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Understanding the Gendered Nature of Abused Women's Health

by

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Abstract

This qualitative study was an opportunistic exploration of an existing data set. The aim of the study was to explore how women who experienced Intimate Partner Violence for whom the police had been called to the home, spoke about health and the violence and how gender intersected these aspects of their lives. This was a unique sample in that it was not shelter or clinic based. A template approach to analysis with constant comparison was utilized to identify themes and patterns to extend the understanding of the experiences and health perspectives of this group of women. Despite the major negative health impacts of IPV, women felt compelled to keep family intact until the abuse escalated. The data also showed that the intersection of gender and the perpetrator's health also indirectly affected their partner's health.

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Dedication

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Epigraph

Home is where the hurt is.

Anonymous

CHAPTER ONE: BACKGROUND

1.1 Introduction

This project explores the relationship among health, gender and violence in a group of women who have experienced Intimate Partner Violence (IPV). Drawing upon secondary analysis of 36 interviews with abused women, it explores how a group of women who share two experiences, IPV and having the police called to the home, spoke about their health, gender and the violence they experienced.

Intimate partner violence (IPV) is a global health problem that has many serious consequences for women's physical and mental health (Bachman & Saltzman, 1995; Campbell, et al., 2002; World Health Organization, 2002). Longitudinal and cross-sectional investigations of women from domestic violence shelter programs, emergency rooms, and primary health clinic settings consistently demonstrate that intimate partner violence (IPV) places women at risk for health problems (Coker, Smith, Bethea, King, & McKeown, 2000; Sutherland, Bybee & Sullivan, 1998; Tollestrup, et al., 1999). Ranging from emotional abuse to severe physical abuse, IPV affects the welfare of millions of women and their families worldwide, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner (Statistics Canada, 2005; Cohen, & Maclean, 2003; WHO, 2002).

In Canada, it is estimated that 653,000 women encountered some form of violence by a current partner or previous spouse or common-law partner during the five years up to and including 2004 (Statistics Canada, 2005). Owing to the sensitivity of the subject, violence against women is "almost universally underreported" and reported levels should

be thought of “as the tip of the iceberg” (Cherniak, Grant, Mason & Pellezzari, 2005; WHO, 2002; Day, 1995).

Canadian prevalence data about IPV draws from two different national studies that defined violence as ranging from verbal threats to acts of physical violence. The 1993 Violence Against Women Survey, (Statistics Canada, 1993) asked women about experiences of abuse and the context of those experiences, and reported that 25% had been exposed to IPV by their marital or common-law partner. Six years later, the 1999 Canadian General Social Survey on Victimization (Statistics Canada, 1999) asked respondents to consider a single episode of violence experienced either in the previous 12 months or 5 years. This survey estimated that in the five-year period prior to the survey, 8% of women and 7% of men, experienced violence by their intimate partner. Although the number of episodes was approximately the same for men and women, women reported more serious forms of violence and more serious consequences of the violence than did men (Statistics Canada, 2000; Bagshaw & Chung, 2000; Patterson, 2004; Statistics Canada, 2005).

Compared with male victims of IPV, women were more than twice as likely to be injured as male victims, three times more likely to fear for their life, and twice as likely to be the targets of more than 10 violent episodes (Statistics Canada, 2005). The most serious outcome of IPV is female mortality (WHO, 2002; Statistics Canada, 2005).

Earlier studies found that 43% of women injured by their intimate partners required medical attention (Statistics Canada, 1993) and that between one fifth and one third of all women treated in hospital emergency departments present with injuries caused by their partners (American Medical Association, 1992; McLeer & Anwar, 1989). It is known

that abused women use health services at rates higher than do women who have not been abused; including more physician visits, emergency room visits, hospitalizations, and they report poorer overall health (Coker, Remsburg, & McKeown, 1998; Kernic, Wolf, & Holt, 2000; Moeller, Bachmann, & Moeller, 1993)

In addition to the devastating cost to human life, IPV has economic and public resource costs as well. Several studies conducted to estimate the costs of various forms of violence against women, including woman abuse in intimate relationships, found that this problem costs Canadian society an estimated \$4.2 billion per year in social services, education, criminal justice, labour, employment, health and medical costs. Criminal justice costs alone total an estimated \$871,908,582.00 per year (Greaves & Hankivsky, 2005; Day, 2005). Disturbingly, these reported costs may be underestimated as several cost components, including criminal justice costs and the cost of the wide range of physical effects that are indirectly related to abuse such as poor general health status, digestive problems, chronic pain, and reproductive health problems, are often excluded from reports (CDC National Center for Injury Prevention and Control, 2003; Health Canada, 2002; Cory & Ruebsaat, 2003; Ferris, McMain-Klein, & Silver, 1997).

Intimate partner violence has severe and persistent effects on women's physical and mental health that carries with it a huge cost in terms of premature death and disability. Therefore, for the purposes of this study IPV is understood to be man on woman IPV.

1.2 Framing IPV as a Social Problem

Over the last twenty years assault by a spouse changed from being largely a private family matter to being a social problem (Heise, Ellsberg, & Gottmoeller, 2002;

Garcia-Moreno, 1999). In part, this was due to the weight of evidence that indicated IPV had long-term negative consequences for survivors that translated into lower health status, lower quality of life, and higher utilization of health services (Campbell et al., 2002).

Violence against women has been distinguished from other forms of violence as “gender based violence”, (Economic and Social Council, 1992) rooted in gender inequality and the perpetuation of male power and control (United Nations Population Fund, n.d). IPV against women is primarily perpetuated by a male intimate partner and occurs within the confines of the home (Dobash, 1980; Jewkes, 2002).

In 1993 the United National General Assembly adopted a declaration that, for the first time, offered an official United Nations definition of gender-based abuse. This general recognition of the problem has been paralleled in the health sector by a growing number of international institutions, including the WHO, the World Bank, the Royal College of Obstetricians and the British Medical Association, who have commissioned investigations and reports into the health impact of violence against women (Garcia-Moreno, 1999; Jewkes, 2000).

In 1988, Canada launched a four-year Family Violence Initiative (FVI) to address, in part, the health issues related to family violence, including IPV. Since 1996, the FVI has received ongoing funding to achieve its mandate of promoting public awareness, strengthening the ability of the criminal justice and housing systems to respond to the problem, along with supporting data collection, research and evaluation (National Clearinghouse on Family Violence, 2004).

The National Crime Prevention Centre (2000) in Canada suggests that gender-based violence flourishes when societal attitudes, behaviours and institutions uphold traditional male power. Such a power imbalance between men and women leaves women vulnerable to abuse. The fear that many abused women experience (Statistics Canada, 2005) tends to reinforce the gender inequality in Canadian society.

Gender refers to the social definitions and expectations associated with being male or female and the widely held beliefs about what men and women are like. In other words, gender can be understood as behaviour in the context of society and the different roles that men and women perform. These roles are defined by the variety of social and cultural expectations and constraints placed upon them by virtue of their sex and the ways they cope with these societal expectations and constraints (WHO, 2001).

However, gender is more than a characteristic of individuals. It also exists in the larger societal expectations for behavior and in the ways in which men and women are differentially situated within social institutions. For example, the labor market is a gendered social institution. Women and men have different kinds of jobs, they are paid different wages, and they have different amounts of power to change the job market.

The government is also a gendered institution and not surprisingly social policy generated and maintained by governments both reflects and reinforces our gendered world. Families too are gendered social institutions. Women and men experience families differently. They have different roles and responsibilities and they face different problems within families. Women and men also have different opportunities to alter or resist the constraints of families.

Therefore, in order to fully understand the health impact of IPV, we need to understand the gendered nature of abused women's health.

This qualitative study, rooted in the underpinnings of feminist theory, seeks to better understand the experiences of women who have experienced intimate partner violence. Feminist research gives primacy to women's perspectives, experiences and contributions in all stages of research.

Drawing upon secondary analysis of 36 interviews with women who have experienced IPV and for whom the police have been called to the home, it explores the relationship among health, violence and gender from the perspective of the women themselves. By examining the relationship of broadly held gendered notions, this project enhances our understanding of both gender and the health consequences of abuse.

From here the study will present a review of the literature on IPV and women's health, beginning with definitional issues identified in the literature.

1.3 Definitional Issues in the Literature

According to Tjaden and Thoennes (2000), there is currently no consensus on the definition of intimate partner violence (IPV), also referred to as domestic violence (DV), spousal abuse, wife battering, and wife beating. Definitions for these terms vary from study to study, making comparisons difficult (Kilpatrick, 2004; Tjaden, 2004). According to the Report on Family Violence in Canada (Statistics Canada, 2005), IPV includes homicide, sexual assault, aggravated assault, and simple assault perpetrated by a current or former spouse or cohabiting partner. Cohabitation refers to partners who live together at least some of the time as a couple. Same-sex and opposite-sex cohabitants are included in the definition (Statistics Canada, 2005). This was the first year that stalking was

included as a form of IPV in the report. Stalking was defined as repeatedly following another person or repeatedly attempting to contact the person against their wishes causing that person to reasonably fear for their personal safety or the safety of anyone known to them (Statistics Canada, 2005). These definitions appear to be based on legal frameworks of what constitutes IPV in the Canadian criminal code.

In addition to physical assaults, IPV often includes emotionally abusive and controlling behaviors, environmental, social, financial, sexual, religious and (or) spiritual, or ritual abuse.

Within the literature, controversies exist over IPV definitions. There is disagreement over whether or not to limit the definition of IPV to acts carried out with the intention of, or perceived intention of, causing another person physical pain or injury. Although this approach presents a definition of IPV that can be readily operationalized in research, it ignores a multitude of behaviors that individuals may use to control, intimidate, and otherwise dominate another person in the context of an intimate relationship (Tjaden & Thoennes, 2000).

There is also disagreement over limiting the definition of the term to violence occurring between two persons who are married to each other or living together as a couple. This definition would narrow the scope of IPV and exclude persons who are dating or coupled but who live in separate housing (Tjaden & Thoennes, 2000). Few studies have examined violence in same-sex cohabiting or dating relationships (Greenwood, Relf, Huang, & Pollack, et al., 2002).

In response to the lack of consensus within the literature on the definition of IPV, Saltzman, et al. (2002) developed a set of recommendations to promote consistency in the

use of terminology and data collection related to IPV. This document, titled *Intimate Partner Surveillance: Uniform Definitions and Recommended Data Elements*, was published by the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention but is intended for voluntary use by individuals and organizations interested in gathering surveillance data on IPV (Saltzman, Fanslow, McMahon, & Shelley, 2002).

1.4 IPV and Women's Health

This section includes a review of studies that focus on the relationship between IPV and women's health. Though the focus of this paper is IPV it should be noted that researchers have stressed the importance of including all types of violence (e.g. child abuse, rape) when examining the effect of violence on health (McNutt, Carlson, Persaud, & Postmus, 2002; Plichta & Falik, 2001). There is an emerging body of evidence that does such; however, the bulk of the available body of research generally examines violence by type, rather than by overall burden, and therefore is reviewed as such. Studies that were conducted from 1980 to the mid-1990s, reported that the health effects from IPV include death, injury, chronic pain, functional disability, poor general health status, and poor pregnancy outcomes (Plichta, 1992; Bohn & Holz, 1996; Resnick, 1997). Early research also found that abused women have worse communication with their health care providers, and that most health care institutions were unprepared to assist women who had been abused (Bohn & Holz, 1996; Plichta, 1992; Sugg & Iniue, 1992).

Current research points to the complex relationship between IPV and abused women's health. The literature is not clear on how health consequences of abuse can or should be categorized. The following sections represent an attempt to capture the main

themes identified in this review. The sections are not mutually exclusive (e.g., physical injury and chronic back pain) and they tend to follow a biomedical model where body systems are separated, as are mental and physical health. This may occur in part because many of the samples and reports originate in specialty medical clinics. It is recognized by some, however, that the consequences may be immediate and direct (e.g. injury or death), longer term and direct (e.g. disability), indirect (e.g. gastrointestinal disorders) or all three (Plichta, 2004; Campbell et al., 2002). As well, IPV negatively affects the use of health services and patient-provider relationships (Plichta, Duncan, & Plichta, 1996).

1.4.1 Physical Health Consequences of IPV

The most serious outcome of IPV is female mortality. Data from countries such as Canada, Australia, Israel, the US, and South Africa indicate that 40% to 70% of females murdered were killed by intimate male partners, often in the context of an abusive relationship (WHO, 2002). In less industrialized countries the percentages may be higher, although global data on murder of women is sparse. As well as murder, mortality associated with domestic violence includes suicides of women in non-industrialized as well as industrialized societies. In Canada, 82% of all solved spousal homicide victims in the five years prior to 2005 were women and in homicide-suicide cases virtually all (97%) of the murdered spouses were female (Statistics Canada, 2005).

The connection between violence and subsequent physical injury is obvious and well documented (Berrios & Grady, 1991; Bohn & Holz, 1996; Cascardi et al., 1992; Forjuoh, Cohen & Gondolf, 1998; Guth & Pachter, 2000; Hamberger, Ambuel, Marbella & Donze, 1998; Kyriacou et al., 1999; Smith, Mills, & Taliaferro, 2001; Sutherland, Bybee, & Sullivan, 2002; Sutherland et al., 1998). Injuries include fractures,

dislocations, head injuries, open wounds, contusions, crushing injuries, injuries to the nerves and spinal cord, burns and poisoning by a substance.

It is also possible that abuse by a partner could make women vulnerable to injuries caused by other factors (e.g., motor vehicle accidents). Several studies have examined the causes of injury in order to determine potential risk factors. One early conceptualization was the “accident-prone personality,” suggesting that certain personality characteristics and psychological mechanisms are implicated in the occurrence of accidents and subsequent injury (Rodstein, 1974). No set of traits have been found that could constitute this type of personality. A variety of factors have been found including youth, authoritarian parents, extraversion, avoidance as a coping style, sexual conflicts, boredom, anxiety, loneliness and frustration (Marusic, Musek, & Gudjonsson, 2001; Rodstein, 1974). Other than youth, authoritarian parents and extroversion, these characteristics may be evident among abused women. For example, anxiety and frustration are two types of negative affect likely to result from abuse (Campbell, 2002; Ratner, 1993; Resnick, et al., 1997) and to be associated with other health outcomes. If women self-medicate with alcohol or drugs to cope with abuse, they may be more likely to have accidental injuries or sustain traumas.

Thus there are a variety of ways in which abused women may be more susceptible to injury. Obviously, they are at greater risk for direct injuries by a partner than non-abused women. However, they might also be at increased risk through such factors as fatigue and engaging in coping behaviors such as alcohol use; and they may be more accident-prone in general due to conflict in the home. Additionally, psychological variables and negative affect appear to play a role as well. Since abused women often

report psychological distress and subsequent symptoms, it is possible that they are at increased risk of sustaining injuries.

The association between migraine headaches and partner violence has been found in different settings including battered women's shelters (Campbell, Miller, Cardwell, Belknap, 1994), hospitals (Caralis & Musialowski, 1997), specialty medical clinics (Diaz-Olavarrieta, Campbell, Garcia de la Cadena, Paz, & Villa, 1999) and among HMO enrollees (Campbell, Jones et al., 2002). These findings support the assertion that chronic headaches could be a problem for abused women (Caralis & Musialowski, 1997). However, it may not be as pervasive as would be expected. For example, only 12.5% of women in a domestic violence shelter reported chronic headaches (Campbell et al., 1994). The characteristics of headaches may also differ. Domino and Haber (1987) studied individuals who had experienced chronic headaches for at least six months. Abused women had more pain than non-abused women, with 62% of the abused group reporting more constant headaches compared to 33% of the non-abused group. Thus, not only do abused women experience more headaches, their headaches appear to be more severe.

This is one of the few categories where researchers have distinguished types of abuse by women's partners. Coker, Smith, Bethea, et al. (2000) found that psychological abuse was associated with an increased risk for developing migraines and frequent headaches. Green, Flowe-Valencia, Rosenblum, and Tait (1999) studied female patients at a multidisciplinary pain center. Women who sustained both physical and sexual abuse were more likely to report head pain than those reporting either type of abuse alone. Thus, different types of abuse may have different health consequences. Clearly, abused

women are more at risk for developing these types of diseases, particularly migraines and chronic headaches than nonabused women, but an association of abuse for other types of diseases in this category is less clear. Stress appears to play a role in pain perception (Melzack, 1999), which may help explain why abused women report more pain.

Direct trauma from an act of violence by a partner could result in a back injury causing permanent changes to the vertebrae and, ultimately, chronic back pain. Repeated violence could make women more susceptible to chronic back and joint disorders. Direct physical injury to joints, neck and back may develop into an arthritic condition.

Additionally, the onset and course of arthritis is often associated with stress (Hermann, Scholmerich, & Straub, 2000; Zautra, Hamilton, Potter, & Smith, 1999). Musculoskeletal and connective tissue disorders have been associated with different types of abuse.

Psychological abuse has been associated with an increased risk of developing chronic neck or back pain as well as arthritis (Coker, Smith, McKeown, et al., 2000). In a study of women in domestic violence shelters, the most common chronic physical symptom reported was a problem with the back or neck (Campbell et al., 1994). Women who were sexually or physically abused reported more than twice the severity of musculoskeletal pain (Drossman, Lesserman, Li, Nachman, & Gluck., 1990) than those women without this history. A population based study found that of the women who reported both partner violence and having a serious health problem, the majority (59.7%) had back or neck problems or a bone or joint injury (Hathaway, Mucci, & Silverman, 2000). In a study of women with chronic temporomandibular disorder, patients reporting violence had more pain than those with a history of either sexual abuse or no abuse (Campbell, Riley, Kashikar-Zuck, Gremillion, & Robinson, 2000). Abused women are therefore at risk for

these disorders due to direct trauma, stress, or a combination of factors related to their partner's abuse.

Research for both men and women has repeatedly shown a relationship between cardiovascular disease and stress (Greenwood, Muir, Packham, & Madeley, 1996; Krantz & McCeney, 2002; Krantz, Sheps, Carney, & Natelson, 2000; Pickering, 2001; Williams & Littman, 1996; Arnold, 1997; Brezinka & Kittel, 1996; Fleury, Keller, & Murdaugh, 2000). Cardiac problems, such as hypertension and chest pain, have been found in battered women (Koss & Heslet, 1992; Letourneau, Holmes, & Chasedunn-Roark, 1999).

More recently, research has shown an association between heart disease and negative affect (Kubzansky & Kawachi, 2000; Lane, Carroll, & Lip, 1999; Rozanski, Blumenthal, & Kaplan, 1999). Thus, stress and the negative affect resulting from abuse may make abused women at risk for these diseases. Elliott (1995) and Fleury et al. (2000) suggested the relationship of stress to coronary disease may depend on the way that women perceive their life situation and the meaning placed on it. Specifically, research has shown that women's stress results not from the amount or number of roles and commitments they have but from satisfaction or disadvantages associated with these roles (Elliott, 1995; Fleury, et al., 2000). Although women's interpretation of their partners' violence is beyond the scope of this paper, it is not difficult to believe they would interpret their role in the relationship as a disadvantage, resulting in negative perceptions and, consequently, increased stress. Moreover, the negative affect likely to result from living with an abusive man could increase the likelihood of abused women perceiving relationship events, and, perhaps, other life events, in a negative way. As psychological, physical and sexual abuses are likely interpreted differently, they may have different

effects on the development of coronary disease. Coker, Smith, Bethea, King, and McKeown (2000) showed an association for physical violence and/or sexual aggression with angina and other heart or circulatory problems. Psychological abuse had no association. Although this is a single study, the results suggest different associations for different types of abuse on cardiovascular health. One study used a population of exclusively Mexican American women and found that heart attack or heart problems were more common in women reporting partner abuse in the past 12 months than those who had not experienced abuse (Lown & Vega, 2001).

The association of gastrointestinal disorders with intimate partner violence has been well documented (Bohn & Holz, 1996; Campbell, Jones et al., 2002; Drossman, Li, Leserman, Toomey, & Hu, 1996; Drossman, Talley, Leserman, Olden, & Barreiro, 1995; Talley, Fett, Zinsmeister, & Melton, 1994). Somatic complaints of a gastrointestinal nature, including vomiting, diarrhea, constipation, irritable bowel syndrome, and spastic colon are among the most frequent presentations for women who sustain partner violence (Bohn & Holz, 1996; Naumann, Langford, Torres, Campbell, & Glass, 1999). Indeed, in a focus group of family practice physicians, irritable bowel and nonspecific complaints were identified as risk markers suggesting the presence of partner abuse (Brown, Lent, & Sas, 1993). In addition, there is some evidence that different types of abuse may be associated with different types of gastrointestinal disorders. For example, women who experienced psychological abuse were at risk for developing stomach ulcers, spastic colon, frequent indigestion, constipation and/or diarrhea (Coker, Smith, Bethea, et al., 2000). Ulcers were found to occur more frequently among battered women than in the general population of women under the age of 45 (Bassuk, Weinreb, Buckner, Browne,

Salomon, et al., 1996). In a study by Coker et al. (2002), gastroesophageal reflux was associated with physical violence. Women who sustain partner violence have more functional gastrointestinal disorders (e.g., irritable bowel, dyspepsia); whereas, other women present with organic (e.g., ulcerative colitis, Chron's disease) gastrointestinal disorders (Drossman et al., 1990; Drossman et al., 1996). Moreover, functional disorders were associated with more severe life threatening violence.

Certain types of functional gastrointestinal disorders have been associated with sexual aggression. Leroi and colleagues (1995) found that females with functional lower gastrointestinal tract disorders, such as constipation, diarrhea or pelvic-floor dysynergia, were more likely to have been sexually abused than were women with functional upper gastrointestinal tract disorders. Similarly, Talley et al. (1994) found that sexually abused women were 2.8 times more likely to have a functional bowel disorder than those without this history. A 1.9 odds ratio for irritable bowel syndrome and a 1.9 odds ratio for functional dyspepsia among women reporting sexual abuse were found. Thus the research supports the association between abuse and gastrointestinal disease. While several different factors are involved in this association, it appears that different types of abuse affect gastrointestinal disease outcomes in different ways.

The unique impact of gender on health in women who suffer IPV from their male partners is translated to problems in pregnancy, birth outcomes and infant health; elective abortion, inconsistent contraceptive use, and gynaecological symptoms and diagnoses, and sexually transmitted diseases (Campbell, Moracco, Saltzman, 2000; Jewkes, 2000; Leung, Leung, Chan, 2002; McFarlane, & Soeken, 1999).

A great deal of research has shown an association between birth outcomes (e.g., low birthweight) and partner violence (Amaro, Fried, Cabral, & Zuckerman, 1990; Bullock, McFarlane, Bateman, & Miller, 1989; Campbell, Poland, Waller, & Ager, 1992; McFarlane, Parker, & Soeken, 1996; Parker, McFarlane, Soeken, Torres, & Campbell, 1993). Partner violence could result in various pregnancy complications due to direct physical trauma to the abdomen. In addition, maintaining healthy behaviors can be compromised by partner abuse and result in pregnancy complications. According to one study, violence during pregnancy may occur more often than pregnancy complications including pre-eclampsia, gestational diabetes or placenta previa (Gazmararian et al., 1996). McFarlane, Parker, and Soeken (1992) found that women who sustained physical and/or sexual abuse were almost twice as likely as others to wait until the third trimester to begin prenatal care. They may also be more likely to use alcohol and drugs during pregnancy (Amaro et al., 1990). Substance abuse (cigarettes or alcohol) prior to pregnancy and during the last trimester has been associated with partner violence (Cokkinides & Coker, 1998). Thus, abused women may engage in high risk behaviors, including little attention to preventative care during pregnancy. Pregnancy complications have been associated with sustaining domestic violence. In one study 91% of women believed that miscarriage is associated with domestic violence (Caralis & Musialowski, 1997), which may be accurate (Ambuel, Hamberger, & Lahti, 1996). Consequences of direct trauma include placental abruption, preterm labor and delivery, vaginal bleeding, and direct injury to the fetus (Goodwin & Breen, 1990; Stewart & Anthony, 1993). Saltzman (1990) found that violence by partners resulted in placental separation, antepartum hemorrhage, preterm labor and rupture of the uterus, liver or spleen. Abused

women, therefore, are susceptible to pregnancy and labor complications from physical trauma as well as risky behavior that may be caused by the stress or negative affect resulting from abuse.

Victims of partner violence are more likely to have been diagnosed with Sexually Transmitted Diseases (STDs) than non-abused women (Bauer, Gibson, Hernandez, Kent, Klausner & Bolan, 2002; Brokaw et al., 2002; Campbell, Jones et al., 2002; Plichta & Abraham, 1996; Plichta, 1992; Wingood & DiClemente, 1997). Eby, Campbell, Sullivan, and Davidson (1995) found that 67% of battered women did not use protection during intercourse either because the sex was coerced or their partner insisted on unprotected sex. The combination of violence and sexual aggression may increase women's risk over that of either type of abuse alone. Martin et al. (1999) found that women who reported both physical and sexual abuse were significantly more likely to have had a STD than those without this history. Women in battered women's shelters who sustained both types of abuse were three times more likely than those who only sustained physical violence to report having had one STD and 5.6 times as likely to report multiple STDs during their relationship (Wingood, DiClemente, & Raj, 2000). Human immunodeficiency virus (HIV), the cause of AIDS, can be transmitted to women through unprotected sex. Adolescent and adult women now comprise 23% of all AIDS cases in the United States, an increase from 7% in 1985 (Brady, Gallagher, Berger, & Vega, 2002). Research shows that determining whether HIV is causally related to violence has been difficult (Koenig & Moore, 2000).

Although direct disease transmission from an infected partner can happen regardless of whether or not violence occurs in the relationship, women who experience

domestic violence may lack the resources to properly protect themselves. Women who are not given choices in a relationship would more likely be at risk for disease transmission because their partners may not allow them to decide whether or not to use protection or to say no to a sexual act.

The disorders that comprise this category of diseases include kidney and bladder infections, inflammatory diseases of the pelvic organs (e.g., pelvic inflammatory disease (PID) and disorders of the female genital tract. According to Campbell (2002) the largest difference between abused and non-abused women is found in this category. She suggests that forced sex results in vaginal, anal or urethral trauma that can lead to a higher number of microorganisms entering the bloodstream or an increased likelihood of bacteria entering the urethra. Also, the stress of having a violent partner may depress the immune system making women more susceptible to invasion of microorganisms, thereby resulting in bladder and kidney infection (Campbell, 2002).

Research has shown physical abuse was associated with frequent bladder or kidney infections (Coker, Smith, McKeown, et al., 2000; Plichta & Abraham, 1996). Studies of sexually abused women in battered women's shelters found that dysmenorrhea (Campbell & Alford, 1989) and unexplained vaginal bleeding (Hamberger, Saunders, & Hovey, 1993) are commonly reported. Severe menstrual problems were found in one quarter of the women who had experienced partner violence in the past year (Plichta & Abraham, 1996). In the same study, Plichta and Abraham (1996) found that partner abuse tripled the odds of a woman receiving a diagnosis of a gynecological problem. Drossman et al. (1990) found that women who experienced either sexual or physical violence reported four times more pelvic pain than those without abuse. Campbell, Jones et al.

(2002) found that women who reported sexual abuse by partners, whether or not they reported physical abuse, had a greater percentage (30%) of having three or more gynecological problems than those women who reported only physical abuse (8%) or those women who reported no abuse (6%).

Schei (1991) found that PID was more prevalent among women who sustained partner violence (58%) than age-matched controls (12%). In a 15 year study of 420 admissions to an emergency department, 48 battered women presented for unspecified gynecological disorders compared to 24 non-battered women (Bergman & Brismar, 1991). This was a statistically significant difference.

Therefore, women who sustain partner abuse are at risk for gynecological problems due to physical factors, such as sexual trauma, as well as psychological factors producing increased pain sensation and reduced ability of the immune system to defend itself from disease development.

1.4.2 Mental Health Consequences of IPV

The mental health consequences of violence against women are widely discussed. For example, sexual and/or physical assaults have been associated repeatedly with increased anxiety (Gleason, 1993; Kemp, Green, Hovanitz, & Rawlings, 1995), depression (Campbell, Sullivan, & Davidson, 1995; Gleason, 1993; Orava, McLeod, & Sharpe, 1996; Plichta & Weisman, 1995), cognitive disturbance such as hopelessness and low self-esteem (Janoff-Bullman, 1992), posttraumatic stress (Astin, Lawrence, & Foy, 1993; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Kilpatrick & Resnick, 1993), dissociation (Briere, Woo, McRae, Foltz, & Sitzman, 1997), somatization (Ullman & Brecklin, 2003), sexual problems (Briere, Elliott, Harris, & Cotman, 1995), substance

abuse (Epstein, Saunders, Kilpatrick, & Resnick, 1998; Kilpatrick, Acierno, Saunders, Resnick, & Best, 2000; Martin, Kilgallen, Dee, Dawson, & Campbell, 1998), and suicidality (Golding, 1999; Thompson, Kaslow, & Kingree, 2002; Ullman & Brecklin, 2002). Similar findings have been reported for victims of stalking (Davis, Coker, & Sanderson, 2002; Pathé & Mullen, 1997; Mechanic, 2002), partner psychological maltreatment (Migeot & Lester, 1996; Vitanza, Vogel & Marshall, 1995), and in women who have experienced sexual torture (Arcel, 2002).

Campbell (2002) reviewed the mental health effects of being in violent relationships, concluding that depression and Post-traumatic Stress Disorder (PTSD) are among the most prevalent consequences for victims of IPV. In addition to depression and PTSD, Sutherland, Bybee and Sullivan (2002) found in a community sample of 397 women, half of whom had been assaulted by an intimate partner within the prior six months, other mental health consequences including stress, anxiety, and substance addiction. In addition, Roberts, Lawrence, Williams and Raphael (1998) found in their study of 335 women that those who reported intimate abuse received significantly more diagnoses of depression, dysthymia, generalized anxiety and phobias.

Although depression, PTSD, and anxiety have been found to be common mental health consequences of IPV, it can also be argued that some battered women may have preexisting mental health issues that are exacerbated by the stress of a violent relationship. For example, depression in battered women is also associated with other life stressors that are often highly correlated with IPV including daily stressors that are often highly correlated with IPV including daily stressors such as multiple children, marital discord, change in residence and child behavior problems (Street, King, King & Riggs,

2003). A history of child sexual abuse (CSA) is also highly correlated with IPV and related to devastating mental health effects including PTSD, depression and anxiety (Dilillo, Giuffre, Tremblay & Peterson, 2001; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Wyatt, 1990; Wyatt, Axelrod, Chin, Carmona & Loeb, 2000; Wyatt, et al., 2002). It could be that life stressors linked to IPV and not IPV, in and of itself, result in declined health.

Golding (1999) conducted a meta-analysis to assess the onset of mental health conditions in relationship to IPV. Specifically, she reviewed published literature on battering as a risk factor for depression, suicidality, PTSD, alcohol abuse/dependence, and drug use or dependence. The meta-analysis evaluated consistency with regard to time, place and circumstance across multiple studies, and the extent to which the IPV/mental health disorders were consistent with the disorder occurring after the violence. Golding determined that IPV caused a mental disorder only if the disorder occurred after the violence. She concluded that although most research has not addressed many criteria for causal inferences, the existing research is consistent with the hypothesis that IPV increases risk for mental health problems.

Street, King, King and Riggs (2003) attempted to understand the nature of the psychological distress and the cognitive perceptions that increase risk for victim depression. They investigated the association among partner violence, a married woman's psychological distress and children's behavior problems. They found that while a direct relationship between married women's experiences and their psychological distress was found, the direct relationship was small and not substantive. The association between violence and wife's psychological distress flowed indirectly through an intermediary

variable-wife's perspective on family functioning. In the model, wife's perspective on family functioning was influenced by both the presence of male violence in the relationship and by her husband's perspective on the functioning of the family.

To conclude, women with experiences of IPV are likely to suffer from an array of mental health problems. The associated physical and mental health consequences of IPV are important findings. However, most studies have not fully addressed the length or extent of these physical and mental health illnesses (Sutherland, Bybee & Sullivan, 2002). There is also much debate about whether health conditions can be directly attributed to IPV. Some argue that certain women may be biologically pre-disposed to some of these health conditions, while other women may have life stressors that account for these health consequences. In addition, Campbell and Soeken (1999) report that many of the physical health studies on women in violent relationships are cross-sectional and may be the result of interactions of other lifestyle and high risk behaviors. These researchers argued that lifestyle choices may account for some of these conditions; therefore, more culturally competent longitudinal research should be conducted to further investigate the extent of these physical health problems (Campbell, 2002).

1.4.3 Nonspecific Medical Conditions

Women in violent relationships appear to experience more nonspecific medical conditions than other women (Ambuel et al., 1996; Bergman & Brismar, 1991; Lown & Vega, 2001; Sutherland, Bybee & Sullivan, 2002). Somatic symptoms, including sleep difficulty, muscle tension, nonmigraine headaches, hyperventilation and choking sensations are common to women who experience abuse (Bohn & Holz, 1996). Chronic uncharacterized pain syndromes and stress related symptoms have been identified as

potential indicators of intimate partner violence (Massey, 1999). Among those in battered women shelters, Jaffe, Wolfe, Wilson, and Zak (1986) found more nonspecific somatic complaints than a control group of nonabused women. Women in group therapy for partner violence reported that physical symptoms, such as non-migraine headaches, unidentified chest pain, and weight gain or loss began or increased in severity when they sustained abuse (McCauley et al., 1998). Further, approximately one third of these women reported that medical problems improved when they left their partner or talked with a health care provider about the abuse. The most common health problem reported by women in violent relationships was chronic pain (33%), followed by 10% reporting faintness, dizziness and anxiety (Cascardi, Langhinrichsen, & Vivian, 1992).

This category of unspecified diseases has been associated with violence not only by women who report abuse, but also by physicians. Vague health conditions may be reported more frequently due to the psychological stress of abuse causing subsequent heightened anxiety and misinterpretation of this anxiety as physical illness.

1.4.4 Limitations of Previous Research

There are several methodological and conceptual limitations in the published research on health consequences of partner violence. Many of these problems involve setting or sample, operational definitions and measurement of abuse. Studies have utilized a variety of settings to collect data, including emergency rooms, battered women's shelters, specialty medical clinics and community or insurance based populations, with each providing advantages and limitations. Hospital emergency departments have been the site for many studies primarily focusing on physical injury and trauma outcomes of partner violence. These studies have excluded women who

present with other types of health consequences (McLeer & Anwar, 1989; Stark & Flitcraft, 1985). A more serious problem with these studies is determining whether or not women have sustained partner violence. The inadequacy of identification of battered women in health care settings has been repeatedly addressed in the medical literature (Campbell & Lewandowski, 1997; Campbell et al., 1994; Guth & Pachter, 2000; McLeer & Anwar, 1989; McLeer, Anwar, Herman, & Maquiling, 1989; Stark & Flitcraft, 1985). Thus, samples drawn from ER or chart reviews are likely biased, missing many women in violent relationships.

Another site for such studies is battered women's shelters or other services for battered women. Studies with these samples represent only the small population of abused women; that is those who actually utilize these services (Pape & Arias, 2000; Straube & Barbour, 1988). As few women use shelters, the results of studies with these samples are unlikely to reflect the experiences of most abused women.

Utilizing specialty medical clinics, such as obstetrics/gynecology or gastroenterology clinics also present sampling problems. Primarily, women present to these clinics with one specific symptom or disease. Therefore, the health outcomes examined in these studies are biased toward the specialty of the clinic. Other health outcomes are ignored. As with emergency room settings, most physicians, regardless of specialty, do not routinely screen patients for abuse (Loring & Smith, 1994; McCauley et al., 1995; Sugg & Inui, 1992). Further, the results of such studies may be generalized only to other women who attend those types of specialty clinics. For example, a study of irritable bowel syndrome patients and domestic abuse conducted in a gastrointestinal

specialty clinic may not generalize to other women who do not attend such clinics but have this disorder.

Psychological, physical violence and sexual aggression potentially may have different health consequences. However, the majority of studies do not distinguish psychological abuse, threats, physical violence or sexual aggression. Some of the more commonly utilized measures of abuse combine threats of violence with actual acts of violence and with sexual aggression (Straus, 1979). Using measures of abuse that do not distinguish type of abuse is problematic when attempting to make associations between types of abuse and health outcomes. Only a few recent studies have made these distinctions (Coker et al., 2002; Coker, Sanderson et al., 2000; Coker, Smith et al., 2000; Sutherland et al., 2002).

As well, abused women suffer more pain, trauma, depression, anxiety, chronic pain, substance abuse, eating disorders, chronic stress-related health related problems, and suicidal thoughts (Bergman, Brismar, 1991; Brokaw et al., 2002; Campbell, et al., 2002; Sutherland, Bybee, Sullivan, 2002; Krug, Mercy, Dahlberg, Zwi, 2002). Families suffer marital disruption and less satisfying and responsive marital and parental relationships (Straus & Gelles, 1990).

1.4.5 Overview

Current research about the health consequences of abuse suggest that: the influence of abuse can persist long after the abuse itself has stopped (Felitti, et al., 1998); the more severe the abuse, the greater its impact on a woman's physical and mental health (Leserman, Drossman, Toomey, Nachman, & Glogau, 1996); and, the impact over time of different types of abuse and of multiple episodes of abuse appears to be

cumulative (McCauley, et al., 1995; Koss, Koss, & Woodruff, 1991; Walker, et al., 1999; Feletti et al., 1998).

Analysis of the relations between partner abuse, health status, and use of medical care in women in population-based and clinical studies has shown poorer overall mental and physical health, more injuries, and more consumption of medical care including prescriptions and admissions to hospital in abused than non-abused women (Campbell et al., 2002; Tollestrup et al., 1999; Wisner, Gilmer, Saltzman, Zink, 1999).

1.4.6 Conclusion

In spite of the growing recognition of the health consequences in women who experience IPV, there is still a lack of understanding of the magnitude and the nature of the problem because current knowledge is based primarily on women who report violence to authorities or who seek services (Crowell, & Burgess, 1996; WHO, 2002; Campbell, 2002). Health care providers can play a crucial role in detecting, referring and caring for women living with violence, but only a small percentage of battered women are identified by physicians when seeking health care (Bachman & Saltzman, 1995; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Jewkes, 2000). Very little is known about those women who do not seek help from public agencies.

We know that IPV negatively impacts women's physical and mental health. Although the literature provides insight into the common health consequences of IPV, there are still many questions to be answered. Statistics, while meaningful, don't provide the depth to understand the different contexts, meanings and consequences for women who have experienced IPV. We can learn more from listening to the voices of experience.

Chapter Two provides a detailed description of the methodology used for this study; definitions and terms, the research design and methods.

CHAPTER TWO: METHODS

This study utilizes secondary analysis of previously collected interviews with abused women, for whom police were called to the home, to explore the relationship among health, gender and violence. The original study was designed to elicit information about justice and community responses to intimate partner violence.

This chapter begins with an overview of the original study. It then moves to the purpose of the current study, defines the terms used, and then details the methods used in this project.

2.1 RESOLVE Study

The data used for this research project was a sub-set of data from a prior study conducted by the Research and Education for Solutions to Violence and Abuse (RESOLVE) institute. All participants were part of a Community-University Research Alliance (CURA) study conducted by the RESOLVE institute. RESOLVE is a tri-provincial prairie research institute on family violence and abuse with offices in Alberta, Saskatchewan and Manitoba. The aim of RESOLVE's study was to assess the efficacy of a variety of law enforcement, justice and community responses to intimate partner violence.

The Calgary data from the RESOLVE study was used for this research project to further analyze what could be learned about health, gender and violence from these women as they shared their challenges and successes in living with IPV. This is a unique sample in that virtually all samples in the literature are clinic or shelter based.

The RESOLVE study is briefly described in order to understand why my focus was only on the methods used to analyze the data and ensure the quality of the interpretation.

The RESOLVE study used purposive sampling (Morse & Richards, 2002) to select women from five major centres in the prairie provinces. In Calgary, women were contacted by Homefront staff to invite them to participate in an interview of women's views of different aspects of the justice system. They were given a full explanation of the study once they contacted the interviewer. The sample consisted of 102 women from the five major centres.

A qualitative approach utilizing a semi-structured interview guide was designed to elicit the participant's personal experiences about the nature of the abuse and their justice system involvement. Interviews were conducted by research assistants who arranged a convenient time and place for the women. Every effort was made to ensure safety and confidentiality when arranging and conducting interviews. Women gave verbal consent after reading through an information sheet. Interviews were tape-recorded and transcribed, or written down if the woman preferred. Data collection included: demographic characteristics, nature of the abuse, and justice system involvement (see Appendix A).

The semi-structured interviews were transcribed verbatim and read into AtlasTi to assist in management and organizations of the data (Morse & Richards, 2002). Initial coding to identify parts of the transcripts relevant to other research projects had been carried out by the primary and co-investigators. In analyzing the data, the primary researchers realized that there was much to be learned about health, gender and violence.

To follow-up on this, the Calgary data, a sub-set from the RESOLVE study, was used in the current study to further analyze what could be learned about health, gender and violence from these survivors.

2.2 Purpose of Current Study

The purpose of this qualitative research project was to explore how a group of women who share two experiences, Intimate Partner Violence (IPV) and having the police called to the home, spoke about health, gender and the violence they experienced. This is a unique sample in that virtually all samples in the literature are clinic or shelter based.

2.3 Research Question

This research was guided by the following research question: What is the intersection of gender, health and violence in women?

2.4 Definitions and Terms

Health Canada's definition of IPV was chosen because it implies all forms of abuse and violence. The other terms were chosen for their simplicity and clarity of meaning.

Intimate Partner Violence (IPV) is defined as a pattern of assaultive and coercive behaviours used against a woman that involves her intimate partner in a current or former dating, married, or cohabiting relationship; the repeated use (sometimes daily) of many different abusive tactics that, without intervention, may increase in frequency and severity over time; a combination of physical violence and psychological attacks and other controlling behaviours that create fear and compliance and inflict harm; patterned

behaviours aimed at controlling her and making her obey the abuser; and her increasing entrapment and isolation (Health Canada, 1999).

Victim refers to a female intimate partner who is the target of violence or abuse (Saltzman et al., 2002).

Survivor is a term often applied to those who have experienced intimate partner violence because it is a more empowering term (Saltzman et al., 2002). Victim and survivor will be used interchangeably in this paper.

Perpetrator refers to a male intimate partner who inflicts the violence or abuse or causes the violence or abuse to be inflicted on the victim (Saltzman et al., 2002).

Violence and abuse are used interchangeably in this paper.

2.5 Research Design and Methods

2.5.1 Design

The epistemological approach to this study, its design and the methods used were guided by the constructivist-interpretive paradigm of inquiry (Lincoln & Guba, 1985; Denzin & Lincoln, 1994). Constructivism, in this sense, is understood to mean that what is unique (in people, events, institutions) is at least as important as what one can generalize about them (Denzin & Lincoln, 1994).

A qualitative research design, using a focused ethnographic approach (Morse & Richards, 2002), rooted in feminist underpinnings, with a template approach to data analysis (Crabtree & Miller, 1992) was utilized to explore the experiences of abused women for whom the police have been called to the home. Focused ethnography differs from traditional ethnography in that the topic is specific and identified before the study commences. It can focus on a loosely connected group of people (e.g., women who have

experienced IPV) that share particular characteristics or conditions completely different from the researcher (Morse & Richards, 2002). This form of ethnography still enables the assumption of shared culture to be met even though the participants may not know each other because they share common experiences. Data may consist only of interviews in focused ethnography (Morse & Richards, 2002, p.53).

2.6 Methods

2.6.1 Secondary Analysis

Secondary data analysis, while common in quantitative analysis, is much rarer in qualitative studies. Despite its infrequency, this methodology is gaining some favour in the health sciences literature (e.g., Corti et al., 1995; Heaton, 1998; Hinds et al., 1997; Thorne, 1998; Santacroce et al., 2000).

Hinds et al. (1997) identified four approaches to the use of secondary analysis with qualitative data: using a different unit of analysis to guide re-analysis, using the sample to extract a subset of cases for more focused study of the original subject matter, re-analysis concerned with exploring a concept present but unexplored in prior analysis, and using the dataset as a basis for the refinement of data collection. Both of the examples above illustrate these points. Miller (1998) drew sub-samples from a larger existing dataset to conduct a more focused study of gender differences in the enactment of armed street robbery. The original analysis of the data (Wright & Decker, 1997) neither thoroughly attended to these differences nor drew upon existing feminist models to explain the findings. Thus, Miller's work illustrates the potential of secondary analysis to expand and enhance existing interpretations of qualitative data and apply new theoretical questions and interpretations to existing data sets.

Any form of secondary analysis, be it qualitative or quantitative, presents challenges, some advantageous, some disadvantageous. In general, one advantage of secondary analysis is the reduction of human and financial costs. Data is expensive and time consuming to collect and prepare for analysis. Further, similar to quantitative data well-collected qualitative datasets should contain a wealth of information that goes unexplored in initial analyses. Reanalyzing datasets adds additional value to rather expensive research endeavours.

2.6.2 Data Analysis

The pre-existing data set was generated from in-depth interviews that were semi-structured and exploratory (Appendix A). The open-ended questions designed for the semi-structured interview allowed the participants to provide rich descriptions of their experiences with IPV (Morse & Richards, 2002 p. 94). The semi-structured interviews were analyzed using template analysis (Crabtree & Miller, 1992) from a feminist perspective.

Of the 41 original transcripts, the final sample consisted of 36. Five transcripts were not analyzed due to obvious audio recording difficulties that were apparent from reading the interviews. Qualitative data analysis software AtlasTi© was used for data management purposes.

The first step in the analysis of the data was to begin reading a sub-set of the transcripts without making notes or considering an interpretation. The sub-set of transcripts was read through a second time to become familiar with the text and to identify and attribute codes to any segments of the data that appeared to be relevant to the research question (Crabtree & Miller, 1992). At this point a meeting was set with my

supervisor to discuss the identified codes, to agree on the coding and to code a few of the transcripts together to check for the utility and appropriateness of the codes.

Categories were defined to include the relevant material (codes) and were organized into an initial template. The initial template covered the main thematic areas emerging from the preliminary analysis. After the initial coding was completed, we met several times to review the progress of the analysis and to discuss any new themes that were identified in the data. Constant comparison (Crabtree & Miller, 1992) was used throughout the analysis to identify additional codes or themes. This allowed modification to the initial template in light of careful consideration of each transcript. Each transcript was analyzed multiple times. Once a final version of the template was defined and all transcripts had been coded, the template was used as the basis for the write-up of the findings.

The template provides a guide to identify meaningful units, or themes, in the text. Each semi-structured interview was transcribed and read through by the researcher. This process is known as coding, and it involves dissecting and labelling data into meaningful parts. Codes were assigned to phrases, sentences and whole paragraphs. Coding and re-coding continued until the data had been saturated, i.e. all the data could be readily classified (Miles & Huberman, 1994). The researcher reviewed the codes and selected quotations to ensure that the data reflected the categories elicited.

2.6.3 Ethics

The original project for which this data was collected was approved by the Conjoint Faculties Research Ethics Board (please see letter, Appendix B and Annual Progress Report, P. 1, Appendix I). Dr. Tutty is Principal Investigator (PI) and Drs.

Meadows, Sethi and Thurston are co-investigators on the study. Each participant signed and was given a copy of a letter of informed consent (Appendix C). Each participant was given a code that was maintained by the PI. The original transcripts and tapes were stored in a secure location by Dr. Tutty and will be kept for seven years. Identifiers had been removed from the transcripts that were used in the analysis for this study. Care was taken in reporting the results so that no participant can be identified in quotations or descriptions of the data. As 'secondary analyst' the candidate is "bound by the same confidentiality and privacy restrictions as the primary analysts" (Burstein, 1978, p. 12).

The highly sensitive nature of this study required that the anonymity of the participant source be imperative. The anonymity and safety of the participants has been fully protected. The identity of the interviewee's transcript was assigned a code and the names were kept separate and are known only by the PI. All data for this project, including transcripts were kept in a secure environment. Computer files are password protected. The investigator of the study is responsible for the security of the data.

2.6.4 Rigor

Due to the subjective nature of qualitative research, the usual quantitative terms of validity and reliability are not applicable (Creswell, 1998; Lincoln & Guba, 1985; Miles & Huberman, 1994; Bryman, 2001). Rather, the term trustworthiness is utilized to represent qualitative research authenticity. Trustworthiness is measured in four ways (Lincoln & Guba, 1985; Morse & Richards, 2002); credibility, transferability, dependability, and confirmability.

2.6.4.1 Credibility

Credibility is comparable to quantitative research's internal validity (Miles & Huberman, 1994; Bryman, 2001). Creswell (1998) describes credibility as the extent to which others can replicate the study. For research to be credible, participants' experiences must be accurately described so that the depth and complexities of their description reflect validity (Marshall & Rossman, 1995). This study attempted to enhance credibility by asking one of the original researchers to validate the findings. In addition, several members of the research centre where I work were asked to review the findings and agreed that the findings made sense for the subject area, thereby increasing the credibility or truthfulness of the findings (Creswell, 1994).

2.6.4.2 Transferability

Transferability relates to external validity in quantitative research. It refers to the generalizability of the research findings to other populations and contexts (Lincoln & Guba, 1985, Miles & Huberman, 1994). The use of participant quotations and the rich, thick descriptions allowed the study to reflect whether the results can be transferred to other settings. The use of rich, thick, descriptive quotations also supported the findings of emerging themes (Creswell, 1998).

2.6.4.3 Dependability

Dependability accounts for any changes in the conditions and design through the use of accurate documentation during the data collection process. This study enhanced dependability through the process of reading the transcripts multiple times. An audit trail of emerging concepts was maintained through systematic and detailed recording to establish dependability. A personal journal to assess reflexivity was used to document

personal biases, thoughts and feelings that may have influenced the study, and methodologic memos were used to record the use of method throughout the research process (Morse & Richards, 2002).

2.6.4.4 Confirmability

In confirmability, the study's findings are not biased and data can be tracked to their original sources (Creswell, 1998). Authenticity was obtained in this study by utilizing participants who personally experience the phenomenon being studied (Creswell, 1998). Linking quotes to the explanation of the codes and themes found within the data enhanced confirmability and demonstrated that the findings emerged from the data (Miles & Huberman, 1994). Periods of distance from and immersion in the text were also interspersed to maintain a fresh approach to the data.

CHAPTER THREE: RESULTS

Demographic information collected from the participants is described in the first section of this chapter. In the second section, the six main themes identified in the analysis, including gender, are described. In describing the first five, the gendered nature of the data under each theme is discussed. In the third and final section, how gender informs the links among these five themes is explained and graphically illustrated.

3.1 Demographics

The final sample consisted of 36 women who ranged in age from 19 to 56 years of age. Thirty-one respondents identified themselves as Caucasian; three as Aboriginal/Métis; and one each as Asian and Central/South American (see Table 1). Twenty-nine of the 36 women reported having children and seven were childless (see Table 2). The women were asked about their relationship status at the time that police became involved and their current relationship status on the day of the interview (see Table 3). The 'Unknown' characteristic in this table reflects the number of women whose relationship status at that point in time was not evident in the transcripts.

The disabilities reported by eight women include: unspecified disability due to a car accident; transfemoral (above knee) amputation; hip injury (result of abuse); limited range of motion in hands and arms (result of attempted murder); fibromyalgia and asthma; profound unilateral hearing loss; severe learning disability; and an undisclosed disability.

Concern for the women's safety, confidentiality, and anonymity prevents writing more detailed characteristics of the participants in describing their demographics.

Table 1 Ethnic background

Racial Background	Frequency	Percent
Caucasian (white)	31	86.1
Aboriginal/Metis	3	8.3
Asian	1	2.8
Central/South American	1	2.8
Total	36	100.0

Table 2 Number of children

Children	Frequency	Percent
0	7	19.4
1	8	22.2
2	12	33.3
3	8	22.2
4	1	2.8
Total	36	100.0

Table 3 Current relationship status by marital status at time of abuse

		Marital status when together				Total
		Married	Common-law	Boyfriend/ Girlfriend	Unknown	
Current relationship status	Married	2	0	0	0	2
	Legally Separated	7	0	0	1	8
	Divorced	3	0	0	0	3
	Common-law	0	2	0	0	2
	Boyfriend/girlfriend	0	0	2	0	2
	Ex-boyfriend/girlfriend	0	0	13	0	13
	Unknown	0	0	0	6	6
Total		12	2	15	7	36

3.2 Themes

The common themes identified during data analysis included: (1) *Types of Violence*; women disclosed the multiple types of abuse they endured: physical, emotional, financial and sexual. (2) *Health*; components of this theme include the physical and mental health consequences of abuse. (3) *Perpetrator*; the women spoke about their abusers in terms of substance abuse, suicide threats, cruelty to pets, property damage, prior criminal involvement, abuse in family of origin, and lawlessness. (4) *Institution*; women identified involvement with various service systems such as health care, police, justice system, child welfare and shelters. (5) *Resilience*; a commonality that emerged from the data was the strength and resilience of these women while they were in the relationship, in the process of leaving the relationship, and once they had left the relationship. (6) *Gender*; how gender informed the women's stories is discussed within each of the aforementioned themes.

Quotations from the individual women are woven throughout the paper to substantiate the claims made. Quotes have been edited to clarify the women's meanings as follows: three consecutive dots denote the deletion of the dialogue that was not directly relevant to the significance of the passage and/or weakened its comprehension. Rounded brackets identify non-verbal body language or emotion or to specify what is being referred to when it is not explicitly expressed in the excerpt. Square brackets signify the researchers' insertions into the quotation to provide clarification. Quotations separated by a line are from different women.

3.2.1 *Types of Violence*

At the beginning of the interview, the women were asked to describe the nature of the abuse they had experienced and the length of involvement with their partner. Women described abuse by their husbands, common-law partners, boyfriends, ex-husbands and/or boyfriends, fathers, and in one case, concurrently by their boyfriend and their mother.

Four types of abuse were identified in the women's stories: physical, emotional, financial and sexual. In this study all 36 women identified verbal and psychological abuse in their relationships. Thirty-five out of the 36 described occasions of physical abuse and five described incidents of sexual abuse. Thirteen women experienced financial abuse. All women interviewed in this study experienced multiple types of the abuse described above (see Table 2).

Table 2 Frequency and type of abuse

TYPE ABUSE	N	%
Emotional, Physical	22	61
Emotional, Financial	1	3
Emotional, Physical, Financial	8	22
Emotional, Physical, Sexual	1	3
Emotional, Physical, Financial, Sexual	4	11

The length of time thirty-one of the 36 participants were involved in a relationship with their abuser ranged from four months to 26 years (five of the participants' transcripts did not contain information on the length of their relationship with their partner). Fifteen women had experienced abuse from a previous intimate relationship and three had witnessed abuse in their family of origin. One of these three women was raped by an

uncle. Of the remaining eighteen women, six did not speak about previous abuse in their lives, one alluded to previous abuse and eleven were not asked by the interviewer.

3.1.1.1 Physical Abuse

Physical violence was experienced by 35 of the 36 women interviewed. Physical violence usually started after verbal and psychological abuse had been occurring for some time although several of the relationships were physically violent from the beginning.

Physical violence ranged from several episodes of physical violence to repetitive brutal beatings that resulted in women being hospitalized. The women spoke about the physical abuse they experienced as: having objects hurled at them, being hit, punched, beaten with objects, beaten with fists, knocked down, grabbed, pushed, slammed, shoved, spit on, thrown, choked, dragged, kicked, bound and gagged, and stabbed.

One woman described the violence she experienced as:

... he was very, very violent. Um, he broke my collar bone, he broke my knee, broke lots of toes, lots of fingers. ...there was no way to get away from him. And if I locked myself in the bathroom, he'd break the door. There was no way to get away from him.

With few exceptions, the women spoke about the escalation of violence over time. Not only did the violence increase in severity over time but it appeared that moderate violence earlier in the relationship evolved into more severe violence later in the relationship. In one incident the woman was beaten about her face with bolt cutters. Another woman described being woken by her partner's attempt to duct tape her mouth shut, before repeatedly choking her to the brink of unconsciousness, and then forcing his fist down her throat.

The gendered nature of the physical violence experienced by these women is clear from their narratives. Though not spoken explicitly by most of the women, it was evident that the weight and size difference between themselves and their partners impacted the type and severity of physical violence they were subjected to.

Many of the women described how they were subjected to attempted strangulation, being thrown across a room or to the ground, pinned, savagely beaten or assaulted with a weapon or object. Most of the women required medical treatment and several were hospitalized. Of the 36 women, only one initiated physical violence against her partner; however, several women did respond in self-defense to the violence they were subjected to. One woman spoke about slapping her husband in a bar for his flirtatious behaviour. The remaining women who reported hitting, kicking or pushing their partners did so in self defence and none spoke of using a gun or knife. In comparison, thirteen women described how their partners used or threatened to use a gun or knife. One woman was reduced to using a rake over her partner's head after kicking and pushing him failed to halt his repeated assaults.

...he had his knee right in here, and [he] had me backwards and his knee was pushing right into my throat and my Adams [Apple] was being displaced, and I was being choked and everything was going black. And I managed to get my foot up and kick him and push him, 'cause he was wobbly on his feet, and I started wranking [sic] out on him just to push him away, just to get him away, and he kept coming back at me. ...So I pushed him down the stairs, pushed him out the door, and then he kept coming back at me. And the rake was standing right there, a metal rake. A metal rake and I warned him. ... And then he hurt me, so I used it on him. And I didn't know how bad it was, but I split his head like, I don't know, the skin only.

The women experienced multiple incidents of physical abuse and suffered far more serious injuries than did the men. In fact, the men were rarely injured. This is consistent with research on woman abuse which states the impact of abuse is far greater on women as compared to men who report experiences of violence and that the severity of woman abuse outweighs the kinds of violence experienced by male partners (Canadian Centre for Justice Statistics, 2000; Bagshaw & Chung, 2000; Saunders, 2002; Statistics Canada, 2005).

This is not to say that women are not violent but that violence used against men is different in social meaning and outcome than male violence directed at women. This is significant when the unequal status of women and the historic entrenchment of gender-based discrimination are taken into consideration.

3.1.1.2 Emotional Abuse

Each of the 36 women in this study experienced emotional abuse. They described how the sequence of abuse started with verbal abuse and escalated into other types of abuse. In most cases it was present at the beginning of their relationship and happened on a regular basis.

Many of the women commented on how much worse the emotional violence was compared to the physical violence they experienced. This became very clear from the crying that accompanied the women's narratives.

And the emotional is much worse because you can't show anybody (still crying) look he justAnd you think that you're actually, you start believing I'm a nag or I'm not good enough or you believe all those things. The physical is much easier to walk away from. (crying)

Most of the women were screamed, yelled or sworn at as the perpetrators flew into rages, had fits, tantrums or tirades. As part of the humiliation, most of the women were harshly criticized, called degrading names, and endured verbal attacks on her personal appearance.

The types of emotional abuse were described in many different terms. Their partners attempted to control types of clothing worn, the places the women could go, and their choice of friends.

I'm tired of trying to make sure that I'm in certain places at certain times and being there or not. Like I'm taking away from my life 'cause I can't do anything. 'Cause if I don't, if he doesn't see me do these things then he automatically accuses me of cheating. Whether it's just going to work, you know he always thought I was cheating on him at work.

Many of the men used the children to further manipulate and control the women.

He'd, he'd tell me that he would, because I'm a recovering alcoholic, he made sure he told me, 'you will not have your children, I will make sure. People will think, I'll tell them you're crazy, they will believe me'. He played this. I bought every bit of it that he would do this. So my fear then was greater than everything. So my fear was not just about him hurting me, it was about me losing my children, which was why, (voice quivering) which was everything to me.

Further to the dominance and control experienced by the women, they spoke about their partners' attempts to isolate them from their families and friends. Most of these men were successful in their abilities to create distance between their partners and loved ones.

He told me who I could not talk to. He told me who I could phone. He told what he thought of my friends.

...because, you see, he never wanted me to see my parents...because he said you have to have my permission for it....This man is so controlling.

And as I look back I was losing my friends, you know? That control was there...

Often the women were abused when they did not put up with their partners' attempts for control.

It would be, it would happen, we would have an argument 'cause see, I'm not a woman who says yea, okay. I have my own opinion too, so we'd have our arguments too, but then it'd be all right for a while....But over time I guess it got really worse.

...he usually would hang around the house and when he did get a job he wanted me to sit in the car and wait for him. And I would tell him to drop dead, so whenever I opened my mouth I would get it...

One facet of emotional abuse that many of the women experienced was the knowledge that her partner had violated her trust by having affairs. In many cases, the man would then falsely accuse his partner of also having affairs and then punish her with either verbal or physical aggression. Jealousy was another characteristic that many of the women commented on when speaking about the abuser.

I was in bed, and I woke up to him on top of me and he was determined to say it was my fault. It's my fault that he committed adultery, it's my fault...

...he would always accuse me of cheating, or accuse me of doing things, or phone me up and check where I've been and what I've been doing and checking, you know, what sites I've been on, on the computer and phoning me at lunch and, so I mean, for a few years he's been like that....Three, four years that, that kind of checking up and you know.

...he had called me at work and had left messages; enough to make me shake. And I had saved them and had my co-

worker listen to them and, and uh, he called me about 3 or 4 times throughout the day...I know about you and him and, I know, I know, I know.

Threats were a means of creating fear and controlling the women's behaviour.

Most of the women received threats to kill them, their children or their families.

Another method of emotional abuse was the threat of suicide. Seven of the women's partners in this study threatened to kill themselves. According to Martz & Saraurer, (2002), the threat of suicide is a means of control as the woman blames herself and feels compelled to help her partner recover.

Emotional abuse is also gendered in that the women are more vulnerable to violence as a result of the psychological abuse they experience. The constant humiliation these women encountered destroyed their sense of self worth and reduced their ability to resist control by the abuser (Wallace, 1999). The effect of social isolation is that the woman feels very alone in her struggle, doesn't have anyone with whom to do a 'reality check', and is ultimately more dependant on the abuser for all her social needs (Jiwani, 2000).

Of the 36 women, one woman appeared to be verbally abusive to her heroin addicted husband. She recounted many episodes of anger in which she threatened to leave numerous times, hurled accusations at him, and declared ultimatums. In one argument she recounts how she accused her husband of contributing to his first wife getting cancer because of the stress he caused her. This example is included to illustrate that women can also be verbally abusive, hurtful and mean. However, findings from current research report that men are much more likely to make serious threats that induce significant fear in women (Tjaden & Thoennes, 2000) and that women report significant long term levels

of fear compared to male victims of female violence. (Malloy, McCloskey, Grigsby, & Gardner, 2003). Women report a larger incidence of being isolated, being called names and being put down (Statistics Canada, 2004). Four times as many women report being threatened, or having someone close to them being threatened and the level of emotional abuse experienced by women outweighs that experienced by men (Statistics Canada, 2004).

3.1.1.3 Financial Abuse

About one third of the women verbally reported experiencing financial abuse in their relationships. Their economic status at the time ranged from living in extreme poverty and being dependent on their partners' income to being the one who was employed as the main wage earner of the family. Regardless of who earned the money, many of the women spoke about the control their partners exhibited over their money.

The stress created by the financial positions in which their partners put them is evident in the following narratives. The following participants speak very emotionally about not having even basic needs met. The misery and despair they feel is very evident.

...whatever I needed he refused to give me kind of thing-
food, shelter. (voice breaking, tears) We were continuously
kicked out of homes and just things like that. That was
tough too. I couldn't, I couldn't stand it.

Um, he hadn't worked in two weeks and we were broke
again, and I got really angry, and I got in his face, and I
(voice starting to crack with emotions, starting to cry),
sorry (whispered).

Financial abuse was not limited to women who were dependent on their partners for food and shelter. Several of the women were professionals and one participant owned her own business. One woman, a high earning professional, spoke about the stressful

effect of living with a drug addicted husband who was impulsively spending large amounts of money and incurring high debt.

Many of the women appeared to be the main breadwinners and they spoke about how for most of their relationship their partners were unemployed and became increasingly dependent on her wages. Despite this dependency, the abusers shunned any responsibility for child care or domestic duties. Another participant spoke about how her health was suffering and continuing to suffer because her abuser was confiscating the meagre amount of money she had to buy the necessary food items she needed.

He owes me a lot of money. He says I'll pay you back, I'll be responsible, I'll be... You know, a large part of our relationship he was unemployed and he never looked after _____ (child's name). He chose not to, you know, I'd ask...

All the money that I got was the Child Tax Benefit that is \$158. And he asked me to give him all that money to him so he could pay the, the, interest on the Master Card and Visa. So then he reduced the money for food too if I don't give him that money. He reduced, he stopped buying meat. He just buy vegetable and fruit and whatever for the house. And all, a lot of junk food, so uh, I'm anaemic. I need meat. And he reduced, he reduced all that money.

The lived stress the women verbalized and displayed through their emotions (e.g., crying, eyes tearing) was amplified by living with a partner who tried (and usually succeeded) to get his hands on money to support his substance abuse or addiction problems.

...the worse was when uh, just before we moved at the shelter he was really, really into the drugs really bad. He took my credit cards, emptied all my accounts, we had nothing left. I had 20 bucks left in my name and rent wasn't paid and, we had no food. It was really bad.

We got talking; the gambling was the final straw. Like he was; we were down to nothing. After fourteen years we have nothing. And five months ago he was asked to leave [by participant] because he spent our RRSPs. All of them. Gone.

One woman described how not having any control of their money contributed to her terror of living with an abusive husband who had drugs in the house and the possibility of losing her children as a result.

And he used drugs too. Hashish, pot, and used to be coke too. And he was planting marijuana plant in the basement too. No, even if Child Welfare got involved, I had no choice. I, I, I (pause) when Child Welfare got involved, I had no idea what to do. And I had to hide those drugs because I was afraid they were going to take my kid away because I'm still in the relationship. I had nowhere to go. I had no money.

Financial conditions did not improve for many of the women after they left their abusive relationships. Few of the women had their own bank accounts or credit cards and when they left the abuser, he had taken the credit cards and emptied the bank accounts.

I'm depressed; I'm that, I'm that. I got not proper home for my kids. I don't have a stable home for my kids. Even if I owned that place with my ex, I can't go back there; I got no money to pay the mortgage.

...he took everything from us - credit cards, money - everything was emptied. And my landlord gave us a notice when he saw the holes on the walls and the cops came so we had no choice. I had to get out.

For some, money was another vehicle by which the perpetrator could continue to control and abuse his ex.

...he's losing control of me and he's feeling it. So every once and a while he'll come out with this big thing that he does to try. And, and right now it's not paying me. He's got a maintenance order right now and he's not paying me. So

that's the (laughed) only thing he has left is this, the money thing.

An example is like right now, I'm not doing what he wants so I haven't gotten child support in like a month and a half and uh, I was going to see my friend in Lloyminster, but he wouldn't fix the van. He wouldn't, he hasn't given me money actually since then because it's the last control he has over me right now. (voice is shaky)

The women in this study illustrate the gendered imbalance of financial power within households. Regardless of whether the women were dependent on their partner's income or were the household's primary wage earner, the men controlled the money. Denying the women access to family income reveals the deliberateness with which women are controlled, manipulated and made dependent on men.

3.1.1.4 Sexual Abuse

Five women reported being sexually abused. The abuse included rape, forced prostitution or sexual coercion through threats of physical force, threats involving psychological intimidation or the actual use of physical force.

For several women, sexual abuse involved being forced to have intercourse either during or immediately following an argument. One participant recounts an episode of sexual abuse after she had been physically assaulted.

So uh, and I was scared. I pissed my pants and he (starting to cry) decided he was going to sleep. And he wanted sex, he wanted sex and I said, no. So I was, I was expected [to have sex] I, I had a black eye, and ... he went to sleep but he wouldn't let me get up to go to the bathroom or anything.

Two months after one woman's partner was released from jail for savagely beating her, she recalled the horror of being found by him and then suffering the consequences.

...he found me and came into, broke into my apartment,
and he raped me three times, and he wouldn't let me leave.

Not only were some of the women degraded through sexual assault, but one participant's partner continued to sexually assault her in front of their children.

Sexual abuse appeared to be a difficult subject for many of the participants to discuss. Many of the women nodded affirmatively when queried about whether they had been sexually abused but did not elaborate further. The following participant shared her thoughts about dealing with sexual abuse and may be representing how many of the women felt.

I, I run away as soon as the sexual [is mentioned] 'cause
I'm definitely not able to handle that yet.

Rape and sexual abuse can be extraordinarily difficult for victims to talk about because of the unimaginable ways in which this type of violence often is perpetrated. When sexual abuse occurs, the victim will often feel very confused as to whether or not she has been 'raped'. Women feel betrayed by the men who are supposed to love them and protect them. It seems obvious in our society that when a woman is raped out on the street by a stranger, that rape has occurred and is wrong. When rape occurs within the marriage, neither abuser nor victim may consider it legal rape. This is partially due to the general acceptance within our culture which tells us that it is the wife's duty to fulfil her husband's sexual demands. Many women don't believe they have the right to refuse sex, that 'sex on demand' is an unwritten part of the marriage contract. When they have been raped by their husband, they are inclined to take responsibility for the abuse, furthering the feelings of guilt and lack of self-worth. This blame-taking is further increased by the abuser's justifications, e.g. '*it's your fault...*'. When no actual physical violence was used

(i.e., coercion) many men will deny that rape has actually occurred and treat the abuse as though it was normal and by joint consent. This has the effect of further confusing the victim as to the reality of her experience, and is part of the explanation of why sexual abuse, a highly stigmatized and traumatic experience, may be difficult for the women to speak about.

Canadian statistics reveal that women constitute 98 per cent of spousal violence victims of sexual assault, kidnapping, or hostage taking (Fitzgerald, 1999). A national survey found that 10% of women were victims of rape or attempted rape by a husband or intimate partner in their lifetime (Basile, 2002).

3.1.2 Perpetrator

How the women described the attitudes and behaviours of their partners demonstrated that the violence they subjected the women to was not impulsive, but purposeful and instrumental. Some of the women recounted how the abuser could be perfectly agreeable with or conciliatory to police officers, bosses, neighbours, co-workers and friends, but chose not to act this way with them. The men abused the women to make them do what they wanted.

The perpetrators described by the women crossed all levels of class, race and socioeconomic status. The characteristics of the perpetrators depicted in the women's stories are congruent to the identified characteristics shared by abusers found in research studying perpetrators (James, Seddon & Brown, 2002; Gilchrist et al., 2003). The severity of the violence and the extreme behaviour this sample of women were subjected to indicates violence and personality characteristics (possibly personality disorders) at one end of a continuum (Dutton, 1998).

The women spoke at great length about the perpetrator. Some spoke positively and others did not. Those that spoke positively consistently described the abuser as charming and nice in the initial phase of the relationship. Eventually the bloom came off of the rose. For some this occurred soon after they began to cohabit and for others when they become pregnant.

He used to drink a lot, but [he was] not abusive to me. I, he's an alcoholic, or he was an alcoholic the way I see it. But before that he never, he was very sweet and stuff until I moved in with him.

...the first time he punched a wall was probably in about (pause) '95 while I was pregnant. He punched a wall in a townhouse we lived in, uh, but he was always moody. Like, I just never knew if he was going to be in a good mood or in a bad mood...

Several women described the perpetrator changing later in their relationship and being taken off guard with that change.

Except the behaviour changed, now I had this person that woke up from his sleep of probably two, three years, who knows? I don't know when he started the drugs, and became this, monster I guess.

Despite the women reporting a change in the abuser's behaviour some of them still had some positive things to say about him. One woman described her partner as charismatic, suave, good looking and well dressed. Another woman spoke about how encouraging and supportive her abuser was when he was sober and conversely how violent and mean he became when he was drinking.

Other women portray the perpetrators in a way that sends chills down one's back.

I like to describe my ex as a pit bull. He sits and watches. He's very charismatic and everyone likes him. And he sits and watches until he can't take it anymore and then he'll

bite or snap. So he'll just sit and wait because it's frightening that way. Nobody else would figure that about him, but I know. So that's how I lived for all that time.

Twenty-four of the 36 women spoke about her partner's substance abuse. Alcohol was the drug of choice for 18 of these men. Substance abuse was previously mentioned by the women as contributing to the escalation of financial abuse. However, it warrants a mention under this section due to the increase in the severity of physical violence and destruction of property when the perpetrator was under the influence of alcohol or drugs.

He thought I could fly, so he threw me through the trees.
[abuser was]...drunk and stoned.

But he was drinking that night and had phoned me and was looking for some additional funds out of the bank account and wanted the PIN number and I wasn't prepared to do that because he'd go off on a whatever. And, and uh, so he was angry, came into the house and started throwing furniture around and things like that. And he had an employee that was with him and then he went back out, and I had a brand new minivan, he took a steel rod to it and did I think it was nine thousand dollars worth of damage to it then. And then he came back in, and he, I, I, he threw me across the floor...he started to punch me and uh, I had broken teeth and a broken cheekbone and...then he beat up the employee as well.

Many of the women were aware of the cycle of violence and were able to verbalize it when they described their abuser's behavior. This may have been because many of the women had left their abusive relationships prior to being interviewed and were in counseling.

...'when I left him the first time, he was good for a couple months. Then it started again. I probably left him, but I'd never leave for more than two or three weeks, I probably left him a total of four times, in the six years, but I'd always come back within a month. And he'd be good for about a month. And then it would start all over again.

Another part of the perpetrator's behaviour many of the women spoke about was how the perpetrator consistently blamed her for his anger, his problems, and his abusive behaviour. A few of the women described further psychological tactics he used such as blaming her for his suicide attempts.

Cruelty to family pets was another way to torment and intimidate the women and perpetuate the violence against them.

I only had that cat [pointing] at the time. He knows how much I love my cat, and he would like threaten to kill him, just to bug me. I know he would never, but he would threaten to kill him if I did something stupid. Like one night we were all drinking and he picked up my cat and kinda tossed him across the room, just to make me mad, just so that I would hit him so he would hit me, you know?

My daughters, they found Squirtle. [family cat] She had the absolute, excuse my language, shit kicked out of her. She was bleeding from her eyes, she was bleeding from her nose, her eye was all swollen and shut. And, um, we don't know what happened, whether he kicked her down the basement stairs, or whether, we don't know what happened.

During the interviews the women were asked if the abuser had previous justice involvement. Some of the women were not aware of previous involvement, others knew that something had occurred but were fuzzy on the details while several were more knowledgeable about the details. Many of the perpetrators had abused a previous partner.

He's got a long youth record for assaults and car thefts, um, vandalism, you name it he's got it. On his adult record there's a drug charge, um, for trafficking coke. He's got a previous assault charge from his previous girlfriend that he has a child with, and now he's got the two uttering [death] threat charges that he went to court for. [against survivor and her room-mate]

He's been married three times and on the other two divorce papers it was mental abuse was the cause of divorce.

Many of the women spoke about the abuse the perpetrator suffered in his family of origin and used this knowledge to explain their partner's abusive behaviour.

His family, sister, prostitutes and addicts and he didn't even want me to know till I left him. I figured it out myself. They are people but that's what they are....so I think that's what it is. A lot of its childhood background. Uh, sexual, sexual abuse, I don't think there's that much hitting, just sexual abuse.

He's from an abusive family (pause).

When the women were asked about the incident that led to justice involvement, many disclosed that there were many episodes of abuse that were not reported. In fact, a unifying theme identified in the analysis was the determination of the women to make their relationships work. Many of the women minimized, denied or avoided admitting to the abuse they experienced. Women spoke about how they didn't believe the violence was that severe. Others believed that their relationship would improve.

When an abusive incident occurred the women tried to find external explanations for their partner's behaviour (e.g., abusive family of origin, substance abuse), but they felt internally responsible.

...if I could just get the cans of soup lined up every night, and every toy put away and every towel hanging, you know, at the proper level, and every shoe put away and every shirt hanging facing left so the police badge is right there when you open the cupboard door, then, if I could just get my life perfect, then somehow all of this would stop.

When the women were asked about the incident that led to the police being called to the home, many confided that there were numerous incidents that were not reported. Reasons that were given were similar to the reasons for staying in the relationship:

embarrassment, shame, and guilt. However, many of the women also spoke about protecting the abuser because of his childhood abuse or substance abuse.

Once the decision to call the police was made, many of the women did not want the abuser to be charged. They continued to protect him and when asked what action they wanted the police to take, almost of the women stated that all they wanted the police to do was take him away and not charge him; just take him away until he cooled off.

Several women expressed how they did not want their partner to have a criminal record but they wanted him to get the help he needed. As one woman stated:

I don't want him to have a criminal record, but I do want him to receive treatment, you know, get help. Cause this is anger, from somewhere...

Women were also asked if they would call the police again if another violent incident were to occur. Some women said yes, others were not sure and several were hesitant. The women who were hesitant continued to take responsibility for the abuse they suffered.

I don't know. [depends] Whether I felt I deserved it or not. Screwing around, if I did that, that's about the only reason. ... (long pause, nervous laughter) Like I said before, if my kids were around, or it depends how I caused the incident, right now if there was like, in a public place, or he freaked out, yea I would.

Some of the women made excuses for their partner's behaviour even after they had managed to escape the abuse. One woman who was abused on a regular basis by her husband for eight years still spoke about him in a way that couches the multiple types of abuse she suffered by him. This same participant that did not want to leave the relationship because she felt she then had failed in her role of keeping the family together

(Lorber, 1994). Many of the women stayed with the perpetrator because of their gendered expectations around marriage.

One woman reflected:

And I thought that I had to continue, if I let it go, (voice breaking, tears in her eyes) the fact that I let the relationship fall apart, that would have been my fault once again. And, I would have been a failure, and my children would have no father and all those things. So yea, it sounds ridiculous. But it's obviously how I was thinking because I still feel that thought, because I still have it even this minute.

As a result of this thinking women endured the abuse until a tipping point occurred: violence escalated or the violence extended to their children. For other women it was the realization that the violence was affecting their children.

Why, because he hit my daughter this time and it's way out of control. For me, (inaudible) ya, go ahead and hit me, I, for me, but once he starts going after my little girl, that's his little girl too, so why are you hitting her. She's only four, and to me, it's, it's way out of control the physical abuse is way out of control when you hit a child.

A strong theme that emerged when the women spoke about the perpetrators was their 'lawlessness'; in other words, the perpetrator's disregard for restraining orders, peace bonds, no contact orders, court dates, mandatory counselling and orders of probation such as alcohol prohibition.

...he's the type of person that wouldn't care if he had a restraining order on him.

I know if he really wanted to, a restraining order is not going to stop him, you know? Anybody, if you really want to do something, nothing is going to stop you from doing it. If you get it into your head one day, yea I'm going to go over there and do whatever, then of course it's not gonna stop him.

...this no contact order, he's just ignoring it. He just doesn't respect the law at all.

The power and control the perpetrators held in these women's relationships was very evident in the women's narratives. This is illustrated time and again in the stories as the women speak about working and trying to make ends meet, caring for the children, and caring for the home while the perpetrator basically does what he wants. He does not look after the children, is frequently unemployed, has a substance abuse or gambling problem, and controls or steals money to support his lifestyle. Clearly the men held a privileged position in the marriage and believed it was their right as a man to use violence as a means to control, intimidate and maintain their power. Women, on the other hand, believed they had to endure all things in order to "keep the family together". Their personal safety and health was secondary to that of the perpetrator or of the children. By excusing the perpetrator's behaviour and attributing it to forces outside of him, the women and society collude in maintaining the men's privileged positions.

3.1.3 Health

The majority of the women spoke about the devastating effects of abuse on their health even though the primary focus of the interview was on the response of the criminal justice system to their case. Many of the women became upset during the interview process as evidenced by the interviewer notes inserted into the transcripts (depicted by round brackets).

They identified both physical and mental health consequences which at times they linked to the abuse and at times did not. This section describes the physical and mental health consequences separately but how the women spoke about the consequences that

they experienced does not suggest that they occur independently of each other. Many mental and physical health consequences came out in the narratives and it was clear from the data that they overlap and affect each other in affecting the health status and well-being of these women.

The women did not speak only about the direct consequences of being hit or yelled at. Indirect, short-term and long-term consequences were interwoven throughout the narratives. The following quote illustrates the different effects on a woman's health from one incident of physical violence. In speaking about this one abusive incident the survivor speaks about the direct consequence - injury to her face; an indirect consequence – the feelings evoked when treating the injury that presents a visible reminder of the abuse; and one of the short-term consequences of her injury - loss of two weeks income.

There were x-rays taken of my face 'cause they [emergency room physicians] thought he had broken my jaw. I had a huge scar that I mended quite well too. I put polysporin on every day so I didn't carry it [abuse] with me on my face. I had taken two weeks off of work...

The long term consequences of mental and physical abuse are accumulative and may not present themselves until much later.

That's what's staying with me now, [mental health consequences] that's why, I mean, I'm much better now (teary, voice cracking) after a year but, it's all these people that you're talking about [Homefront workers] and family and friends that have helped me stay away from him.

3.2.3.1 Physical Health Consequences

The injuries reported by the women included fractures, dislocations, head injuries, open wounds, contusions, lacerations, crushing injuries, nerve and dental injuries,

permanent disabilities and disfigurement. Often women received more than one of these in one episode and for some, the injuries were clearly life threatening.

My nose was broken; there was a fracture of the nasal bones which apparently is a good thing. I don't need surgery. He must have hit me on both sides of the jaw 'cause I was bruised and swollen, and both eyes were almost shut by the next day. I have circles here; the doctors said that I could have that for the rest of my life. It's probably just a stain. I might have had a fractured skull. I had a huge swelling on my forehead, but it was just the nose that was uh, that was swollen.

And then he yanked my arms back and he tried taping my mouth shut with, uh, well at the time I didn't realize it was duct tape. So, I grabbed hold of the tape and I don't, he had his arm, I was in between his shoulder and his uh, his (elbow)...and he had me cranked and that's when he started strangling me, and um, he held me to the point where I was going unconscious...and it happened three times that night...all of a sudden I feel his hand is in my mouth, ... every time I kind of moved, his hand was going deeper down into my throat (voice wavering), so it was cutting off my oxygen again...to the point that I started going unconscious, like everything that I saw, started seeing black and white...

Most of the women reported injuries that resulted from being choked. The extent of reports on choking injuries leads one to believe that direct threats to the woman's life were intended in more cases than they report.

He would pull my hair lots, but the main thing is he liked to choke me...

...when I woke up he was hitting me and he had blackened my ears. There was blood coming out of my ears and, and he was choking me...

Some descriptions of injuries sounded less severe than those above, but were still significant for the woman involved. Sometimes the woman's current health status and health problems were clearly jeopardized by the injuries, even though she may not have

articulated that herself. For some participants the long term effects of the major physical injuries they survived have left them with a permanent disability.

Uh, had a black eye, cut lip, I think that was about the most serious. Um, I've had my back and my hip hurt, like I've had nine artificial hip replacements so I'm really easy to get hurt in that area and in my back cause I have arthritis on my spine. So that's been jarred around quite a bit. I think the most serious was like I said, black eye, swollen face, swollen cuts. Oh, and choking, that's one of his favourite tricks.

...he broke my hip, three pins in my hips ... Yea, I gotta bad leg now (laughed) very bad leg.

The women talked about the direct health consequences that result from being hit or yelled at but it is not always obvious that health consequences like headaches are a result of abuse. However, one may conclude that headaches were a consequence of the physical types of violence the women were subjected to when reading the following excerpts:

And he jumped up and grabbed my throat and slammed me against the door. And uh, then he turned me and grabbed my neck and slammed my head into the kitchen floor and held me there.

...I landed on the floor ... got up, started running and uh, he grabbed my arm, turned me around and then slammed me against that door... then he grabbed my throat and slammed me against the wall.

...your head is getting smashed into the wall, your neck is, is possibly fractured ... you have a bruise.

One participant developed a headache as she recounted the abuse she suffered.

I, I'm getting a headache. [holding her head with her hands] Yea, this happens. It's just a (sigh) that's what happens when I get thinking about things that I try to let go of. I end up getting a headache.

Several participants revealed chronic problems they suffer from and have to live with as a consequence of the abuse they have endured.

...if anybody went to grab me here [pointing to neck] I'd collapse, cause he was always (voice cracking) grabbing me [by the neck] to pick me up.

And my neck is all messed up. Like I have to go to the chiropractor, it's all clicky and it get stuck and that.

I know my jaw is stiffer. At times I yawn...it took me awhile to get the full range of opening my mouth again...I just know I have after effects of the actual.

One woman indicated that after an episode of abuse she would vomit as a result of the physical and emotional trauma.

It was hell. (pause) I would lie down on the floor and throw up. (crying)

Another woman did not articulate the gastrointestinal effects of her abusers' covert actions but one can infer the results nonetheless.

...he'd put laxatives in my coffee. Like, he'd turn my coffee pot for me in the morning and he'd put laxatives in it. Sometimes he'd put cow shit in it when he was mad at me. He'd pull it off his boots and put it in my coffee pot. Um, near the end he was trying to put laxatives in my coffee 'cause he thought I was too fat.

When asked by the interviewer when the abuse began, several women reported abuse beginning during pregnancy and increasing as the pregnancy progressed. For other participants the violence decreased during pregnancy. Abuse during pregnancy caused preterm labour and loss of the pregnancy for some of the women. One of the participants spoke of losing her unborn babies from a previous abusive relationship. The next section

will show that another woman lost a pregnancy because of a sexually transmitted disease contracted from her husband.

Many of the women spoke about the promiscuity of their partners and the devastating effects on their reproductive, physical and mental health.

The worst incident I'd say mentally is that he fooled around on me...and gave me a disease (still crying) which caused me to lose my baby and almost lose my life.

Though only two women spoke about contracting a disease from their partner, sexual abuse was part of the story for many of the women who spoke about the abuse they endured.

One woman indicated how genitourinary problems can result from abuse. For instance, not being allowed to go the washroom could result in an infection.

So uh, and I was scared, I pissed my pants ... (starting to cry) ...he went to sleep but he wouldn't let me get up to go to the bathroom or anything.

3.2.3.2 Mental Health Consequences

Each woman's story contributed to the mental health effects identified in the analysis. Many negative emotional experiences emerged from the data but fear stood out as the dominant negative impact on mental health. The women spoke about the different types of fear that became part of everyday life for them and their families. Some of the types of fear the women described included: fear of the next episode, fear of being killed, and fear for the safety of their children, family and close friends and fear of retaliation.

For many of the women living in fear of the next episode included the fear of being killed. They did not question the murderous intent of their partner.

Cause he told me, he said, 'we're going to die together you and I.' He told me that he was going to kill me, but he promised me it wouldn't hurt. And he said, 'Stop looking over your shoulder. You are never going to see it coming.'

This fear of the abusers' murderous intent extended to her children, consuming the women with a constant, energy depleting worry for the safety of their children.

Anything that happened happened to me. And if I saw him getting upset with her [daughter], the one day he got angry at me he backhanded a coffee at me, a big mochaccino that I had just made, he backhanded it off that side of the island and ___ (daughter) was over here by the table. So that's what, five, six feet. And it hit her, the coffee. And uh, luckily it wasn't hot enough that she got burnt but uh, that was all. As things started getting worse I was hyper-vigilant. I never left her with him ... maybe playing in the backyard for a couple minutes, that's all.

He just, he threatened; he always threatened that he would kill me and my son.

And he picked ___ (daughter) up ... and held on to her and just looked at me. I knew what he meant. He was threatening me with her... to hurt her. And uh, I got really, really scared...

For one participant this fear materialized into reality. Nearly killed by the perpetrator in an earlier incident, she indicated that she had feared for the safety of her child at that time. In an attempt to schedule a follow-up interview it was learned that the child had died at the hands of his father since the first interview had been conducted. He was two years old.

In addition to worrying about personal safety and the safety of their children, many participants (with and without children) worried about the safety of their families.

...he knocked my parents out, both of them. They were in ICU for a few days.

...he threatened to kill me and my family for telling anyone...

...he was threatening to kill my son and my parents. He knew nothing of my sisters.

Fear extended further than the survivor and her family to include friends and even neighbors or strangers who were witness to the abuse or who tried to help the women.

...and I'm yelling at people call the police, and, um, apparently he threatened one of the other tenants who came out to see what was going on. And he threatened one of the other tenants, the woman who cleans the apartments.

... I had gone in because I had waited a long time outside, I said, 'can you just come out, I've been waiting a long time'. And I was like eight or nine months pregnant, I can't remember. And some city worker was standing there and he made a comment to _____ [abuser] about 'don't be so rude, the poor woman is just asking you to come out', and he beat that guy and two other guys up at that situation...

Feelings of safety were destroyed for many of the women while they were in the relationship because of their fear of retaliation. It was never far from the minds of most of the women and persisted for many even after the perpetrator was apprehended, removed from the home or incarcerated.

He will come after me until the day he dies.

Um, I just, coming home from work the last few months I just wondered if I go through those doors right now, when I get the car in the carport, is he sitting on the bottom stair with the shotgun.

...a man like that going to jail will come out and kill me the minute he gets out. He'll buy a gun and he'll shoot me.

The fear of retaliation was heightened for some of the women who had managed to escape their abusive situations as they experienced the terror of their ex-partners

following them, watching them or harassing them. Often, this harassment extended to their children, family and friends.

The fear was so great for some women that they could not consider staying in their own home and chose to stay elsewhere. And for a few, returning to the home where the abuse took place was not an option. Several participants spoke about how they were still living with fear up to three years after separating from their partners. For the woman whose abuser repeatedly stabbed her, slit her throat, and left her for dead, his death would be her only escape from the embedded fear she lives with.

I think there will be some closure at least, if, if he is designated dangerous. He'll die. He's 52; he'll have to do 17 years. Yeah, he'll die when he's 80. And I won't believe it until I've seen the sucker. And I don't like looking at dead people ... But then I'll know he's dead... that there's peace. I don't have to look over my shoulder, and there's closure.

In addition to living with fear, many of the women spoke about the devastating effects of abuse on their mental health. Their confidence, self-esteem and self-identity eroded regardless of the type of abuse they were subjected to.

I was withering away to nothing and it was mentally draining, physically draining, emotionally and I had lost who I was.

And you think that you're actually, you start believing I'm a nag or I'm not good enough or you believe all those things. (crying)

I had no self-esteem left, (sigh) none. Hard thing to admit. Yeah, it's just stripped away...

They also experienced a loss of trust in others, future relationships and in themselves.

...it's like, I know what to expect when I live with him. That's what's normal to me; the abuse and the being paid for sex and, and everything, everything. I knew how to deal with it. I don't know how to live like this. I don't know what people want from me when they're kind to me, or whatever.

... basically I just wanna be by myself for now, not have to worry about being in another, [relationship] cause I'm scared now, I scared to get involved with anyone again.

Social isolation was another negative impact of the abuse that the women spoke about. Some of the women displayed sadness as they recalled their experiences of social isolation.

I pretty much isolated myself from other family members.

I don't um have a lot of relationships because of what goes on, of what had gone on in my home. I isolated myself, you know. I, people got this close and then that was it. So I didn't have sort of those kinds of conversations. I talked on the phone all day because I'd be talking to people about work and business and people who do data collection for me and then you know the people I was working for. So, I was on the phone all day, but I wasn't talking to anybody.

I never went outside of my home. So, of years [of abuse] going on, I just became this recluse and I just hung out in my house and I never went anywhere. So I didn't even know my neighbours.

Memory loss and cognitive confusion were prevalent throughout many of the narratives. For instance, when describing certain occurrences of abuse, many of the women could not remember specifics. One participant recognized and spoke about the effects of abuse on her cognitive abilities.

One of the things about being with him for that long is that I can't remember things. He's kind of mumbled up my brain, so once something comes in, it kind of shoots out rather quickly.

Some of the women spoke about being depressed, anxious and not being able to sleep. Medication in some cases was required to facilitate day to day functioning and well-being. For those that did not express in certain terms that they were depressed or anxious, the language they used left little doubt as to their meaning. One of the women felt such despair she attempted suicide after being physically assaulted.

When one woman was asked if she had written her victim impact statement for court, she replied,

...and I'm just too tired. Like I, (pause) what do you say and do?

The violence the women experienced was not isolated in that the abuse each woman suffered was only part of her experience. The women were concerned about how witnessing the abuse would affect their children and experienced the violence again through their eyes.

My children are seeing that abuse left, right, and center. And ___ [daughter], my eldest ... seen the bruises. She's seen the hair falling out the next morning, when there's clumps of hair. She's seen me on the floor throwing up. She's seen total devastation. Total. This is not right for a kid to grow up like that.

...poor kid, she saw it. She was like an adult, 'Mom it's okay. Go sit down and I'll make you a cup of tea'. Four years old, she was like my mother. That, that's what really bothered me because ...she knew. I can never erase that from her eyes, you know. That's so sad.

The impacts on health from the severity and multiple types of violence these women endured are clearly identified in this section. They spoke of multiple consequences to violence with the most obvious being physical injury. On average, men

have a physical advantage as some of the women vocalized when speaking about the violence they suffered. Given men's size advantage, the harm and injury these women incurred was severe. A large body of evidence clearly states that women experience far more injuries and far more serious injuries from violence than do men (Saunders, 2002).

Other consequences of violence are also gendered. For example, the meaning, contexts and consequences of violence for these women differs (Loseke & Kurz, 2005) from men who experience violence. The women spoke overwhelmingly about living in fear (Cascardi, O'Leary, Lawrence, & Schlee, 1995). Langrichsen-Rohlingn, Neidig & Thorn (1995) found that many women, but not many men, who experience violence report fear. Men use psychological and emotional abuse as a technique for either obtaining or maintaining control over the victim and keeping her in a relationship with him (Dutton et al., 1999; Dobash et al, 2000).

The women also expressed how the violence they lived through was experienced through the eyes of their children. This in turn impacted not only the children's behaviour and mental health but added another layer of worry, guilt and anxiety as they realized how their children were affected by the violence. These feelings continued to haunt those even after they managed to escape and leave the abusive relationship. Not only did the women experience the violence through the eyes of their children but also through the eyes of family members, friends and others (such as neighbours) impacted by their situation.

3.2.4 *Institution – Service Systems*

The women described their voluntary or in some cases involuntary involvement with various institutions. The women's experiences included service systems such as: the

justice system, health care system, child welfare and shelters. A few women had empowering and positive experiences while many spoke about feeling re-victimized. This varied response applied to every system with which the women came in contact. According to the women, the individual representative of a specific agency assigned to them was the determining factor to whether she felt supported, heard, cared for, understood and most importantly, protected.

3.2.4.1 Justice System

For many of the women their first involvement with the justice system was when the police were called to the home. Some of the women felt safer after their involvement with the police in knowing that their safety was a concern. Those who spoke positively were believed by the police, were supported and had a quick response to their seeking help.

For others, police involvement did not increase their feelings of safety. Some women spoke about how the police appeared to take the abuser's side while others reported having to prove that they were the ones abused. Several participants could not convince the police that they were the one being abused and felt helpless and scared because they were not being heard. One woman described how she tried to convince police that her abuser had tried to kill her.

I told them [police] exactly what happened right, and then they came in here and got his story, and uh, then they go back over there [to the neighbours where survivor is] and they said 'well, are you telling the truth ____ [survivor]?' And I don't recall exactly, like the officer said, or the constable said uh 'was he choking you?' And I said he was choking me. And he said 'with his hands?' And I don't recall the actual question or the actual 'cause I was upset and what not, but I said yes he was choking me. ...And

they're trying to say that they're doing a good job trying to protect me, after the fact that they're telling me that they don't believe me, like half an hour earlier and I was mortified.

Another woman described her disbelief and embarrassment after being charged by the police after calling them for help. Her partner had assaulted her, she defended herself and was yelling at him to stay away from her or she would kill him – this occurred while she was on the phone with the police. They took his word over hers and arrested her seeing that they overheard her threatening to kill him.

Calling the police for help multiple times over the length of their abusive relationship was identified by several of the women as the reason for the lack of police response or support to their situation. Other women experienced discrimination from the attending police because they did not exhibit visible injuries.

Once police were involved and charges were laid, the women faced representatives of the many components of the justice system such as: Homefront workers, Crown Prosecutors, judges, child welfare workers, abusers' probation officers, and lawyers. Many of the women found the process confusing, overwhelming and stressful. They also felt at a disadvantage dealing with the legal system.

According to many of the women, the assigned Crown Prosecutors indicated little interest in the women or in what they had to say. In addition, they remarked on how busy the prosecutors were and as a consequence were constantly shuffled from one to another.

Standing in front of the judge was intimidating to some of the women but felt that they were being heard and that the judge was taking into account their wishes and recommendations.

Showing up in court and appearing in front of a judge was not a positive situation for many of the women. They did not understand what the judge was saying nor did they feel that the judge understood their situation. They also talked about not having their opinions, recommendations or wishes being taken into consideration.

This participant was able to verbalize what many of the women felt about the justice system.

The judge he's, he's more for the fathers, Judge _____. My lawyer told me that too, that he's more for the fathers than for the mothers.

The amount of energy and time required by the women to follow through on the conditions placed against the perpetrator was draining. For example, one participant spoke about how she understood that procedures had to be followed by the probation officer, but having to put in writing when her abuser was breaching was too draining.

Well I called her a number of times when he was breaching majorly and she said that she couldn't do anything until she had it in writing. For me to gather my energy to write that, it was tremendous. Like, my house is a mess 'cause I'm too tired to deal with things, and so...she has procedure to follow.

Many of the women did not feel that by giving the perpetrator probation, the justice system held the abuser accountable. In fact, one participant went so far as to say that even if a perpetrator was incarcerated he was still getting off easy.

Unless he went to jail, but still in there it's like, let's go do crafts. You get to sit around and do nothing. At least they should do some labour because it's like getting off Scott-free. Behind bars, sitting around with a bunch of other guys, well, that's what you do out here anyways.

Speaking overall about the justice system, many women were disillusioned. They felt their situation was not taken seriously and that the perpetrator was not punished appropriately or made accountable for his actions.

They, it's common in society, they [men] have total reign, and you don't have freedom of speech, don't have the right to protect yourself or your children, and you have to hide, behave as a victim. Look over your shoulders every time I see a white truck. ...There is a group of men within Calgary that backs up pedophiles in the court system and backs up men.

Several of the women spoke about how they were the ones punished for being abused and for reporting the abuse by both the perpetrator and the justice system.

And I just remember thinking; I wish I could do those weekends. That's what they [justice system] should give us. They should let him stay home with the kids and make everything work, while I go to jail for the weekend and sleep and then come out and make you feel miserable because you had to go away for the weekend and I ruined your life. And I did this. His consequence was my greater consequence, much greater.

They're [justice system] a waste of time, yea. They're more abusive than probably the offender because they abuse you emotionally, physically, financially, all of this, the system kills ya. ...they don't warn you that it's not only the offender, it's the police that'll be after you, it's the court system that will be after you, it's welfare that will be after you. You have to protect yourself from a whole barrage of people, not just the offender now.

Some of the women believe that wealth was used by the perpetrators to influence and sway the justice system with success.

Yes this justice system for domestic violence is quite interesting 'cause if people have money (talking slower), and they can hire a hotshot lawyer, in which case my ex-husband did...And because he had a lawyer we were in

court in December and ____ [abuser] brought what I call a grand stand of people to show his innocence to the judge.

He walked into court. My lawyer, the first time he saw him was shocked. He walked into court with a thousand dollar Vallentino suit; well dressed; smelled nice. Judge looked at him and smiled. She was actually smiling at him quite often, almost like she thought he was handsome. You know it was a sick, sick thing because if the man can't, he could be a good father and wear a pair of blue jeans and work construction, don't look down on him because he's in a pair of blue jeans. But you're looking, like, high on this man here 'cause he's, and my lawyer said that. He's well dressed, he's so polite to the judge he said 'these guys they like, they know what they're doing.'

Many women described feeling re-victimized, unsupported, invisible, insignificant and responsible for being abused once they became involved with the various agencies and as a result had lost confidence in the justice system.

The system is just a joke anyways. I'm frustrated with it. And I said I just want to get out. I just want my life back. And I said this is preventing my life getting there.

The laws are changing. There's a great help from the domestic and everything but as soon as you go to court it's almost like it's outta their hands. Like the police said to me 'it's outta our hands. We did the best we could. We fought for you. It's in the judge's hands now.' And I really believe that judge believed me and the Crown said the same thing. But because of that nonsense [about] reasonable doubt, all men are getting off. Unless the man admits he did it, they get off. So every good lawyer now that you're paying \$500 an hour, like he was, 'don't admit to anything.' The only men who get in trouble are the ones who admit to it. All the other men who are listening to their lawyers say plead not guilty, they are getting away with it.

Finally, many of the women verbalized how the people in the system don't understand what it is like to be abused. Women felt that the those involved in the justice

system required specialized education to increase their understanding and sensitivity of intimate partner violence and the impact of abuse on women.

Not all of the experiences with the justice system were negative. Several of the women were extremely positive about the treatment and support they received and a few did feel safer once they became involved with the justice system.

The [Domestic Court worker] so you know what's happening and what your rights are and what you can do about it, the police coming and taking him away right now, and the judge talking to both of us. And, she, she uh, didn't just, it wasn't just the guy's life, she actually talked to us and she was actually expressing to him what he was doing to like his sons, and it was like uh, she gave us about a half and hour talk.

The uh, people that were calling me made me feel safe knowing that I could, if he did do something crazy, I could call or I could, which is better than what it was before [comparing to prior abusive relationship] where I didn't feel safe at all and that I had to stay in order to be safe.

3.2.4.2 Health Care System

A primary care physician was identified by one participant who reached out for help and was subsequently rejected. In retelling her story she did disclose that her husband sexually abused her, but in the following excerpt she does not explicitly state her daughter being sexually abused, but the implications in her narrative certainly indicate this to be the case.

When I don't got no bruise, no, you know? Nothing to prove anybody. And, my ex is very smart. He know to put down and calling us names, that way we would be bruised inside, not in the outside. He destroy us from the inside first and I could not open up to anybody to show them how hurt that is inside. I just wish I have a jacket or some kind of skin to show (starting to cry). (pause) Even sexually, you know, I went to the doctor and even the doctor turned me

down too. (pause, crying, tape cut out) The doctor wouldn't do nothing. Wouldn't open the diaper to check. He just said, tell me, tell me. Yea, just turned me down, you know? You go to people, you reach out so much and people turn you down. I just didn't wanna bother anymore.

Not all experiences with the health care system were negative. Several women spoke positively about medical system support received from primary care physicians, dentists, psychologists, emergency room nurses and physicians. These women were not dealing with sexual abuse.

3.2.4.3 Child Welfare

Many of the women's experiences with Child Welfare were favourable. Though most of them feared the power and ability Child Welfare wielded in being able to remove the children from the home, most of them felt that they had benefited from having Child Welfare involved.

For several of the women, however, the involvement of Child Welfare was horrific. They had negative feelings about their dealings with Child Welfare. The women were not only dealing with the consequences of their own abuse but at the same time were trying to remain strong for their children and to parent the best way they could. Add to this mix Child Welfare involvement and the underlying fear and knowledge that they have the legal authority to remove the children is terrifying for these women. They felt re-victimized and made to feel inadequate all over again.

They made me do a KGB statement, and they videotaped it, about all the abuse. They just sat there and asked me everything over again. I had to relive it all AGAIN [upper case added], and again, and again. And it just felt, I felt violated. It's hard enough, I mean, people always say they understand, and 'I know what you're going through', and you don't have a clue! Just put yourself, imagine yourself

in my shoes for a day. You have no idea what I've been through, what I'm going through, and what I'm dealing with. I have no time to heal myself; I'm too busy trying to heal them! It's way too hard.

Ya, as soon as, as soon as we went to a shelter and identified that [abuse], Child Welfare was involved. They're awful. I hate them. I wish I'd never, ever become involved with them, ever. The worker I have is just awful. I haven't talked to her probably in a month and a half. I have my ECSS worker, I have ____ downstairs trying to call them and leave them messages and she won't return her calls, she's not even my welfare worker. She's an investigator. She should have passed my case on months ago and she hasn't. I don't know what I'm supposed to be doing with my kids. She's awful. She's awful. She's not helpful at all.

3.2.4.4 Shelters

Shelters were another agency that some of the women had experiences with. For some it was the one place where they finally felt safe and heard.

They were amazing. They were really great. Just the amount of counseling, I felt, I felt protected by them, I did. Like, more so by them than the police. They kept me safe. They were there for me 24 hours a day. You know, 2:00 in the morning, I was scared, I wanted to talk, somebody was there to talk. It was amazing. It was really good. I would never ever trade my experience there for anything.

I went to shelter, I feel good. I had a bed, a bedroom, I have food. I had everything, I had everything there. I was there when I started to laugh again. They helped me a lot. ... They did was what I needed.

For others the experience was quite different. They spoke about men being brought into the shelter by some of the residents, substance abuse amongst the residents and inconsistency with enforcement of policies by shelter staff. The following participant tells her story about reporting to police the infractions of policies that she observed on one occasion.

And I was like, this is a women's shelter, there's no men allowed in here. 'Well, you're going to have to talk to the workers about it.' I know! I was like, this is a women's shelter. Do you not understand this? And they wouldn't do nothing about it. The police wouldn't come and remove him. I went downstairs and I smelt alcohol. And then they ended up waking _____, which is like the neighbour. She just moved out, the lady I told you about. Yea, her daughter, she's 13, they just finished waking her up because they were having sex so loud. I was like unbelievable! And she's still living here.

One woman reported the difficulty she had getting into a shelter because she was not being physically abused. Her husband was a drug addict and she was told that her children would be taken from her if she allowed them to be exposed to him. She lived in constant terror of having her children removed from the home. It was not until her husband had taken all of her credit cards, all of their money and they were evicted from their home that a shelter finally allowed her and children access.

As several women experienced, the number of days a woman can remain in a shelter is limited. Without financial resources these women's choices were limited and she had to return to her abusive home.

In summary, the service systems were not women centered according to the women. Overall, the women felt that they were not being heard, supported or understood.

3.1.4 Resilience

The women who participated in this study displayed varying degrees of resilient behaviours while in their abusive relationships, in the process of leaving, and in coping with the problems they faced after leaving their relationships.

Many types of resilient behaviours utilized by the women were identified in the narratives. For example, social skills were used including effective communication and maintenance of an outside network of friends and family.

I started meeting other people and his condition worsened, like from the moment I met him. But, mine got better, because you know, I was just home alone with the kids and, and all of a sudden I'm thrown in a completely, I'm thrown in a completely different universe where I have to study hard and be around bright people. So, all of a sudden we're in two complete different planets and he didn't like that one bit. And it opened my eyes to what my life was with somebody like him around. So, it just, basically forced me into action. I had decided a year ago that school was my way out and I was, I wasn't about to give it up because of his abuse. You know, so, I just decided to do it on my own and, he's gonna have to take care of his problem.

The ability to overcome difficulties and utilize a variety of strategies to facilitate leaving was also employed by women in this study.

I had made up my mind that I had to get out of this marriage, I couldn't stay in this until I was 80, I just knew I couldn't. The kids were getting close to adult age, age of consent, and I started a get out of town savings account that he didn't know about, and a bank he didn't know about. And it was only 20 or 30 dollars per pay cheque, but it was just a little bit of money, a little bit of money. And then, um, I had gone for counselling, I had called the Sheriff, King and through the EAP [Employee Assistance Program] at work, I had gone to...I forget what it's called, just to get counselling and to get legal advice about how do I get out of the house, cause you can't do it overnight.

The belief that the women had some measure of control over outcomes is another example of resilient behaviour. Women identified problems and/or decisions within the relationship and in the first number of months after leaving and spoke about their belief that they would be able to overcome those problems.

So I'm going to learn how to deal with this situation myself and that's what we're talking about in my group. I'm like ok, how do I behave; what do I do in a situation like that? You know, the first time it happened I called the police there wasn't a problem, the second time now I feel, I felt like I was being punished because I dropped the charges before.

I really don't want him again coming near me or to even come around here saying I've got something over at her place I left. If it's left here, I'm not going to be responsible for it. I'm gonna just toss it out in the garbage, and that's what I did. I tossed whatever I found that belonged to him; I said if he wants it he can go dig it out and take it.

Several women were told by their abusers that if they left, the abusers would retaliate by harming them or members of the women's family. The women believed the abusers and actively made plans to keep themselves and their families safe.

And he's a sharpshooter with the police so I, you know, you go to ____ Mall and you just sort of look around and you think, is his van here? And if it is, which bush is he hiding behind? So you just start shopping at a different place every Saturday, and not being predictable, parking in a different place every day at work.

Many women believed that they had some control over their families' safety and none of them allowed the threats to force them to stay with or return to their abusers. The women's belief that they were able to exert some measure of control is a component of resilience.

...you, you phone 911. You either hit that alarm button on that thing when you're in the house. They [children] all have cell phones. I said, you see him, he comes close to you, you dial 911.

Some of the women in this study demonstrated resilient behaviour in their ability to make sense of what happened to them without taking responsibility for it. A few participants stated that they believed that the abuser was responsible for the abuse.

Other women stated that both of them were responsible; the abuser for committing the abuse and themselves for allowing it to happen.

...So what made me, what made me deny all of those behaviours and make choices, and that's where I'm at. But I know exactly why I chose them.

The final example of resilient behaviour was the ability of the women to grow through finding meaning in their experiences after leaving the abusive relationships. Finding meaning involves gaining perspective by choosing the way in which one interprets and explains what happens to them.

I was, I was only 17. I couldn't afford to live for \$600 a month or whatever in the basement suite. I couldn't afford to do that, so I needed him there. At the end, eventually I'm like, I can do it. He made me believe I needed him. And then eventually I realized I was the one that was working. I was the one that was paying the bills, you know? I didn't need him for anything.

3.1.5 Gender

Gender informs each of the five themes. In describing how gender informs each of the themes it may seem there is no overlap or blurring between them, which is not the case. All the themes are connected and difficult to fully isolate one from the other. Intimate partner violence is a very messy and complex issue. For example, how physical violence impacts women's health and how it is gendered is easy to understand. The severity of the injuries described by the women in this study conveyed the imbalance in sheer physical strength and power between the perpetrator and the survivor. Men on average have more upper body strength predisposing the women to grave injury, harm, disability, or death making the impact on women's health.

However, we cannot say that only the battering is gendered. How these women view the meaning, context and consequences of the violence is gendered. One woman's response to one incident of physical violence was to lie on the floor and throw up. Her story illustrates how she chose to remain in a private place (her home) rather than run to or phone a public institution to obtain help. If the attacker had been a stranger, however, she likely would have. Instead she falls to the floor because she is physically hurt and since she is emotionally distraught she throws up. In telling this story, the participant conveys the immediate and short term consequences of the abuse to her physical and mental health and the likely long term impact on her health from the accumulated abuse she has suffered over eight years. Not reporting the violence because of embarrassment, shame, guilt and not being believed. These are responses that not only this participant but many of the women gave.

When reading through the transcripts, a few women spoke about how men and women are treated differently, specifically regarding the various service agencies they were involved with. They understood and were able to articulate the patriarchal hierarchy that these agencies operate under. For these same women, an emerging understanding of these same hierarchical principles that apply in the social institution of marriage and family were verbalized. However, the majority of the women spoke about themselves and their abusers on an individual level. This has the effect of obscuring the role of gender as a social institution that shapes individual experiences.

3.2 Gender's Influence on Health and Violence

Gender is a social institution. This means that gender is the socially constructed range of roles, ideas, and behaviors that every society creates to distinguish between

women and men and girls and boys. While gender is something enacted by individual people, gender is also embedded in social institutions. By stating that gender is a social institution we are saying that women and men are treated differently because of their biology. For example, governments, economic systems, community, and marriage and family institutions are all gendered. That is, these institutions treat women and men differently and are treated by women and men differently.

Figure 1 is a simple representation of a very complex issue. It is an attempt to illustrate the relationship among gender, health, and violence in order to understand the effects of abuse on women's health. With the appropriate lens (gender), perpetrator and resilience were additional themes that were identified during the analysis. The connections are complex but can be clearly drawn out of the women's narratives.

The context, meaning and consequences of IPV for women are different than for men. Therefore, gender shapes violence.

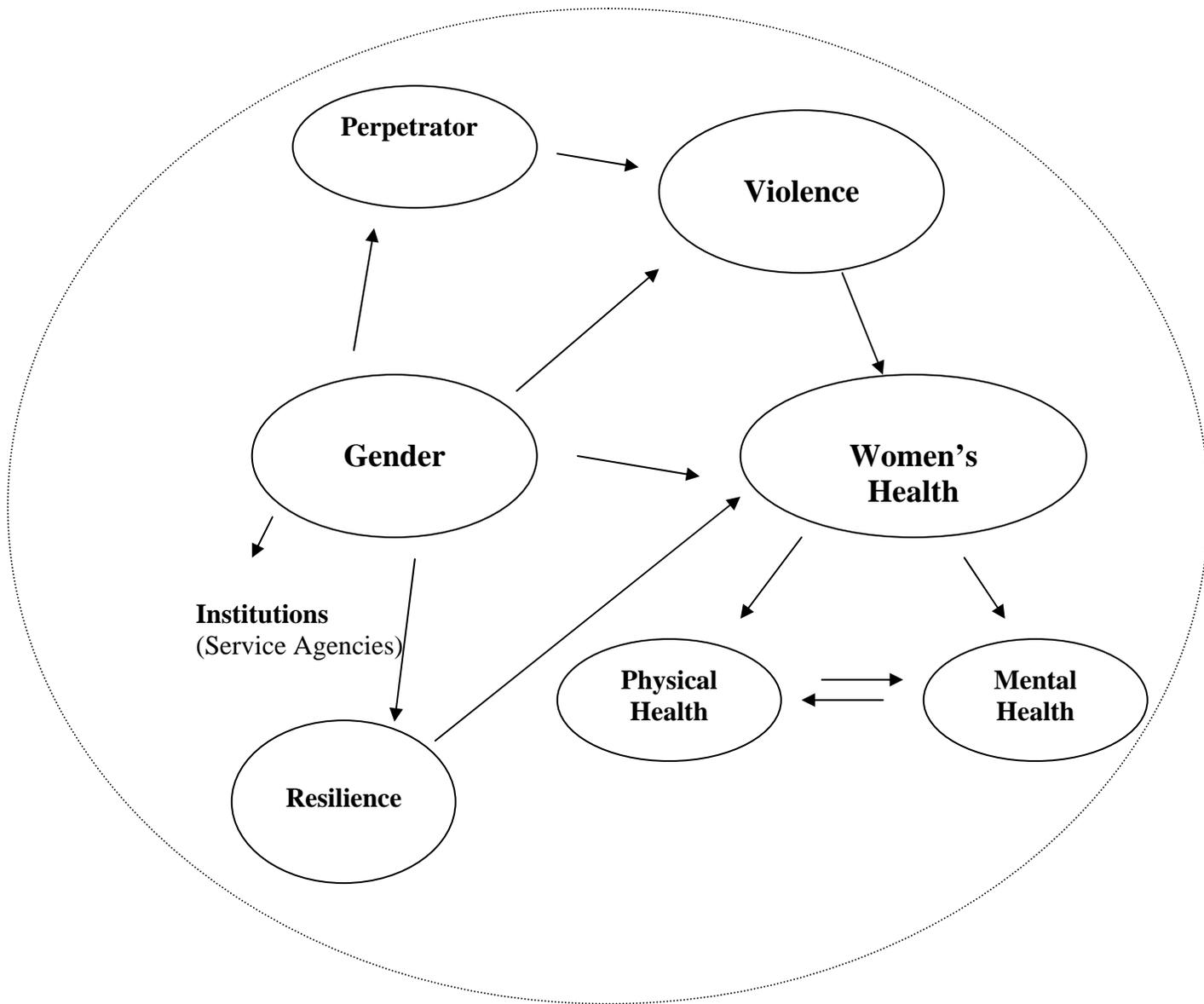
Women suffer more injuries and more severe injuries than men. Victimization is associated with significantly more negative psychosocial outcomes for women than men (Anderson, 2002; Kimmel, 2002). Gender thereby informs health, both physical and mental. Resilience, in this context, affects women's survival and is highly gendered.

Gender informs the perpetrator theme; men are more likely to be the perpetrators of aggression and women the recipients of partner violence (Johnson, 1995). In turn, the perpetrator's attitudes and health affect violence. Substance abuse, attitudes towards relationships, (i.e. male privilege), mental health, and witnessing or experiencing abuse in his family of origin contribute to how violence is influenced. Violence, then informs women's health.

Service agencies are gendered in how men and women respond and are responded to within these institutions.

Gender informs all aspects of women's experiences. The arrows, which link the categories and sub-categories, demonstrate that the gendered nature of abused women's health is inter-linked and inter-connected. The large circle encompassing these components represents institutions. Institutions influence these components in a wider social context. The broader influences are not discussed because it is beyond the scope of this paper.

Figure 1. The relationship among health, gender, and abuse



CHAPTER FOUR: DISCUSSION

This chapter includes a summary of the qualitative research conducted for this study, including a summary of the study's purpose, discussion of the findings, and support of current research and literature. Strengths and limitations of the study are also discussed.

4.1 Summary of the Study

The purpose of this qualitative study was to assess the intersections of gender with health and violence in a group of women who shared two experiences, intimate partner violence (IPV) and having the police called to the home.

4.2 Discussion of Findings

The women who were interviewed appeared eager to speak about their experience and provided valuable insights into the physical and mental health consequences of abuse; the various forms of violence they experienced; the men who were, and in some cases still are, their intimate partners; and the various systems they came into contact with as a result of the abuse they suffered.

Despite the horrific relationships women endure, one of the commonalities identified throughout the women's narratives was resilience. The resiliency displayed by the women was integral to their survivorship in all stages of their relationship; during, while leaving and having escaped the relationship.

Overall, the women's descriptions of their experiences were lengthy and richly detailed. The woman began the unfolding of their story at a much earlier point than was requested by the interviewer and extended the narrative in an attempt to establish the abuse in its historical context. This is not to suggest that the women did not find it hard to

speak about abuse. The women hesitated and showed how difficult it was by sighing, pausing, laughing nervously, and crying. Still, all of the women described different experiences of violence and/or threats (not always directly), and the corresponding physical and mental health consequences. This study cannot establish whether violence causes particular health problems (with the exception of injuries); however the results of this study are consistent with other research which has found strong associations between violence and both physical and mental health symptoms of ill-health (Coker et al., 2000; Campbell et al., 2002; Heenan & Astbury, 2004).

The manner in which these women spoke about the different types of abuse in terms of the consequences they suffered made it clear that violence was a better suited term than abuse to describe the multiple types of violence they were subjected to. When the heart-wrenching stories are read it is clear how each event of abuse was violent to these women. Even if an incident did not lead to being hit, the intent was violent because she knew it could happen and more than likely would happen.

The severity of the injuries described by the women in this study conveyed the imbalance in sheer physical strength and power between the perpetrator and the survivor. IPV is generally, though not exclusively, imposed on men by women. Men are physically stronger and so if abuse turns violent it is often with severe consequences (Statistics Canada, 2005, WHO, 2002). Men on average have more upper body strength predisposing the women to grave injury, harm, disability, or death. This explanation, however, treats gender (in this case, physical size and strength) as an individual characteristic. To understand how gender influences violence, one must also consider the ways in which gender is used to organize social life. For example, men's size advantage is

not simply an individual trait; it is built into the organization of how we choose our mates. Although men, on average, are slightly heavier and taller than women, on average, there are many women who are larger and taller than many men. Gender norms organize heterosexual pairings such that tall women often seek male partners who are taller than themselves, and short men seek shorter women (Loseke & Kurz, 2005). Men's size advantage is thus a social construction of heterosexual relationships; it is not simply a reflection of individual gender characteristics.

Despite the serious and at times life threatening injuries incurred by the women, emotional abuse was described as being much worse to endure. Being humiliated, degraded, controlled and manipulated ate away at their self-esteem, confidence and joy of life. Many studies have documented the negative emotional, social, and psychological consequences of partner violence for female victims (Stark & Flitcraft, 1996, Anderson, 2002; Statistics Canada, 2005). When proof of the abuse is visible only on the inside, abused women have difficulty being taken seriously. This in turn reinforces the abuser's message that she is insignificant and worthless.

The violence the women experienced were not isolated, individual events, but rather a pattern of repeated behaviors. Assaults were repeated against the same women by the same perpetrators. These assaults occurred in different forms, including physical, sexual, psychological and financial. While physical assaults may not have occurred for some frequently, other parts of the pattern could occur daily. The use of these other tactics was effective because one battering episode built on past episodes and set the stage for future episodes. All tactics of the pattern interacted with each other and had profound effects on the women. Examples of the commonly used control tactics

included: isolation, using the children, damaging relationships, attacking property and pets, and stalking partners or ex-partners. It was the abuser's use of physical and sexual force or threats that gave power to his psychologically abusive acts. Psychological abuse became an effective weapon in controlling his partner because she knew through experience that her abuser would at times back up the threats or taunts with physical assaults.

Despite the impact of IPV on their health, many of the women chose to stay with their abusive partners. It was evident that the men carried the power in these relationships and the women gave them this power in several ways. They minimized the abuse, made excuses for the abusive behaviours, and lied to various authority figures to protect the perpetrator and in turn the family unit. They viewed unsuccessful relationships as representing failure on their part to fulfill traditional feminine expectations of every *girl's dream* - a "boyfriend, a fiancé, a husband, and the fairy tale prospects of living happily ever after with one's children in a nice house in a good neighbourhood" (Lorber, 1994, pp. 70).

Once cohabitating, the balance of the power shifts in that men are normally considered to be the *heads of the household* and they usually control the economic resources. Even when the women are the wage-earners, men can take economic power because the women want to preserve the family. Women carry a greater responsibility for holding their families together (Lorber, 1994), but this responsibility also heightens their vulnerability. Women are also isolated from support networks of family and friends (Dobash & Dobash, 1998) thereby increasing their dependence on their abusive partner.

Women carry a double burden; working outside the home and inside the home. Responsibilities inside the home may include housework, childcare, eldercare, socialization, (e.g. holiday traditions, entertaining), all of which women do more of compared to men (Bianchi & Spain, 1996). This often sets them up for failure at least in the eyes of the perpetrator.

The abuser's mental health, substance abuse and addictions were significant health issues that the women in this study identified when they spoke about their partners. While the perpetrator was not the focus of this study, it became increasingly apparent that his health status affected not only his partner's health but also the frequency and severity of the violence he inflicted. One can safely assume that issues such as intergenerational abuse, substance abuse and mental health problems create stress. Men typically respond to stress by putting on a tough image, keeping their feelings inside, releasing stress through denying the problem, abusing drugs or alcohol, or otherwise attempting to control the problem. There is support in the literature to support the theory that men react to stress by drinking and drug taking (Lengua, Liliana, & Stormshak, 2000; Mahalik & Cournoyer, 2000; Efthim, Kenny, & Mahalik, 2001; Field, Caetano, & Nelson, 2004), which exacerbates their propensity to violence (Frye & Karney, 2006). Women are assigned responsibility for the care and nurturance of others in the relationship (Lorber, 1994) and therefore may be more likely than men to feel guilt and responsibility for their partner's abusive behaviour (Langhinrichsen-Rohling et al., 1995). This in turn may contribute to depression and lowered self-esteem (Kirkwood, 1993). Women react to stress by becoming depressed (Martire, Stephens, & Townsend, 2000; Goldstein, 2006), which lowers their capacity to resist and worsens the home situation exacerbating the

men's stress. The perpetrator's substance abuse increases the frequency and severity of the abuse.

Most of the women took help-seeking action when the abuse became so severe it could not be endured any longer or the violence extended to their children. For many of the women, the institutions that deal with IPV perpetuate the problem. The burden of proof ignores non-physical violence, the courts can be manipulated, and the escape options for women are few. For example, when police demand "proof" of violence, it effectively narrows the definition of violence acknowledged by policyholders and those charged with the implementation of those policies. The focus then is physical violence, which can be proved with documentation of physical injuries, but the pattern of financial violence, emotional violence, domination, and coercion goes unrecognized, is background or minimized.

Women are more likely than men to experience poverty upon dissolution of a marital or cohabiting relationship (Kurz, 1995). These patterns are consequences of the way in which gender organizes labor and compensation patterns and they have implications for the way in which women and men experience intimate assault.

Qualitative studies of heterosexual women's experiences of partner violence victimization consistently find that women feel trapped into violent relationships due to their inability to earn enough to care for themselves and their children (Kirkwood, 1993; Kurz, 1995).

Social change has to occur around gender roles and expectations rather than trying to fix this pervasive problem with programs about interpersonal relationships. The

women spoke in very clear voices that teaching anger management; incarceration; and counselling is not enough nor is it that effective.

System responses to abused woman must be consistent, accessible and inclusive as she works through the process. Her full participation should be encouraged and should include access to information, and honouring and respecting her voice in decision making.

Women and men will experience partner assault differently because they are differentially situated within societies organized by gender inequality. This perspective suggests that although rates of perpetration and victimization may not vary by sex, the consequences of victimization will differ for women and men because these groups face different opportunities and constraints.

4.3 Strengths and Limitations

Qualitative research often focuses on small samples of participants. Consequently, research findings derived from such studies are often dismissed as anecdotal and not transferable. The value of qualitative research, however, lies in the diversity and depth of the data collected and analyzed and the complex understanding attained of the context and conditions under which particular findings appear (Luton, 1996). Moreover, qualitative research using small samples is often very useful for identifying future research questions and directions.

4.3.1 Strengths

The strength of this study is that it captures the impact of abuse from the perspective of women who experienced abuse. However, others involved may have experienced or perceived these episodes differently. The purpose of this study is not to

generalize about this population but rather to extend our knowledge on how women experience abuse; consequently the representativeness of the sample is not the primary concern. Still, caution must be exercised in transferring the findings from this study because the impact of violence might be experienced differently by those with different demographic characteristics or by those who do not access services and therefore not identified as potential participants for this study.

The uniqueness of this sample of women, in that virtually all samples in the literature are clinic or shelter based, is also a strength of this study. The women's accounts of violence and its affects were like those of women from clinics or shelters reported in the literature. This demonstrates that some women are able to navigate services without access to residential programs and staff. The resilience of women may have been more salient in this sample because the participants were not in "client" roles.

4.3.2 Limitations

This study has several limitations which should be acknowledged. This study was qualitative and provided in-depth, rich data regarding women's experiences with IPV for whom police were called to the home. The results comprise expressions of life experiences that are richly within the particular context (Sandelowski, 1993), and therefore is unique to this sample at this specific point in time.

There are several drawbacks to secondary analysis (Thorne, 1994). One significant problem is the fact that the secondary analyzer may not have been involved with the collection of the data, and information gleaned from field observations or other first hand interactions with the interviewees is not available. The easiest way to surmount this problem is for the secondary analyst to have contact with the collectors of the

original data. That is what was done here; it was possible to discuss questions and issues with the original researchers as they arose. Whenever necessary, I was able to talk with one of the principle investigators on the project (save the fieldworker). Such contact was invaluable and led to clarification in the data as it was received, yet the overall value of the field experience was not conveyed.

Due to the nature of secondary analysis, I was unable to go back to the original women interviewed to recheck information or get additional insights. As questions arose, I was only able to reread the existing transcripts. Although I did so extensively, I still could not examine data that was not present. This highlights another problem with secondary analysis that is present in both qualitative and quantitative data sets. Questions that are central to the secondary analysis may not have been asked, or were asked in a different fashion. Essentially, this is a problem of missing data. As Hinds et al. (1997) point out, the data may be missing either because the phenomena in question was rarely encountered or because of a lack of attention paid by the primary collectors. It may not be possible to determine the cause of the lack of data. However, through reference to the literature and consideration of the goals of the original project, tentative hypotheses about the absences may be made. In this study, many of the transcripts had gaps because the interviewer appeared to turn off the tape recorder when participants veered off topic from the question being asked. As a result, many comments made by the women in this study were not probed as extensively, (or not recorded), as I would have liked.

Another drawback to secondary analysis was that the transcripts did not allow for tone of voice and emphasis, meaning that the transcribers' accuracy and attention to detail had to be relied upon. Additional errors could also occur with punctuation that

could potentially change the meaning or inference. To overcome this, I spoke regularly with one of the principal investigators to ensure that my understanding of the narratives was judicious.

The interviewers appeared to have technical difficulties with the audio recorder as several interviews were taped over each other and had to be excluded from the analysis. However, with 36 transcripts as the final sample, I am confident that the excluded transcripts did not limit the results of the analysis.

4.4 Conclusion

In examining the intersections in the data and in Figure 1, it is clear that gender is both a central and key determinant of behaviour and of women's health and also is so embedded within descriptions and stories that it is easily overlooked. The health consequences of IPV are multiple at both the individual and population level, yet the health sector has been slow to respond to IPV (Krug, Mercy, Dahlberg & Ziwi, 2002) or to take up gender based analysis of policies (Krug et al., 2002). As a result, two women with broken arms (one sustained in a car accident and one broken by her husband) may receive the same diagnosis and treatment from health professionals. This study shows that the response to therapy, risk of additional injury, and mental health consequences, to name a few clinical issues, may be quite different for the two women.

The study also shows that women escaping IPV show power and resistance (coded as resilience in this study) at levels appropriate to their personal experiences and context. The gendered nature of social institutions limits resilience in some ways and sanctions other forms. Women cannot be "empowered" without changing these social institutions and recognizing gender inequalities.

Intimate partner violence is a complex problem that can not be attributed to a single cause. There are risk factors, such as alcohol and drug abuse, poverty, and childhood witnessing of or experiencing violence, that contribute to the incidence and severity of violence against women. Overall, however, it is a multicausal problem, influenced by gendered social, economic, psychological, legal, cultural, and biological factors.

By applying gender perspectives to understanding the dynamics of power and control in relationships, and the societal structure violence operates in, research will be pushed towards answering questions of how gender matters. In this way we draw closer to developing effective strategies for reducing the appalling rates of intimate partner violence.

This study gave voice to women who need to be heard and in doing so increased our understanding of the gendered nature of abused women's health.

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APPENDIX A: CURA RESEARCH: INTERVIEW SCHEDULE WITH WOMEN

<p>NATURE OF THE ABUSE</p>	<p>How long were you in a relationship with your partner? Were you married, living common-law, in an intimate partnership? Current marital status? If separated/divorced, for how long? When did he start acting abusively towards you? What was the nature of the abuse? Did it change over time? [If the woman seems comfortable talking about the nature of the abuse, you might ask her about] 1. the most serious incident, and; 2. the most recent or the last incident Were you together or separated when these occurred? <i>(May want to clarify if woman was living together or dating respondent when abuse occurred.)</i> Were children or any other family members present during the abuse?</p>
<p>JUSTICE SYSTEM INVOLVEMENT</p>	<p>Police</p> <p>Does your partner have a previous criminal history or involvement with the police? Were the police involved at any time because of the abuse? How did they become involved (i.e. were the police called?) Had you ever considered calling them? If not, how come? How many incidents were there that you did not call the police? If the police were involved, how many times? Did you call the police every time? How did the police respond? (i.e. laying charges, arrest partner, confiscating weapons, obtain emergency protection order, issue a prohibition/no contact order, escort woman to shelter)</p> <p>If arrested, was your partner released on bail? Were you notified? If so, by whom?</p> <p>Did the police ever lay charges against you or threaten to lay charges against you? If so, what happened? Did you make a statement to the police? Did you feel pressured to make a statement? Did you feel supported and protected by the police? Did police involvement make you feel safe? Do you feel your safety was a priority for the police?</p> <p>Was there anything you didn't tell the police? If yes, what was it? If another violent incident were to occur, would you contact the police? Why or why not?</p> <p>Were you involved (have you ever been involved) with the specialized domestic abuse unit (for Calgary – Domestic Conflict Unit)? How did you find them to deal with? How could they have been more helpful to you?</p> <p><i>(If respondent discloses disability)</i> Do you believe your disability was a factor in how police responded? <i>(If respondent is an immigrant or refugee)</i> Do you believe your immigrant or refugee status was a factor in how police responded?</p> <hr/> <p>Court</p> <p>Did the charges proceed to court? Do you know what happened at first appearance (docket) court? How did your partner plea? What was the outcome at first appearance court? Did you change or withdraw your statement?</p> <p><i>Homefront clients:</i> With respect to the Domestic Court Workers [formerly Victims Advocates], did you find their involvement helpful? In what way? If not, how could they have been more helpful to you?</p>

Did you feel your wishes were taken into consideration? Do you feel your safety was a priority for the Domestic Court Workers? Did you feel supported by the Domestic Court Workers? What did you think their role would be? Did they fulfil this role? Were you referred to other agencies? Did you follow up with the referrals? Why or why not?

(If respondent discloses disability) Did the Domestic Court Workers respond or accommodate to your disability needs?

(If respondent is an immigrant or refugee) Did the Domestic Court Workers respond to your needs as an immigrant or refugee (i.e. referrals to culturally competent services, interpreters, give information re: immigration, etc.)

Did the case proceed to trial? Were you subpoenaed? Did you testify? If not, why not? Did you change your mind about giving information to the court? What was the Crown's response to your withdrawal or change of information?

Were you offered the opportunity to make a victim impact statement? Did you complete one? Why or why not?

Were you informed about what would happen in court? Did you understand the court proceedings? Did you want to be more involved or less involved?

What was the outcome of the trial? [**sentence? probation? mandated to treatment? found not guilty? peace bond?**]

If the case did not proceed to trial, what happened?

What was your experience with the Crown Prosecutor's office?

Were your wishes taken into consideration by the Crown Prosecutor? Do you feel your safety was a priority for the Crown? Did you feel supported by the Crown Prosecutor?

Was there anything you didn't tell the Crown Prosecutor? If yes, what was this?

(If respondent discloses disability) Did the Crown Prosecutor respond or accommodate to your disability needs?

(If respondent is an immigrant or refugee) Did the Crown Prosecutor respond to your needs as an immigrant or refugee (i.e. accessed interpreters)?

Did you understand what was going on in the case? Were you involved in the case? Did you want to be involved?

If you received information about your case, what kind of information did you receive? Where did you get your information?

Do you believe your wishes were taken into consideration? Did you feel supported by the Court?

What are your opinions of the court system? Did you feel safer? Do you feel your safety was a priority for the court system?

If another violent event were to occur, would you do things differently? Explain.

(If respondent discloses disability) Did the court respond or accommodate to your disability needs?

(If respondent is an immigrant or refugee) Did the court respond to your needs as an immigrant or refugee?

	<p>Protection Orders</p> <p>Have you ever had a Restraining Order? Peace Bond? Emergency Protection Order? If yes, did these help you to feel safer? Were you aware of these Orders? If you did, how did you hear about them?</p> <p>If another violent event were to occur, would you apply for a Restraining Order or protection order again? Did you use the Court Preparation Program and Restraining Order Program at Calgary Legal Guidance?</p> <hr/> <p>Family/Civil Law</p> <p>Have you been or are you currently involved in custody/access or divorce issues? How is that going?</p> <hr/> <p>Probation</p> <p>Did you have contact with the Partner Support Program through Probation? Did they contact you for partner checks? What was this like? Did this make you feel safe?</p> <p>Do you believe the probation officer properly supervised your partner? Did the probation officer monitor all conditions?</p> <p>Did you report breaches? How did the probation officer respond? What was the outcome of the breach? Did probation make you feel safe? Explain. Do you believe your safety was a priority for Probation? Explain.</p> <p>Justice System – General</p> <p>How did the justice system response affect the relationship with your partner?</p> <p>Did the justice system response enhance your safety or the safety of your children? If so how? If not, how could it have?</p> <p>Did the justice system response put your safety and the safety of your children at risk? Explain.</p> <p>Do you believe your safety was a priority to the justice system? Explain.</p> <p>If another violent incident was to occur, would you do things differently?</p> <p>Have you had previous justice (i.e. police) and/or court involvement (<i>i.e. prior to Homefront [May 1999]</i>)? Did your previous court experience differ than your present one? Did you feel safer?</p>
<p>DUAL OR CROSS CHARGES</p>	<p>What happened to the charges police laid against you? Did they proceed to court?</p> <p>Were you released on bail?</p> <p>Did you access legal services (i.e. defence attorney)</p> <p>Did you access community services (Elizabeth Fry Society)? Were services helpful?</p> <p>What happened in the first appearance court with the charges?</p> <p>Did charges against you proceed to trial? If so, what happened? What was the outcome of the trial?</p> <p>How did the charges and/or conviction affect you and your children (i.e. child welfare involvement)?</p>

**OTHER
SERVICES**

Did you ask for assistance from services specific to family violence such as counsellors, support groups? If yes, what was the response? How helpful was this response? If not, why not?

Have you ever gone to a shelter for abused women? If not, why not? If yes, how helpful was this?

If you did not seek services, why or why not?

(If respondent discloses disability) Did services respond or accommodate to your disability needs?

(If respondent is an immigrant or refugee) Did services respond to your needs as an immigrant or refugee (i.e. referrals to culturally competent services, interpreters, give information re: immigration, etc.)

What other things could have been done to help you?

Did your partner receive treatment for abuse? If so, how did he respond? What do you think of the treatment? Did you feel safer during and after he received treatment?

Did you have contact with Partner Check Program? Was this helpful (i.e. did this help you feel safer?)

Did anyone refer you to services for your children? What services, if any, did you access for your children? Were these helpful? What else could have been offered or made available to your children?

Was Child Welfare involved with you and your family when the abuse was identified? Did you find their involvement helpful? If yes, in what way? If not, why not?

APPENDIX B: CONJOINT FACULTIES RESEARCH ETHICS BOARD

APPROVAL LETTER



UNIVERSITY OF
CALGARY

CONJOINT FACULTIES RESEARCH ETHICS BOARD

c/o Research Services
Telephone: (403) 220-3782
Fax: (403) 289-0693
Email: plevans@ucalgary.ca

To: Dr. Leslie Tutty
Faculty of Social Work

Date: January 22, 2002

From: Dr. Janice P. Dickin, Chair
Conjoint Faculties Research Ethics Board (CFREB)

Re: **Certification of Institutional Ethics Review: Evaluating the Justice and Community Response to Domestic Violence in the Prairie Provinces: Interviews with Key Stakeholders (Women Respondents)**

The above named research protocol has been granted ethical approval by the Conjoint Faculties Research Ethics Board for the University of Calgary. Enclosed are the original, and one copy, of a signed **Certification of Institutional Ethics Review**. Please note the terms and conditions that apply to your Certification. If the research is funded, the sponsor should be notified, and the original certificate sent to them for their files. The copy is for your records. The Conjoint Faculties Research Ethics Board will retain a copy of the Certification on your file.

In closing, let me take this opportunity to wish you the best of luck in your research endeavour.

Sincerely,

Patricia Evans
Executive Secretary for:
Janice Dickin, Ph.D., LLB,
Professor and Associate Dean (Research)
Faculty of Communication and Culture

Enclosures (2)

cc: Research Services

APPENDIX C: ANNUAL PROGRESS REPORT



UNIVERSITY OF
CALGARY

CONJOINT FACULTIES RESEARCH ETHICS BOARD

Annual Renewal / Progress / Final Report

1. Applicant: (USE RESTRICTED: Faculty, students, staff from the UofC)	
Name Leslie M. Tutty	
Department/Faculty Social Work	
E-mail Address tutty@ucalgary.ca	Telephone: 220-5040
If you are a student, include your supervisor's name and email address here	
2. Other Participants: If another person is involved in the project, please provide their name, department or other details as required to identify them. Use an attachment, if necessary Irene Hoffart, Synergy Research Kendra Nixon, RESOLVE Alberta	
3. Project Details:	
3.1 Exact Title of the Project (and File No. if available) Evaluating the Justice and Community Response to Domestic Violence in the prairies: Interview with Key Stakeholders: Women Respondents (file #2991)	
3.2 Have you commenced this research? <input checked="" type="checkbox"/> Yes When did it commence? Date: 2001 <input type="checkbox"/> No If no, why not (attach)	
3.3 Is the study completely closed to all research activity? <input type="checkbox"/> Yes When was it closed? Date: March 2004 If the study is not completely closed, what is the expected date? Date: September 2005	
3.4 How many people participated in the research? Over 80 women respondents	
3.5 Have all modifications been reported? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If no, please attach)	
3.6 Have the results been published or presented? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, if yes, indicate where results can be located. Tutty, L. (2003, September). Specialized justice responses to domestic violence: Women's perspectives. 8 th International Conference on Family Violence, San Diego, CA.	
3.7 Have there been any complaints about the research <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, if yes, please attach information with details.	
Signature of Applicant:	
Thank you for submitting your report on the above protocol.	
As Chair of the Conjoint Faculties Research Ethics Board, I am pleased to advise you that ethical approval for this proposal has been extended to: _____ . Please note that this approval is contingent upon strict adherence to the original protocol. Prior permission must be obtained from the Board for any contemplated modification(s) to the original protocol. An annual progress/final report concerning this study will be required by _____	
Please accept the Board's best wishes for continued success in your research.	
Janice P. Dickin, Ph.D., LL.B. Faculty of Communication and Culture and Chair, Conjoint Faculties Research Ethics Board	

APPENDIX D: LETTER OF CONSENT**Faculty of Social Work**

2500 University Drive NW, Calgary, Alberta T2N 4N1

Research Consent Form: Women Respondents**Research Project Title: Evaluating the Justice and Community Response to Family Violence in the Prairie Provinces****Investigators:** Leslie Tutty (RESOLVE Alberta).

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more details about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of this study is to identify important issues and concerns about the justice system dealing with domestic violence. This is part of the study looks at the criminal court system and its specialized components (i.e. spousal police teams; domestic violence courts), various civil remedies (i.e. restraining orders, emergency protection orders, etc.) and the various systems and organizations which deal with domestic violence either directly or indirectly. In the course of this research, we will be speaking to others who have been victims of intimate partner violence, offenders, justice personnel, and service providers who work in the area of domestic violence.

We are asking you to talk about your experiences in interviews that will likely last from two to three hours. During this time we will ask you about your experiences with the justice system and other organizations that deal with domestic violence. The information that you provide will be used to assess the justice and community response to domestic violence in the prairie provinces.

D.1. Letter of Consent, P.1

The interview will be tape-recorded. After the audiotape has been transcribed into written form, the tape will be erased. If you wish, you may look at the typed transcripts and change any aspect that does not reflect your opinions or experiences. Your participation is completely voluntary and confidential. The only exception is that we are required by law to report any current child abuse that you may disclose. Further, if you are involved in legal proceedings, this interview may be subpoenaed.

You are free to refuse to answer any question and you have the right to withdraw your participation at any time. No identifying information will be recorded on audiotapes or other research materials. Signed consent forms, audiotapes and computer disks will be kept in a locked filing cabinet at the University of Calgary for seven years after completion of the research. The information that you provide will remain anonymous for the final report, nor will it be possible to name or identify any individual.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed throughout your participation. If you have further questions concerning matters related to this research, please contact:

Dr. Leslie Tutty, Ph.D. at 220-8634

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-president (Research) and ask for Patricia Evans at 220-3782.

I agree to participate in the interview as outlined above and have it used in research reports and publications.

Signature

Date

Investigator/Witness (optional)

Date