for, sharing control, and being connected to support is the antithesis of what women experience in their abusive relationships. Thus, enabling health-care experiences can have profound effects on women by undermining the abuse and its health impacts. They also reinforce women's own strategies in striving for health, in getting safely out of abusive relationships and, thus, in regaining health.

Undermining Abuse

The isolation women experience in abusive relationships means that the vast majority of the messages they receive are from one, abusive person. Messages from health-care providers can indicate to women that someone supports them and their decisions, validate their point of view, feelings, and knowledge, and help them to connect with useful resources. These strategies contribute to the process of undermining the abuse and its impacts on women's health. For example, Andradea's enabling health-care encounter, in which she felt someone spoke to her with genuine concern, helped her to identify that the abuse was not her fault. "[I now] realise that the abuse is entirely his fault....[It] has been three years, but [the health-care provider] helped plant the seeds of that....It just takes awhile to digest a few things" (Andradea, 309-15).

Most of the women described how important it was to their health to know that someone cared about them. For example, Judy described the impact of her first counselling session in which she felt radically different from how she was made to feel in her relationship: "It was amazing because I hadn't felt that good in a long time. And then going back home...just feeling so caged again...but I had this sense of relief that I was getting help. Somebody out there was helping me" (510-4). Margaret described the importance of knowing that someone "out there" cared about her: "It had gotten to a point where I was just living [in the abusive relationship], but what really kept me sane was knowing that there were people out there who cared. My doctor cared, though she didn't even know who I was. These strangers showed empathy, they listened, I think they understood, they tried to be helpful" (192-6).

Enabling interactions with health-care providers and community-support services can help women to regain their health. Judy recounted the emotional "reinforcement" she felt: "Everyday feels better because of [the counselling], even the rough spots....It helps a lot, and gives you that much more energy because somebody else is able to care for you or watch out for you, or just give you that kind word to carry you on to your next step" (2311-4). Such experiences helped several of the women sleep better, as well as deal with other physical consequences of the abuse, such as disordered eating and drug use. Susan described the role a support group for women in abusive relationships played in enhancing her strength and in helping her stay off drugs, as well as the importance of knowing it was always there if she needed it: "If this program didn't come up, I can honestly say that a month or two down the road I would have ended up using [drugs] again....If I feel like I'm weakening, I'm going to go for another ten weeks, pick up on the support again. Because it really did help. Big time. And sometimes you forget things, and it's really nice to know that you can go back there and just have it reinforced" (119-29).

Supporting Women's Strategies

The women also described the health impacts of health-care providers supporting women in pursuing their own strategies in striving for health. For example, Luisa explained that she started to regain her health when her new physician asked open-ended questions that allowed her to give input, share control of the decision-making process and be supported in gaining more knowledge about her body: "That's when I started getting better, when I started saying, 'This is what I need. This is what I need you to do. And this is what I'm going to do'" (Luisa, 75-6). Jessica described the positive impact of having her decision to not involve the police respected by health-care providers: "If I was to press charges it might have caused more anger and animosity. He would have been extremely upset....I don't think I need to drag this on any further....[I'll just] get on with the recovery, instead of adding to [my health problems] by causing more grief" (464-70).

Experiences that undermine the abuse, as well as those which support women in implementing their own health-seeking strategies, synergistically assist women in getting free from the abuse. In the face of being constantly degraded by their abusive partners, women strive to regain their self-worth. Jessica described the role that the counselling her doctor told her about played in undermining the abuse, supporting her efforts and, ultimately, in her leaving her abuser: "It's really helped me to get my self-esteem back....It's been able to give me a clear head to think....'I can carry on with life without this person in it'. And it helped give me strength to actually do that, to just send him on his way and strength to say 'enough is enough'" (Jessica, 199-205). Getting connected to other women who have had similar experiences is particularly helpful for women in gaining useful ideas about getting safely free from the abuse. Judy explained the significance of receiving support from women who understood her situation: "It's been invaluable to have these other women that have been through the same thing and can say...what were the key good moves and things to watch out for, because their learning [is] first hand. It's not like there's a rule book out there for things to think of when you're splitting up and you might be concerned for your safety...[a] survival guide. So I was using these women as my guide" (1912-9).

All of the women who participated in this study described a process of regaining health after being free from their abusive partners. Mina, who moved across the country, described the negative impacts of her relationship slowly ebbing: "Little by little I became fine and my sleep habits became regular" (199-200). Judy, too, described the positive impact on her sleep of being free from abuse, in addition to reclaiming mastery over her life: "Now things are better and so I sleep better. I feel more comfortable and each day [I'm] taking more control back of my life and what I'm doing" (1048-9). Jessica's gastrointestinal symptoms diminished after her relationship ended: "I had developed an irritable bowel syndrome, which has since...let up as the relationship has let up" (Jessica, FG, 79-80). Many of the women also described having more energy, having stronger immune systems and regaining their ability to eat normally. Andradea explained how her health improved after leaving her abuser: "Vitality and fitness-wise, I've got a lot more energy to do things and to be with people and have more fun. I don't usually get sick very often...so I think I'm getting it together" (597-601). Susan described the direction her health has taken since her relationship ended: "I do feel a lot stronger now. I can actually see the rainbow, the pot of gold....I've put on a lot of weight. People actually say I look a lot healthier, a lot better, a lot more alive. I was probably down to 100 pounds. I've put on 25 pounds since I left" (395-400). Enabling health-care encounters show women that people care, support their strengths and expertise, and help them to achieve safety and health. Such experiences help women in regaining their health and support their process of staying safe until they eventually leave their abusers.

The Context of Health-Care

Enabling and disabling health-care experiences may be influenced by the context in which health care is delivered. Although the women believed that there were actions that individual health-care providers could take to improve their own practice, they also recognised that their ability to do so was largely determined by systemic factors, including: resource limitations, the medical model of care, health care as business, increasing specialisation of physicians, power relations, and the hierarchical structure of health care.

Resource Limitations

Shortages in personnel, space, and time were named by most of the women as affecting issues of privacy, the building of trusting relationships, waiting, rushing, and the impersonal tone of many health-care experiences. Whereas the women generally wished that they were treated better by particular health-care professionals, they also recognised that "maybe she [the health-care provider] is not miserable, maybe she's overworked, maybe the whole system needs to have a look at how many hours and how much stress they put on the workers....Maybe that was her fourteenth hour on the third day of fourteen hour days....I couldn't imagine doing a job where someone's life and death is in your hands, as far as giving needles or medications or that, when you're tired....It's inhumane" (Andradea, 1030-52). Many of the women believed that health-care providers generally wanted to provide good care, but were unable to do so because of shortages. For example, Bethany said, "Everyone that I know that went into the health professions did it so they could help other people. But the system drives that out of you, makes you cold. It's not the people, it's the government, the lack of funding. It's made it so that no matter how much a person cares, they only have five minutes to spend with you" (Bethany, 25-8). And most of the women saw this situation getting worse under the current provincial government. As Sam said, "I'm disheartened with all the cutbacks" (120-1).

The Medical Model

The "medical model" of care, which focuses on physical symptoms, was believed by many of the women to be responsible for health-care providers missing emotional and mental health issues, treating the effects of abuse without addressing underlying causes, and creating a "cold" environment. For example, Jessica described how her family doctor was "just generally interested in the physical things that are going on" (1289-90). She went on to describe differences in the degree of influence of the medical model in two different health settings: "[One hospital] was just, 'Well, we'll treat your condition...check your blood pressure every so often, take your pulse, make sure you're not slipping further...do your medical'....Actually treating the emotional part of it was much better at [another hospital]" (1126-30).

The medical model was brought up often in discussions about the prescribing of medications without addressing the root causes of health problems. Roberta described this phenomenon as: "Here's some more pills, let's not deal with your health problem" (60). Many of the women believed that because the health system treats only one part of a person's health and well-being, the underlying cause of a health problem is missed. Andradea expressed, "I just think this is all out of balance…the medication and treating the effect, not the cause, is just wrong" (769-70). The women suggested that the focus on physical health, and lack of attention to mental and emotional concerns creates clinical environments that are "austere" (Andradea, 1020). The impact of such environments was to make the women feel a lack of individualised care and privacy. As Judy expressed, "They have partitions and little cubicles and…that's really impersonal" (1727-8).

Health Care as Business

The women also discussed the effects of business-like, management models on creating health settings that were more likely to lead to disabling, rather than enabling, health-care encounters. The women in this study described the health-care system as being overly focused on efficiently processing patients to maximise profit and doctors who were perceived to be unduly influenced by pharmaceutical companies. The impact of "thinking solely in a business sense, " explained Judy, is that "you lose the care aspect of it" (1762-3). For example, Tahmine described how the focus on money makes health-care providers "look at you like [you're] part of their paycheque….[When instead] you're a human being, you need help" (Tahmine, 1008-11). The women also discussed how the prescribing of medications is in part due to doctors "wholeheartedly supporting the drug companies…[such as] my family physician [in the BC interior]. He's notorious. You go in for anything and he's already scrawling on the prescription pad" (2330-6). "It makes me mad," concluded Glenna, "because it's all about money" (103-4).

Increasing Specialisation

The medical model's reduction of health to physical aspects of the body and a focus on the business side of health care, have been partially responsible for the increase in physicians specialising and the proliferation of walk-in clinics. The women discussed how receiving individualised, personal care and building of trusting relationships with health-care providers are increasingly difficult as it becomes harder to find good family doctors. Judy described the situation a few decades ago: "In the late 70's our physician came to our home because my mom didn't want to take me in, I was too ill. Well, now that's unheard of....It's very different, much more impersonal" (1773-6). Nancy further explained the rarity of that situation today, "I know that there is a group of doctors....[in the Interior] that have a very loyal bunch of patients because people do feel that they're treated like human beings, they visit shut-ins, they make house calls to the elderly. It's a wonderful group that they are. But they're few and far between. Everybody's specialising now" (156-60). She described the difficulty this can create for women building relationships with health-care providers in which they can discuss abuse: "Everything is done in these quick, easy, low overhead, walk-in clinics, so you keep meeting someone new. To establish a relationship is going to be difficult. You're not going to go in and talk to anybody about anything important" (Nancy, 129-33).

Power Relations

Many of the women believed that their health-care experiences were also influenced by their gender, race or socio-economic status. For example, Tahmine expressed that the minimising of women's health concerns may be part of a more general minimisation of women in society: "The health-care system, when it comes to women, usually neglects, 'Oh, she'll be fine, nothing important'. It's like we're not as important as men are" (346-8). While caution must be taken in making generalisations from 16 women's experiences, it was generally the white, middle-class women who had more positive experiences, and the women of colour, First Nations women, poor women and young women who had more negative experiences and fewer positive ones. Roberta said, "If nobody was listening to me – and I'm white, middle-class, and in a business suit – how would they listen to someone who didn't have that power in society?" (288-90). Some of the women posited that, although it is difficult to ever truly understand all the forces that affected their treatment within the health-care system, they perceived that stereotyping on the basis of class or race may have been a factor in uncaring or controlling health-care experiences. One woman found that all her health-care experiences were of being treated very "coldly" and surmised that her immigrant status may have played a role. She said, "People of colour, marginalised people in general…you feel you're not wanted, you're not welcome…not just in the health-care system, everywhere you go you feel that attitude [but] obviously you can't prove it" (Mina, 558-63). Susan, who was often mistaken as First Nations, thought this may have played a factor in how she was treated: "A lot of people have mistaken me for being North American Indian and I do believe that it did play an important role [in my health-care experiences]….I hate to say it, but I think [people in the health system] are very prejudiced toward First Nations [people]. And they have this idea of the way they are supposed to be, they're all alkies [alcoholics] or addicts….They all get beaten up and they deserve it" (501-5). Another woman of colour suggested that women who are marginalised in society can be "doubly neglected" by health-care providers who do not give them the opportunity to express their concerns. "Most women, especially women of colour who don't speak English, they don't demand, they don't know their rights, they're shy....They don't insist [and] the doctor doesn't really pay attention" (Tahmine, 425-9).

The women also recognised that discriminatory treatment can be based on class, as well as race and gender: "Even some European background women, they can go through the same [negative experiences] because of their status, their class. The same kind of prejudice, class is" (Mina, 501-3). One woman, for whom poverty was an issue, speculated on why she may have been treated poorly during one particular experience: "It was a summer day and I was wearing a little summer dress and I've got large breasts and long blonde hair...and I was wearing high heels and, I don't know, maybe she thought I was a [sex trade worker] and thought I was a lower level of life form and she could treat me like that" (Andradea, 135-9). Tahmine described the vicious cycle where not being treated well in one "system" or situation can lead to not being treated well in others: "People who are on welfare [may have] already been put down by welfare people [making them feel] that 'You're dirt, you're a bum, you're not working, you're using our system'. And then they have this in their mind that everybody's putting them down, so they go to hospital, and they get the worst treatment [because they do not speak up]. They go to medical labs, and they get no treatment. They go to their doctor, and hear 'Oh, you're fine.' They get no treatment. They're the ones who really suffer" (Tahmine, 494 - 499). Although the women experienced sexism, racism and classism in health care, they did not believe it was localised to the health-care system; rather, the women described the health-care system as a microcosm of the larger society.

The women in this study perceived the hierarchical structure of the health-care system to be a related factor in perpetuating unequal power relations. The women named both gender and race as factors shaping the hierarchy. They recognised that in health care, "women don't have a lot of power. It's all directed by the powers that be, the doctors" (Jessica, FG, 544-5). Many of the women believed, as Tahmine expressed, that "we need more women in the medical system [but] not the lower part....We don't have power, we don't have control because the top hierarchy are men, and they're making the decisions" (561-3). She went on to point out that, although "they're telling us this is a democratic country, [with] minorities in all the fields", immigrants and people of colour are also not in positions of power in the health-care system, which may play a role in shaping health-care experiences (Tahmine, 567-8).

These women also perceived the power granted to the health-care system in society to influence their experiences. They had difficulty accessing more natural or holistic health care, because it was not recognised or reimbursed through the provincial medical services plan to the same degree that "western" medical procedures were. As well, because women's own assessments of their health or what they need is not generally valued in society, the women often needed a note from a doctor to validate what they were saying. This granting of power to health-care providers further contributed to the lack of worth and control these women were already feeling. Judy described that, because of the effects of the abuse, "I was missing work and in order to have sick leave for my work, I needed a note from my doctor" (Judy, 185-6). She went on to say, "that's what I turned in...feeling like a little grade schooler, 'I played hooky, here's a note from my mom'" (2243-4). Thus, while there is a lot that individual health-care providers can do towards creating enabling health-care encounters, the context of health care can facilitate or hinder those efforts. Of course, many of the elements named above are not unique to the health-care system. The health-care system was constructed within a hierarchical society which could also be argued to prize men over women, white skin over dark, profit over quality, and the physical over the emotional.

Propositional Statements

To summarise, the theoretical framework presented in this chapter can be conceptualised as a series of propositional statements that have been generated and tested through the grounded theory approach. These are:

1. Women in abusive relationships are engaged in unique strategies to regain their health in the face of being degraded, controlled, and isolated in their relationships.
2. The impact of a health-care encounter is directly related to the degree to which the experience supports a woman's strategies of rebuilding self, reclaiming control and reaching out.
3. If women do not feel cared for in health settings, or feel that they will further lose control in the situation, they are unlikely to disclose abuse and are more likely to delay or avoid treatment in the future.
4. If women receive health care that is reminiscent of their abusive relationship (for example, they are made to feel that they or their concerns are unworthy of attention, decisions are made for them, and they are left feeling that no-one cares about the situation they are in or wants to help them) the messages of

their abuser can be reinforced, albeit unintentionally, and their strategies in striving for health are undermined.

5. Health-care encounters that women perceive to be uncaring, controlling and disconnecting are more likely to lead to adverse health outcomes for abused women.
6. If women in abusive relationships receive health care that is caring, in which they have some control in decisions being made about their health, and in which they feel they can return for additional care, they are more likely to disclose abuse.
7. When women are made to feel that they have worth, have control over decisions shared with them, and are connected to other helpful sources of support, the messages of their abusers are undermined and their strategies in striving for health are supported.
8. Health-care providers can support women in their strategies of striving for health without ever knowing they are in abusive relationships.
9. Women who are more marginalised in society (for example, due to race or class) are less likely to experience caring, sharing control and connecting in health-care encounters.
10. Aspects of the context of health care, including resource limitations, the medical model of care, health care as business, increasing specialisation of physicians, and the hierarchical structure of health care, can hinder the ability of individual health-care providers to provide enabling care to women in abusive relationships.

Conclusion

This chapter presented a grounded theory that centres around women striving for health, describing how women are actively engaged in unique and frequently isolated struggles to regain health in the face of their abusive relationships. Women's strategies to regain health can be supported through enabling health-care experiences that include caring, sharing control, and connecting. Conversely, their strategies can be undermined by disabling experiences that are uncaring, controlling and disconnecting. The women in this study generally described their enabling experiences in health care as the exception, rather than the norm. In order for the health-care system to improve its capacity to promote the health of women in abusive relationships, significant shifts in theory and practice need to occur. The next chapter discusses the implications of this theoretical framework for health-care practice, theory, and future research.

CHAPTER 5

Discussion and Implications

Overview of the Chapter

The purpose of this study was to identify essential components of health-care encounters for women in abusive relationships and to explain how those components may affect women's health and well-being. A further aim was to develop theory for the purpose of advancing knowledge and practice, particularly with regard to health-care providers' responses to woman abuse. In this chapter, the current study findings are discussed in light of the extant literature on the health-care response to violence against women in relationships, and implications for the development of theory and practice are outlined. These are as follows:

1) Health-care providers must recognise and support women's strengths. Women-centred care is discussed as a good overall model from which to do this;
2) The health-care system's inherent potential to retraumatise women in abusive relationships must be recognised and addressed. Empowerment training and cultural safety are two strategies for beginning to undermine disparities of power within the health-care system;
3) *Caring, sharing control* and *connecting* are three important components of health-care experiences that are capable of mitigating some of the impacts of abusive relationships and improving health outcomes. While health-care providers can begin to create these components in their individual practices,

their efforts will be hindered by current models of care which narrow the purview of health professionals. Moving towards a more comprehensive model of care could better prepare health-care providers for seeing and supporting women in all their complexity.

4) Equating identification of abused women in health settings with improved health outcomes or program success is not supported by the findings of this study. The tendency to "add on" such protocols to conventional practice, without changing the context of care, may be a symptom of the medicalisation of woman abuse. Health promotion models of responding to woman abuse are likely to yield a more effective health-care response by connecting health-care providers to the larger community of people also working to end violence against women.

Chapter Five concludes with a discussion of the limitations of the current study and its implications for future research. Health researchers are encouraged to continue to advance knowledge and practice through health research in this area.

Supporting Women's Strengths

This is not the first study to find that women in abusive relationships are actively engaged in strategies to mitigate the negative aspects of their circumstances. The core category, *Striving for Health* adds to the growing body of evidence that challenges the myth of women as helpless or deficient [298]. Previous knowledge, accumulated mostly through qualitative research, has shown other abused women to also employ particularly adaptive survival strategies [275]. Researchers have also reported on the ways in which women make and constantly revise risk-benefit calculations about leaving their abusive relationship [233]. Additional research clarifies that what appears to be tolerance of violence in their lives may actually reflect deliberately considered life-preserving behaviour [299]. Women have been also described as surviving the abuse while getting ready to break free [275], and their decisions to stay or leave as highly rational choices [300]. Leaving an abusive relationship has been previously described as a process [222, 275], and conceptualised as a web of entrapment and a spiral of escape [301]. According to a grounded theory study in which a researcher interviewed 13 abused women in-depth, the ability ultimately to leave comes from a shift in power within the relationship [275].

The findings of the current study, which demonstrate that women are actively engaged in unique struggles to regain health, are also supported by quantitative research findings reported in the health-care literature. In an analysis of the 1994 Statistics Canada *Violence Against Women Survey*, Ratner found that abused wives who responded in anger were likely to manifest fewer symptoms of psychopathology, less likely to resort to drug use, and had better health status [54]. The anger exhibited by these women may have been part of their resistance to the abuse through rebuilding self and reclaiming control and thus played a role in their regaining health. Campbell, through structural equation modelling of the experiences of 141 abused women, also found that self-care agency was a protective factor against the effects of abuse on women's health [302]. The concept of *Striving for Health* supports, and may further our understanding, of the complexities of the links between abused women's strategies, the response of health-care providers, and women's health outcomes.

As was found in the current study, other researchers have concluded that health-care professionals need to acknowledge that abused women need to be perceived as experts in their circumstances [238, 299]. Abused women want to have their wisdom and experiences listened to [89], and to have responses tailored to their unique situations and needs [233]. Women's sense of agency must be facilitated and their personal strengths supported [46, 303]. To be relevant, all health service and education protocols, on behalf of woman abuse survivors, must be grounded in the realities and complexities of the abuse experience. The key to survivors' empowerment is shared control in their interactions with health-care providers that recognise that women are in charge of their healing and do not expect to be rescued [184]. The fortifying of women's strengths, by any of the people in their lives, has previously been described as what can help them to break free of abuse [275]. This also has been demonstrated in studies within the justice system [304]. Interaction with supportive others also has been previously found to be part of the healing process [305]. Healing after departure from an abusive relationship is not solely about physical separation from the abuser, but includes women realising their own potential [275, 305].

From Rescuing to Empowering

The conceptual shift from rescuing abused women to aiding in their empowerment has implications for health-care practice [29]. Yam suggested that practitioners need to view an abused woman as an individual who can make decisions and collaborate with others to change her situation. Health-care practitioners begin to make this shift by examining their own attitudes regarding abused women, and asking themselves, "Do I blame the woman for her predicament? Do I see the abused woman as a powerless victim? Do I think the abused woman is able to participate in freeing herself from the controlling relationship?" [29]. Yam suggested, as did the women who participated in this study, that practitioners should approach abused women as survivors of life-threatening situations who are adaptive and have many strengths. The types of questions raised should be "What do you want to do?" and "In what way can I be helpful to you?" [29].

Just as the women in this study asked health-care providers to recognise that they were doing the best they could given their circumstances, the women also recognised that often health-care providers are doing the best *they* can given the conditions within which they work. Garcia-Morena of the World Health Organization pointed out that too often recommendations developed for health providers address only the individual provider and do not take into account the realities of the health system in which the provider works [306]. Understanding the context in which individual health-care providers work can improve clinical practice and help develop more realistic strategies [307]. Social forces need to be taken into account in recommendations for change [212]. It has been suggested that severe obstacles in the medical tradition need to be overcome to accommodate the voices of female patients in clinical practice [308]. Some of the contextual factors that may facilitate or inhibit the supporting of women's strengths are discussed below.

Stereotypes of Abused Women

The findings of the current study suggest that stereotypes of women, especially abused women, may work to the detriment of supporting women in striving for health. Although they often waited to seek health-care until their health condition was serious, the women in this study perceived that health-care workers often reacted as if they were overstating the seriousness of their illness. Stereotypes of women exaggerating their symptoms to get attention can be traced back hundreds of years [309]; stereotypes of abused women as weak, passive, or even addicted to abuse have emerged alongside the public's increasing attention to the issue of violence against women [128]. Such stereotypes persevere and contribute to a lack of recognition of abuse in women's lives by both health-care providers and women themselves [310]. Many women who participated in this study did not immediately recognise the abuse in their relationships because they did not perceive their experience as the abuse portrayed in mainstream discourses. This parallels Kelly's report that over 60% of 60 abused women interviewed did not initially define their experiences as a form of violence, and over 70% changed their definition of their experiences over time, almost always in the direction of re-labelling particular incidents as abusive [26].

In teaching second-year medical students, Thurston found that many physicians-to-be accepted prevalent myths about violence against women [212, 236]. If health-care providers uncritically incorporate stereotypes of abused women into their practice, they may expect them to be (1) severely physically beaten, (2) passive, and (3) of certain racial, ethnic or socio-economic backgrounds [216, 311]. These stereotypes fail to incorporate the realities of the women for whom physical abuse does not form part of their experience of being controlled, isolated and degraded. It also fails to understand that passivity may be part of a woman's strategy to avoid directly challenging her abuser's control. Stereotyping also discourages the recognition that abuse cuts across all socio-demographic categories and that a substantial percentage of patients in any health setting may be experiencing abuse. Some of the women in this study felt that their health-care providers did not appear to consider the possibility that they might be in an abusive relationship, especially if they were white, middle-class, university educated, assertive, knowledgeable about women's issues, or seeking care for health problems other than physical trauma. On the other hand, the few women who did appear to "fit" the stereotype felt it was often automatically assumed that they were in an abusive relationship, regardless of what they said about their circumstances. This "recognition" of abuse rarely translated into health care that was helpful, and they often felt dismissed as somehow deserving of the abuse. Limandri and Tilden [230] similarly found that physicians and nurses have a tendency not to think that individuals who are similar to themselves could be in abusive relationships, and to blame those women they see as different[6]. Such perceptions make it difficult for health-care providers to recognise women's strengths and adaptive strategies, much less to support them.

The Health-Care Provider as "Expert"

When abuse is identified during a woman's health visit, stereotypes of abused women as helpless can contribute to health-care providers thinking that they should "take over" because they perceive the woman as not capable of dealing with the situation herself. This tendency is supported through the training of health-care providers, especially physicians, to be the "expert" on health matters, and to not perceive patients as legitimate "knowers" of their own health [312, 313]. Alpert, physician and researcher, wrote, "We are taught to be fixers and helpers...to be decision makers...to be in charge....However, this model tends not to work very well when providing services for patients at risk for domestic violence" [234]. Another physician and researcher, Warshaw, suggested that to address violence against women appropriately, the health-care system needs "to change the doctor-patient relationship itself, a relationship in which the unacknowledged need to maintain control and power reproduces an abusive dynamic antithetical to the care a battered woman most needs" [44].

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[6] The irony, of course, is that significant numbers of physicians and nurses have reported experiencing abuse in their intimate relationships [162-164].

The notion that health-care providers are experts in all matters pertaining to health has the potential to make both abused women and their doctors feel powerless. Health-care providers are trained and expected to solve their patients' problems [199]. However, because health-care providers cannot "fix" woman abuse, their image of themselves as healers can be challenged [46, 99]. A study of physicians' attitudes towards violence against women, found that physicians became frustrated with women who were not "compliant" and did not follow their prescribed advice concerning the abusive relationship, which typically consisted of directives to leave the abuse or press charges [21, 161]. Yet, if a woman's problem is coercion and control in her relationship, an appropriate health-care response should not involve health-care providers imposing edicts [212, 307]. The doctor as expert serves to undermine women's expertise about their own situations [1]. Further, the patient role as a dependent serves to support subservient relationships more generally [30].

Women-Centred Care

Women-centred care is a model of practice designed to address hierarchies between health-care providers and patients. The aim of women-centred care is to put women and their concerns at the focus of their health-care decision making. The concept of "women-centred care" has been under development for some time, and is beginning to be operationalised throughout health-care systems in the industrialised world [314-318]. Women-centred care differs from "patient-centred care" by explicitly maintaining a social/structural analysis of power and oppression, specifically on bases such as gender, race, class, sexual orientation, age, ability and gender identity [316]. In February of 2000, the Vancouver/Richmond Health Board approved the use of Women-Centred Care as a framework for guiding its policies, programs, services and structures [319]. The elements of the framework support processes that engage and empower women, and address gender differences that affect women's health and access to health care and social justice concerns [319]. Four factors named in the report as contributing to women's empowerment are: (1) a core sense of self, (2) the ability to take action based on that sense of self, (3) a sense of control over one's life, and (4) being connected with others [319, 320].

The framework for women-centred care recognises the importance of "an awareness of power issues between providers and women and the effects of the abuse of power" [319]. It suggests that health-care providers should "listen to women, [and] take their concerns, opinions and feelings seriously. [Providers are advised to] take time to build relationships, provide room for women to tell their own story, and be nonconfrontational....[They should] acknowledge the likelihood of any woman having experienced violence and abuse and recognize the consequences of violence on women's physical and mental health...[and] provide an environment that welcomes diversity and those with different needs" [319]. A report to the British Columbia Ministry of Health recommended that "best practices" for woman abuse are those that support a women-centred framework [23]. This same report suggested that health-care planners and policymakers cannot assume that whatever response is being made is, in fact, "better-than-nothing". While "doing something" may satisfy the needs of health-care providers to feel good about their practice, there is the chance it may have the opposite of its intended impact if the potential for retraumatising women is not considered [237].

Reinforcement of Abuse in Health Care

The potential for inadvertent re-traumatisation of abused women within the health-care system has been previously discussed in the health-care literature [16, 17, 49, 71, 307]. Health professionals have self-critically asked if they are part of the problem, or part of the solution, and wondered if their actions could possibly escalate a woman's danger and increase her entrapment [175]. Unfortunately, this critique is absent in much of the planning of health-care programs to address woman abuse. Many programs, especially those employing a screening model, are based on the notion that any intervention must be better than none at all [10]. Garcia-Moreno warned about the dangers of individuals working within untransformed institutions and discussed the risks of unforeseen outcomes of well motivated change [17]. The institution of health care has demonstrated its potential to reinforce the conditions of women's abusive relationships.

The current study's findings that women's health-care experiences can echo their abusive relationships are congruent with other research that incorporates women's perspectives of their health-care experiences. Nicolaidis reports women's observations of parallels between the controlling behaviour of abusers and some doctors [89]. Through the use of grounded theory methods, Merrit-Grey and Wuest also discovered that helpers can mirror abusive behaviour [275]. Frank reported that an authoritarian treatment relationship can compound a woman's sense of unworthiness [233]. Health-care encounters can also reinforce shame, humiliation and a sense of responsibility [46]. Physicians' all too common strategies to deal with abuse in the lives of their patients – denial, rationalisation, and minimisation – can mimic the actions of the abuser who neither identifies nor accepts responsibility for his violent behaviour [321]. For one client of a local, emergency-based "domestic violence" program, the emergency room was "like re-living a bad experience" [189].

In the current study, the women who were the most marginalised in society – because of their economic situation, immigrant status, geographical location, or race – were those who seemed to have the worst health-care experiences. This notion of being "doubly neglected" is supported by previous research findings. Plichta and colleagues found through a telephone survey of 1,082 women in co-habiting relationships, of whom 7% were experiencing abuse, that abused women were the least likely to have satisfying health-care encounters and that "patients with the fewest personal resources are at a distinct disadvantage" [96]. Jiwani reports on research that found that for immigrant women of colour, the health-care response was poorer and influenced by stereotypes [76]. These findings have been shown to be applicable beyond women experiencing abuse. Hall and colleagues found that although poor and minority patients wanted as much information regarding their conditions as did other patients, they received less information regarding their conditions, less positive or reinforcing speech, and less communication overall from health-care providers [322]. In speaking with First Nations women, Browne and Fiske heard that women's invalidating experiences reinforced paternalism and the power exercised over them in society [250]. Thus, not only can woman abuse be reinforced in health care, so can intersecting forms of abuse and oppression.

Intersecting Oppressions

Race and class stereotyping of women in abusive relationships can discourage First Nations women, women of colour and poor women of all ethnicities from disclosing abuse in their relationships to avoid exacerbating the racism directed at both men and women in their communities [37, 76, 323]. In a 1989 Ontario study on Aboriginal family violence, 82% of responders "expressed a fear of the wider implications of involving Canadian police in Aboriginal family disputes", which "would only serve to criminalize Aboriginal men and leave Aboriginal women open to the charge of race treason" [323]. Jiwani described how stereotypes "not only contain people in tight little boxes, but also victimize them further by blaming their cultures for perceived and negatively valued practices" [324].

Several researchers have suggested that by "multiculturalizing" the problem, or making it an issue of providing "culturally sensitive" care, the problem becomes one of "difference" rather than the inequalities of power, such as racism, and the role of institutions in their perpetuation [324-326]. Cards with information about women's resources are increasingly provided in several languages within health-care settings [209]. This intervention, however, does not address the issue that if certain women speak out about abuse, they may be more likely to have their children apprehended. Women of colour, First Nations women and poor women who are victims of relationship abuse face an increased likelihood of having their children apprehended by provincial authorities [324]. If this reality is not taken into account, linguistically or culturally targeted information may perpetuate existing inequalities, rather than help to undermine them.

In the practice and structures of health-care, power relationships must be addressed to prevent the perpetuation of inequality. At the level of the individual practitioner, it has been suggested that physicians must gain a deeper understanding of the abuse of control and authority in their professional – and personal – lives [321]. Incorporating change into practice is not simply a matter of health-care providers deciding to do so. Individual practice takes place within the contexts of the health-care system and the larger society; aspects of these contexts can facilitate, or conversely, hinder the implementation of such change. To facilitate practice-level change, programming for the prevention of violence against women should address structural level forces that can perpetuate and reinforce abuses of power.

Hierarchies Within the Health-Care System

To address the power relations between doctors and patients, many researchers argue that the existing hierarchies within the health-care system need to change [36, 128, 313, 324]. The way health-care providers receive their training can shape their practice with regards to relations of power. Warshaw pointed out that many aspects of medical training are also abusive [327]. She described the demanding and debilitating schedules and peer isolation on clinical rotations, lack of validation during emotionally upsetting situations, harassment from attending physicians, and a failure to make more senior medical staff accountable for their behaviour towards medical students. She stated, "Recognizing the potentially abusive aspects of medical training and the importance of creating environments that do not permit such behavior is important not only in improving the health care response to domestic violence but also in creating a society that does not tolerate abuse" [327]. Campbell noted that "there is endemic paternalism in the medical system that tends to disempower women" [234]. The unequal distribution of power between different professions, most notably between doctors and nurses, is significant [324].

The health-care system itself is a gendered, racialised and classed hierarchy that in many ways mirrors society in general [127, 212, 307, 312]. Jiwani wrote that "the western health care system is a system where the majority of doctors are male, and the majority of nurses are female - again gendered on power lines; where the people of colour tend to be found either in the rolls of the patients, or in the kitchens, laundries, and janitorial services of most hospitals" [324]. Commonalities between women in the health professions and abused women have been recognised. "The origin of the plight of abused women and the struggles of female health workers lie in the worldwide social and economic inequality of women," wrote Hoff "[and] the concomitant devaluation of women and their work keeps battered women with violent men, and women, especially poor women of colour, in inequitable service roles" [184]. In a study of a Toronto hospital, researchers found that racial minority nurses were severely underrepresented at the decision-making and supervisory levels [75]. Further, they were more frequently passed over for promotion, while white nurses were promoted at rates significantly higher despite sharing similar levels of qualification with black nurses.

Abuses stemming from these unequal relations of power within the health-care system are well documented in the literature. Studies report frequent abuse of nurses by physicians [328], and the sexual harassment of female physicians [307]. As well, health-care providers have been reported to be marginalised by their colleagues for addressing woman abuse [217]. Professions need to address the abuse of its own members and to recognise that, in the health-care system, there are both abusers and the abused [212]. Thus, unless the health-care system addresses oppression within its walls, it will be difficult for it to address issues of power and control in the larger society and their manifestations in the lives of female patients [324]. Empowerment training and cultural safety represent two promising strategies to address relations of power within the health-care system. Both concepts have been previously suggested to be compatible with, and perhaps integral to, women-centred care [64, 237, 314, 316, 319].

Empowerment Training

It has been argued that one cannot teach health-care providers to share control by controlling means [15, 320]. Rather, educators must model non-abusive ways of interacting [307]. One way to achieve this is to involve staff in the planning of programs. The principles of health planning suggest that participation is vital in changing health-care professionals' behaviour [329]. Initiatives that respect staff input empower them in developing programs that may also help to create a culture of non-violence [330]. Developing curricula with those being trained and keeping training accountable to local needs and conditions are important ways to keep training "grounded" and useful [81, 247]. Empowering health-care providers through training and program development is an important way to teach them to support the knowledge and strengths of their abused patients [320].

In the same way that women know best their home situations, health-care providers know best the context of their work. In recognising that abused women know what strategies are possible within the circumstances of their relationships, it must be recognised that health-care providers understand best what sort of a response is possible within their own practice [81]. Health professionals have been made to feel guilty that they are not doing anything to address violence against women if they do not screen for abuse in the lives of their female patients [21], and forced compliance to the screening model has even been suggested [189, 195]. This has parallels to making women feel that they are not doing anything about their situation if they do not immediately leave, or do not involve the police. Empowering methods of educating about violence against women can instead model how providers can interact effectively and supportively with their patients. Health-care providers may be more likely to exhibit principles of caring, sharing control and connecting in their own practice if they experience those same principles at work. This may include having personal and professional experiences of abuse validated and addressed in the health-care system. Health-care workers can experience the principle of sharing control by having a say in decisions about abuse protocols.

One example of empowerment training is found in British Columbia. A program for woman abuse that educates health-care providers about women-centred care, and addresses structures of power within the health-care system is established in a local hospital, and has spearheaded an initiative to support the creation of similar, site-specific, programs province-wide [237]. The Woman Abuse Response Program at British Columbia's Women's Hospital is educating health professionals to provide compassionate, non-judgemental and safe care to women experiencing abuse and to support women's choices, consent, respect, cultural safety and confidentiality. It also supports staff in their own experiences of abuse, and includes health-care professionals in the creation of strategies for responding appropriately to abuse in the lives of their patients. "Core teams" in each area of the hospital play a leading role in developing site-specific protocols for implementing women-centred principles of care for abused women, and have led to positive evaluation of the program by health-care providers [242].

Cultural Safety

Changes in the ways that the health-care system treats issues of race, both within the workplace and in regards to patients, can also help provide better care for women in abusive relationships. However, "the issue isn't one of cultural sensitivity", according to one researcher knowledgeable about issues of race and culture, "it's one of respect....Talking culture doesn't make sense here, but understanding the impact of migration, of gendered relations, does. Knowing where to refer these women becomes critical and treating women as whole beings is an absolute necessity" [324]. Therefore, a broader model of "cultural safety" has been proposed that argues for health-care providers to take into consideration the socio-political reality of their patients, not simply culture in isolation. Rather than being interpreted within the ideological framework of multiculturalism, culture should be addressed in terms of the political status and historical experiences of the social group for whom one is caring [37, 324-326, 331].

Addressing cultural safety more appropriately within its structures may mean that the health-care system needs to hire and promote more people to management who represent the patient population being served [324, 332]. Without assuming that women will automatically be better treated by health professionals of their own ethnic or religious background, it has been argued that representation within the health-care system of the diversity of the population can only help to better reflect the needs of all patients [49, 332]. Having health-care providers that reflect patients' diversity also does not mean that there are resident "cultural experts". Rather each staff person needs to make the investment of time and resources to become culturally competent [332]. This involves a commitment to self-evaluation and critique, to redressing the power imbalances in the patient-provider dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities [333]. A culturally-competent intervention respects an abused woman's right to dictate the course of her actions and recognises that she will accept an option only if it makes sense from her frame of reference [332]. Thus, cultural safety and empowerment training not only work to undermine abuse and support women's strengths, they also focus on undermining the conditions in health-care structures that perpetuate inequalities and abuses of power. It is hoped that, in addition to the tactics discussed in the next section, that these strategies will help to enable the provision of *caring, sharing control,* and *connecting* in health-care settings.

Components of Helpful Health-Care Responses to Woman Abuse

The concepts of *care, control* and *connection* identified in the current study are consistent with findings from several other studies. Rodriguez and colleagues heard in telephone interviews with a random sample of 375 ethnically diverse, abused women in San Francisco that experiencing compassion and understanding in health-care encounters was very important [334]. For many women, this was much more important than a clinician's gender [226]. Hathaway, through interviews with 49 clients of a hospital-based domestic violence program, found that care and follow-up are important components of good health care [231]. Using a phenomenological approach with four abused women in Australia who had multiple hospital admissions for injuries from partner violence, McMurray and Moore described women's needs as including honesty, support, understanding, explanations, non-judgemental attitudes, a feeling of safety, being listened to and feeling that a nurse was close to them [228]. Newman found that women in transition shelters specifically named the lack of concern in the health-care system as a barrier to getting help in leaving their abusive relationships [335]. Plichta and colleagues found that a significant proportion of the 1,082 women they surveyed (7% of whom were in abusive relationships) reported having health concerns minimised and being told "it's all in your head" [96]. Patient satisfaction in the study was positively associated with physicians' willingness to discuss emotional or personal issues.

Other research provides evidence that the concept of care is generalisable beyond abused women. Hall and colleagues found that female patients were more satisfied with caring health-care providers who showed concern, talked about psycho-social problems, were emotionally supportive, and appeared interested in what they were saying [336]. In another study, patient satisfaction increased when physicians encouraged them to talk about psychosocial issues, provided them with a friendly atmosphere, and listened with interest [337]. Survey findings on patient satisfaction from 537 chronic disease patients and 127 physicians found that women prefer responsive and egalitarian physicians, irrespective of physician gender [338]. Statements of empathy, concern, reassurance, and legitimation, along with psychosocial questions, information, and counselling, enhance women's satisfaction with health care [338]. A British Columbian study of the health-care experiences of First Nations women reported that their encounters were also perceived along a continuum from affirming to invalidating [74]. One of the important components of affirming encounters for these women was feeling genuinely cared for in health care. Invalidating encounters included feeling diminished, not listened to, negatively stereotyped, and having personal circumstances disregarded.

The concept of sharing control also is supported in the literature. In addition to hearing that they want to feel cared for, Hathaway found that the abused women she interviewed needed to feel no pressure to undertake any specific course of action, and to have their confidentiality respected. McMurray and Moore reported that the women in their study needed to have respect for their decisions, including the decision to return to the abuser, and the freedom to disclose or not, to talk or not, and to be counselled or not [228]. Gielen and colleagues reported that the abused women they surveyed needed to have control over reporting their abuse and many expressed fears and concerns about negative consequences of routine screening and mandatory reporting [339]. Plichta and colleagues found that both abused and non-abused women prefer responsive and egalitarian physicians [96].

The importance of the concept of shared control is further supported in the literature. Hall reports that, in addition to emotional sensitivity, women want an egalitarian doctor. Female patients were more satisfied with less dominant health-care providers, such as those who talked about the patient-provider partnership as a "we", actively listened, asked fewer close-ended questions, and did not interrupt [336]. Roter and colleagues also found that a dominating demeanour on the part of physicians lessened patient satisfaction [338]. Bertakis and colleagues reported that patients were most satisfied with physicians who did not dominate the conversation, and when the number of biomedically-oriented questions decreased [337]. First Nations women reported that an important element in affirming health-care encounters is the sharing of knowledge and power over health-care decisions, where health-care providers encourage women to ask questions, are unconcerned about time constraints, and help women to increase control over their health [74]. The BC Women's Hospital Consultation Report found that women want the health-care system to be a supportive environment that creates conditions for women to be empowered; women want attention paid to their daily lives, they want validation for what they feel and they want knowledge and skills so that they can take control of their health [245].

The concept of connecting also has been identified as important to quality health care. Rodriguez and colleagues collected qualitative data through semi-structured focus group interviews with 28 abused Latina and Asian immigrant women and heard that trust, communication, creating personal relationships and having a supportive atmosphere were important components of good health care [334]. They also found that abused women require multiple visits to a health-care provider to build the trust necessary to disclose their situation [334]. In individual interviews and focus groups with immigrant women of colour who experienced abuse in their intimate relationships, Jiwani found that a trusting relationship was conducive to disclosure [76]. It has been observed that, conversely, previous negative experiences in health care make women less likely to disclose abuse [33]. The concept that negative experiences can lead to disconnection from the health-care system is supported by research findings from other marginalised groups. Researchers of lesbian, gay, bisexual, transgendered and intersexed patients report that negative experiences can lead to distrust and an unwillingness to disclose personal details in future health-care encounters [340]. Building relationships with health-care providers is also part of affirming health-care experiences for First Nations women; these women often describe becoming reluctant to seek future health care after an invalidating experience [74].

Previous research supports the findings of the current study that some referrals are more helpful than others, and that those connections that support women can help them in regaining health and escaping the abuse. Interviews with 31 abused women found that social support may be critical to leaving an abusive relationship [341]. Abused women in transition shelters have reported that calling the police often did not help and could escalate the violence. They also found that it was often difficult to deal with social agencies [335]. McCauley and colleagues found that women's groups were often a good referral for women, and that psychiatrists often were not [114]. Coker, too, found in a population-based survey of abused women in South Carolina that 100% of the women who used support groups found them helpful [342]. A qualitative study on the process of healing after an abusive relationship found that interaction with supportive others was an important part of the healing process [305].

Putting *Caring, Sharing Control,* and *Connecting* into Practice

The findings of this study and others suggest that there is a great deal that concerned health-care providers can do in their individual practice to support abused women. Health-care providers can achieve caring health-care encounters by considering women's feelings and needs, expressing concern about those needs, and taking women and their concerns seriously. Active and non-judgemental listening and accepting and supporting women in their choices are essential aspects of a caring health-care encounter. Caring approaches help ensure that women feel comfortable returning to the health-care setting for additional support as they work at regaining their health and escaping their abusive relationships.

Sharing the control of health-care encounters with abused women can be facilitated by asking open-ended questions in privacy, listening carefully to the responses, and acknowledging women's expertise about their own situations and health. Sharing control also involves giving options and information rather than directive advice, and supporting the decisions women make. This includes supporting women's choices around documentation and disclosure of the details of their relationships. Supporting women's decisions requires maintaining the confidentiality of disclosures and not making referrals without a woman's consent.

Connecting women to support services should be based on two principles: caring and sharing control. Health-care providers building relationships with abused female patients represent one opportunity for connecting women with support. Health-care providers can also connect women to other helpful resources and services. To be effective in connecting women to support, health-care providers need to become acquainted with community resources, provide women with sufficient detail about these resources, and promote referrals to resources that also adhere to the principles of caring, sharing control and connection. The women in this study found that the most supportive resources were those that provided them with an opportunity to connect with other women in similar situations, and many suggested that health-care providers should focus on referrals that facilitate a woman's safety and support, rather than emphasising services aimed at punishing the abuser. To adhere to the principle of sharing control, health-care providers should describe resource options without pressuring women to pursue them. Such shifts in practice depend on changes being made to the health-care system itself, including the medical model of care and economic incentives.

The Medical Model

The dominant model of practising medicine has been termed the "medical model", whereby "sicknesses are cast as problems of the body and its immediate environment...as problems of individuals rather than groups of persons in certain social positions" [312]. Focusing on the physical does not appear to facilitate appropriate and comprehensive care for women in abusive relationships. By focusing on the individual for answers to the problems, a medical model approach can make women feel blamed for the abuse or be prescribed unnecessary or inappropriate medications or treatment [33, 44, 48, 99, 205, 343-345]. The medical model individualises and de-politicises women's problems by providing the message to women, like their abusive partners do, that "the problem is with *you*, so *you* must do the changing" [346].

Under a traditional medical model, health-care providers are trained and expected to identify and attend to women's symptoms as the problem, rather than recognising and tackling the broader issue of abuse [30, 156, 240, 347, 348]. This approach can result in women being pejoratively characterised and labelled as neurotic, hysterical, hypochondriacal, having personality disorders, or as a "well-known patient with multiple vague complaints" [98, 128, 139, 303, 307, 309, 332, 345]; that these outcomes may be effects of abuse or signs of coping with it is rarely recognised [137, 212]. Thus, connections between abuse and health are generally concealed through prevailing methods of diagnosis [233].

The medical model focuses on diagnoses and treatment often to the exclusion of identifying and addressing the root causes of various case presentations [36, 44, 126, 309, 312, 349, 350]. The greater the focus on injuries, the less likelihood there is of the creation of an understanding of the abuse that culminates in those injuries [321]. Failure to recognise abuse can further disconfirm the experience and minimise the consequences [229]. The model's focus on treating only physical problems also detracts from the physician-patient relationship [81, 334]. According to the BC Women's Hospital Consultation Working Group, women in British Columbia are concerned that doctors do not ask questions about what is happening in their lives [245]. They report feeling dehumanised and having their knowledge of their bodies discounted because of the health-care system's current reliance on the medical model, which defines health primarily in terms of the absence of disease and focuses on the physical dimensions of health.

Economic Disincentives to Enabling Health Care

Significant changes in the practices of health care have added to the pressure to quickly diagnose and fix problems. Several women in this study discussed how family practitioners now rarely make "house calls", how increasing specialisation means that many people do not have long-standing relationships with their family doctors and, as drop-in clinics become more common, patients may see different practitioners every time they seek health care. Changing health-care delivery models, coupled with economic factors such as fee-for-service medical treatment and drastic shortages of health-care personnel, mean that women are more likely to experience an impersonal, rushed health-care encounter [324]. The block funding model of Canada's Health and Social Transfer payments, which provide the provinces with cash payments and tax transfer to support health care, social assistance, and social services and reduction of provincial funds spent on health care has translated into fewer available hospital beds for women in abusive relationships [42]. However, in response to the recommendations of the 2002 report authored by Roy Romanow [351], $34.6 billion in federal money has now been allotted to the provinces over 5 years, specifically for health care [352].

For physicians, primarily because of the method of receiving payment for services in Canada, the lack of financial reimbursement for spending needed time with abused women is a deterrent to intervening [245]. As health care becomes increasingly governed by private sector, business models, physicians are expected to see more patients in shorter periods of time [99]. Current allocation of resources and billing practices do not facilitate professionals taking the time to counsel and support patients as well as not rewarding the behaviour [329]. An ethnographic study of two British Columbia Emergency Units reported that nurses were so focused on the "efficient processing" of patients, physical problems, and cost savings, that only blatant physical injuries were dealt with and the other sequelae of relationship violence were otherwise obscured [216]. Time constraints and the rapid processing of patients are widely recognised to be significant barriers to providing good care for abused women [20, 46, 76, 89, 299, 307]. As well, privacy may be difficult to maintain when only a thin curtain separates patients from each other. Limited availability of physical space and shortages in staff numbers and time create a climate that is not conducive to good care for women who are struggling to regain their health as a result of experiencing an abusive relationship.

Ecological Models of Health Care

Exclusively physiological models of medicine began to be challenged in the 1970's, as the "biopsychosocial" model was asserted in hopes that it would "take into account the missing dimensions of the biomedical model" [353]. This model "asserts that in order to be effective, medical practice must recognize the centrality of the patient's perspective and social environment in defining and explaining his or her condition and in designing and implementing medical response" [312]. Feminist practitioners have taken this idea one step further, suggesting that issues of power, gender and race must also be recognised and incorporated into the conceptualisation of health and illness and formulation of the medical response [76, 313]. Rather than viewing the patient as pathological, the situation must be reframed to recognise the abuse as problematic and often the cause of physical and emotional problems and to identify "the social, cultural, and political-economic structures that sustain, support, and mediate its impact" [327]. The World Health

Organisation also has recommended the use of an "ecological model", which includes the examination of the individual, the family, the community, and the society in the treatment of any health issue [306]. It has been asserted that when helpers shed the medical model approach, they provide abused women with an opportunity to speak about broader factors surrounding their physical conditions [29]. Women-centred care is an example of an ecological model that takes into account the condition of individual women's lives, as well as the condition of women in general in society [314-316, 319].

Identification Does Not Equal Success

Giving women an opportunity to speak about the context of their lives during health-care encounters is an important aspect of enabling health-care experiences for women in abusive relationships. The current study found that women are more likely to disclose abuse if they experience caring, sharing control and connecting. However, it also found that disclosure does not ensure a successful health-care encounter, as is often claimed in the literature promoting screening for abuse. Women in this study described instances in which they had an enabling health-care encounter without ever disclosing abuse, by being cared for and having their strategies supported. They also described encounters during which they disclosed and did not have a caring, helpful encounter, and in which their danger escalated because their confidentiality was breached or they were pushed into courses of action not of their choosing. While the women described a host of positive experiences in health care, none of them included screening. Rather, screening played a role in several of the women's negative experiences. Thus, the findings of the current study add to an emerging body of literature that questions whether identification of abuse per se is necessarily beneficial [16, 17].

It has been suggested that "a problem that is not recognized cannot be addressed adequately" [354]. However, rather than focusing on identification of individual women in abusive relationships through the use of screening questions in health-care settings, health-care providers could benefit from shifting their recognition towards understanding that abuse may be part of the experience of many of their patients because of the magnitude and pervasiveness of the problem in our society. Practitioners who are aware that any of their patients may be experiencing abuse may be more likely to recognise the impacts of abuse on health. Yet, even if they are not aware of abuse in the lives of particular patients, health-care providers can validate and include their patients' knowledge of their home situation and other contextual factors into their treatment plans. Health-care providers who do this are also more likely to be able to 'co-construct' realistic and helpful plans to support women experiencing abuse in regaining their health.

Redefining notions of what constitutes success within the health-care system can also help abused women and their health-care providers. Many health-care providers feel that they have not done anything to address woman abuse if they have not complied with screening protocols, and they often feel that they have not helped if a woman does not leave her abuser [46]. According to the women who participated in this study, this is not the case. Their stories made it clear that by focusing on women's health, rather than the punishment of their abusers, and providing care, sharing control and connections, health-care providers *are* doing something very valuable for women and their health. While safely leaving their abusers is ultimately an important part of the process of women regaining their health, severing ties with their abuser can be a time of increased danger for them and their family. Remaining in their relationship while they develop the supports and resources to be safely independent of their abusers is sometimes the best way for women to begin the process of regaining health. Thus, requiring that women leave for the situation to be considered to have a successful outcome, or making them feel guilty if they choose to remain in the situation for the time being further undermines women's autonomy and is unlikely to be part of a helpful health-care response to woman abuse.

Practice must be based on evidence and the knowledge base is growing; there is evidence that routine screening can have unintended negative consequences for abused women [16, 17, 215], and that empowerment strategies can be helpful [225, 303, 320, 355, 356]. The provision of caring, sharing control, and connecting in health-care encounters can help women, even if health-care providers do not know they are being abused. As discussed earlier, it can also increase patient satisfaction for women who are not being abused. The focus on identification of woman abuse in health settings may be in part due to the "medicalisation" of the issue. More helpful strategies may be engendered through health promotion frameworks that include co-ordinating with other sectors working to stop violence against women.

The Medicalisation of Woman Abuse

Medicalisation refers to the process whereby an activity or a condition becomes increasingly defined as an illness, and is thereby moved into the sphere of control of the medical profession [357]. As woman abuse becomes more frequently conceptualised as a health issue, it forms part of a larger trend towards the medicalisation of women's lives through the "professionalisation" of the provision of health care [350]. The elevated social position that doctors currently have is a relatively recent phenomenon. The rapid rise in power and prestige is due to the professionalisation of medical practice – when the occupation attained a monopoly over its area of expertise. This includes a legal monopoly over the delivery of services, such that licensed physicians comprise the vast majority of legitimate practitioners of medicine, maintaining its dominant position by warding off competitors such as naturopaths and midwives [312]. As medicine emerged as a profession in its own right, women became encompassed within the sphere of medical observation and control. Whereas, in earlier times, the health needs of ordinary women (especially pregnancy and childbirth) were addressed by other women in the community [346]. The young, overwhelmingly male medical profession usurped women's role in the management of women's health. Through professionalisation and medicalisation, "conditions whose origins are in part social, such as...marital problems and abuse, are increasingly treated as medical conditions so that their social origins are obscured. Moreover, physician control reinforces societal ideas about the distribution of knowledge and authority" [312].

As it becomes increasingly viewed as a public, rather than private, problem, there has been a shift in the ways of thinking and talking about violence against women [350]. Those who hold the power to define women's needs and problems also hold the power to determine the solutions. Women's "problems" are more frequently medicalised, and interactional or structural problems are defined as medical ones, with health-care providers prescribing pills and surgery when social and political change may be a more appropriate remedy [346]. The positive side of medicalisation is that the visibility of formerly "invisible" problems like woman abuse is increased substantially once they are labelled "medical problems". A medicalised issue is also more likely to draw public attention and sympathy, to attract research funding, and to appear on the political agenda

[346]. However, women's groups have clearly identified that a holistic community-based approach to abuse is what is meaningful to them, and that professionals have often professionalised this problem to the extent that they are not helpful [182].

Medicalisation may also include health-care professionals and researchers working under traditional paradigms and using gender-neutral terminology, such as "intimate partner violence", and applying medical concepts such as screening to this socio-political issue. While the concept of "early identification" may be appropriate for health problems such as prostrate or breast cancer, it can be counterproductive and even harmful when applied to the complex social problem of woman abuse. It is also arguable whether screening for abuse actually serves the function of early detection. Screening approaches typically aim to identify women in the advanced stages of an abusive relationship, when they have experienced physical assault. Because they do not assess for other forms of abuse – such as controlling, degrading, or isolating behaviours which often precede and coincide with physical assault – they can overlook many women who are experiencing abuse [124]. Current models of screening for abuse also do not offer adequate strategies of "treatment" or prevention of further abuse, an important requisite for effective community-health screening programs [204]. Health-care programs that utilise a traditional biomedical intervention approach are treatment-centred and the underlying root causes of problems, if dealt with, are addressed in the short term and within a context of individual recovery and change. Thus, the onus is on individuals, generally the woman, to change. Such an approach does not demand change in the larger society or allocate responsibility for resolving abuse beyond the woman affected [358]. Innes and colleagues, in their review of health services related to woman abuse, concluded that one of the four factors that impede effective program development for woman abuse is the continued use of a traditional model to deliver services [358]. Rather than "adding on" to existing structures that can serve to perpetuate the problem, researchers suggest that an effective response instead needs to work at changing those structures. The findings of the current study support models that focus on the broader context and earlier prevention of the problem by addressing its root causes and working in collaboration with a larger community [42, 46, 198].

Health Care in Context

While the doctor-patient encounter is important in responding to woman abuse, it should not be addressed in isolation [49, 98]. Systemic change must also occur in order to respond to the full range of women's needs [42]. Addressing violence against women in a meaningful way, in its larger social context, requires the health-care system to become part of a broader community-based response aimed at stopping violence against women [17, 23, 185, 198, 199, 237, 306, 307, 359]. The substantial amount of work accomplished by the anti-violence women's community must be incorporated into and supported by the health-care response to woman abuse.

Women-centred care advocates for the fostering of connections between those who work in all areas and at all levels to address this issue [319]. To date, health-care providers have demonstrated some interest in becoming part of larger initiatives to address violence against women. They now sit on co-ordinating committees across the province of British Columbia alongside other sectors and groups addressing violence against women in relationships [304]. As program developers in the health-care system recognised the need for health professionals to work closely with community groups, anti-violence women's advocates have been invited into the health-care system to form partnerships in addressing woman abuse [234, 237, 360].

Successful health-care responses to violence against women will advocate for change at a societal level by addressing the status of women [21, 48, 71, 306], and related forms of violence women face, including poverty and cultural genocide [246]. Health researcher MacLeod asserted that to effectively address woman abuse, we need changes in employment, income, health, education and social services policies, a change in the ways service providers work with one another, and a change in our ways of living and working together [42]. The health-care system clearly cannot do this in isolation. It must recognise that violence against women in relationships is not exclusively a health problem. By viewing woman abuse as a complex social issue with implications for women's health and the practice and structures of health care, the health-care system can, however, help work towards solutions.

Limitations of the Current Study

While previous qualitative studies have described some of the aspects of helpful health-care encounters for abused women, the current study generated an emergent theory in which the important components coalesce in an abstract, comprehensive framework grounded in the realities of women's experiences. The significance of the components of *care, control* and *connection* can be understood in the context of women's abusive relationships, and the linkages to their impacts on women's health and relationships are described. Patient-provider interactions are placed within the larger context of health care, and the implications of the theory for practice and policy are discussed in detail.

While this grounded theory is based on the experiences of a small number of abused women, it is rich in depth and scope. It cannot be said, however, that the experiences of this group of women can be generalised to all women in abusive relationships. Although attempts were made to include a diversity of women, in terms of demographics and experiences, all of the women who participated in this study were connected to community supports and felt comfortable talking about their experiences. Women who were not currently connected to community supports or who did not wish to speak to an interviewer, may have had different perspectives.

As discussed in Chapter Three, the objective of utilising a grounded theory approach in this study was not to discover "truth", but to gain "understanding" of the experiences and perceptions of study participants. In order to ensure as close an approximation as possible to understanding, issues of rigour were attended to from the outset of this study. Theory was generated through a systematic, iterative process of repeatedly testing emerging hypotheses against the raw data. The theory produced through this process is cohesive and congruent with many other reported research findings. Thus, while the method and sampling technique do not permit generalisability of findings, they do allow "theoretical generalisability", where aspects of the emergent theory can be applied to the experiences of other individuals [252]. Theoretical generalisability is demonstrated here in the "fit" of the emergent theory with other theory described in the literature, including that not specific to women in abusive relationships. Although caution must be exercised, the emergent theory can be provisionally used to inform program development and evaluation. However, the ten propositional statements that have emerged must be subjected to hypothesis testing through further research.

Implications for Future Research

Rather than focusing on identification and referral rates, women's descriptions of their health-care experiences in the current study suggest that the success of health-care responses to woman abuse should be measured by their quality (i.e., the extent to which health-care encounters are enabling for abused women). Thus, current criteria of program success must be reframed. Evaluations of programs should become more sophisticated and move beyond tallies of the women asked, identified and referred for woman abuse. Inferences previously drawn about the impacts of these activities on women's lives and health are not supported by this study. Measures that have been developed to assess dominance and control in women's intimate relationships [92] or in patient-physician relationships [96, 336, 337] may be adaptable to these needs. Statistical correlation between health-care components and women's health outcomes and experiences of abuse could also be assessed.

In addition to evaluating patient-provider relationships, measures for relevant aspects of the context of health care could be monitored for change. For example, data on the time allotted to patients and financial rewards for providing additional support could be used to assess for economic incentives in providing enabling care. Characterisations of abused women in their medical charts could be observed for changes in stereotypes or assumptions about women in abusive relationships. The involvement of health-care providers in community co-ordination is a measure of the involvement of the health-care system in the larger community movement to end violence against women. The promotion of more women and minorities to decision-making positions within health care can be a proxy measure for the dismantling of hierarchies on the basis of gender, race or other factors. The adoption of women-centred policies and protocols can be a measure for organisation support for women-centred care. These, and many other indicators, could be collected and analysed to measure systemic and contextual changes.

Future research must continue to advance theory about the health-care response to woman abuse by asking abused women themselves about their health-care experiences. The aims of all knowledge production in this area should be consistent with the broader aims of addressing woman abuse. Women's voices must be at the centre of research about their lives and they must be given opportunities to define what is important and relevant to them. The measures employed should not focus solely on the physical dimensions of abuse or health, and the derived knowledge must be placed within the larger context of health care and society. We might do well to remember that "the role of the intellectual is", according to French philosopher Foucault, "to re-examine evidence and assumptions, to shake up habitual ways of working and thinking, to dissipate conventional familiarities, [and] to re-evaluate rules and institutions" [361]. By exercising our academic prerogative to question freely, researchers, too, can be part of a broader social agenda of ultimately bringing to an end the abuse of women in intimate relationships.

Conclusion

Violence against women in intimate relationships remains a pervasive problem in our society with potentially devastating health consequences. Health-care providers and researchers have the opportunity to play an important part in an effective response to woman abuse. In order to do so, they must ensure that they do not re-create or perpetuate the conditions and structures that allow such gross violations of power. If they want to be effective, health-care planners cannot simply insert a program into the existing structures.

Work instead needs to happen on changing those structures. As well, the realisation must be made that the most important thing that can change is not *whether* health-care providers see women as abused, but *how* health-care providers see abused women. Health-care providers, managers, and researchers can make a difference, but only if they are willing to listen to the experts - abused women - and to recognise their diversity and strengths.

I conclude, as I began, with the words of a woman I had the pleasure of meeting while conducting this study. She experienced various forms of abuse as a child and as an adult, and has since discovered that it *is* possible to love another without losing her self. She explained that the best gift she ever gave herself was to learn to listen to her own voice. By taking personal and professional responsibility for putting the voices of women who have experienced abuse at the centre of our efforts in this area, health-care professionals and researchers can move towards creating a world in which women and children can write their own dreams, and have them come true, rather than living in a nightmare not of their own making.

A Woman's Book of Pain

> I am hoping there is a rainbow at the other end of this pain. This is a book of women's pain. A book that any woman who has dared to dream of love and be disappointed by the cruelty of the men in her life could relate to.
>
> As young girls we are encouraged to dream of white knights and of handsome princes who will awaken us with a kiss. No one tells us that these are only fairy tales, that no man is truly a white knight or a prince. That no man knows how to awaken us to our own inner beauty. No one tells us that our innocence, although beautiful, is dangerous, for we do not know the world of men.
>
> For they enter our bodies, come into our lives, and then never truly let us into their lives, for freedom is their god. They clutch tightly to their rights, their privileges, claiming to have none. They feign innocence so that we may feel safe

in their arms, for they have learned that when we feel safe we open to them the heavens within our bodies.

They do not share their bodies with us in the same way for they are trained from a young age to rape and to pillage. Since youth the messages have been clear to us both. They are takers, powerful, worthy of respect. And we, well, we are givers, weak, in need of their protection. Quite the setup.

No matter their age they expect or should I say feel entitled to a "young" woman. Of course we age and they want us no more. Ironically, we age for they have taken our life force, our energy, our love, and they give nothing in return.

It is not wise to forget that they still control the world, the economics. They do, however, allow a select few women to enter their domain and don't be fooled by this. They are women who can be trusted to maintain the status quo. Women who believe they are different than us. They tell them they are special, not simple like us who love the earth, who care about mothering, about foolish things such as love. Sadly, these women sell us out for they have bought the stories of their men. They still believe that men have the answers. They still believe in the promises of men.

It is time we women told the truth to ourselves and to each other. It is time we let go the dreams that are woven in deception for us. It is time we wrote our own dreams, time we claimed our power.

- Jonina Kirton

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Appendix A – Characteristics of Interviewees

CHARACTERISTICS OF INTERVIEWEES

Name	Age at time of inter view	Ethnicity culture or religion (self-defined)	Geography	Education level	Family income (in last year of relationship)	Length of relationship (years)	# of children	Dominant form(s) of abuse	Major health problems attributed by the women to the abuse	Health professional or settings visited
Mina	35	Iranian immigrant	Urban	College	$40,000	7	0	Verbal Physical Infidelity	Depression Unwanted pregnancy Irritability Sleeping problems Gynaecological problems	Psychiatrist Family doctor Abortion clinic
Tahmine	45	Iranian immigrant	Urban	University	$50,000	9	1	Verbal Emotional Threats	Depression Unwanted pregnancy	Abortion clinic Family doctor Walk-in clinics Emergency
Judy	27	White Presbyterian	Urban	University	$60,000	3	0	Verbal Emotional Financial Social	Unwanted pregnancy STD Difficulty sleeping Stress and fatigue Suicidal ideation Compromised immune system	Abortion clinic Family doctor Emergency Naturopath
Susan	43	Eurasian Christian	Urban	Trade school	$46,000	16	1	Physical assault Verbal Emotional Infidelity Weapons used	Substance use Broken ribs Depression Weight loss Sleeping problems	Emergency Substance abuse program
Jessica	50's	White	Urban	University	$70,000	7	2	Emotional Physical	Bruises Exacerbation of pre-existing health condition Suicide attempt Prescription drug use Irritable bowel syndrome Sleeping disorder	Emergency Family doctor Paramedics Psychiatrist Chiropractor
Andradea	37	Caucasian New Age spiritual	Rural	University	<$20,000	6	0	Physical assaults Verbal Threats	Bruises Head injury Eating disorder Sleeping problems Self-mutilation Depression	Emergency Family doctor Naturopath

									Digestive problems	
Luisa	30's	First Nations	Urban	College	$20,000	6	1	Physical Threats Stalking	Exhaustion Suicidal ideation Depression Eating disorders Sleep disorder Back injury Chronic pain Arthritis Substance use STD exposure Injuries Heart palpitations	Family doctor
Sara	43	White	Urban	College	<$15,000	5	0	Physical Sexual	Inability to concentrate Suicide attempt Panic attacks Self-mutilation Eating disorder Strangled to unconsciousness Cold sores	Mental health services Family doctor Emergency
Bethany	21	White (Italian descent)	Urban	College	<20,000	1	0	Sexual Emotional	Depression Exposure to STD	Family doctor Walk-in clinic STD clinic
Tanya	43	Asian Christian	Rural	College	$20,000 - $30,000	7.5	2	Physical Sexual Financial Emotional Mental Social Verbal Using children	Postpartum depression Suicide attempt	Family doctor Emergency Ob/gyn Hospital admission
Glenna	30's	First Nations	Rural	College	<$30,000	12	4	Physical Verbal Emotional	Hepatitis C Substance use Broken ribs	Walk-in clinic Blood specialist
Roberta	48	Caucasian Canadian	Urban	Grade 12	$60,000	8	0	Physical Financial Emotional Mental Social Verbal Pets/property	Victim of attempted murder Broken ribs Arthritis	Family doctor Emergency Walk-in clinic
Sam	50	WASP (Roman Catholic)	Rural and Urban	College	$10,000 – $20,000	3	3	Physical sexual Spiritual Financial Emotional Mental Social Verbal	Substance use Heart condition Unwanted pregnancy Pelvic infection	Respirologist Hospital admission Mental health services Counsellor

								Pets/ property Using children Cultural	Mental health diagnoses (manic depression, schizophrenia) Physical disability Son diagnosed with psychosis	Psychiatrist
Nancy	50's	Irish Immigrant	Rural	University	$40,000	17	5	Verbal Emotional Sexual abuse of children	Depression PTSD	Family doctor
Margaret	40's	Asian Canadian	Urban	University	$60,000	8	2	Emotional Verbal Mental	Enlarged heart Possible internal organ failure Hypertension Severe weight loss Depression Osteoarthritis Concerns about daughter's mental health	Family doctor Psychiatrist Ultrasound services Social worker Counsellor
Angel	61	Caucasian	Urban	Post-graduate	$40,000 - $50,000	33	3	Physical Sexual Spiritual Financial Emotional Mental Social Verbal Pets/property Using children	Osteoporosis Arthritis Fibromyalgia Stroke	Family doctor Mental health services Counsellor Psychiatrist Support groups

Appendix B – Draft Interview Guide

Draft Interview Guide
For Women Who Experienced Abuse Within Their Relationships

[italicized questions added June 21, 2000 after first interview]

Preamble (after informed consent is granted): In our discussion today, I am interested in talking to you about your experiences with the health-care system during the time you were in an abusive relationship. Although the health-care system is not the only place where women in abusive relationships can look for help, because abuse often has serious health consequences, we want to begin to understand how health-care providers can better support women experiencing abuse. Ultimately, this study is to help health-care providers understand how they can help create more effective health-care programs and polices to address violence against women.

The questions I'm going to ask you to think about today have no right or wrong answers, and are just starting points for you to tell your story in your own words. You may want to take a few minutes to think about your responses to questions and that may create some silence. That's OK. I'm comfortable with that and I hope you will be, too. If you'd like, you can always choose not to answer a question. If you're not sure what I mean by a question, please feel free to ask me to clarify. What we are speaking about today may bring up some unpleasant memories. I want you to know that if you need or want to debrief with someone, XXXXX (someone at their respective support service organisation) is available to talk with you. Do you have any questions before we begin?

Interview Questions:

a) Why don't you start by telling me about your relationship?
   Further probing questions:
   - How did you meet?
   - How long were you together?
   - When did you first know that some of his(her) behaviour felt abusive?
   - When did it end, if it has?
   - Women talk about experiencing abuse in many forms, such as physical, emotional, sexual, religious, cultural, social isolation, and financial abuse. Can you tell me about some of the kinds of abuse you experienced? Which aspects of the abuse were the most distressing for you?
   - Did you experience any injuries or health problems as a result of the abuse?

b) What health care did you seek during *(or after)* your relationship (e.g., visits to family doctor, specialists, walk-in clinic, obstetrical care, emergency department)?
   - Did you ever seek health care for the health effects of the abuse?
   - Where did you go for health care? Why?
   - Can you describe a situation where you chose not to seek health care when you thought you needed it?

- How did your relationship affect your ability or willingness to seek health care?

c) How do you think your relationship affected your health and well being?
   - Some women have talked about having sleeping problems, using alcohol or drugs, as well as experiencing depression and stress. Is this part of your experience? What kinds of interactions with health-care workers did you have in relation to these health issues?
   - Women also have talked about the physical injuries. Is this part of your experience? What kinds of interactions with health-care workers did you have in relation to these health issues?
   - We've also heard women describe their experiences with pregnancy complications as a result of the abuse in their relationships. Is this part of your experience? What kinds of interactions with health-care workers did you have in relation to these health issues?

d) I'm trying to get some idea of what distinguishes positive and negative experiences with the health-care system. Thinking back on all the experiences or encounters you had with the health-care system during your abusive relationship, I'd like you to describe what you consider to be the most positive experience you had during that time.
   - Tell me about what happened during this health-care encounter.
   - How would you describe the health-care workers who were involved?
   - Was there discussion about the abuse?
   - How would you describe this discussion?
   - Where you given information, advice, referrals, etc.?
   - How useful were this information, advice, referral, etc.?
   - Did you receive any other kind of response?
   - How useful was it?
   - How did this encounter make you feel?

e) Some women have said that they felt they were treated in certain ways because of the way they dressed, the colour of their skin, the way they spoke, who their partner was or other things like that. Is this part of your experience?

f) Now I'd like to ask you to think about the most negative experience you had with the health-care system during your abusive relationship. In thinking about all the encounters you had with the health-care system, how would you describe the most negative experience during that time?
   - Tell me about what happened during this health-care encounter.
   - How would you describe the health-care workers who were involved?
   - Was there discussion about the abuse?
   - How would you describe this discussion?

- *If there was no discussion, what do you think would have happened if you had told your health-care provider about the abuse? Why didn't you tell?*
- Where you given information, advice, referrals, etc.?
- How useful were this information, advice, referral, etc.?
- How did this encounter make you feel?
- *What do you wish would have happened? What could have made this a positive encounter?*
- Some women have said that they felt they were treated in certain ways because of the way they dressed, the colour of their skin, the way they spoke, who their partner was or other things like that. Is this part of your experience?

g) How would you describe the way your health-care encounter(s) affected your relationship?
  - For better or worse? How?

h) How would you describe the way your health-care encounter(s) affected your health?
  - In the short term? Can you describe some examples of what you mean?
  - In the long term? Can you describe some examples of what you mean?

i) How did your experience(s) affect your expectations of the health-care system?

j) Did your experience(s) affect future decisions to seek health care? How?

k) Given your experiences, how do you think the health-care system can respond better to women experiencing abuse in their relationships?
  - Which health-care providers are in the best position to help women?
  - What needs to be done to help health-care providers understand the issue better?
  - What needs to be done to help health-care providers develop better skills to help and support women?
  - Some people say that there is something wrong with the broader health-care system that prevents health-care workers from becoming more actively involved in addressing the issue of abuse in intimate relationships. Based on your experience, how do you think the health-care system creates barriers that prevent health-care workers from more actively addressing the issue?

l) Is there anything else you want to tell me about our experiences with the health-care system during your abusive relationship?

Thank you for taking time to talk with me about your experiences. Some of the questions may have brought back some unpleasant memories. I want to remind you that if you need or want to debrief with someone, XXXXX (someone at their respective support service organisation) is available to talk with you.

REMEMBER: Give participants their $20 and have them sign for it.

Appendix C – Background Questions

Health-Care Experiences of Women in Abusive Relationships
BACKGROUND QUESTIONS

a) Have you been in an intimate relationship in the last 10 years where you experienced abuse? Yes_____ No______

b) Although abuse cannot be neatly categorized into different 'types', I just want to get a sense of the range of abuse you experienced. Please check all that apply, and feel free to write more in the blank spaces:

☐ Physical
☐ Sexual
☐ Spiritual
☐ Financial
☐ Emotional
☐ Mental
☐ Social
☐ Verbal
☐ Pets/property
☐ Using children against me
☐ Cultural

c) How long were/are you in the relationship, roughly? If there was more than one relationship, please answer the question for each: ___________years/months (___________years/months ___________years/months ___________years/months)

d) What kinds of formal health-care did you seek during your relationship? (It did not need to be specifically for abuse-related health issue)

☐ Family Doctor
☐ Emergency department
☐ Obstetrician/Gynecologist
☐ Abortion clinic
☐ Walk-in clinic
☐ Hospital admission
☐ Mental health services
☐ Counsellor
☐ Psychiatrist
☐ Other ___________

e) How old did you turn on your last birthday? ____________
f) How many children do you have? ____________
g) During your relationship(s), was/is your partner working full-time, part-time, going to school, keeping house, or something else? ______________________
h) During your relationship(s), were/are you working full-time, part-time, going to school, keeping house, or something else? ________________________
i) What was the highest level of education that you completed? ____________
j) What was the highest level of education that your partner completed? ________
k) What was the total income of you and your partner for this past year (or the last year you were together) before deductions and taxes? I don't need an exact amount, just the general category (e.g., less than $10,000; $10,000 - $20,000; etc.) ____________
l) What percentage of this total income did you contribute, roughly? __________
m) Where did you live during the time of your abusive relationship? ___________
n) Is this where you had most of your contact with the health-care system? ______
o) If asked to describe your ethnicity, culture or religion, how would you do so? ____
p) If asked to describe the ethnicity, culture or religion of your partner, how would you do so? ____
q) Is there a name (not your real one) that you'd like me to use if I quote you?____

Appendix D – Consent Form

Appendix E – Additional Input Form

Health-Care Experiences of Women in Abusive Relationships

Lynda Dechief Phone: XXX-XXXX E-mail: XXXXXXX Mailing Address: XXXXXXX Vancouver, BC XXX XXX

Is there anything else you want me to know that you didn't get a chance to say today?

Any thoughts on how the interview went? How could I make it better?

Any thoughts on what we're planning to do with the research? Is there anything you'd like to see us do?

Other comments?

Thank you!