

University of Lethbridge Research Repository

OPUS

<http://opus.uleth.ca>

Theses

Health Sciences, Faculty of

2009

An apple a day won't keep the violence away : listening to what pregnant women living in intimate partner violence say about their health

Martin, Debbie F.

Lethbridge, Alta. : University of Lethbridge, School of Health Sciences, c2009

<http://hdl.handle.net/10133/2514>

Downloaded from University of Lethbridge Research Repository, OPUS

**AN APPLE A DAY WON'T KEEP THE VIOLENCE AWAY:
LISTENING TO WHAT PREGNANT WOMEN LIVING IN INTIMATE
PARTNER VIOLENCE SAY ABOUT THEIR HEALTH**

DEBBIE F. MARTIN

R.N., Galt School of Nursing, 1978
B.N., University of Lethbridge, 1996

A Thesis

Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfilment of the
Requirements for the Degree

MASTER OF SCIENCE (NURSING)

School of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

©Debbie Martin, 2009

Dedication

This study is dedicated to the six incredible women whom I interviewed. They have given me more than they received back. I have been forever changed by their stories and courage.

Abstract

Researchers have provided evidence that living in intimate partner violence while pregnant negatively impacts the health of both the women and their unborn children. The purpose of this narrative study was twofold, first to gain understanding of the meaning of health as described by pregnant women who lived in intimate partner violence, and second to gain strategies for health care professionals. Six purposefully selected women participated in two interviews. The data were arranged under five themes: loss of body health, loss of mind health, loss of spirit health, coping with loss of body, mind and spirit health, and advice for health care professionals. The results revealed that these women's health was negatively affected by living in intimate partner violence while pregnant. Universal screening, coalition building, further research, changes in health care policies, and changes in nursing education and practice are needed to properly address this serious health issue.

Acknowledgement

I am not the same person I was when I started my Master's. I would like to recognize key people who have provided support, guidance and patience in my journey.

I would like to thank my supervisor, Dr. Judith Kulig, who despite being very busy patiently gave me the guidance I needed. Dr. Jo-Anne Fiske and Dr. Ruth Grant-Kalischuk, who are also very busy, were always encouraging and provided me with important insights and advice. A special thanks goes to Judy O'Shea, who provided much-needed editing and encouragement.

I would also like to thank the College and Association of Registered Nurses of Alberta, Chinook Health (Bigelow Fowler scholarship), Galt School of Nursing, and Dr. Ed McNally for funds I received.

Finally, I would like to thank important people in my life who have encouraged me along the way. I thank my parents for instilling in me that learning must never stop and hard work is essential for success. I thank my in-laws for their support. I am deeply saddened by the loss of my father-in-law prior to my completing my Master's degree, because he always encouraged me. My children and their partners, Patricia (Jaime), Nicole (Max), and Trevor, and my three wonderful grandchildren, Brandon, Logan and Ryan, were instrumental in challenging me to complete my thesis. I want them to know, just as my parents taught me, that the world is open and we can attain any goal we set for ourselves. A very special thank you goes to my rock in life, my husband Derek, who calmed me, encouraged me, supported me, and understood my desire to gain my Master's degree. I could not have completed it without his help. Lastly, but most importantly, I thank God for the many blessings he has placed in my life.

Table of Contents

Dedication	ii
Abstract	iii
Acknowledgement	iv
Table of Contents	v
List of Tables	xi
Prologue	1
Chapter 1. Introduction	3
Discussion of Concepts.....	3
Intimate Partner Violence	3
Holistic Health	6
Intimate Partner Violence and Health.....	7
Intimate Partner Violence, Health and Pregnancy	8
Nursing.....	9
Nursing, Intimate Partner Violence, and Pregnancy.....	11
The Knowledge Gap: Significance of the Study.....	12
Research Question	13
Summary.....	13
Thesis Structure	14
Chapter 2. Review of the Literature.....	15
Introduction.....	15
Intimate Partner Violence	15
Related Terminology	15

Theories of Intimate Partner Violence.....	16
Cycle of Violence	18
Consequences for Society.....	19
Consequences for Women	20
Myths and Barriers.....	22
Intimate Partner Violence and Pregnancy.....	24
Consequences for Pregnant Women	26
Becoming a Mother.....	28
Holistic Health	30
Body Health	31
Mind Health	32
Spirit Health	33
Intimate Partner Violence and Health Care Providers	35
Summary.....	39
Chapter 3. Research Methodology.....	40
Introduction.....	40
Theoretical/Philosophical Perspective	40
Ontology	41
Epistemology	43
Axiology	44
Methodology.....	45
Research Design.....	46
Narrative Inquiry.....	46

Narrative or Story Telling	47
Data Collection	49
Selection of Participants	49
Study Size	50
Ethical Considerations	51
Informed Consent.....	51
Confidentiality	52
Recruitment Sites	52
Safety Protocols	53
Pre-Interview Contact	54
Interviews.....	55
Follow-Up Interviews	58
Post-Interview Summaries	58
Data Analysis	59
Trustworthiness.....	60
Credibility	61
Dependability	61
Confirmability.....	62
Transferability.....	63
Summary	63
Chapter 4. Findings.....	64
Participants.....	64
Individual Participants	65

Setting the Stage	68
Theme 1. Loss of Body Health	71
Before Pregnancy.....	71
During Pregnancy	73
Theme 2. Loss of Mind Health	77
Before Pregnancy.....	78
During Pregnancy	81
Theme 3. Loss of Spirit Health.....	84
Before Pregnancy.....	85
During Pregnancy	89
Theme 4. Coping with Loss of Body, Mind, and Spirit Health	92
Minimizing the Abuse.....	92
Justifying the Abuse.....	93
Making Sense of the Abuse	94
Trying to Protect the Baby.....	94
Hiding the Abuse	95
Theme 5. Advice to Health Care Providers	95
Ask And I Will Tell You if I Trust You	96
Tell Me What I Need to Know About Pregnancy.....	98
Don't Judge, Because I Need Your Help.....	99
I Would Like to Develop a Relationship With You	101
Summary	103
Chapter 5. Discussion and Implications.....	104

Strengths and Limitations of the Study.....	105
Strengths	105
Limitations	106
Discussion of Results.....	107
Health and the Health Belief Model	108
Body Health	109
Mind Health	109
Spirit Health.....	111
Quality of Life.....	113
Summary	114
Recommendations.....	115
Nursing Practice.....	115
Nursing Education	117
Health Care Policies.....	119
Universal Screening.....	121
Coalition Building.....	123
Further Research	123
Reflections and Unexpected Learnings	125
Conclusion	Error! Bookmark not defined. 126
Epilogue	128
References.....	129
Appendix A. Letter of Invitation	146
Appendix B. Consent Form	147

Appendix C. Confidentiality Agreement	149
Appendix D. Poster Invitation to Participate	150
Appendix E. Safety Protocol.....	151
Appendix F. Interview Guide	152
Appendix G. Demographic Information	153

List of Tables

Table 1. Participants' Demographic Information 65

Prologue

My daughter Mary, when she was 18 years old, developed a relationship with a man (Tom) who was 10 years older. As the relationship developed I found it more difficult to have “alone” time with Mary and was noticing other strange behaviors, such as Mary giving up her friends and waiting by the telephone for calls from Tom. I was beginning to question some of Tom’s controlling behaviors that I was witnessing. The more I asked questions, the more Mary stayed away from the family. Within a few months Mary announced that she was going to move with Tom because he had secured work near a small community in central Alberta. I begged her not to go but she was determined. She was unable to give me particular directions to the house but assured me she would call as soon as she could. I did not hear from Mary for a couple of weeks, and so I contacted Tom’s parents, who said Tom and Mary were doing fine and settling into their new house. I was frantic but could not do anything about it because she was 18 years old.

I constantly thought and worried about Mary. Finally she called and said all was fine. I heard from Mary sporadically over the next 18 months, until one day she told me where she was and asked if I could pick her up as soon as possible because she needed me. I jumped in the car, drove about four hours and picked her up. I was shocked and stunned to see how much weight she had lost. I also noticed bruises. She looked tired and pale and initially made no eye contact. During the drive home, Mary told me about some of the abuse she was experiencing. She told me she was not allowed money, transportation, friends or access to a telephone. That morning Mary had waited until Tom

left for work. Then she walked miles to find the closest neighbor. She confided that she had called me because she was pregnant and needed me.

Chapter 1. Introduction

This story was told to me by Mary's mother, a good friend of mine, and became the impetus for my study. The story illustrates the hardship and suffering of this young girl, but it also shows her strength and willingness to fight for her own and her baby's survival. Stories are a "way of listening and learning from each other" (Fairbairn & Carson, 2002, p. 8). After I heard this story, I had questions that I wanted to ask, but it was not the right time. This study is the right time. I have listened to and learned from amazing women who have all experienced intimate partner violence during pregnancy.

Chapter 1 includes discussion of various concepts that are integral to this study. These include intimate partner violence, health, pregnancy, nursing, and the knowledge gap in the literature, which this thesis attempts to address.

Discussion of Concepts

Intimate Partner Violence

Definition. A number of definitions of intimate partner violence have been proposed in the literature. As the World Health Organization (Roberts, Hegarty, & Feder, 2006; WHO, 2005) argued, the lack of a universal definition for this societal issue has caused problems. A standard definition is needed for research in prevalence, causes, proper screening, assessment and interventions.

Intimate partner violence does not always involve physical violence. It is any controlling behavior, such as humiliation, constant criticism, attempts to isolate, extreme jealousy, tight financial control, and threats of harm. Smith (2008b) describes it simply as "anyone who lives in fear of her partner is a victim of intimate partner violence" (p.22). For the purposes of this study, intimate partner violence refers to "the abuse of power

within relationships of kinship, intimacy, dependency or trust that endangers the survival, security and well-being of another person” (College and Association of Registered Nurses of Alberta [CARNA], 2008, p.1). This definition was chosen for this study because it is sanctioned by the professional organization for Registered Nurses (RN) in Alberta.

Prevalence. Intimate partner violence is a health, safety and societal issue. It poses increased risks to women and during pregnancy to their unborn children. Chamberlain and Perham-Hester (2000) describe intimate partner violence as the leading women’s health issue and identify it as a public health priority.

Intimate partner violence has no boundaries. This dark side of a prevalent societal issue transcends people’s finances, marital status, gender, education level, age, country of origin, race or sexual orientation. It is difficult to obtain a complete picture of the full extent of intimate partner violence because it often remains hidden. Intimate partner violence happens all around the world. The WHO (2004) claims that from 10 to 69 percent of women worldwide experience abuse from an intimate partner. The higher rates of intimate partner violence are found in countries where there are increased inequalities between men and women.

According to Statistics Canada (2005), 7% of Canadian women experienced intimate partner violence during the five-year period of 1999-2004; this equates to 653,000 women across Canada who experienced some form of intimate partner violence in each year. Furthermore, women in Alberta experienced the highest rate of intimate partner violence in Canada at 10%, and British Columbia and Saskatchewan were close behind at 9%.

Across Canada, 38,000 incidents of intimate partner violence were reported to the police in 2006, accounting for 15% of all violent incidents (Statistics Canada, 2008). Women in Nunavut and Quebec experienced the highest police-reported rates in Canada at 20%, and close behind were Alberta (18%), Prince Edward Island and the Northwest Territories, both at 16%. The lowest proportions of police-reported intimate partner violence incidents were recorded in British Columbia (8%) and the remaining Atlantic Provinces (8 to 10%).

The above-noted statistics show a large discrepancy between the number of incidents and the actual reported incidents, illustrating one of the many issues related to intimate partner violence. The lack of reporting can be due to concerns with the woman, her partner, the police, the justice system or society as a whole.

Populations at risk. In 2005, Statistics Canada identified certain populations in our society who are particularly vulnerable:

- the young, in particular those under 25 years of age
- those in common law relationships, who were three times more likely to experience violence
- those in relationships less than three years in length
- Aboriginal women experience three times more intimate partner violence than non- Aboriginal women, particularly the more serious types of violence
- those with partners who were frequent heavy drinkers experienced 44% more intimate partner violence.

The World Health Organization (2004) included two additional vulnerable populations:

- women who have experienced emotional abuse in relationships, an important predictor for future physical violence
- women in marital separation, a critical time of concern when the risk of being killed increases.

In 2005, Statistics Canada reported income, education and place of residence (urban or rural) as low risk factors for intimate partner violence.

Holistic Health

Definition. Optimal health is defined as a “balance of physical, emotional, social, spiritual, and intellectual health” (O’Donnell, 1989, p. 3). In other words, health is “a dynamic, holistic state encompassing mind, body and spirit dimensions, not simply the absence of disease” (Youngkin & Davis, 2004, p. 104).

Significance. We are holistic beings, greater than the sum of our parts. Therefore it is important for women to understand their perceptions about the effects of intimate partner violence on their holistic health. According to Olshansky (2000), when we think holistically we refer to a “philosophical belief in which the parts can only be understood in relation to the whole entity.... Optimal health care is comprehensive, complementary, balanced and encompasses a biobehavioral, mental, emotional and spiritual approach to wellness and well being” (p. 5). Within our bodies, all three areas of mind, body and spirit health are interconnected and hard to separate, as one affects another. For example, if we break a leg, need surgery or are depressed, we are distressed physically, mentally and spiritually. The women participating in this study were asked how they thought the

abuse affected them physically, mentally, and spiritually. Their responses show how integrated our holistic health is, as one physical symptom leads to other symptoms in the areas of mental and spiritual health. For example, one woman reported that her loss of physical contact affected her mental health, in particular her self-esteem, and therefore affected who she was as a person.

Historically, women's reproductive health system has been viewed from the perspective of women's health, whereas other systems in women were viewed from the perspective of men's health. As Youngkin and Davis (2004) explain, "It is now known that women respond differently physiologically, emotionally and cognitively....Women's healthcare is evolving to a comprehensive approach which involves physical, social, emotional and spiritual needs" (p. 102). When we focus on women's holistic health and wellness, we need to use the framework of body-mind-spirit (Karren, 2006; Olshansky, 2000; Scaer, 2007), which is being used to inform this study.

Intimate Partner Violence and Health

Intimate partner violence can affect body, mind and spirit health in many ways. The longer the abuse goes on, the more serious are the effects on the victim's health. Generally, women who experience intimate partner violence have worse health than the average population. Many victims of intimate partner violence suffer physical injuries (Alberta Justice, 2005; Alexander, 1993; Bair-Merritt, Blackstone, & Feudtner, 2006; Best Start, 2003; Bonomi et al., 2006; Campbell, 2002; Coker et al., 2002; Hayward, Steiner & Sproule, 2007; Health Canada, 2002; Kramer, Lorenzon, & Mueller, 2004; McCracken, 2008; McGarry et al., 2006; Moore, 1999; WHO, 2005). Some are minor,

such as cuts, scratches, bruises, and welts, while others are more serious, such as broken bones, internal bleeding, chronic pain and head trauma, and can cause lasting disabilities.

Intimate partner violence may leave invisible scars by causing emotional harm, for example, low self-esteem, anger, stress, anxiety, panic attacks, depression, post-traumatic disorder, and suicide (Alberta Justice, 2005; Alexander, 1993; Austin & Boyd, 2008; Best Start, 2003; Bonomi et al., 2006; Campbell, 2002; Carlson, McNutt, Choi, & Rose, 2002; Coker et al., 2002; Frank & Rodowski, 1999; Golding, 1999; Jones, Hughes, & Unterstaller, 2001; Lynch, & Graham-Bermann, 2000; McCracken, 2008; McGarry et al., 2006; Moore, 1999; WHO, 2005; Wuest, Merritt-Gray, & Ford-Gilboe, 2004). The harm that has occurred with the abuse may make it hard for victims to trust others and to be in relationships, thus affecting their quality of life. Harmful health behaviors have been linked to intimate partner violence as well. Victims are more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual activity. This in turn puts them at risk for other medical health issues.

Intimate Partner Violence, Health and Pregnancy

Pregnancy is an important experience in a woman's life, and pregnant women are not immune to intimate partner violence. The estimated prevalence of intimate partner violence in pregnancy is 6 to 8%, and this range is considered low due to women's under-reporting of the problem (Smith, 2008b; SOGC, 2005). If we were to apply this range to Southern Alberta's former Chinook Health Region's 2239 live births in 2005, it would suggest that between 134 and 179 women would have experienced intimate partner violence while they were pregnant in this health region (CHR Annual Report, 2007).

Intimate partner violence during pregnancy has been linked with delays in obtaining prenatal care. This is significant because, as research demonstrates, pregnant women living in intimate partner violence have increased poor health outcomes such as sexual transmitted diseases (STIs), pre-term labour, dehydration, vaginal bleeding, severe nausea and vomiting, kidney infection and urinary tract infections (Bacchus, 2006; Bloom, Curry, & Durham, 2007; Bohn, 2000; Chamberlain & Perham-Hester, 2000; Cloutier et al., 2002; Libbus et al., 2006; McFarlane, Parker, & Soeken, 1996; McGarry et al., 2006; Sharps, Laughon, & Giangrande, 2007; Smith, 2008b; Stewart & Cecutti, 1993). Complications to the fetus may include miscarriage, low birth weight, stillbirth, intrauterine injuries, and death (Murphy, Schei, Myhr, & DuMont, 2001). Pregnant women living within intimate partner violence ideally should visit their health care professionals more frequently to monitor potential pregnancy complications due to the abuse.

The stress of intimate partner violence takes a huge emotional toll on women, who may experience increased smoking, drug and alcohol abuse, poor maternal weight gain, and depression (McGarry et al., 2006; Martin, Casanueva, Harris-Britt, Kupper, & Cloutier, 2005). These could further complicate these women's and their babies' health.

Nursing

Definition. Nursing is a healthcare profession focused on the care of individuals, families, and communities so that they may attain, maintain, or recover optimal health and quality of life from birth to the end of life (CARNA, 2008).

Nursing and health. Nursing has long been committed to holistic health, where health is viewed as a resource for everyday life, not the objective of living. The College

and Association of Registered Nurses of Alberta is the licensing and professional body for RNs in Alberta and CARNA's (2003) nursing practice standards state the following:

Nurses must recognize that health is more than the absence of disease or infirmity and must work in partnership with people to achieve their goals of maximum health and well being.... With respect to the self, the person is made up of four equal parts (the physical, the emotional, the mental and the spiritual) and each of these parts must be nourished in order to live a healthy, happy and productive life. (p. 14)

I undertook this investigation in part because of the importance of its implications for nursing practice. Registered nurses view people as unique, complex beings who must be considered as a whole in order to understand and effectively promote their health according to their individual life circumstances, health needs and goals. Clients' life experiences and health are interconnected, interdependent and continuous and cannot be separated into isolated episodes. People have the capacity for self-direction, learning, making choices, coping, adapting and changing (CARNA, 2003).

Registered nurses are professional caregivers. Values fundamental to professional nursing include the following: safe, competent, and ethical care; health and well-being; choice; dignity; confidentiality; justice; accountability and quality practice environments (CARNA, 2005). Registered nurses incorporate these values into their practice through compassionate involvement with clients, maintaining and fulfilling commitments and maintaining personal integrity and professional behavior. Caring is inherent and central to nursing practice.

Role of registered nurses. Registered nurses are employed in a variety of work places. These include hospitals, community health sites, homes, schools, physician offices, plus many more settings. Registered nurses use the nursing process to deliver care to clients. The nursing process is a patient-centered, goal-oriented method of caring that provides a framework for nursing care. It involves five major steps: assessment, nursing diagnosis, planning, implementation or intervention, and evaluation.

Although their role may vary by setting, the RN promotes and facilitates continuity of care across care settings and between care providers. One of the honored roles is that of advocacy, where the RN assists clients in navigating the health-care system through understanding its structure, system and process, and provides them with strategies for working within that system. This role of advocacy puts a moral and ethical obligation on the RN to address systematic issues that oppress marginalized groups. Women living in intimate partner violence fall into the category of a marginalized group. The RN is in a unique role to address social inequity as advocates for health and well being (Benbow, 2009).

Nursing, Intimate Partner Violence, and Pregnancy

Nursing has the advantage of working in several settings where they are in close contact with a large segment of the population that is vulnerable to violence. Registered Nurses are seen by the public as accessible and non-threatening, which allows them to initiate therapeutic relationships built on trust. They often provide the first line of contact with the health care team and are well positioned to initiate interventions and mobilize resources.

Pregnancy is a time when women visit their health care professionals on a regular frequent basis. With nearly one in three women at risk for abuse in her lifetime, intimate partner violence is more common than pre-eclampsia and hypertension, both commonly addressed during pregnancy. Yet women are rarely asked about abuse or given information about the links between violence and their health (McGarry et al., 2006). The average number of visits during a typical pregnancy is between 12 and 13, yet fewer than half of health care professionals screen for domestic violence (Smith, 2008b). If RNs are situated within the health care team, are committed to their role as enhancing health, and are seen by women as non-threatening, the question that needs to be answered is why this critical screening is not being done.

The Knowledge Gap: Significance of the Study

A review of literature on this topic indicates that there is more to know about women's experiences of living within intimate partner violence while pregnant, the meaning of such experiences for the women involved, and the consequences for their health. Little research has focused on the lived experiences of pregnant women and their health while living within intimate partner violence. Consequently, nursing has minimal understanding of what it means for women to live within intimate partner violence when pregnant and how they view their health. Without a better understanding, many questions remain and the health care needs of these women cannot adequately be met. In facing challenges, pregnant women living within intimate partner violence have developed coping strengths that are important for RNs to identify and understand. Health care professionals need to gain a sense of the "meaning" women give to living within intimate

partner violence while they are pregnant and its negative health effects. Davis (2002) emphasizes this point:

Much can be learned by listening to what abused women have to say....Until women can acceptably use their voices to tell what they know about abuser behaviors, we will continue to find reasons why abused women are using faulty judgment in choosing partners. Not only does listening provide a vehicle for catharsis, it also validates women's experiences, allowing them to build even stronger inner resources. The collection of women's voices is pivotal for successful research studies related to domestic violence issues. (p. 1261)

Research Question

The primary research question guiding this study asks how women who live with intimate partner violence during pregnancy view their health. A secondary question asks what health care professionals, especially RNs, can learn from these women.

Summary

The findings from this study may enhance our understanding of how women who live in intimate partner violence while pregnant view their health. Including women who have an understanding of this phenomenon and are able to suggest strategies for improved care will help us to improve health care for those in one of our most vulnerable populations. Holloway (1997) stresses the importance of "knowing the target population and tailoring interventions to meet the needs and barriers that exist for them" (p. 41). A narrative study was chosen as an ideal way to unfold the rich data needed to answer the research questions.

Thesis Structure

Chapter 1 has provided an introduction to the study, including a story that was the impetus for this particular research. Concepts of intimate partner violence, pregnancy, health and nursing were discussed. This chapter has also detailed the knowledge gap and the overall and secondary research questions.

An overview of the literature is presented in Chapter 2 in order to describe the relevant concepts concerning intimate partner violence, pregnancy, holistic health, and nursing. This chapter includes a brief discussion of the significance of the study.

The design and methodology of the study are described in Chapter 3. First the underlying theoretical and personal assumptions are examined. Chapter 3 includes a description of the procedures used for selection of participants, study size, recruitment sites, data collection, the interview process and data analysis. Ethical considerations and trustworthiness are also discussed.

Chapter 4 first introduces the six women who were interviewed and then presents the findings. Several themes derived from the data are described under the main headings of health during the relationship, health during the pregnancy and advice for health care health care professionals, especially RNs.

Chapter 5 includes a discussion of the findings and limitations of the study. The results of the study have implications for health care professionals, in particular those in the nursing profession.

Chapter 2. Review of the Literature

Introduction

The literature review is essential to “recognize a previously reported concept or pattern, refer to established explanations and theories, and recognize any variations between what was previously discovered and what you are now seeing” (Morse & Richards, 2002, p. 169). This chapter examines the concepts and challenges associated with intimate partner violence, its consequences for women and society, intimate partner violence and pregnancy, the effects of intimate partner violence on women’s holistic health, including mind, body and spirit, and lastly intimate partner violence and health care professionals, in particular RNs.

The search was completed using the EBSCO collection of health-related research databases, “grey” literature (that is, the literature produced by organizations such as Health Canada), sentinel articles referenced in reviewed documents, and articles sent to me by friends and co-workers.

Intimate Partner Violence

Related Terminology

One issue afflicting intimate partner violence is its being referred to as, or used interchangeably with, many other terms, such as “battered women,” “intimate partner abuse,” “domestic violence,” “partner violence,” “gender violence,” “violence against women,” “abuse,” “wife abuse,” “spousal abuse,” “interpersonal violence” and “family violence.” The following literature review may use any of the preceding terms. Hughes (2006) and Mitchell and Lacour (2001) argue that this lack of a common terminology is a barrier for women, as individual words can carry several meanings. Hughes further states

that research in the area of intimate partner violence has moved slowly because of the many complexities of the phenomenon, including how we talk about, conceptualize and address violence. By using varying definitions and terminology for intimate partner violence there is a potential risk for important data to be missing from research studies.

Theories of Intimate Partner Violence

In order to understand intimate partner violence, it is important to look at past and present ideas about this delicate issue. Doing so involves examining the theories of different disciplines about causes. Prior to 1970, theories on family violence focused on the assumption that intimate partner violence was the product of mental illness. These theories viewed both the victim and the abuser as having certain character traits that would cause a man to abuse his wife and his wife to accept this violence. The common attitude of blaming the victim rose directly from these views. In the 1970s, the feminist movement motivated three main frameworks for societal theories: psychological, sociological, and feminist (Roberts et al., 2006).

Psychological. The theory of mental illness as a cause was dismissed by researchers because of the high rates of intimate partner violence within the community. In addition, it became apparent that women's symptoms of mental illness resulted from the effects of abuse, not the other way around. Finally, it was shown that abusive men did not have difficulty controlling their anger in any other parts of their lives, just with their wives; consequently, theories about poor impulse control traits were discounted.

Social learning theorists explain intimate partner violence as a learned behaviour; that is, abusers have seen battering in their childhood and adapted it as a strategy to control their intimate partners. Ehrensaft and Cohen (2003) report that experiencing child

abuse doubles the risk that men will abuse their intimate partner, and that witnessing violence in childhood triples the risk that individuals will grow up to become abusers. Critics of these theories ask why all of these children do not grow up and abuse, and why some men who were not abused as children and did not come from violent homes grow up and abuse (Smith, 2008a).

Sociological. Theorists in this field view social structures as having an effect on people, an effect that results in violent behaviours. These theorists look at social structures such as family, work, justice systems and community. If we look at societal roots, we see an accepted division between private and public lives which still exists today. It is comfortable for society to accept what happens behind closed doors if it stays behind closed doors, which keeps the secret of intimate partner violence hidden.

Some sociology theorists have tried to identify risk factors and predictors of violence. The one factor that has been associated with intimate partner violence is poverty, which increases risk through its effects on women's power, male identity, and conflict (Jewkes, 2002; Roberts et al., 2006; Sitaker, 2007; Smith, 2008a). Sociologists now suggest that it is more likely the combination of environmental, social, and economic factors that contributes to intimate partner violence, rather than a single cause (Roberts et al., 2006).

Feminist. Researchers with a feminist perspective view intimate partner abuse as a form of social control that emerges from the patriarchal structure and ideology of the family. The theories adopted within a feminist viewpoint reflect an unequal power relationship where social attitudes support male authority over the family (Roberts et al., 2006). From an early age, most children raised in North America will ascribe qualities

such as strength, power, height, and money to successful boys and men (Smith, 2008a). From this viewpoint of male superiority, the unequal power balance is accepted. Smith noted that 85% of intimate partner violence is violence by males against females. Critics of these theories question why all males do not abuse their partners and why some women abuse their partners.

Cycle of Violence

To understand the complexity of intimate partner violence, one must understand the seriousness of this concept to the health of the victim. The cycle of violence was first described in 1979 by Lenora Walker (McCracken, 2008). The abuse often follows a repeating pattern. There will be a period of tension when the abusing partner shows signs of aggression. This could occur from a few minutes to days before the violence takes place. The period of tension is followed by a violent episode in which the woman's partner explodes and abuse follows, such as threatening violence, hitting, throwing her down, and forced sexual acts. The violating partner usually feels remorse afterwards, and the couple goes into a "honeymoon phase." The partner may be truly apologetic and may want to make things right, promising that it will never happen again. The victim wants to believe this and usually forgives.

This pattern, known as the cycle of abuse, is difficult to break. After the offending partner realizes that they will not keep their promises to change or stop the violence, they forget the honeymoon promises and usually become indifferent. As the relationship worsens over time, the offender may feel resentment and hatred. The violent explosions usually increase in frequency and severity. Sadly, the victim begins to realize what may trigger the abuse and, knowing there will be a loving phase afterwards, may trigger an

incident of violence to “get it over with” so that it doesn’t happen in a badly timed way. This is one reason why families of the victim are often unaware of the violence, because they will witness only the loving phase of the cycle (Smith, 2008a). The cycle of abuse will continue until the victim seeks help, leaves or dies.

Consequences for Society

There are many societal consequences of intimate partner violence. Sister Theresa, a member of the Congregation of the Sisters of Mercy of Newfoundland and Labrador and Chairperson of the Canadian Health Services Research Foundation, spoke at the Primary Care Conference in Edmonton, Alberta (April 2008). She was appalled by the lack of societal response. In a talk entitled Moving Forward, she noted that we have addressed bullying in schools and safety in our workplaces but are loath to do anything about violence within our homes.

One obvious negative effect to society is financial burden. In 2003, Canada spent \$4.2 billion on matters directly related to intimate partner violence, including social services, education, labor, employment, health and medical; in the same year it spent \$871,908,503 on criminal justice (Statistics Canada, 2005).

Bonomi, Anderson, Frederick, and Thompson (2009) just released the largest United States study examining health care costs for women experiencing intimate partner violence. This quantitative, 11 year, longitudinal study involved 3,333 women who lived in the Pacific Northwest. Bonomi et al. took a random sample from the membership files of a large health plan and then conducted a telephone survey to assess intimate partner violence history. The authors were then able to review the health records to determine health care costs related to intimate partner violence. The study showed that women who

experienced physical abuse from intimate partner violence spent 42% more on health care per year than non-abused women. But the costs did not end when the abuse did, as this study revealed that women who had suffered physical abuse five or more years earlier still spent 19% more per year on health care than women who had never been abused.

A major finding from this study suggests that we should be putting more money into intervention programs designed to help women living in these situations as intimate partner violence affects women's behaviors in terms of how they use health services and the cost associated with it.

Women who were psychologically abused with verbal threats and chronic controlling behavior but had not been in the relationship for five years had a 33% increase in health care costs. Bonomi et al. (2009) attribute this to women needing to take extra time to deal with psychological abuse. As the study also revealed, women who experienced abuse, whether it was physical or psychological, used significantly more mental health services. This finding indicates that it is very important for mental health workers to ask about abuse history when working with women.

Consequences for Women

Intimate partner violence affects a woman's holistic health, which includes her mind, body and spirit health. Women who live within violence have generally worse health than the average population. They tend to have chronic problems with digestion, stomach, kidney and bladder function, headaches, and other health issues (Campbell, 2002). Women living within intimate partner violence also exhibit increased use of substances, further harming their holistic health (Alberta Justice, 2005). Health Canada

(2005) estimates that 63% of women seeking assistance with intimate partner violence have a substance abuse problem.

Hayward et al. (2007) conducted a qualitative descriptive study of eight Idaho women's perceptions of the impact of intimate partner violence. These women all had partners who participated in a court mandated treatment program for batterers following an arrest for intimate partner violence. These authors commented:

Women who are abused by an intimate partner often have more severe physical and mental health problems than women who are assaulted by a stranger, as the sacred bond of trust is shattered....Women struggle with emotions not experienced by victims of strangers and work through feelings of fear, loyalty, love, self-blame, shame and guilt. (p. 77)

In addition to physical and mental health effects, intimate partner violence has "associations with economic and social disadvantage, particularly homelessness and poverty" (Chung, Kennedy, O'Brien & Wendt, 2000, p. 53). When women's health is damaged by intimate partner violence, their ability to work and provide for themselves is affected, which makes it difficult to leave their situation. According to a national survey completed by the Public Health Agency of Canada (PHAC, 2005) for the year 2003, 30% of women affected by intimate partner violence had to cease from regular activities and 50% of these women had to take sick leaves due to intimate partner violence.

To escape the abuse, women and their children use shelters and crisis lines. The women and their children are uprooted from their residence and often leave with only the clothes on their backs. This affects women's holistic health and may affect their ability to

cope. Damaged health can affect women's ability to parent effectively, which in turn affects their holistic health, causing more damage, and the vicious cycle continues.

In 2007-2008, over 12,000 women and children were sheltered in Alberta alone; over 14,000 women and children could not be sheltered because the shelters were not able to accommodate them. In the same year over 70,000 calls were made to crisis lines in Alberta (ACWS, 2008).

Campbell (2002) reports that 40 to 60% of women murdered in North America are killed by their intimate partners. Each week between one to two women in Canada are murdered by a current or former partner, according to the Alliance to End Violence Resource Library (2008). The Alberta Council of Women's Shelters (ACWS) 2008 document states that, between 2000 and 2006, over 170 women died who were identified as victims of domestic violence. This figure represents about one-third of all homicides in Alberta in that period of time.

Myths and Barriers

Friends, family, health care professionals and others who cross the paths of women who live in violence can be a potential source of support. In fact, family and friends can help to support these women by labeling the abuse as unacceptable and work to lessen the effects of isolation and depression experienced by many of these women (Bybee & Sullivan, 2002; Carlson et al., 2002; Coker et al., 2002).

Myths regarding intimate partner violence add fuel to the fire of societal beliefs that create barriers for women living within this dynamic. Many family members, friends and others can be a source of further abuse by projecting negative beliefs regarding a woman's role in the abuse. Criticizing, blaming, shaming, minimizing and normalizing

abuse are only some of the behaviors that abused women experience from those whom they think might understand the abuse and offer support (Frank & Rodowski, 1999; Goodkind, Gillum, Bybee & Sullivan, 2003; Lempert, 1997). Such behaviors may cause abused women to shut others out and not disclose to them. For example, Smith (2008a) reports that women may even trigger abusive episodes at opportune times so that families will not become aware of the abuse. Goodkind et al. (2003) found that “Women are faced with family and friends who do not believe them, who blame them for the abuse, and/or who are too frightened themselves to intervene” (p. 349). Women who leave an abusive relationship may also feel abused by family and friends who they felt would support them. Women need support systems to confirm their experience of abuse as harmful. Barriers to leaving successfully are created by changes to women’s standard of living due to changes in income causing money difficulties and child custody battles with an ex-partner (Varcoe & Irwin, 2004), emotional difficulties, all of which make it difficult for them to access legal help, police protection, housing and so on (Wuest et al., 2004). As well, the women may need to cope with physical and mental issues that result from living with abuse (Campbell, 2002).

Harrison and Esqueda (1999) provide examples of negative myths that create barriers for women to seek help: “Battered women are perceived to be helpless, vulnerable, ashamed, weak, passive, dependant, unassertive, depressed, defenseless and predominantly White” (p. 131). These labels are disempowering to women who live in intimate partner violence, and they skew understanding from society. Alexander (1993) reports that society judges a woman who stays in a violent relationship: “She can be accused of being masochistic or having provoked the abusive behavior; and if a woman

seeks intervention or leaves the relationship, she is considered to have failed in her role and responsibility to preserve the marital relationship” (p. 234). Harrison and Esqueda (1999) report a pervasive societal myth: abuse is “a regrettable but acceptable part of marriage” (p. 131).

The most damaging myth that represents a significant barrier to women experiencing intimate partner violence is that leaving their partner will end the abuse. In fact the opposite is often the case. Fleury, Sullivan, and Bybee (2000) report that the frequency of threats before the woman leaves is related to the risk of violence she will experience after leaving. In other words, the more a woman’s partner threatens her before she leaves, the more violence she will experience after she leaves. Women who leave a relationship feeling that leaving will end the abuse may misinterpret stalking or spying behavior by the abusive partner, not realizing that these abusive behaviors have the potential to be lethal. Campbell et al. (2003) report that women who were stalked or spied on after leaving an abusive partner were twice as likely to become the victims of attempted or actual murder. Women whose partners threatened to harm the children unless they returned to the relationship had a nine-fold increase in risk for murder or attempted murder. The WHO (2004) describes marital separation as a critical time of concern when the risk of being killed increases. Negative myths cause barriers for women who are living with intimate partner violence, and these women may stay in the relationship because of them.

Intimate Partner Violence and Pregnancy

Pregnancy is a time of increased risk for abuse to start or escalate due to the abusive partner’s ambivalent feelings about pregnancy, increased vulnerability of the

woman, body changes including weight gain, mounting economic pressures and decreased sexual availability (Health Canada, 2000; SOGC, 2005). Living with abuse during pregnancy causes many problems for a woman, some arising from the abuse itself and others from the stress of being abused. This is further complicated because of the normal stressors that many couples feel during a pregnancy. According to the Canadian Maternity Experiences Survey (PHAC, 2009), the level of violence during pregnancy decreased for 47% of women who experienced abuse, stayed the same for 47.6%, and increased for 5.4%.

There are significant barriers to disclosing abuse during pregnancy, including the following:

- fear of retaliation
- fear of being reported to child protection agencies
- desire to maintain a positive public image of a normal family
- perceptions that abuse is normal or the woman's fault
- lack of knowledge
- fear of not being believed
- shame, embarrassment and guilt
- limited financial options (Best Start, 2003; Cloutier et al., 2002; Lutz, Curry, Robrecht, Libbus, & Bullock, 2006; Martz & Saraurer, 2005).

Unintended pregnancies may put women at greater risk for violence. Moore (1999) stated, "The prevalence of physical violence during pregnancy ranged from 12% among women with unintended pregnancy to 3% among women with intended pregnancies. Overall women with unintended pregnancies account for 70% of women

who reported abuse during pregnancy” (p. 307). McGarry et al. (2006) reported that 41% of the Utah women who reported abuse also reported that their partner did not want her to be pregnant in contrast to 8% who did not report abuse. Smith (2008b) notes how serious the abuse may become: “Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause of death” (p. 22).

Consequences for Pregnant Women

Abuse during pregnancy can have direct and indirect effects on mothers and their unborn babies. Women have a higher risk of experiencing intimate partner violence during pregnancy than of experiencing other health problems, such as gestational diabetes or pre-eclampsia. However, these latter health concerns are routinely screened for during pregnancy. Many different complications and adverse pregnancy outcomes are linked directly to violence such as physical trauma.

Stewart and Cecutti (1993) conducted a fundamental baseline quantitative study of 548 pregnant Ontario women. The women answered a self-report questionnaire at their physicians’ office during a routine prenatal visit. Thirteen women chose not to participate even though there was an option of anonymity. The results showed that 10.9% of the women experienced physical abuse prior to pregnancy and 6.6% experienced physical abuse during their current pregnancy. Of the women disclosing abuse in pregnancy, 63.9% stated that it had increased with the pregnancy, and 66.7% required medical treatment. The women reported the most common area struck during pregnancy is the abdomen. Such a blow may cause adverse pregnancy outcomes, such as placental separation, premature birth, fetal death, hemorrhage, rupture of organs in abdomen, or

fetal injury. Smith (2008b) adds to the list of pregnancy complications miscarriage, low birth weight, preterm labour and sexually transmitted infections.

More troubling for health care professionals are the indirect effects that stem from complex and interrelated factors such as stress, substance abuse, suicide attempts, depression, anxiety, post-traumatic stress disorder, and inadequate or late-entry prenatal care (Bohn, 2000; Health Canada, 2005; McGarry et al., 2006; Smith, 2008b). The effects of stress and adverse pregnancy outcomes have been well documented in the literature (Condon, 2004; Espinosa & Osborne, 2002; Health Canada, 2005; Martin et al., 2006, PHAC, 2009). Stressors indirectly cause women to behave in ways that are harmful to their health, such as smoking and substance abuse. Women experiencing stress may find it difficult to care for themselves by maintaining adequate nutrition, rest, exercise or appropriate health care.

Stress during pregnancy can also have physiological effects, such as upset nervous system and hormones, increased blood pressure, decreased blood flow to the uterus and fetus, increased susceptibility to infection, premature birth, and low birth weight. Espinosa and Osborne (2002) note that in pregnant women stress can release a maternal B endorphin, which in turn can negatively influence how fetal nervous tissue is developed. Stress also releases catecholamine, which can adversely affect the fetus by potentially leading to preterm labor, or placental hypoperfusion, which can lead to intrauterine growth retardation (IUGR) (Berenson, Wiemann, Wilkinson, Jones & Anderson, 1994; Bullock & McFarlane, 1989; Espinosa & Osborne, 2002; McFarlane et al., 1996; Murphy et al., 2001). The lifelong results of IUGR for the baby may include physical, mental and learning disabilities.

Becoming a Mother

Our society places expectations on pregnant women. Mercer (2004) states, “Becoming a mother assumes a positive, supportive intimate partner relationship, yet pregnancy and being in an abuse relationship often coexist and present competing behavioral demands and social expectations for the woman” (p. 228). The woman is assuming the role of becoming a mother while making decisions about her relationships, her pregnancy, her health and her baby’s health. Rubin (as cited in Lutz et al., 2006) developed a binding-in theory that describes the process that women undergo as they realize they will become mothers. Rubin’s theory encompasses four maternal tasks:

- seeking and ensuring safe passage for mother and infant
- securing and ensuring acceptance of the pregnancy and the new family member by significant others
- binding in to the child and
- giving of oneself to the dependent, valued child (p. 122)

Lutz (2005) proposes the concept of double binding, “which is the two internal opposing forces encountered by pregnant women in abusive relationships: becoming a mother and being in an abuse relationship” (p. 121). The quality of the mother’s relationship with the baby’s father affects all of her maternal tasks outlined above. Living within abuse consequently affects the mother’s goal of having an ideal, loving, supportive family and home. The mother is living in two separate worlds. In other words there is a disconnection between her private and her public life. One life is public for all to see, representing the idealized view of the woman’s life, pregnancy and family, her idealized experience of pregnancy, whereas the other is private, reflecting the reality of the hidden

physical abuse (Lutz et al., 2006; Smith, 2008b). These women spend a lot of energy putting forth the image that their life is ideal. The stress can take a huge emotional toll on women in an abusive situation. Stewart and Cecutti (1993) found that 77.8% of the 548 pregnant women in their self-report questionnaire study remained with the abuser.

Lutz (2005) generated a grounded theory of living two lives by conducting a study based on 21 in-depth interviews with 12 women who were living in abusive relationships during pregnancy. Lutz's theory resulted from the interviews, where the women described the two phenomena that were happening together, pregnancy and abuse. Few of the women left their abusive relationships while pregnant; in fact pregnancy provided reasons for reinvesting in the abusive relationship where it was important to form a family.

In a qualitative study of nurse case management interventions, Libbus et al. (2006) interviewed 35 ethnically and socio-demographically diverse women ranging in age from 16 to 34, who were at risk for abuse. The women were interviewed up to four times each during pregnancy and following delivery for a total of 43 in-depth, face-to-face, semi-structured interviews. Eighteen of the women disclosed active abuse. They indicated that they felt trapped in the relationship and would remain with the violent partner if they believed that it was in the best interest for their unborn child. This study provides more evidence in support of Rubin's binding-in theory.

Qualitative data from the above two studies suggest that becoming a mother is extremely challenging when a pregnant woman is experiencing abuse by the baby's father. The maternal processes of binding in to the baby and seeking safe passage for both the mother and her baby are complicated by difficult choices. For some, this means

leaving the abuser, but for others it means binding in to the relationship with the abuser, the baby's father, to achieve safe passage for both the mother and the baby. This includes securing the father's acceptance of the pregnancy in order to move towards being part of a "normal family." The story of my friend's daughter, Mary, showed how her baby's health and safety outweighed the other decisions she was making, in particular binding in to the relationship with Tom. She had to decide whether to stay with Tom and endure intimate partner violence with the risk of harming self and baby, or to leave and risk losing hopes and dreams of a "normal" family and financial security.

Martz and Saraurer (2005) conducted a study using participatory action research with rural women living in East Central Saskatchewan. The design included interviewing 19 women who survived domestic violence and holding three focus groups, two with survivors of intimate partner violence and one with service providers. The women had experienced intimate partner violence during pregnancy and disclosed that they left their abusive partners only when the violence escalated and the need to protect the children intensified. By leaving they risked many problems, such as poverty, fear of increased violence, loss of their homes and rejection by the community. This study shows the hard decisions that women make in trying to maintain a maternal role.

Holistic Health

In the following section, the framework of body, mind, and spirit health will be reviewed. First a definition will be provided for each parameter of health, and then studies will be reviewed under two sections: before pregnancy, which includes any period outside of pregnancy, and during a pregnancy.

Body Health

Condon (2004) states that it is easy to determine body health, as our present western medical model health system focuses on the physical. This, simply put, is the physical being of a human, which includes both the internal and external structures.

Before pregnancy. Coker et al. (2002) performed a random-digit-dial telephone survey of 6780 women age 18 to 65 who lived in the United States. Questions were asked about violence, victimization and health status indicators. Of these, 28.9% disclosed experiencing intimate partner violence within their lifetime. The results indicated that women who experience intimate partner violence are likely to report poor physical and mental health by having signs of depressive symptoms, using substances, having chronic medical or mental illness and injuries. Bonomi et al. (2006) analyzed telephone interviews with 3429 women, aged 18 to 64 years, who were randomly selected from a large United States health plan. The results indicated that the longer women were exposed to intimate partner violence, the worse their health outcomes were.

During pregnancy. Several studies have illustrated the traumatic effects of intimate partner violence on women's physical health during pregnancy. Bacchus, Mezey and Bewley (2006) performed a qualitative study based on the interviews of 16 women living in London, England who had experienced intimate partner violence in the prior 12 months. Twelve of the 16 women reported abuse during a previous pregnancy with physical injuries due to violence including cuts, bruises, burns, broken bones, broken teeth, and persistent headache. Four had suffered a total of six miscarriages, which they attributed to a blow to the abdomen. Martin et al. (2006) found that 43% of the 95 women in their qualitative study had been physically injured in the year prior to a pregnancy, and

27% of the 95 women were physically injured during the pregnancy. The women were six to seven months pregnant at the time of the interviews, which took place in prenatal clinics in North Carolina, United States.

Mind Health

Condon (2004) defines mind health as including psychological and emotional states. Injury to these states is far worse than physical injury, as the wounds are disruptive in lives and also invisible, which makes them harder to heal. Past intimate partner violence can also affect current well-being of the mind (Carlson et al., 2002).

Before pregnancy. Golding (1999) and Jones et al. (2001) conducted meta-analyses of intimate partner violence studies and found strong evidence to support that intimate partner violence is linked to various negative health outcomes. The results indicated that abused women were three times as likely to be diagnosed with depression as women who were not abused. Furthermore, abused women were 3.5 times more likely to be suicidal than women who were not abused. Fully 63.8% of abused women suffered traumatic stress symptoms compared to 12.3% of women who were not abused. Finally, abused women were six times more likely to misuse drugs and alcohol.

Physical violence is pretty clear and sometimes it takes time to come to the understanding that what women are experiencing is emotional (mind) abuse. Bonomi et al. (2009) found this to be the case in their US study of 3,333 women, and further explained that women may not actively seek services during the mind abuse.

During pregnancy. Several studies discuss the devastating effects of intimate partner violence on women's mental health during pregnancy. A prospective study by Bloom et al. (2007) of 500 pregnant women living in Oregon showed a strong association

between violence and mental health issues, in particular depression. The women in this study filled out assessment questionnaires a total of five times over a two-year period: at 13-23 weeks pregnant, 32 weeks pregnant, time of delivery and then twice in the post partum period. Bloom et al. recommended that all pregnant women should be screened for abuse and depression. Bonomi et al. (2006) also found depression rates to be higher for intimate partner violence women, even higher than for people who were recently diagnosed with heart disease. Martin et al. (2006) conducted a qualitative interview study at a prenatal clinic in North Carolina and found that 75% of 95 women studied who experienced any level of abuse in pregnancy also experienced high depression levels. Furthermore, women who were injured by their partners showed higher levels of depression.

Mezey, Bacchus, Bewley, and White (2005) studied 200 pregnant women receiving antenatal care in South London Hospital maternity services. They screened the women for lifetime experiences of trauma and intimate partner violence by obtaining information about self-harming behavior, suicidal thoughts and attempts and psychiatric history. The authors report that traumatic events are under-recognized risk factors in the development of depressive and post traumatic stress symptoms (PTSS) in women's childbearing years. They conclude that severe PTSS and severe depression are associated with physical and sexual abuse.

Spirit Health

Research into spirituality is challenging due to our culture's need to define and measure such a concept (Moloney, 2007). Moloney compared spirituality to the wind "as it is not a phenomenon that lends itself to imposed boundaries, conceptual or otherwise"

(p. 116). Within the western medical world, spirit health is not acknowledged or separated out from the body and mind (Burkhardt & Nagai-Jacobson, 2002). We almost always relate spiritual health to religion, God or a higher being (Davis, 2002). Davis (2002), who commented in her phenomenological study of 17 abused women that spirituality, is more than religion, it is learning about self, life meanings and connections with others. “Spirituality is linked to a sense of life purpose and personal identity, and is seen as a key element for individuals to find their place in the world” (Austin & Boyd, 2008, p. 30).

According to the relational model developed by Surrey (1985), women’s sense of self is primarily relational: “[Women] develop their sense of self through their ability to make and then to maintain affiliation and relationships” (p. 3). Seaward (2004) defines spiritual health as the “maturation of higher consciousness through strong nurturing relationships with both the self and others” (p. 24). This view of self-development is essential to understanding the needs of women who are living in intimate partner violence.

For the purposes of this study, spirit health is referred to as women’s sense of self, which includes life’s purpose, self-identity and development of relationships. An extensive literature review was done; however, no studies were found that related directly to spirit health, intimate partner violence, and pregnancy.

Gillum, Sullivan and Bybee (2006) investigated the importance of spirituality in the lives of domestic violence survivors. They carried out a study in Michigan State, USA on a sample of 151 women who had experienced physical abuse in the prior four months. The women were recruited from first response emergency services and to be included in

the study were required to have at least one child. Gillum et al. concluded that spirituality or a belief in God was a source of strength for 97% of the 151 women interviewed. Both the women's belief in a higher power and the support they received from their faith community were integral to their healing. Boehm, Golec, Krahn, and Smith (1999) and Giesbrecht and Sevcik (2000) found that many survivors of domestic violence turn to their religious community for strength, comfort and support.

Kreidler (1995) points out that women's experience of being hurt by someone who they believe should love, cherish and protect them causes a great deal of spiritual distress. As discussed, Gillum et al. (2006) found that spiritual healing groups can be useful to women who have survived intimate partner violence. Kreidler further relates life satisfaction to spiritual health and argues that spiritual health is necessary to restore a sense of meaningfulness and power over one's life.

Intimate Partner Violence and Health Care Providers

Health care professionals, often termed health care professionals, are individuals who provide a health care service to individuals. Registered nurses fall into this category. The majority of health care professionals (e.g., physicians, RNs, LPNs) work side by side in different health care settings. It is not always identified within studies which health care professional is providing the differing services or interventions for women who live in intimate partner violence.

Women often enter the health care system because of unique circumstances related to their reproductive organs (Youngkin & Davis, 2004). Pregnancy is one of those times when women enter the health care system. It gives health care professionals a unique opportunity to have access to these women, as many women have their only

contact with the health care system during pregnancy (Espinosa & Osborne, 2002).

Intimate partner violence victims frequently use the health care system for treatment related to the consequences of intimate partner violence, and pregnant women access the health care system for care during pregnancy. It is surprising that pregnant women who have endured intimate partner violence are invisible in the health system, considering that roughly one in ten women experiences intimate partner violence in pregnancy. Boy and Salihu (2004, cited in McGarry et al., 2006) conducted a systematic review of intimate partner violence and birth outcomes. Reviewing 22 maternal intimate partner violence deaths, they found that only two health care professionals were aware of any violence happening within the woman's lives, even though they were seeing the woman for a pregnancy.

All clinicians who provide service to women will inevitably encounter clients affected by intimate partner violence. However, Stewart and Cecutti (1993) found in a study of 548 Canadian women, based on a self-report questionnaire, that only 2.8% told a health care professional about the abuse. The Canadian Maternity Experiences Survey (PHAC, 2009) reported that 61.0% of women experiencing abuse during pregnancy discussed the abuse or received information about what to do if one is experiencing abuse. The report does not separate the above data to clarify whether they received the information about abuse after disclosing or as a standard package of information. Furthermore it does not identify with whom the women discussed the abuse.

McGarry et al. (2006) reported that just over 50% of the abused women in their study had not disclosed the abuse to anyone. The women who did disclose reported the abuse to friends (43%), family (41%), law enforcement (28%), social worker or

counsellor (23%), religious leader (17%), physician (12%), emergency department (10%), health link (8%), and other health care professional (3%). Some of the women in the study disclosed the abuse to more than one person. In the same study, 39.2% of the women reported that their health care professional asked whether someone was hurting them emotionally or physically. However, 28.9% of the women stated that the health care professional discussed physical abuse while their partners were present. The study consisted of telephone interviews of 6784 Utah women from 2000 to 2003. The women were contacted two to four months post partum and were asked questions about intimate partner violence prior to pregnancy and during pregnancy. Of the total sample of women, 3.3% disclosed intimate partner violence during the year before pregnancy, 2.7% during pregnancy, and 2% during both time periods.

Some communication difficulties exist between health care professionals and their clients (Arnold & Boggs, 2003). Some studies indicate that many intimate partner violence cases are not recognized by health care professionals. Freedberg (2006) identifies barriers for women within the US health system: “Approximately 25-50% of women who seek emergency medical care are intimate partner violence victims, however the emergency staff recognize less than 50% of these” (p. 18). Why don't health care professionals, including RNs, ask their patients about intimate partner violence? Fulfer et al. (2006) identify six reasons: fear that they would offend the women, concern that asking might affect the patient-health care practitioner relationship, time constraints, fear of opening a Pandora's box, feelings of inadequacy regarding interventions, and their own personal experiences with intimate partner violence either in childhood or at present.

Webster, Bouck, Wright, and Dietrich (2006) describe the experiences of 11 Canadian Public Health Nurses (PHNs) who screen for intimate partner violence within their practice. Webster et al. found that the PHNs' continuum of experience had influenced their practice. The novice practitioner often wanted to take control of the women's situation, whereas the expert PHN defined success with the women in terms of personal growth over time by gaining trust and being supportive of the women. Kramer (2002) found both physicians and nurses in emergency departments to be action focused; that is, they assumed that for abused women leaving the situation was the only way to solve the problem. Webster et al. (2006) argue that health care professionals need to "relinquish their need to fix it and shift the goal of intervention toward understanding where the woman is at present, not where they want her to be" (p. 146). Webster et al. conclude that abused women do not expect or want health care professionals to fix their situations, but rather to guide them in identifying a healthy relationship by recognizing patterns of power and control and making their own decisions.

Registered Nurses spend much of their work time telling and listening to various stories. Asking difficult questions is part of the role of a nurse. According to Munhall (1994), researchers need to discover a common language that will help to address these difficulties. Research that explores lived experience can improve communication and understanding among nurses and their clients. Van Manen (2003) suggests that when we ask research questions and participate in a research process we view the world from a particular position. In this study, the perspective is that of a nurse. Some of the significance and complexity of this phenomenon of pregnant women living in intimate partner violence became apparent when I was working in my current role. Women shared

their knowledge through painful stories when asking for help. Stories are a good way to illuminate the beliefs, values, and wisdom of individuals and also provide a common way for clients and nurses to engage with real life situations (Fairbairn & Carson, 2002). Koch (1998) proposes that the wealth of nursing work “is found in the intensely personal, highly emotional, often brutal stories of everyday life as lived by clients and witnessed by nurse practitioners” (p. 1183). In listening to the voices of these women, nurses have access to incredible wisdom, understandings beneath decision making, and hidden contextual issues that significantly influence choices around health (Paton, 2005). The sharing of stories allows for the development of shared understanding and the valuing of different perspectives (Fairbairn & Carson, 2002). Women’s ways of knowing and the sharing of this information through oral stories have come to be recognized as important for informing nursing practice (Leight, 2002).

Summary

The relationship between knowledge and power is a crucial issue for RN practice, education and research. Studying women who have experienced intimate partner violence is a complex and sensitive task. Add to the mix a pregnancy and another set of values comes alive. This chapter has provided a review of the literature with reference to intimate partner violence, pregnancy, health and nursing. Several studies have outlined the serious consequences of intimate partner violence for women’s physical and mental health before and during pregnancies. Very few studies have asked the women how they view their own physical and mental health, and no studies were found that asked women about their spiritual health during pregnancy. These gaps are addressed within this study.

Chapter 3. Research Methodology

Introduction

Historically, women's health has been viewed through a scientific lens that valued quantitative research methods as the sole approach to knowledge development; however, this approach has often offered a limited understanding of perplexing human phenomena that are not easily quantified (Speziale & Carpenter, 2003). Research approaches that are holistic, which explore and value women's perspectives, what they know, and how they respond to this knowledge, have come to be valued and reported in the nursing literature (Leight, 2002). Some questions can be answered by measurement, while others do not fit into the tight constraints demanded by the positivist or traditional approach to research (Speziale & Carpenter).

This chapter describes the research methodology used in the current study.

Holloway (1997) explains the meaning of methodology as follows:

Methodology refers to the principles and philosophy on which researchers base their procedures and strategies, and to the assumptions that they hold about the nature of the research they carry out. It consists of the ideas underlying data collection and analysis. (p. 62)

Theoretical/Philosophical Perspective

The researcher approaches a study with a particular philosophy or set of beliefs. Philosophical stance pursues theoretical knowledge, enlightens theoretical perspective and reveals the "what" and "how" of scientific inquiry (Creswell, 2003). Polit, Beck, and Hungler (2001) describe four concepts that underlie theoretical stance:

- Ontology: what is the nature of reality?

- Epistemology: how is the inquiry related to those being researched?
- Axiology: what is the role of values in the inquiry?
- Methodology: how is the knowledge obtained?

The researcher needs to embrace a paradigmatic perspective along with the corresponding ontological, epistemological and axiological claims in order to gain knowledge (Polit et al., 2001).

Ontology

Ontology refers to the nature of reality for the researcher (Polit et al., 2001). As Creswell (1998) states, “Multiple realities exist, including the realities of the researcher, those of individuals being investigated, and those of the reader or audience interpreting the study....The qualitative researcher needs to report on these realities” (p. 76). It is the reality, the lived experience, as passed on by the participants’ stories in the perspective of their surroundings that is of interest. My reality is that I am a RN and I gain knowledge from stories as the audience. Another reality is that the wealth of RN work is found in the intensely personal, highly emotional, often brutal stories of everyday life as lived by clients.

Personal philosophical stance. I approached this study from an interpretivist perspective, “a paradigm that sees the social world constructed, interpreted, and experienced by people in their interactions with each other and with wider social systems” (Ulin, Robinson, & Tolley, 2005, pp. 17-18). Within this framework, the study seeks discovery, understanding and insight into women’s stories of intimate partner violence. Interpretivists derive meanings from perceptions, experiences and actions in relation to social contexts. This framework agrees with using open question and

observation interviews, research participants being active partners in the data collection, and participants being aware of their engagement in the research process with the possibility of gaining insight into their own behaviors (Ulin et al. 2005). Within an interpretivist framework, research questions tend to ask why, how, and under what reasons, rather than what and how many. The former questions lead into questions designed to explore deeper subjective meaning.

Theoretical framework. During my course work before beginning this research, I searched for a framework that would shape the study. The framework for health behavior that I used was the health belief model. This model offers useful guidance for understanding risk behaviors, such as living in a relationship that includes intimate partner violence, and the connection of these behaviors to individuals' beliefs about health. Nutbeam and Harris (2004) explain:

The model predicts that individuals will take action to protect or promote health if they perceive themselves to be susceptible to a condition or problem; they believe it will have potentially serious consequences; they believe a course of action is available that will reduce their susceptibility, or minimize the consequences; and they believe that the benefits of taking action will outweigh the costs or barriers.

(pp. 10-11)

The basic premise of the model is that individuals differ in two ways: how they perceive the personal benefits or value of avoiding illness or getting well, and their expectations that a specific action can prevent illness (Ulin et al., 2005).

Applying this model to my research study, the key concepts as they relate to women are the following: perceived susceptibility: whether they are at risk for harm or a

decreased quality of life; perceived severity: belief that the consequences of intimate partner violence for their mind, body and spirit are serious; perceived benefits: perceptions of the efficacy of the recommended action to reduce health risks; cues or triggers to actions: events that increase the likelihood of actions; self-efficacy: the conviction that an action can be successfully carried out.

Epistemology

Epistemology refers to how the inquiry is related to those who are being researched and how we know what we know (Polit et al., 2001). In other words, one must examine the relationship between the inquiry, participants and the researcher. My role as a student researcher enabled me to explore sensitive data laden with values and gave me the opportunity to take the data and give back on behalf of a generally silenced group. “Philosophical underpinnings of qualitative research methods reflect beliefs, values and assumptions about the nature of human beings, the nature of the environment and the interaction between the two” (Munhall, 1994, p. 10).

My assumptions or personal worldviews for this study are the following:

- Women who have experienced intimate partner violence during a pregnancy are best qualified to provide understanding about this topic, as they can provide valuable insight.
- intimate partner violence has an impact on the health of a woman and her unborn child.
- Women are resourceful and have coping strategies.
- Women do not intentionally harm their unborn children.
- Narrative approach empowers women who usually do not have a voice.

Axiology

Axiology examines the role of values in an inquiry (Polit et al., 2001). The researcher needs to look at his or her own values to acknowledge how they might shape the inquiry (Creswell, 1998). Despite good intentions to represent participant stories accurately, the researcher becomes implicated in the interpretation of meaning, particularly when the topic is personal and value-laden (personal communication, Ruth Grant-Kalischuk, 2005).

I am a middle-aged mother of three grown children and three grandchildren. I have been married to the same man for 32 years and have not experienced intimate partner violence personally. I feel privileged to have been raised in a home where the goals and expectations were the same for all the children, who included two boys and five girls. I was expected to complete a post-secondary education and succeeded in doing so. I am a wife, friend, homemaker, mother, and grandmother.

I have been a Registered Nurse for 31 years and have worked with women and children for my whole career. I think back in embarrassment and shame to the women I let down who were experiencing intimate partner violence. When I first started my career I was naïve. Sometimes I would wonder why things were “strange” but did not ask questions. In retrospect, I suppose I did not want to believe that a pregnant woman’s partner could do something to harm her or her baby. Maybe I did not want to offend the woman by asking, but mostly I did not know how to help. The following story helped to shape my values in working with women who may have experienced intimate partner violence.

I remember Linda (pseudonym) very well. She was admitted with pregnancy and depression and stayed on our unit for several weeks. She was known in our small community as dressing “slutty” because of the clothes her husband chose for her. He really liked the thought of other men looking at his “prize” wife. She disclosed to me that her husband did not let her go out without his permission. He videotaped their sex and replayed it to her while pointing out all her mistakes and threatening her if she did not get it right. He told her that she could gain a maximum of only 10 pounds in her pregnancy. She was afraid that if she did not obey him there would be serious consequences. I never asked if she felt safe with him. She told other nurses about other aspects of her life, and together as a nursing team we discussed what we had heard and took it to the head nurse. No one knew what to do, so we did nothing, and the head nurse supported us in doing nothing.

Methodology

Methodology refers to how the knowledge is obtained (Polit et al., 2001). Qualitative research is a rewarding path by which to understand personal and social meanings of life in ways that consider the experiences and perspectives of people who have lived it (Ulin et al., 2005). Qualitative research “involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, generating rich, descriptive data that helps us to understand their experiences and attitudes” (Rees, 1997, p. 375). The interest in narrative has spread to nursing, and notions of narrative and story are being drawn upon in a number of ways in nursing practice and research. The goal of a qualitative researcher is to provide ways of

understanding experience from the perspective of those who live it (Bailey & Tilley, 2002).

Research Design

Qualitative research attempts to understand and make sense of a phenomenon from the participants' perspective. A qualitative method was indicated for this research based on the researcher's desire to understand, from the women's point of view, the meanings of their health in relation to having lived within intimate partner violence and as a means to address the sensitive nature of the topic. Thus the study naturally lent itself to a narrative inquiry as the most appropriate method. The women I interviewed had a story to tell which had deep meaning and personal connection for them, and I, as the listener, had the responsibility to recreate their story through analysis and interpretation.

Narrative Inquiry

Narrative inquiry is a qualitative approach that has been described simply as "stories lived and told" (Clandinin & Connelly, 2000, p. 20). Ulin et al. (2005) describe four characteristics of narrative inquiry:

- strives to understand the meaning people construct about their world and their experiences / analysis strives for depth of understanding
- researcher is the primary instrument for data collection, and analysis/assumptions of the researcher need to be identified
- inductive process – data needs to be gathered to build concepts
- richly descriptive from context, participants' involvement, activities, quotes, field notes, interviews (p. 39)

The purpose of a narrative approach is “to reveal not resolve the stories, although resolution may be a result” (Latimer, 2003, p. 131). In other words, the work of the narrative researcher is to show the stories or meanings from the stories that he or she has been entrusted with. The women I interviewed entrusted me with stories of their lives, their memories and their perceptions. Their stories bring up mental images or pictures that transform private experience into words and language. Narrative inquiry research involves taking these stories and then uncovering or creating meanings and understanding within these experiences, while honoring the story (Latimer, 2003). I am committed in my research to generating a body of knowledge obtained from these lived experiences. Through the story telling process, I had a deep connection to the women I interviewed. I therefore want not only to pay respectful tribute to the women I interviewed, but to produce something that will be helpful or useful.

The interest in narrative has spread to nursing, where notions of narrative and story are being drawn upon in a number of ways in nursing practice and research. As Latimer (2003) argues, “The goal of nursing research as we practice it is not to produce results that can be acted upon.... it is to produce ideas and concepts that enable nurses and fellow nurse researchers to think more deeply about their practices” (pp. 111-112).

Narrative or Story Telling

“Narration is as much part of human nature as breath and the circulation of blood” (Hurwitz, Greenhalgh, & Skultans, 2004, p. 2). Story telling has been used for centuries as a powerful vehicle for communication. Individuals make sense of their world most effectively by telling stories (Bailey & Tilley, 2002). By telling a story, the participants offer a powerful compilation of facts, thoughts and feelings (Weber, Rowling & Scanlon,

2007). Through telling their stories, individuals are able to find meanings that help them make better sense of their thoughts and emotions. They organized their experiences and weave it into a story to be told. It may be particularly important in women's health because, for many women, the traditional marriage-children stories constitute a "good story to live by" (Leight, 2002, p. 111). When my friend told me her story about her daughter Mary, she invoked in me meanings, images and questions. I was positioned as an audience and was part of the re-experiencing of the event; I was a collaborator in her retelling of her story.

Narrative is understood in nursing practice in therapeutic terms, such as "restorying" of a major life experience. This is a technique employed to facilitate greater acceptance of what has happened and a deeper understanding of self and others (Koch, 1998; Latimer, 2003). Language gives expression to experience.

The literature review revealed some opposition to storytelling as "real research," since a participant may not be telling the truth. Bailey and Tilley (2002) explain:

It is important to note that, for the interpretive researcher, the historical truth of an individual's account (story) of an event is not the primary issue, but rather the researcher recognizes that storytellers select the components of the stories they tell (construct) in order to convey the meaning they intend the listener to take from the story. (p. 576)

Bailey (1996) further explains: "The narrative reconstructions [are] attempts to account for and repair breaks in the social order as meaning-making events interpreted by the teller, then the analyst" (p. 187). Therefore, it is the reconstruction of meaning, not truth, that the researcher wants to understand (Bailey & Tilley, 2002). The storytellers select

the components of the stories they tell in order to convey the meaning they intend the listener to take away. As Frank (2000) states, “Stories as acts of telling are relationships ... stories reaffirm what people mean to each other and who they are with respect to each other” (p. 354).

Data Collection

This narrative study follows the guidelines proposed by Creswell (2003) for data collection and analysis. Although typically occurring simultaneously, the processes are described separately. Personal in-depth conversational interviews with volunteer participants in a selected setting initiated the data collection process. Interviewing continued until data saturation occurred.

Selection of Participants

Qualitative research, including narrative inquiry, normally uses small non-random sampling techniques, since control, manipulation and generalization are not the intent (Polit & Beck, 2004; Speziale & Carpenter, 2003). A purposive sample was sought for the study, with the guiding principle that participants must have experienced the phenomenon and must be able to describe what the experience was like (Polit & Beck, 2004). From an interpretive perspective, the investigator views ordinary people as experts by virtue of the experiences and ideas they can share and their willingness to help explore the research problem (Ulin et al., 2005). The participants, in this case women who have experienced intimate partner violence while pregnant, are the experts and have knowledge of a “certain way of being in the world” (van Manen, 2003, p. 39). Since life experience is the criterion for selection, some researchers refer to this method of selecting participants as criterion sampling (Polit & Beck, 2004).

The researcher decided that participants in this study must meet several criteria. They must be over 18 years of age and able to provide consent. They must be self-identifying volunteers who speak English and must self-identify that they are not at present pregnant. In order to participate, participants must have experienced intimate partner violence while pregnant within the past five years. They must not be using medications or substances that may hinder thought processes and must not have a diagnosed mental health condition that could curtail full participation. A letter of invitation (see Appendix A) was handed out to potential participants. The letter identified the focus of the study, the researcher, the criteria for participation, and the means by which those interested could make contact.

Study Size

Predetermination of sample size is inappropriate and less clear in qualitative studies (Speziale & Carpenter, 2003; Ulin et al., 2005); therefore, purposive and snowball sampling strategies were used to obtain a variety of women who could contribute depth and richness to the data. The depth of the data and degree to which the data adequately answer the research question directed the number of participants and consequently the number of interviews required (Munhall, 2001; Ulin et al., 2005; van Manen, 2003). In this study, sampling and data collection were continued until data saturation was achieved, or in other words, until little new information was being obtained. It was anticipated following a review of the literature that saturation of the data would be achieved after interviewing four to twelve women (Munhall, 2001; Polit & Beck, 2004; Speziale & Carpenter, 2003; van Manen, 2003). The final sample size was six in-depth interviews.

Ethical Considerations

The following issues were dealt with prior to the first face-to-face interview: gaining participants' consent, ensuring confidentiality, transcribing the data verbatim, storing data, making a token payment for each interview, explaining the participants' right to stop an interview and to have the tape recorder turned off, explaining participants' right to cease participation and for the researcher not to use information already given, debriefing after interviews for both the participant and researcher, arranging for counseling to be available, and reporting of legally bound issues.

An application was sent to the Ethical Review Committee in the Office of Research Services at the University of Lethbridge for approval to conduct the interviews needed for this study. Approval was received after one revision was made on the participants' consent form (Appendix B).

Prior to the first interview, a transcriber was hired to transcribe the interviews. The transcriber signed a statement of confidentiality (Appendix C). Narrative data is very personal and intimate, and the maintenance of confidentiality was paramount. The data were and continue to be stored in a locked file cabinet. The participants were informed that interview tapes and transcriptions would be destroyed five years after the interview.

Informed Consent

It is important that participants know what is being asked of them. Participants were given details about the interviews and what they would entail prior to the initial face-to-face meeting. At this first meeting I reviewed the consent form (Appendix B) with each participant to ensure that she was aware of the general nature and goals of the study, and that she understood the consent information. Participants were informed that

their participation was voluntary and they had the right to withdraw at any time without consequences.

Risk and benefits of the study were explained along with potential adverse effects, particularly the possibility that feelings and memories about the abuse might come back. Participants were reminded of the availability of a counsellor, provided by the Young Women's Christian Association (YWCA), if they required one. They were also reminded that disclosure of child abuse would be reported to the proper authorities as per legal requirements. Consents were obtained from all participants. The women were offered a copy, and one woman chose to accept.

Confidentiality

Several steps were taken to protect the confidentiality of the women. Respect for participants' privacy was promoted through verbal and written information on the consent agreement. Only the researcher knows who participated in the study. A code was used in place of names on all transcriptions. In the write-up of the analysis of the results, each woman was given a pseudonym. A list that identified names and the corresponding codes and pseudonyms were placed in a locked location, along with the consent forms. No personal information that might identify the women was used in the thesis. The transcriber signed a statement of confidentiality (Appendix C) prior to transcribing.

Recruitment Sites

My first contact was with the managers of the YWCA Harbour House and Lethbridge Family Services, which offer women programs and counselling, including for situations such as intimate partner violence. The managers were given posters (Appendix D) which, following approval through appropriate administrative processes, they were to

post in private and public places within their agencies. Within a few weeks, over ten telephone calls were received requesting interviews. My intent was to put up posters at other agencies, such as Transition House, the Court House, University of Lethbridge and Lethbridge College, but I did not need to do so.

The potential participants had two options in order to participate in the study. The first option was to fill out the letter of invitation (Appendix A) with their name and safe contact telephone number and give it to the administration of one of the above agencies. The agencies (YWCA & Lethbridge Family Services) ensured participants' anonymity by putting the information in an envelope and having the participant seal the envelope. The envelope was then placed in the manager's mailbox to give to me. The other option was to telephone the confidential number listed on the poster invitation for participants or letter of invitation and then to leave their name and safe telephone number on the answering machine.

Safety Protocols

The very nature of this study might involve possible risk for the woman if she were to talk about intimate partner violence without safety measures. Safety protocols (Appendix E) were set up using Langford's (2000) guidelines for developing a safety protocol in qualitative research involving battered women. The protocols fell into three sections: participant contact, interviews, and confidentiality. These women were potentially risking their personal wellbeing and trusting me with their sensitive stories; consequently, safety was of the utmost importance.

Pre-Interview Contact

The initial contact with each participant was by telephone. For the participants' safety, I never left a message if there was no answer, and I asked at the beginning of the telephone call if it was safe to talk, before going on. The plan was that, if someone other than the woman answered the phone, I would say I was a salesperson. During the initial contact, I screened to ensure that participants met the inclusion criteria, and to start building a trusting relationship through conversation prior to the initial face-to-face interview. During this telephone call, I explained the purpose of the study, sought oral permission for audio tape recording of the interview, and answered any questions posed by the prospective participant. It was important for the woman to know what I was asking for the study, with no hidden surprises.

Each participant and I agreed upon a date and time for the conversational interview, to take place at the YWCA, a safe environment for both of us. I instructed each participant that on-site counseling would be available if she felt she needed it during or after the interview. Childcare was organized with the YWCA for those who would need this service. Lastly, I told each participant to think about things she might want to say about living within intimate partner violence while pregnant. In particular, I wanted her to think about how it affected her health and about any advice she might have for health care professionals. I phoned the day before the interview with a reminder of the date and time of the interview and reminded each participant of things she might want to think about for the interview.

Interviews

For this narrative study, I wanted participants to feel that they could tell their stories with minimum interruption. However, I needed certain questions answered in order to obtain rich and clear data. It was decided that the best way to complete this objective was to conduct a semi-structured interview. I developed an interview guide (Appendix F) that I used for the conversational interviews.

An interview guide was used to illuminate the meaning of five broad dimensional areas:

- experiences of intimate partner violence,
- experiences of intimate partner violence during pregnancy,
- experiences of health and intimate partner violence
- experiences of health, intimate partner violence, and pregnancy
- experiences with health care professionals

The guide consisted of an introduction, an initial question on what they thought abuse was, and then an invitation to begin telling their story. Before attending the interview, the women knew the topic of this study: their stories about their health during the relationship and in particular during pregnancy. Before ending each interview, I reviewed the guide to see if all the questions that were of interest had been addressed. Each interview finished with a broad question.

I began data collection by greeting participants at the door at the YWCA. It was important to promote a comfortable, safe, relaxed environment in which the women would feel safe to reveal their innermost feelings and tell their stories of their experiences. The participants were led to the interview room, which was set up ahead of

time with tape recorders, tissues and two bottles of flavored water. Each participant chose the chair she wanted to sit on. We sat face to face so that I could observe facial expressions during the interview. Tape recording the interview allowed me to concentrate on the process of the interview, focusing my attention on the participant and engaging in eye contact and other non-verbal communication.

A light “warm up” conversation was held prior to addressing any questions, obtaining informed consent and commencing the interview. I asked participants if they wanted a copy of their informed consent. I again assured each woman that there was counselling available if she felt she needed it at any time during or after the interview. I informed participants of the duty to report any child abuse and then answered any questions they had regarding this point. Before the actual interview, I collected demographic information (Appendix G) and assured each woman that she could stop the interview at any time. I answered any last questions, and we agreed upon a signal that she could use asking me to turn off the tape recorder. Three of the women stopped their interview because of emotional reactions to the topic they were discussing. They then took time to pull their thoughts together and continued on, as they wanted to finish the interview.

I allowed the women to tell their stories, only interrupting to clarify things that they were saying. The goal of the interview was to obtain rich descriptions directed toward the focused area of the study. After each participant had completed what she wanted to tell me, I quickly looked over the remaining questions to see if all had been answered; if not, I posed these remaining questions to her. The interview guide (Appendix F) served as a tool for gleaning the rich data needed for the study.

I was the research instrument posing the questions and participating in data collection (Munhall, 2001; van Manen, 2003). Registered Nurses frequently use formal and informal conversations or communication techniques to acquire data within their practice; they are, therefore, skilled in the act of formal and informal interviewing (Arnold & Boggs, 2003). Since I have been a RN for over 30 years and am currently still practicing, I believe that I have effective verbal and non-verbal communication skills needed for the interviews.

During her face-to-face interview, each woman was encouraged to reflect on and describe her experience of living within intimate partner violence. Interviewing allows entrance into another's world; as van Manen (2003) proposes, we can "borrow" the experiences of others. Broad open-ended question(s) formed the basis of the conversational interviews. Interviews from this perspective situated me as the researcher or "unknower" and the participant as the "knower" (Munhall, 1994).

I listened intently to each participant's story or description, noting certain phrases or words, and then probed the participant, if necessary, to expand on her meanings or to give examples of the information she had shared. Probes included expressions such as "Go on," "Can you tell me more?" and "Can you give me an example of that?" They also included non-verbal prompts that encouraged the women to expand on their thoughts. Using questions that invited the participant to think about differences facilitated depth during interviews (Rubin & Rubin, 1995).

Van Manen (2003) implied that good conversations begin with silence and return to silence. Once silence was reached and I turned off the tape recorder, the participant and I engaged in a debriefing conversation in which the woman could ask any questions.

I again offered counselling. Only one woman, who found the interview particularly painful, saw the counsellor after the interview. When we came to silence again, I handed each woman a thank-you card, that contained the \$50 token payment. The women were aware of this token payment, as we had discussed it earlier and it was mentioned on the poster. Two women did not take the money as they stated they did the interview for themselves as a way of 'healing' from their experiences.

Follow-Up Interviews

Each participant was seen in a face-to-face interview that lasted approximately one to two hours. I then followed up with a telephone interview within a couple of days of the initial interview in order to answer any questions and also to give the participants a chance to ask any questions that had arisen and to express any final thoughts on the topic.

Conversational interviews are only one resource for collecting data. Other resources, such as personal diaries, journals, literature, and art forms, are valuable and relevant when viewing phenomenon from a holistic perspective (van Manen, 2003). For this study, these other forms of data were included if offered by the participants. Two participants chose to show me their journals or diaries, which they had brought to the interview. Another drew a picture for me and brought it to the interview; it represented her journey in a life that included intimate partner violence.

Post-Interview Summaries

The researcher must acknowledge, monitor and reflect on his or her personal orientations, subjectivity and biases in relation to the study and participants (Munhall, 2001). Immediately after each interview, I prepared a summary of the interview consisting of a general description, my personal feelings and observations. I also had

each participant's demographic information, which I reviewed to make sure all the details were included. After each interview, I added information to these sheets by highlighting the main points that the participant had shared. These notes helped me to reflect on the interview. Reflection is important as it helps the researcher to review the interview and prepare for the upcoming ones. While reflecting on each interview, I was able to review the participant's emotional level and other pertinent issues, and I also reflected on my feelings during the interview.

Data Analysis

Polit and Beck (2004) describe analysis as "labour intensive activity that requires creativity, conceptual sensitivity, and sheer hard work" (p. 394). This simple statement holds an amazing amount of truth. Narrative analysis involves looking at how the story is arranged, features of the telling, cultural and personal resources that are drawn upon, as well as the ways in which the narrator tells the story to convince the listener of its authenticity (Riessman, 1993). Data collection was followed by review of the data, which in turn gave new direction for new data collection (Giacomini, 2001). Data were constantly compared back and forth between interviews to determine commonalities, variations and relevant categories (Creswell, 1998; Polit & Beck, 2004; Webb & Kavern, 2001). Throughout this process similarities and differences were monitored.

Each interview was confidentially transcribed verbatim by a transcriptionist. I reviewed the transcript along with the taped interview. All identifying details were changed to protect informant confidentiality. Analysis consisted of reading and re-reading several more times to increase familiarity with the transcripts. Qualitative research data analysis usually involves segmenting, coding and categorizing stories. The

interview data were examined using thematic analysis, which involved “the search for and identification of common threads that extend throughout an entire interview or set of interviews” (Morse & Field, 1995, p. 139).

Creswell’s (1998) six-step method of data analysis and interpretation was used. The steps include reading the transcriptions thoroughly, identifying significant statements, identifying phrases, developing patterns, relationships, and meanings, clustering these into themes, and producing a narrative description. After reading the interviews several times and immersing myself in the data, I began to organize the women’s words into categories, identifying themes and patterns. Initially I physically cut the interviews into segments identifying health, health care professional, and other. It was useful to focus on the research question when splitting data into segments. The health pile was further divided into body, mind and spirit health. Once this was completed each pile was further divided into pre-relationship, relationship, pregnancy and other. I used colored highlighters to identify significant words and statements in each of the coded topics. Lastly I put “like ideas” together to form five major themes drawn from the stories the women entrusted to me. The themes will be discussed in Chapter 4.

Trustworthiness

Trustworthiness is simply defined as establishing validity and reliability in qualitative research. In qualitative research, the goal of trustworthiness is to “accurately represent study participants’ experiences” (Speziale & Carpenter, 2002, p. 38). No one process of ensuring rigor or trustworthiness is appropriate for all qualitative research (Emden & Sandelowski, 1999; Koch, 1995).

The gold standards for establishing trustworthiness proposed by Lincoln and Guba (1985) were used in this study. Nurse researchers have used Lincoln and Guba's four criteria for establishing rigor or trustworthiness in qualitative research: credibility, dependability, conformability, and transferability (Polit & Beck, 2004).

Credibility

Credibility or truth value focuses on confidence in the truth of the findings (Ulin et al., 2005). To be selected as participants in this study, women needed to have knowledge of the topic at hand. My aim was to understand the meaning and perspective of the women I interviewed. How better to judge if my understandings are accurate than by giving my accounts back to these women and asking them to judge? Lincoln and Guba (1985) refer to this as member checking. I was able to contact only four of the six women to discuss my themes with them. Two of the four cried when we discussed some of the findings, as they realized what their situation was and how far they had come. This reaction validated that the reported findings represent their experiences. Credibility has been enhanced by the inclusion of excerpts from the women's primary accounts in their own words. Another way of checking for credibility is through peer checks. My supervisor has read several of the interviews and has compared them to the analysis.

Dependability

Dependability is the ability to replicate the processes used to obtain the results (Ulin et al., 2005). Qualitative data are not likely to produce exactly the same results or answers; however, it is expected that the data are dependable and "the research process is consistent and carried out with careful attention to the rules and conventions of

qualitative methodology” (p. 27). I have outlined the step-by-step process used for participant selection, data collection, analysis, and interpretation.

Confirmability

Confirmability refers to a way of knowing that the researcher has maintained the distinction between personal values and those of the study participants, and that the data reflect as accurately as possible the participants’ perspectives and experiences. Applying the concept of reflexivity contributes to the confirmability of results. Reflexivity refers to the influence that the interviewer’s presence may have on the data collected (Russell & Kelly, 2002). Researchers have an obligation to observe and document their own roles in the research process, including assumptions, biases or reactions that may influence the collection or interpretation of data (Ulin et al., 2005).

To ensure rigor in my narrative research, I will discuss the possible effects that my past experience may have had on the interview process. I previously discussed in detail my personal situation coming to the study. Prior to starting the interviews, I knew that my experience in working as a nurse with high-risk pregnant women might make it hard for me to not to act as a counselor for the women. This issue adds complexity to the situation, as I was caught between the standards of my academic discipline for rigorous research and the ethical responsibility of my caring profession to help people in need. It was important for me to anticipate as much as possible any ethical responsibilities that arose from these interviews. I had to make a conscious effort not to revert back to acting as a counselor during the interviews. I also acknowledged the five assumptions about women living within intimate partner violence that were noted earlier.

Transferability

Transferability refers to the ability to spread the findings to a wider population. What is important is whether the conclusions of a study are transferable to other contexts. The lessons learned from a qualitative study can be applied to other contexts if samples have been carefully selected to represent viewpoints and experiences that reflect the key issue in the research; therefore, the “goal is to produce data that are conceptually, not statistically, representative of people in a specific context ” (Ulin et al., 2005, p. 27). Lincoln and Guba (1985) state, “[The] task is to provide an index of transferability; it is his or her responsibility to provide the data base that makes transferability judgment possible on the part of potential appliers” (p. 316). In this study I located women who had experienced the phenomenon of intimate partner violence while pregnant and interviewed them about their views on their health during this time.

Summary

A well organized research design assures the relevance and integrity of the research. Flexibility is the key to a good qualitative design as new questions and analysis become apparent. The researcher needs the flexibility to “examine the data as it arrives, throw out invalid assumptions, restate questions, and shape the design as the study progresses” (Ulin et al., 2005, p. 63).

This chapter has included a discussion of the narrative research method used and the steps taken in conducting the research, including the gaining of ethical approval, the selection of participants and the interview process. The chosen method of analysis was applied to the stories told by the participants in the study. This rather arduous process yielded noteworthy results.

Chapter 4. Findings

This chapter begins with a description of the sample, a summary of the characteristics of the women who were interviewed, and a brief introduction to each participant. Following the introduction is a brief section on setting the stage in which the women discuss the beginnings of the relationship and how they define abuse. Major themes drawn from the women's stories describe the loss of mind, body and spirit health of the women according to their remembered experiences of living in intimate partner violence before and during pregnancy. Sub-themes were developed under each of these major themes to demonstrate the loss of health for the women of this study. A theme of coping emerged from the descriptions of behaviors these women carried out in order to survive and be part of the relationship. This is followed by the women's suggestions for health care professionals and lastly after the interview thoughts described by the women are discussed.

Participants

Six women, three of whom are Caucasian and three Aboriginal, agreed to be interviewed for this study. Their ages ranged from 22 to 42, and they were in the abusive relationship for 6 to 12 years. Three women had been in one abusive relationship, two had been in two abusive relationships, and one had been in four abusive relationships. All of the participants had left the abusive relationships; however, one woman stated that her abuser keeps coming back into her life and she allows it. At the time of the interview, she was separated from the abuser. Five of the six women have a high school diploma, and three have post-secondary education. Table 1 details the demographic information of the participants in the study.

Table 1. Participants' Demographic Information

Pseudonym	Age	Years in Relationship	Highest Level of Education	Relationship With Abuser	Yearly Income
Amy	32	12	College Diploma (currently attending university)	Separated (married)	27,000
Brenda	34	7	University Business Degree (just graduated)	Separated (married)	Student loan (plus money from sale of home)
Carol	30	11	College Certificate	divorced	18,000
Dani	31	10	High School	Separated (common law)	Supports for Independence (SFI)
Elly	29	6	High School	Separated (common law)	26,000
Fiona	42	8	Grade 10	Divorced	Supports for Independence (SFI)

Individual Participants

Knowing more about each of the six women helps one to understand their background and gives a human face to each woman in the study. These women represent more than numbers and themes, as they have lived the stories on which this study is based. The description of each woman includes her age, number of children, present relationship with abuser, duration of their relationship, when the abuse began in the relationship, the type of abuse experienced, how the abuse changed during the identified pregnancy, and lastly whether the abuse is still going on.

Amy is a 32-year-old mother of three children and is separated from her husband. She met her husband when she was 19 years old and dated for almost a year. She has no recollection of abuse during this time. They were married less than six months when the emotional, mental and financial abuse began. She first experienced physical abuse between her first and second pregnancy. Amy obtained a restraining order after 12 years in the relationship, and her husband had to leave their home because of an emergency protection order. She then moved closer to her parents for support, but the abuse still continues through the relationship of her husband and their children. He is refusing to give her a divorce, even though he has been engaged twice to other women.

Brenda, a 34-year-old mother of one child, is currently separated from her husband. She met her husband at age 25 after a rebound from another difficult relationship. The relationship with her husband lasted seven years and was abusive from the beginning. Brenda experienced increased episodes of abuse during her pregnancy. Although she perceived the abuse was mainly verbal, emotional and financial, she also described her husband grabbing her arm and throwing her out of the house or shoving her, on more than one occasion. Her husband has made no contact with her or her child since she left two years ago. Brenda has just graduated from university and has accepted a position in another community.

Carol is a 30-year-old mother of three children, two of whom live with her and one lives with her grandmother, and is divorced from her abuser. She began her relationship with her ex-husband when she was 17 and was married to him for 10 years. The physical, emotional and mental abuse began after they were together for about three years, at a time when her husband's alcohol use had increased. The abuse, including

physical abuse, escalated during pregnancy. Initially after the relationship ended the abuser stalked her; however, he has since moved on to another partner and has nothing to do with her and their children.

Dani is a 31-year-old mother of two children; one lives with her and one has been adopted, both children have the same father. She has had an on and off common-law relationship with her abuser for about 10 years. She initially met her partner on the streets after she ran away from home at 16. The physical, mental and emotional abuse was present right from the beginning of the relationship and escalated with her pregnancies. This partner had broken into her house and stole her wallet, which included cash and all of her identification two nights before the interview.

Elly is a 29-year-old mother of three children. She had a common law relationship with her abuser for six years. The physical, emotional, and financial abuse she experienced began about three months into the relationship. The physical abuse quickly became very violent. The violence did not stop with the pregnancy, and Elly stated that the closest she came to fearing for her life was during pregnancy. Her abuser has since found a new relationship and had no contact with her for about four months at the time of her interview.

Fiona is a 42-year-old mother of one living child. She lived with her ex-husband for eight years and was married for seven of the years. Fiona endured physical, mental and spiritual abuse, which began about two months into the relationship and continued through her pregnancies. She lost her first son when she was six months pregnant and lost a set of twins when five months pregnant. She suspects that she lost the babies due to abuse but is not certain, since the physician told her it was because of other factors (she

did not disclose to the physician that she was living with intimate partner violence). She was thrilled to carry her daughter to eight months of pregnancy. Her abuser had several relationships with other women while they were together, and Fiona was treated for several sexually transmitted infections. She is now divorced and has no contact with her ex-husband.

Setting the Stage

Growing up. All of the women discussed some of their childhood experiences at some point during the interview. Two of the women had been abused as children, and four had witnessed abuse of their mother or female relative. However, one participant stated that as a child she was neither abused nor had witnessed abuse. Five women identified their previous experiences with having been abused or witnessing abuse as a strong influence on their expectations in relationships. The following excerpts indicate how they felt their childhood experiences affected their relationships.

With my childhood, it was my foster mom who was abusive. She was physically abusive, she was emotionally, psychologically abusive and then I took that, got into unhealthy relationships where I was really insecure [such as being] jealous, possessive, and then I got into the relationship with (xxxx) and it was drugs, drug addiction, sex addiction. (Dani)

I'm still trying to figure that out. That's one of the questions that comes to mind, is where exactly does all this start. I do know that all my relationships were abusive. I think my first boyfriend/girlfriend relationship started about grade ten, and they've all had an abusive element, now that I look back. I don't know why I stick myself in that situation. I do know when I was younger I was quite overweight so I think I got abuse even from family in a sense, oh well if you lost weight you'd do better, or you know you really have to lose weight, or you'd be so good looking if you lost weight. So I think I'd classify that as verbal abuse and I think it kind of started that way in which I started to abuse myself in a sense, kind of all the negative words and putting myself down, and then looking back it's like I almost in a very sick way got myself in relationships that had that abusive edge, it's like almost like a weird craving, like it just felt like natural that's what I thought was normal. (Brenda)

Like I didn't know how to stand up for myself, because I was always scared, I was a scared little girl from seeing my parents go through that, and seeing my older sister going through that, and then I didn't learn how to speak or stand up for myself. (Elly)

So I believe I grew up believing that my father and my brothers and my husband had that right...privilege to beat me, discipline and that's the way I was raised was that the men were in charge with everything, they supported me you know, and we catered to them, make sure that they had a meal on the table and our children were disciplined and we were the perfect little wives, we didn't really have many choices, and to be allowed those choices we had to ask our husbands for permission for everything and we were being disrespectful if we didn't listen and we didn't follow those rules. (Carol)

I waited for a long time for a relationship because of my own fears of abuse because that's the way I was raised. I didn't want to enter that kind of relationship. I [had] seen my sisters, my aunty, my mother, in those kind of relationships and that's what I didn't wanted. I wanted what my grandparents had. They respected each other. (Fiona)

Meeting Mr. Right. All of the women described meeting the partner who abused them. It seemed important to them to reflect on their reasons for choosing their partner and staying with him for the period of time they did. They talked about how they and their partner were friends first and that there was a trust built up between them. The following passages reflect how the women met and felt about their partners initially.

We met through mutual friends. I was actually in a relationship with one of his friends. And then I broke up with him and before dating another person who was waiting for me to call, I ended up going out to a movie just basically as a friend, not anything more but then that friendship built into a relationship. (Amy)

I was single and looking for a job and then I met (xxx) which just seemed absolutely like amazing, I mean he had a job, seemed very charismatic, got paid a lot of money, good looking, and so I thought he was a lot different than my previous husband. And so I just kind of latched on and even though I wasn't ready to deal with that kind of relationship. (Brenda)

We were into our program I'd say a month and he eventually talked to me and we just started talking and then he asked me on a date and we just talked, that's all we did was talk. And I felt that I could confide in him and I could trust him in anything I said and he seemed so supportive. (Carol)

I met him on the streets in Calgary. I was doing my laundry, and he was doing his laundry, and we just kind of hit it off from there. (Dani)

We had met in high school and became good friends. I can say we were kind of like really, really good friends because he looked after me, he'd come and give me money if I needed it. (Elly)

We had met in the bar. We were friends at first and I felt that I could confide in him and I could trust him in anything I said and he seemed so supportive. Because when we started it was like everything I ever thought a relationship would be you know (teary) we were friends you know, it was so beautiful, we talked about everything and anything. (Fiona)

The women's descriptions of their previous childhood experiences and courtship seemed to set the stage for normalizing the relationship in which they experienced intimate partner violence. Because they became friends first and developed a trusting relationship with their partner, the women believed that the relationship was going to be different from what they had experienced when growing up. This seemed to become their idea of a normal bond between couples.

Participants' definitions of abuse. Each woman was asked to define abuse. Their responses were very similar: abuse is hurting a person physically, mentally, verbally or sexually. Interestingly, the first type of abuse that the women identified was physical abuse. In fact, Brenda stated that she was unsure if the information she shared would be useful, since she never felt she experienced "true abuse," by which she meant physical abuse, and so had nearly cancelled the interview. Dani went further and defined abuse as "knowing how to use the person's goodness against them" and Amy defined abuse as "any violation of my right as a human being, so someone taking that away from me."

Five major themes were drawn from this study: loss of body health, loss of mind health, loss of spirit health, coping with losses of body, mind, and spirit health, and advice for health care professionals. The women describe how the abuse took something

from them and how it affected their health; therefore, subthemes regarding losses of body, mind, and spirit health were developed to support the major themes. Dividing the themes into “before pregnancy” and “during pregnancy” illustrated the effect of being pregnant had on their health, the major question for this thesis. A theme of coping emerged from the descriptions of behaviors these women carried out in order to survive and be part of the relationship. Lastly the women had suggestions for health care professionals about their health and living in intimate partner violence.

Theme 1. Loss of Body Health

Loss of body health refers to the women’s belief that the intimate partner violence affected them physically. There is a common societal idea, even today, that one is not abused unless the abuse is physical. The women illustrated this by easily identifying ways in which their bodies or physical health was affected. This speaks to thoughts the women had about physical abuse or “true abuse.” This theme is divided into two sections, before pregnancy and during pregnancy; each section has subthemes describing how the women felt their body health was affected, expressed using their own words.

Before Pregnancy

Prior to a pregnancy, each woman had experienced physical abuse in varying degrees of severity. No matter what the degree of severity, all were left feeling helpless, unable to trust and feeling unsafe. They felt used and abused by their partner but powerless to defend themselves.

Loss of physical strength. The women told stories about feeling physically weak not only due to the physical assault of their bodies but also because of feeling helpless, vulnerable, and betrayed. Brenda stated that she didn’t even want to get out of bed some

days as she felt wiped out from the constant fighting and trying to deal with it. Elly reflected on her feelings of helplessness, knowing that her partner was physically stronger and in a position of power and she believed that she had none:

Because he was an armored guard and he was running, chasing me around the house with a shotgun and I had to call the police, and he locked me in the house, and he started physically abusing me right in the front of my at the time my daughter was seven years old.

Fiona told of a time when she felt totally at the mercy of her partner and knew that she had no control over what would happen next. She felt vulnerable and her body paid the price. She commented that she was surprised when he stopped:

After he threw me and then I hit my head on the wall, my head started bleeding and then that's when he was looking at me and he was like go...go fucking take a shower and wash all that blood off you.

Carol described the first time that she experienced physical abuse, when her partner left evidence of a physical assault. Her partner had displayed other forms of abuse but she felt shocked and betrayed with this physical attack. Carla remembered:

I didn't see it coming and I got punched on the side of the head and that was the first time he assaulted me when he left a bruise on my body. Before that it was just like pushing and slapping (sigh), throwing food at me, throwing things at me, tearing things that were, you know, intimidating me.

Loss of feeling well. All participants had memories of being physically unwell when they were living with their abuser. Often there were physical signs, such as headaches, tiredness and weakness. Amy spoke of often feeling so tired that she felt she "could not carry on" but knew there would be consequences if she did not. Brenda concurred with feelings of tiredness but believed her frequent headaches were due to the stress of trying to keep a "balanced life" where she would excel at work and at home. She did this in order to make her husband proud of her, but never felt that she measured up to his expectations. It was only after she left that she recognized the stress was from the

intimate partner violence. Dani had other physical symptoms that concerned her physician, and stated, “Now I realize the problems were because of the abuse and I am healing but it will take a long time.” Fiona talked of a time when she was not feeling well and had gone to a physician who told her she had a sexually transmitted infection. Not only did she feel betrayed by her partner, but her body paid the price as she required “embarrassing testing” and was told that the infection could affect her ability to have children. Elly articulately stated, “I don’t think I ever felt well when I was with (XXX). I am now just starting to heal my body.”

During Pregnancy

When a woman’s body health is suboptimal before pregnancy, it can affect both the woman and her baby during the pregnancy. Pregnancy adds extra burdens to a woman’s body because it brings many physical changes. The women saw that pregnancy as a special time in their lives and were shocked that their partners would be physically abusive during a pregnancy. Fiona asked, “What kind of a man would do that to a woman while she was pregnant? What could possibly be going through his head?” The women all described deterioration in their body health during pregnancy, as highlighted in the following subthemes.

Loss of physical strength. The participants mentioned that pregnancy was a physically demanding time for them and that the abuse made them feel even less strong and physically tired. They commented on their physical exhaustion.

Physically it affected me where I was always, when I was pregnant, I was tired...I was tired a lot, my body was sore, but I tried to keep strong for myself, where I wouldn’t let him see that I was hurting, I’d be like oh, I can do this, but I couldn’t because it was painful, like if you beat the shit out of me and then I was bruised all upon my legs and stuff, and you’re pregnant, it hurts you know and I can’t do any housework but I made myself because I didn’t want him to be mad at me, but

physically like it was hard because like I was hurt, I was in pain, and I know like I said, I kept quiet about it, I never did nothing, I never told anybody anything at all. (Carol)

I felt like I had no choices you know I was diabetic when I was pregnant, and I found it was a constant battle trying to tell him I need to have a stress free life, I need to take care of myself, I need to monitor myself all the time, and it was like he never believed me you know, anything about my health, like he just wanted things done his way all the time and not taking care of myself because I was so stressed out and I was always on the edge, I was always fearful, my sugars were just like skyrocketing, up and down, up and down. (Elly)

I would be so exhausted, my daughter took everything from me you know, just like I totally evolved. (Amy)

I felt tired and drained, sick all the time, like I couldn't keep food down, I was hardly eating because I was so stressed and tired, tired and drained. And it was all about him, all about him, so I wasn't taking proper care of myself at all. I neglected myself. (Brenda)

Carol described her exhaustion from working while pregnant: "And physically also too, I'm still recovering from working so much and being tired. I have to take vitamin supplements now, because I wasn't properly eating at that time." Brenda stated that her home expectations never changed when she was pregnant: "When I was tired and needed a break I was expected to perform just as I was all along."

Participants also described having bruises or sore muscles as a result of physical abuse during their pregnancy.

I'd say when I was three months, well not even three months, I was two months pregnant when he started hitting me. He was drinking and he was raising hell and he was at his sister's house and her boyfriend was home and they were drinking together, and because I didn't cook for him fast enough he started hitting me and so I ended up with two black eyes. (Fiona)

[I] became pregnant during that time and I didn't know, and I got into an awful argument because he was so controlling and he started hitting me and he starts assaulting me, pushing me around. (Elly)

Their exhaustion was compounded by the stress of being on guard for signs of impending physical abuse.

I was about eight months pregnant and he pushed me down the stairs but I caught myself. But just the idea of him wanting to push me down the stairs that was what really scared me. (Dani)

I was pregnant at the time and I remember that fight, I just shut the whole thing out of my mind, I didn't want to remember it, it was horrible, it could have been fixed quite easily and he just got so angry and if I wasn't pregnant this wouldn't be happening and then whack and I got it right across the face. (Amy)

Another stressor the women described was the knowledge that they did not have the strength to fight back, even to protect their babies. The men were stronger and held the power and control. Fiona shared a humiliating story of when she felt helpless for herself and her baby and thought she might die from the physical abuse, yet she never told any family or friends about the incident:

He grabbed me and it was wintertime and I was staying in the bachelor suite and my stomach was really big and he was telling me that it was his son and that he was going to say what happens to him and stuff like that. He dragged me out into the snow by my hair and he started beating the shit out of me in the middle of the street. He started kicking and jumping on me and I was trying to cover my stomach and then there's this pizza guy coming by and he jumped off and he was screaming at him and he had a knife, so I don't know what he was going to do with that, but he took off. And I couldn't get up, I couldn't cause like he really beat me up and my legs were hurting, and the cops came and then I charged him, that was the first time I charged him.

Loss of physical intimacy. Pregnancy is a time when women need to be nurtured while they are nurturing their babies. Five of the six women discussed their need to feel loved, including the need for physical intimacy. They thought that the lack of physical intimacy was related to their changing body and further affected their overall health. Carol described physical intimacy as "being safe and trusting." Yet she commented, "it always became an issue, well I didn't trust him, especially physically, how long until you hit me again, you know." Other women defined physical intimacy as physical closeness. They commented that their body changes during pregnancy changed how their partner viewed them.

And then even as, you know, as the pregnancy progressed of course you know, if the woman's body changes, and there was a bunch of comments about that, like you know how he wouldn't really sleep with me, oh well, because I don't find you attractive, so there was a lot of pushing away in that sense. (Amy)

By not sleeping like trying to, when you want to be in intimate relations, like in an intimate way, I didn't want to be touched like that, I didn't want to be, I felt really kind of dirty, I think because I didn't really want to be like that anymore. (Fiona)

After I got pregnant I didn't tell him right away. I just basically stayed away from him and the crowd that we were hanging around with, because I knew what would happen, he would leave me because of my body changing. (Elly)

I mean if your partner doesn't even want to sleep with you, I dealt with I think body issues from before just of the type of guys I was with expected a certain type of woman, so I mean as your body changes you know you feel bad, even though you realize why you're gaining weight, and then you just felt like isolated kind of like, tossed away, so it was really hard on me but yet it was like there was like this image I had to withhold. (Brenda)

Loss of ability to protect baby. The women described the effects they experienced from physical violence, in particular feeling unable to protect the baby. The needs of their partners came before the needs of their babies. Amy describes how her need to take care of her partner's belongings (which required heavy lifting) from a job he had lost superseded her high-risk pregnancy:

There was a bunch of supplies at the house that had to go back to his place of employment plus the final cheque to pick up. I had already had some spotting and some bleeding with this pregnancy, and I was told to restrict my activity, to limit what I do. He didn't think it was right that a doctor would give me permission "to sit on my butt on day, watch TV and eat bonbons from him." Um...and I said, well that's not really it, I'm not being given permission to just sit like a princess but I do have to watch what I do so I don't bleed anymore, if I keep bleeding they're going to throw me in the hospital and I can't leave, that's a huge problem because I have a son to look after, a husband looking for work. While I was explaining this to him, his back went out, never diagnosed by a doctor but his back went out, and he said I can't move, you're going to have to take these boxes back they had to be back at the office by a certain time or I won't get my paycheck. I picked up the boxes, I carried them to the van. In the process of doing so I started bleeding, I ended up in the hospital.

The women related further instances of feeling defenseless to protect themselves and their babies.

I'm worried like what's happened, are you dead, are you hurt, and so I just made a simply inquiry, like oh, I didn't realize you're staying out late and it was like this really huge blowup like I don't have to account for what I do, I could do what I want, I'm making money, and he actually kicked me out of the house when I was about seven and a half months pregnant, like in the middle of the night, he pushed me out the door and I had to sit on the steps. (Brenda)

Then once I got pregnant with my other daughter, the father of the baby would just sit on my stomach and pin me to the bed and start yelling in my face and sometimes he would just punch my stomach, try and kill that baby and he would sometimes grab my middle and start squeezing really hard and that was very hard for me, and going through all that stuff, and he starts telling me I'm damaged goods and that kind of stuff so, which that's kind of hard things, stuff like that, and he starts calling down, using racial slurs to me and stuff like that so. (Elly)

Not really anything wrong with the baby, just I was always scared that I'd miscarry. (Dani)

He started hitting me and he threw me across the apartment and he came down and he started kicking me, kicking me in the middle of the stomach. (Fiona)

When I was eight months pregnant my husband came home and saw me sitting on the floor ... he said I should kick you in the gut and you would lose the baby. (Carol)

Theme 2. Loss of Mind Health

Loss of mind health refers to how the women felt the intimate partner violence affected them mentally including psychologically and emotionally. The women described mental abuse as both harder to endure and harder to heal from than physical abuse.

Brenda stated, "You can heal from cuts and scrapes but when he messes with your head it is there forever." This theme is divided into two sections, before pregnancy and during pregnancy and each section has subthemes describing how the women felt their mind health was affected with use of their own words.

Before Pregnancy

Each woman in this study had experienced emotional and psychological abuse prior to a pregnancy. For all six women, the mind abuse occurred before any physical abuse. In general, the women's mental health was suffering and the following subthemes describe the state they were in.

Loss of ability to think clearly. All six of the women described their inability to think clearly and becoming desperate as a result of the abuse. They used expressions such as "distorted reality," "zombie-like" and "just too tired to think clearly." Amy reflected on how she responded to the initial period of abuse with her new husband:

[I] withdrew almost immediately. As soon as we moved in together he got very angry with how I acted, he got very angry with how I would carry myself around the house or sit and watch TV, or do crafts. I was big into crafts and why can't you find anything better to do with your time?

Later in the interview, Amy discussed how she believed that her husband was controlling her mind and she was helpless. She saw her boss, a lawyer, as stronger than her and that no one could control her mind:

So I ended up going and working for a lawyer who did work for my [father in law's] company, and that was a good opportunity for me. She was a female lawyer who basically had a mind that could not be swayed the way that my mind was being swayed.

Dani remembered that her partner was affecting her to the point that she felt helpless and unable to think clearly. She described this effect:

It's like I was mesmerized by him or something and I could only do what he asked or said, you know even though I knew it was wrong, and it was putting me in more jeopardy. But I thought I was so in love with him and you know, he was the strong hero type that knew the streets well, so I thought he was the great big whatever protector or something like that.

Elly expressed that her mind was in a fog in which she did not think clearly and make decisions for herself:

I don't know, I mean it's kind of interesting thinking back on it, because I guess at the time it was like...just like this fog, you don't really realize what's going on, it's like a sense that something's wrong, but yeah, there's definitely concerns.

Brenda described feeling helpless while enduring mental abuse in her relationship. She talked about not knowing where to turn for help and not being able to think clearly in order to get help:

Then just the verbal abuse, the yelling, the name calling, threatening, and me feeling powerlessness and helpless and even more insecure and I didn't know what to do. I didn't know who to go to for help, cause he would just turn it all around and make it sound like it was all my fault and really nothing's wrong. He really messed with my mind. And I'd say it was more of the mental abuse than anything.

These women clearly spent so much energy surviving the relationship that their mental health was affected. All six had experienced a diagnosed depression during the relationship, which included feelings of loss of self-esteem, shattered dreams and being destroyed by the abuser. Elly described the extreme depression she felt, when all she could do was to cry and try to deal with what was happening in her life:

I cried a lot. I cried when he wasn't around, there were nights where I'd stay up and I'd cry, because I had nobody. I cried when he wasn't there, I cried myself to sleep. If I had to take a shower when he was there, I cried in the shower and that's how I emotionally I dealt with it, ...I cried.

Amy recounted a time in her relationship with her husband when he and his family tried to convince her that she was depressed. She was withdrawing from their relationship due to the mental abuse that she was experiencing at the hand of her husband. She later commented that she could not believe how someone can make you believe you are "crazy":

[husband talking to Amy] "You know what? I think you're just depressed, I think you're clinically depressed, I think you need to go see your doctor about it." But I had gone to my doctor and it was not a clinical depression, I was feeling some depressive tendencies because of the crap I was going through, but they [husband and his mom and dad] didn't think my doctor knew what he was talking about,

told me to go see their doctor. My father-in-law had actually booked an appointment with the doctor prior to me going to see him, and he told him all about me in his own words, so that when I went in to go see the doctor, the doctor had diagnosed me as clinically depressed, put me on antidepressants and now that they found a good doctor, I should keep going to see him so that he could take care of my health properly unlike the other doctor who you know, obviously couldn't diagnose something as severe as depression. And at 23 you believe if a doctor diagnoses it, so I pretty much assumed I was so far out...so far chemically imbalanced that I couldn't even see it myself. And the depression was used against me for many years, many...many...many years. The idea of the depression itself depressed me. Once I thought I was sick, sick physically, sick mentally, sick beyond what I could repair myself with without medication I went down, I was very down and very sad. (teary) And I probably went into a clinical depression.

Loss of trust. All of the women mentioned feeling betrayed in some way. They talked about the trust they thought they had and how it was destroyed. Clearly, trust was very important to them. They believed that if they could show their partner trust, he would give it back; when trust was not reciprocated, the women felt betrayed. The women described the trust they thought they had and how its loss affected them.

So in my relationship, when I entered that relationship it seemed like he was looking out for me you know. He was an ear, I could confide to him. I realize now there was like a lot of isolation, like if I didn't do what he wanted me to do, and I had to be like a mind reader, then I would suffer the consequence. (Elly)

So of course, the more I shared with him, the more he knew about me personally and I opened up very well to him, and that was something he made comments on regularly, how honest I was and truthful I was, I fell for it, I trusted him, and I have to remind myself now to not beat myself up, because I trusted somebody. But that's exactly what you're doing in a relationship is you're making a very big decision and it turns out now, people who can trust, put trust into somebody and that trust doesn't get broken, are very fortunate and lucky people. Yeah. And I was not quite as fortunate. (Amy)

I also think every guy is up to something, is out hiding something, I can't trust anybody other. (Dani)

I compromised myself, my values, my morals, to fit around him because I trusted him. (Brenda)

I felt that I could confide in him and I could trust him in anything I said and he seemed so supportive. (Fiona)

And when we started school together and (sigh) he started a relationship in school with another student and as far as I was concerned we were committed to each other. (Carol)

During Pregnancy

A woman's state of mind can affect both the woman's and her baby's health during a pregnancy. The women described their mind health as not optimal at the beginning of the pregnancy and felt it further deteriorated during the pregnancy. This was disturbing for the women as they thought pregnancy was suppose to be a time for joy. The following subthemes describe the further loss of mind health.

Loss of voice. The combined effects of the abuse, isolation, fear and despair left many women feeling alone with nowhere to turn for help. Society has little understanding for women who are pregnant and staying with an abuser and not trying to protect the unborn baby. The women expressed compounding feelings of shame, embarrassment and guilt about the abuse. They were unsure of any "safe" venues in which to disclose the abuse, and so they deteriorated further into states of not thinking clearly, taking on unhealthy behaviors in pregnancy (e.g., smoking), and, thus, losing their voice. The following excerpts illustrate this point.

I started to smoke. I started smoking because I was so stressed out. I started smoking and my daughter was kind of below birth weight. (Carol)

I was fogged in pregnancy, I was fogged in a hospital, I was put on bed rest and I couldn't even take care of my son. My whole world was a mess. You could have gotten me to sign a declaration on you know war, and I might have done it at the time. I was just so out of control with my life. Everybody else was telling me what to do. Felt pretty helpless, yeah. (Amy)

There were a couple of times I started smoking again, because I used to smoke before and I really don't know why I did that. It was like there was just so much emotion. Basically, I was in Ottawa, I was completely isolated because where I ended up working was at his company where he worked. I really didn't have any friends outside of that cause I didn't know anybody in the city, I was pregnant and so basically I'd go to work and come home, however he had a Director position so

he'd have a lot of dinner meetings and stuff, he would go out, so I was like stuck in the house with no one there and just all my emotions, and it was like almost like an outlet. I mean like when I smoked, I smoked at the very end only, and not a lot, when I say smoke it sounds like a lot, but maybe like one cigarette every second, third day but during the whole pregnancy he would smoke in front of me, even before that point, so I mean I was really worried about that as well. (Brenda)

[He was] telling me I was crazy and you know, just all this stuff and what kind of a woman was I, what was wrong with me. Then I started crying, you know expected kind of helpless or whatsoever, because I was completely alone. (Dani)

[He] was more physical with my second pregnancy, and a lot more violent just like threatening and throwing things, and like making me feel scared, and I couldn't go to anybody because I didn't trust anybody. (Fiona)

For Elly, the intimate partner violence was so intolerable, with no one to talk to or trust, that she contemplated suicide, the ultimate loss of voice:

I was very unhealthy at the time. I didn't feel like eating, I had to force myself to eat, and I was also thinking of giving the baby away for adoption and also [thinking of] committing suicide at those points. And I did have a plan and everything, and I had talked to my doctor about it and then I went for counselling and the doctor has put me on antidepressants and stuff like that to deal with everything so, because I was so in deep into depression with that child. That's when the doctors were giving me Zoloft one, 150 mgs. a day and I was on Ativan to calm my nerves and sometimes I wouldn't talk, I'd just sit there and not talk for a whole day. I was just scared to talk to him. (Elly)

Loss of joy in pregnancy. Because of the abuse, these women feared for their pregnancies and described losing joy in being pregnant. They felt disconnected from pregnancy in that they were unable to accomplish maternal tasks, especially a safe journey for baby and mother. That is, the pregnant woman is trying to bind in with her partner and, therefore, has little energy left for her four maternal tasks: seeking and ensuring safe passage for mother and infant; securing and ensuring acceptance of the pregnancy and the new family member by significant others; binding in to the child; and giving of herself to the dependent, valued child. Bonding is an important task for a pregnant woman, first while she is pregnant and continuing throughout the child's early

life. Amy described how, during her first pregnancy, her partner put his own needs ahead of the pregnancy. She was saddened over not being happy during the pregnancy. Amy reflected:

We were just in the process of deciding should we have kids or should we look at a new vehicle, and I always, when I tell this story, make it far more theatrical. It was the choice between a kid and a truck and my husband didn't get his truck, and that really, did to a certain extent, take place. He mourned the loss of his truck, he couldn't get the new vehicle, we had a kid on the way, I kept a journal, I kept a diary of my pregnancy.

Amy showed me her journal of this particular pregnancy and it revealed very sad entries from not being happy with the pregnancy to being a bad wife, mother and person. She had written apologies in the journal to her unborn child about not being a good mother. Fiona also expressed sadness concerning her pregnancies. "I felt I had no choice in my pregnancies and when he abused me I really had no hope."

Carol had experienced abuse and loss of her babies in two previous pregnancies and consequently was unable to experience joy during her third pregnancy. She was afraid that this pregnancy would end as the others had: "In the back of my mind, I just knew that, somehow, some way, my child wouldn't survive, you know, I didn't want to give myself that hope."

Several of the women discussed being depressed during the pregnancy due to the abuse they were experiencing. They used words such as feeling down, could not get going and unhappy. Amy described her first realization that the abuse was affecting her mental state and, therefore, affecting her baby:

When I was really down with the first pregnancy and my doctor said "you're rather sad and that's not good for you or your baby." I didn't think about that. I did not think that my mental health affected my child, not even a little bit. I did not make that connection. No... I did not relate my pregnancy to my own personal health at all like, baby it's not born yet, it's just a part of me to allow that

to happen to me is fine, to recognize there's a whole separate being inside that it's affecting did not...didn't dawn on me, not even a little.

Brenda articulated it best, as she described her mental state and her health during pregnancy:

I don't know, I just was in a fog. It's like I wasn't myself. Oh, it affected my health really bad. I was very depressed. They put me on antidepressants half way through the pregnancy because I had a history of depression before, and I was feeling quite depressed and they were really worried about postpartum depression. My health was just horrible. I mean, I was like very depressed and because of how I was coping that's not good for the baby. So I was really concerned about the baby's development and then you read a lot about how they, of course they don't understand, but they hear your voice, so what I mean if certain voices are anxious or angry that can't be that good for the fetus. I mean, I can't believe that they have the development yet to understand the difference, but I mean anything reacts with them. I knew a bit back then but I know a lot more now from my classes, even stress and how the different cortisol levels affect the development of the baby so, during the whole time I was quite worried.

Theme 3. Loss of Spirit Health

The theme loss of spirit health refers to how the women felt the intimate partner violence affected them spiritually. When asked how the intimate partner violence affected their health, all six women disclosed physical, emotional, and mental health issues without further prompting. However, not one woman mentioned "spirit" health until asked about it. When they discussed spirit health, they talked about a higher power or religion only. The subthemes below describe the loss of "self" identified by connections to self, God and others.

This theme is divided into two sections, before pregnancy and during pregnancy, and each section has subthemes describing how the women thought that their spirit health was affected, in their own words.

Before Pregnancy

The following themes describe a loss of spirit health due to loss of relationships that identified who they were as a woman. Due to the intimate partner violence the women describe how their spirit health and consequently their self identity deteriorated.

Loss of relationships with family and friends. The women told stories about hiding the abuse from their family and friends for a variety of reasons. Mostly they did not want their families and friends to worry about them. Other reasons for hiding the abuse were embarrassment, shame, and concern for the safety of their loved ones. All of the women discussed the importance of their relationships with their family and friends. Perceived loss of their relationship with family and friends further isolated the woman and made her more vulnerable to abuse. It takes away a piece of her spirit health. Carol had a close relationship with her mother; however, she could not bring herself to disclose the abuse to her: “I hid it from her [mother], and he’d push me around.” She thought that her partner was putting a wedge between her and her mother.

Fiona described how her partner isolated her from family and friends:

I never told my mom because I didn’t want her to know, never told anybody. It was like I was, he took me away from my friends, he took me away from my family, and I let him, and I cried because I had nobody and I always cried.

Amy was moved to a new city by her partner and rarely saw her parents and brother. She did not feel comfortable inviting them to come and stay, as her husband would make “scenes that were embarrassing for her and them. It was just easier not to have my family or friends over.” Brenda moved to a new province and almost never saw her family. When she did, it put a strain on her as she was always “kind of diffusing the situation or re-explain what he was saying” to keep the abuse hidden. She described an embarrassing situation that happened when she went on a vacation with a friend:

I was away on vacation with a friend of mine in Toronto, a female friend. She's from Winnipeg and we met up there, and he ended up calling up my parents at four or five o'clock in the morning and telling them I'm a slut, and I'm a whore, and I'm sleeping around and all this.

Brenda told her parents her partner was drunk. She never discussed it with them again, and they did not ask.

Loss of relationship with a higher power. The women were passionate when they discussed their loss of faith in a higher power as a result of the abuse. Five of the six women began to weep when discussing it. They were very disturbed that one's spiritual beliefs could be treated with such disregard. They considered that their relationships with a higher power were jeopardized when their partners abused their beliefs. The loss of this relationship seemed the final destruction of who they were. One woman described the loss as "having nothing inside"; another described it as "sliding into emptiness." In the following excerpts, the women describe how their spiritual health was affected by abuse.

Spiritually, that's why I stayed for as long as I did. I wanted to be a good person, I wanted to be someone God could love. God's going to love me whether I'm divorced or not, (teary) I just didn't know that then. I was told that if I divorced, I won't be loved, I will be disliked, I will be distrusted by everyone, not just anyone in Heaven, but everyone on earth, and it would have been my decision to walk ultimately. What ended up happening is after he hit me the last time, I said, "You need to leave." (Amy)

I was being spiritually abused during the whole thing as well (teary) I was being told by my husband's family that the God you grew up with was not the true God. That's just not right. (Brenda)

Things I believe in, about the soul, and growth and how a person changes for the better, it's like he didn't believe in that. It was like all garbage, so I wasn't like criticized for it, but I just knew you don't talk about it, you just don't talk about it, and you kind of hide it. There is the whole thing about faithful practice because I don't go to church every weekend. And I think it, added with everything else, it really did affect me because there was like no calm, like nothing I could grasp onto for faith, like it was like taken away from me, because even though he never made any specific comments on a daily basis about it, it was almost just as bad, because I just knew not to talk about it, because if I did, he'd make some kind of comment. (Carol)

It affected me for years, where I even to this day I have to say, I don't even know when it was the last time I prayed. I turned away from God, you know. I just drifted away and went sliding to emptiness. There was nothing inside, and I just didn't have that kind of confidence, like exact confidence, that God would be there. I did, because I wasn't sure of a lot of things you know. It was all unstable, and I didn't know what was going to happen from the next moment to the other. (Fiona)

I stopped going to church right now, because I'm so ashamed of myself, because I am still legally married to my first husband. (Elly)

In contrast, Dani believes that her spirituality is the "one and only" thing her partner could not take away from her. She had experienced physical and mental abuse but considers that each person's spirituality is unique to himself or herself, and the only way to lose spiritual health is to consciously give it away. Dani used her spiritual beliefs for guidance and help, and she attempted to deal with what was happening by praying more.

Dani reflected:

Not necessarily, because, no matter what I will always have spirituality. That's something that he can't take, or that I could give to him, because whatever connection that I have with that Higher Power is mine alone, and he could never have that. So I'd say it wasn't, it was maybe affected because I maybe was praying more and asking for help and guidance more.

Loss of relationship with self. All of the participants discussed how the intimate partner violence affected their spiritual health in relation to religion; however, they did not associate its effect on their self identity and the relationships that were important to them. The stories that these women told went even further to describe a loss of self. While they described feeling not very good about themselves or their relationships, they also described a loss of their identity. In other words, their spiritual health and sense of who they were as a person was diminished, and they had lost their will or spirit to fight back and regain their sense of self. The theme of loss of relationship with self emerged in their comments.

Brenda commented that she “didn’t have a relationship with myself” and was “always made to feel like the bad person.” She further commented that she didn’t or couldn’t love herself: “It really affected my spirituality because being abused, I couldn’t learn to love myself, and I already didn’t really completely love myself, you know.”

Fiona expressed the ultimate loss of self: “[It will] continually cut pieces away until you are gone ... you are no longer an existence.” When the women were reflecting back on living with abuse, they seemed saddened by this realization. Amy reflected on when she starting losing her sense of self:

There’s a lot of shift work available, there was a lot of these 24 hour services willing to hire, but he didn’t want me to work those hours. “You find a day job or you don’t work.” Well, when did it become your decision what I do. “Now that I’m your husband, I have a say in it.” And I said, “not more than a say than me.” In which he said “Maybe if you’re not thinking straight enough for yourself, you don’t know what you’re talking about.” That was the first signs of you can’t think for yourself.

Carol describes losing her self: “I was in a shell, I stayed in this shell, I just lost myself and got to the point where I took drugs to have emotions, to feel, because I was empty, I was void.”

These women were raised with morals and values that they held dear. When they realized that they had compromised beliefs they valued, they were surprised and saddened and slid further into spiritual emptiness. Some described it as a drowning and a death of self.

A lot of things that I did in that relationship I did not feel good about myself, because it went against everything I believed in, everything that I was raised to believe, against my morals and my values, and I could not look at myself in a mirror anymore, and among the things that I allowed to happen. (Elly)

A wife should be submissive. Your role as a woman in this man’s life is to support him, there was nothing coming back from the other end, and that left me empty. That left me in turmoil internally. I did not have inner peace. I talk about this honeymoon stage when I got out of my marriage. I had my own honeymoon

stage, for the first year I felt some peace, some calmness, some decisions that made sense in my core. I didn't have that for the ten years I was in the marriage. (teary) The spiritual connectiveness I have now very much lacked. I thought I was a spiritual person, there was just so many aspects of it missing. So much of me was not in my own life, because I was focused on him. I was focused on what he felt was important. My own spirituality took second seat to everything, and I took second seat to everything. In doing so, I just wasn't there, I didn't exist in a lot of it. And it wasn't until I came out of it that you realize, it's like being in a middle of a lake, you're just looking around seeing water, and you don't know where you are. When somebody pulls you out and sets you on the side, you see a big lake. But you don't know you're in a lake because you're just so busy drowning. (Carol)

But I was really, in a sense, forced to, and not like physically forced but verbally forced to feel that if I didn't do something he wanted he would disapprove. Because that that is what he wanted, that is what was best for us, even though it might not have been best for me. Because to me my career defines me so much, I was really changing a definition of myself. (Brenda)

I knew that I was going to be punished for it, and I lived on eggshells all the time, constant fear. In the back of my mind I thought I have to leave this man, but how can I leave him. I had so much compassion for him, so much love. I was his mother, I wasn't his partner, I was his mother. I had cared for him, I was always there for him, I felt if I just leave him and go and start my own life, then what's going to happen to him. (Fiona)

During Pregnancy

Pregnancy and birth have been associated with a time in a woman's life that is described as a spiritual experience. Women are inclined to develop relationships to nurture the pregnancy. The women of this study describe how their spirit health was further deteriorated by the intimate partner violence they endured.

Loss of relationship with partner. The women were making a conscious effort to do everything in their power to try to establish a normal family unit. This involved believing that their partner would eventually come to realize that they were going to become a family and intimate partner violence would not be part of it. Even though these women tried diligently to attain this ideal, the time came when they realized that this was

an impossible task. The women described believing that they had let their partners down and therefore their relationship with their partners changed.

He came to the hospital room almost every day, telling me how inconvenient this was, how I should just go home and start taking care of things, so he could go back to work. When I expressed this to the doctor, I actually said to the doctor I don't think you understand my problem I need to get out of here, and the poor doctor had to not laugh at me and say "You don't get it (teary) you're life is at risk, you can't leave, you really can't." And I said, no I understand. I have to leave as my husband needs me, he can't have me here. (Amy)

No matter how hard I tried, I was not good enough, even when I was pregnant I continued on as I did before which didn't change a thing. He would not sleep with me after I started showing, said it was because of snoring but I knew. He would get angry with me and throw his wedding ring out the door. I knew things were not going to change after the baby. (Brenda)

Because it was like an addiction, like I was so weak you know, all he had to do was snap his finger and I was there. And he was running around on me while I was pregnant, he was in another relationship. He wasn't living with me and I was still hanging on to his broken promises and life was unbearable. It was like I couldn't let go. (Carol)

He didn't want me there for like a relationship or anything, and I was basically just a punching bag, even when I was pregnant and I let it happen. (Fiona)

Loss of relationship with a higher power. Loss of spiritual faith during a pregnancy created an extra burden, since the women were not only trying to establish a "normal" relationship but also trying to provide safe passage for their unborn child. They depended on their faith in a higher power to try to accomplish these tasks, but when they realized that it was not happening they experienced a further loss of spiritual health.

There were times when I was pregnant I prayed and I said, "Oh please look after me, let this stop, help me." It never did, it just got worse and worse, and worse to the point where I thought what's the use. I was praying and nothing was happening, so what's the use. (Elly)

I tried to leave this relationship but couldn't, even when I was pregnant. He'd always keep coming back. Then I started having doubts. I'd keep praying to God and tell him "Please Lord give me the strength to leave this relationship, to walk away and not come back." I just felt they were empty words, they were empty

prayers, cause there was no real heart in there, no real feeling emotions, or spiritual completeness ... they were just words. (Carol)

And with my daughter I prayed and I prayed. I would cry because I almost lost my daughter three times during my pregnancy. I'd just cry and, pray. I begged God to let me have just this one child, this one child. I just begged and I pleaded and I wanted to change everything. Even when I was crying and begging and pleading with God to allow me to have my daughter I felt like they weren't going to be answered. I wasn't certain, not like before when I'd pray and I'd just know that my prayers are going to be answered. I had that confidence. I said, oh yes, I thanked him...thank you for answering my prayers and I knew that yes, they were going to be answered. I didn't have that kind when I was in that relationship. I even got to the point where I thought, God how could you love me. (Fiona)

Loss of relationship with self as a mother. For the women in this study, a sense of self was both created and challenged by their sense of the importance of becoming a mother. Bonding is the intense attachment that develops between parents and their baby. It makes parents want to protect, nourish and shower their baby with love and affection. Loss of a sense of attachment to the baby during pregnancy further disconnects the woman from identifying herself as a mother, as the following excerpts illustrate.

But it was really focused all on “well you're pregnant so the depression is around the baby” right. You can't really blame them because, of course, I never gave any hint or told them that there was anything else going on. They never really inquired, so it was more focused on mother attachment to baby. (Amy)

I was crying all the time and sad, angry. I didn't feel any attachment to when he was in my womb, yeah, so I don't know if that makes sense. (Dani)

Other women expressed guilt and shame over placing their children secondary in the relationship. They were so busy trying to make a “normal” family that the baby was not acknowledged as central.

[I] hate to admit this but my child was secondary when I was pregnant, because we were so involved in our battling. I couldn't accept that, I laid blame on myself because I couldn't tell them that I was so involved in that abusive relationship that my child came secondary. (Brenda)

Baby, it's not born yet, it's just a part of me to allow that to happen to me is fine. To recognize there's a whole separate being inside that it's affecting did not...didn't dawn on me, not even a little. (Amy)

I just wasn't a good enough wife, I wasn't a good enough mother, I was an idiot you know, I was mentally sick, I was emotionally disturbed. (Carol)

Theme 4. Coping with Loss of Body, Mind, and Spirit Health

Clearly, these women were coping as best they could in order to try to manage their lives. It is difficult to understand why traumatic events such as deaths, major illnesses and relationship difficulties seem to devastate some people but strengthen others. Each of these difficulties is devastating in its own way, yet some people are able to get up each day and carry on with living. Doing so is part of how they cope with the traumatizing event. The women in this study needed to try to make sense of what was happening by attempting to carry on while struggling for control. While the women told their stories it became noticeable that there were intentional and unintentional ways of coping. This theme is further broken down into topics that illustrate different behaviors that the women used to cope.

Minimizing the Abuse

The women tended to minimize or deny the abuse as a way of coping with what they had lived with, as Dani described:

I didn't think that it was abuse but I mean (sigh) he would lie, he would steal from me and I would be trying to help him out and I'd have to pay off his debts, and he always try to manipulate me somehow into giving him money or (sigh) to going back to him.

Brenda articulated this the best when she described her relationship as only emotional and financial abusive; however, she stated that when her partner was mad at her he would grab her arm and throw her out of the house. She did not consider this physical abuse. Brenda described the types of abuse that she believed she experienced:

”I’ve never really experienced any physical abuse but there’s been a lot of emotional, a lot of financial, manipulation, that kind of abuse.” Later she stated:

I mean, the closest physical would be kind of sexual in a sense but it was never like grabbed or forced that way, but I kind of classify it physical because it’s like a physical act. I’d be made to do things that I really didn’t feel comfortable with.

At another point Brenda described, “So we kind of got in an argument and he kind of pushed me. I don’t really remember what happened after that because I was kind of in a daze, but that was about it.”

Justifying the Abuse

The participants discussed the positive qualities of their abuser, which suggests that they needed to justify or explain why they stayed with someone who abused them. They wanted others to know that they did not deserve to be abused but their abuser had positive qualities that had once attracted them. Amy described how her partner was always looking out for her: “He was an ear. I could confide to him. You feel somewhat more committed to the relationship if somebody’s going to, you know, risk another relationship, risk even a child for you. I felt very secure in that.” Dani agreed with Amy and described her abuser as a “strong hero”:

It’s like I was mesmerized by him or something and I could only do what he asked or said. Even though I knew it was wrong, and it was putting me in more jeopardy. But I thought I was so in love with him and, you know, he was the strong hero type that knew the streets well so I thought he was the great big whatever protector or something like that.

Brenda remarked, “He wasn’t always abusive, he had lots of good qualities too.” Elly had commented to her friends, “I am lucky to have such a caring boyfriend”, even though at the time she had doubts about him.

The previous exposure to abuse in five of the women’s childhood framed some of the women’s views about the abuse as a way of justifying it. Carol stated at one point

“My sister’s husband was a lot more abusive.” Other women were self blaming, convincing themselves that they were somehow responsible for the violence. Fiona, who had endured severe intimate partner violence, stated that sometimes she thought that she may have deserved it because she would do things to “set him off.”

Making Sense of the Abuse

Some of the women expressed in different ways that finding meaning in their experiences was an important part of coping with what had happened. They needed to figure out why the abuse was happening and why they were responding in the ways they were. It helped to put some sense back into their world. Brenda articulately described the need to make sense of the abuse. It seemed in order to survive the relationship she had to stop feeling or being real:

Everyone has the desire to be real, but when you live in an abusive relationship you cannot be real. If you attract conflict you will be the loser and you end up submitting in order to be able to cope. (Dani)

During this time, the women evaluated and re-evaluated their life circumstances. Dani described making sense of her circumstance as thinking “this is just the way life is” and was satisfied with this until it became too unbearable. Then she had to leave.

Trying to Protect the Baby

Although these women felt unable to protect their babies from their abuser, they did attempt to shield them. They did what they could do for their babies.

He dragged me out into the snow by my hair and he started beating the shit out of me in the middle of the street. He started kicking and jumping on me and I was trying to cover my stomach. (Fiona)

I probably was a little more in touch with things, I felt very protective of my stomach at that time. (Amy)

When he hit me I’d always covered my stomach. (Carol)

Elly disclosed that she fought back for the first time while she was pregnant because she had to protect her baby:

I knew he wasn't going to stop and that's the first time I looked in his eyes and I didn't see anything, it was just empty and he kills me in there, and I was looking around for something to protect myself. There was small little scissors just broken in half and I grabbed them and I held them. I told him, stay away from me, don't even touch me again and I sat on the chair.

Hiding the Abuse

Before becoming pregnant, all of the women hid the abuse because of embarrassment, shame, protecting their family and friends so they would not worry and concern for safety of their loved ones. During the pregnancy, they hid the abuse for the sake of the baby and protection of the family unit. Three women shared the importance of children having a father. Carol described growing up without knowing her real father and how this “caused her some issues in her life” which she did not want her child to experience. She expressed concern that if she would have exposed the abuse, her family “would have taken me away” or the legal system may have “taken him away.”

Dani described having a terrible upbringing and believing that maybe her partner would be there for her and their baby: “My family was all fucked up and I thought the baby would bring us closer.” Fiona also discussed believing that she needed help in raising the baby: “I thought he would help out, you know, I didn't expect him to change diapers or anything like that but he didn't even stick around until the baby was born.”

Theme 5. Advice to Health Care Providers

Meleis and Im (1999) state, “It is not the culture that shapes the health care experiences of clients. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around” (p. 96). Myths about intimate partner violence persist among nurses and

other health care professionals. Women may be accused of liking the abuse because, if that were not the case, they would just leave. Or they may be accused of accepting the abuse because “It’s part of their culture.”

The women in this study offered suggestions for health care professionals about steps that might have made a difference for them. Below are topics that the women discussed during the interviews that support the theme of advice to health care professionals.

Ask And I Will Tell You if I Trust You

Health care professionals are generally considered to be “professionals who help.” However, in the eyes of an abused woman, health care professionals become accomplices to the violence if they ignore obvious physical signs of intimate partner violence, such as bruises or swelling. Carol commented that it is, “kind of hard to ignore when you have bruises on your arms.” Fiona concurred:

You know, it’s just like he’s the doctor and he’s just concerned about my health. That’s what I would think because if you’re walking around with bruises all over your body, then of course it’s obvious they’re going to be asking how you got them and things like that. If you suspected, and you have no doubts, then do something. Please help because we feel we’re in no position to ask for help, or we are too afraid to because if we do, we know what’s going to happen to us when we get home and they find out, cause we’re living it and they’re [health care professionals] on the outside.

Elly stated:

She’d [health care professional] look at me and she’d see a bruise on me. I’d say something happened, but then I thought well, they’re not stupid, they must know, but I don’t know if they wanted to ask. I’d say “just ask” then I can say something. I don’t want to be a burden. If you know something, if you think, even if you see something, ask.

Although they lived in fear of having the abuse publically known, most of the women in this study wanted the health care professional to ask. Their fears did not

preclude the desire for help or a listening ear. Elly stressed the importance of communication and explained how health care professionals should ask:

[Health care professionals] can ask. I think if they do it in a right, be diplomatic when asking. Ask how their relationship with their other partner is. I guess you'd say be more articulate on how choosing their words on asking questions about their relationship with their other partner. Communication is important.

Most of these women would not disclose the abuse unless asked, which results in a further sense of isolation and resignation. The women did not volunteer the information but were waiting and wanting to be asked. Furthermore, some would not disclose unless there was a sense of trust in the relationship with the health care professional. Fiona wanted to tell her health care professional why she was having pain in her pregnancy, but she never felt at ease with the physician and, therefore, never told of the abuse: "Even with professionals, it's hard for me to trust people, very hard for me to trust people." However, disclosing abuse is vital in order for the health care professional to give appropriate advice and treatment. Carol disclosed:

When he hit me I'd always covered my stomach. I was concerned about the pregnancy so I would make up things just to go see my doctor. I'd tell him "I got this pain from you know." I didn't want to tell him that he hit me. My doctor would reassure me that I think it would be fine.

Fiona related an experience with her health care professional, who had asked if she wanted birth control. Fiona wanted birth control but her partner did not: "[The health care professional told me] 'It's your choice what you do with your body,' and I felt like saying I had no choice what I did with my body." Fiona did not disclose this information as she was uncertain what would happen; she did not trust her health care professional.

Brenda expressed that health care professionals should "not be scared to ask" as she felt her physician was uncomfortable with the topic. Abuse was never brought up directly in her visits to the physician, but the conversation skirted around the subject. Her

physician talked about her depression in pregnancy but never asked of any causes she might be aware of.

Several women expressed that they were afraid about how the information would be used if they did disclose. Fiona stated that she feared, “They were going to call the cops or social services so I kept quiet.” She described an incident in the Emergency Department:

He looked again, and he asked me, are you being abused, and I lied, I lied through my teeth, I told him no. I told him no, and I was trying to explain what it was, and he was watching me. He goes, “Because you know if you are, I have to report that,” and I told him no.

In contrast, Elly told the nurse at her physician’s office of the abuse. She explained, “I told her because I trusted her.” Carol discussed her difficulties in first disclosing the abuse but also the benefits of telling the nurse at the community health office:

In the beginning, I felt that it was very hard to be talking to somebody you barely know about your problems. But then when I got it out, a few days later, I start to feel better because I’m starting to talk about it. Talking with somebody, and especially because it’s confidential, and it was better than talking to someone different, like a family member, because as you know family can start saying things when you say stuff in confidence.

The women of this study all wanted help in dealing with the intimate partner violence and would have been willing to disclose if there was trust between them and the health care professional.

Tell Me What I Need to Know About Pregnancy

The women described their desire for information about their pregnancy. Even though they were dealing with other issues, they were still pregnant women who needed information. Amy stated, “I am a woman who is pregnant and I need information about pregnancy from an expert so I can make choices. Don’t assume I don’t care about my baby, because I do.” Amy had read several books about pregnancy and commented that

information is out there about everything one might want to know about pregnancy, except abuse:

Even in some pamphlets with regards to the pregnancy, please recognize that as you do this, yes you're taking it in, and only a small portion is going to your baby, but recognize as much as your one body, there's two bodies there, that never sunk in you know. Here are some warning signs, warning for what, well you know there's a million warning signs, there's warning signs on how to prevent muscular dystrophy and spina bifida and take your folic acid, it's information overload, but maybe even posing a question what are you most susceptible to, what are things you're susceptible to that you've never even thought of.

The women in this study commented that they needed information on abuse and in particular how to recognize if one is in an abusive relationship. Amy was experiencing many controlling incidents with her partner but did not recognize that she was being abused until he hit her, which occurred after her first pregnancy. She believed that if she had information on abuse earlier she might have been spared some painful memories. Amy considered that such information could easily be passed on in a pregnancy when a woman visits her health care professional several times. These visits represent good opportunities for health care professionals to discuss intimate partner violence. Brenda felt this information should definitely be brought up in a prenatal class in a non-judgmental way with "maybe just [information about] warning signs or something to look out for."

Don't Judge, Because I Need Your Help

These women needed help regarding mental health issues from health care professionals with non-judgmental attitudes. Dani stated, "Don't judge me, as I am already feeling like I am letting my baby down and I am making choices that I feel are best for me and my baby." In other words, these women wished to be active participants in decision making regarding their health and the health of their babies. Choice is an

important health promotion strategy, an integral component of mental health. Amy described her experience in the hospital:

So at the hospital, the nurses were very aware of what was going on. They made notes of it. I snuck one of their charts one time and I started reading, because I noticed every time they came into the room they were writing on those little notepads and I thought what are they writing. So I sat down and read it, and I used to think you know, oh they wrote down medications, whatever tests are happening and then I realize I'm getting the same medication every day, and I'm not going for a lot of tests, maybe once a week I go for an ultrasound. It wasn't a whole lot going on, blood every now and then. So I grabbed one of the charts while the nurse had just stepped out, because she forgot something, and I started reading, and it really sunk in, they were writing down my emotional state, what was weighing on my mind and what was bringing me down. Went in to visit patient today, she was down again, fifth fight with her husband today, two on the phone, three in person. It hit home, it really shocked me (teary) that they would be writing stuff like that down, keeping track of it, and that was just one day. There was three months, it was a long hospital stay.

Amy was shocked and dismayed that no one had asked about what was happening, yet the nursing staff were charting their observations of the situation. It became apparent that the staff were judging Amy's actions. Doing so not only blames and shames the woman but can further decrease her self-esteem.

Brenda discussed the need for health care professionals to ask about a woman's state of health if they notice changes in her. She noted that people tend to state, "Because you are pregnant is the reason you are feeling down." Brenda believed that health care professionals should ask about the mother's health separately from the baby's health. In other words, the woman is as important as the baby she is carrying.

If everything affects the baby this includes the mom and the dad. Just from reading studies it shows that, especially when pregnant, abuse is common. I mean if a woman comes in depressed or feeling down, I don't think there's anything wrong with inquiring how the woman is doing as a whole ... whole person. I mean there's much more than just the baby. They [health care professionals] do inquire about eating, but it should be more around mental health as well.

One participant made a practical suggestion encouraging women to write a journal about their experiences. This is a concrete way for women to do something for themselves. Amy found that she made entries into her journal almost daily. When she looked back to her entries, she was surprised about how she felt then and how she feels today. It was a positive exercise for her, she explained:

Keep a journal about how you're feeling that day. If you could force women to keep a journal you'd be amazed on how much they've learned. The hard part is getting them to go back and read it. I don't know why I did it the first time, probably because I was pregnant, because it's just all fun That's one of the things you do, you plan the photo album and you have a journal that you write everything in, and just a very useful tool. And I remember reading for the first few months, just sadness.

I Would Like to Develop a Relationship With You

Some of these women wanted a deeper personal connection or relationship with their health care professional, not just a sense of being a number in the system. The kind of connection that they desired ranged from basic human decency to friendship. They appreciated staff who talked with them in an open, honest and respectful manner. This might involve sharing stories from their own life and connecting with them on a personal level. Having a personal connection with the health care professional can help women feel able to talk about personal problems, such as becoming a mother and needing help to transition to that identity. These opportunities serve as a glimmer of hope in the woman's eyes. Fiona discussed her need to reach out for help and develop a relationship with a health care professional as an important step toward personal health:

I worry so much that when I have to talk to people or get help from them, then I would think okay, if I do that then what's going to happen to me. In the past when I tried to reach out, it was always painful so that I couldn't just reach out or ask questions without feeling my face turning red hot and embarrassed. And it was hard for me to reach out and ask for help because of all the negative things that happened. Now I realized that he can't hurt me anymore and that asking for help and reaching out is a good thing because becoming educated and learning will

give you power. It empowers you because you're being educated on these things you need to know. You're not ever going to know until you actually reach out to actually find out, because how are you going to know. You're always going to stay there in your own box if you don't reach out, and to people like professionals. Because you just can't open a person's mind or see inside of them to know what's going on in their life. A lot of people hide it very well, what's going on inside, cause sometimes for us it's a life process, hiding who we are. So we can't be who we want to be, and we can't get the help we need because we don't know how to reach out. We're afraid to reach out, so when someone shows us act of kindness that's a hard thing for some people to accept. I don't know, maybe some people get afraid of that, tears and what not, or feel uncomfortable, but I think you have to be straightforward. You have to be blunt, because family violence is not something that can be just gently approached or addressed. You have to be straight forward, because when you are straight forward, then the other person can be straightforward back. And ask those tough questions, ask them, because they need to be asked, because sometimes that's all we're waiting for is someone to just reach out and help, that's the way it was for me.

The five major themes and subthemes describe, using the voices of six women living in intimate partner violence, health before and during pregnancy, coping behaviors and advice for health care professionals. The following paragraphs describe two important aspects from the interviews that need to be addressed.

A similarity among the women was their reason for agreeing to be interviewed. All the women spontaneously, without prompting, stated either early in the interview or near the end their reason for deciding to be interviewed. They expressed in their own words the hope that some good would come from the information, that it might help another woman so that she would never experience what they have lived through. It seemed that this hope gave the women some peace, thinking that their experience would help other women, that what had happened to them would not be in vain.

Another similarity among these women was how they felt after the face-to-face interview. When I called the women to follow up after the initial interview, all expressed feelings of body, mind and spirit weariness. It was if they had relived the experience and needed to deal with the fallout. The following excerpts illustrate this reaction:

It opened up cans that I thought were sealed and put away for good.

I couldn't do anything all evening. I was physically tired.

I cried because the feelings came back.

It took a piece out of me. It was hard but it helped me to see where I was then and where I am now.

I was mentally exhausted but still glad I did it

I laid around in the evening, which was unusual for me, but I realized I was just really tired after the interview.

Summary

The lives of these women were filled with fear, sadness and uncertainty. They were trapped in circumstances where they attempted to maintain some control by trying to manage their abusers. When they realized that this was impossible, their health was affected. Pregnancy brought further deterioration to their already fragile health. The women wanted help in order to deal with their chaotic lives but were unsure how to get it without causing further violence or disruption in an already overburdened existence. They did not know whom they could trust or to whom they could disclose about their delicate situation.

This chapter presented the findings from a detailed and in-depth analysis of six women's narrative interviews. This study focused on how women describe a change in their health while pregnant and living in intimate partner violence. The women in this study described several losses that they experienced in relation to mind, body, and spirit health. Their emotionally vivid descriptive quotes illustrate the themes derived through the analysis of the data.

Chapter 5. Discussion and Implications

Robson (2007) uses the analogy of a brick wall when describing qualitative studies. He describes a brick wall as a general topic of studies, in this case, intimate partner violence and each study as a brick in the wall. All bricks are needed to make the wall or study strong, and all the holes need to be filled in order to make sure the wall remains sturdy. When we are researching for a study to investigate, we are looking for the holes in the brick wall. I find this study to be part of the intimate partner violence wall, not as a brick at the base as a foundational study but as a supporting brick for the foundational studies.

This chapter begins with reviewing the purpose and method of study then moves on to the strengths and limitations. A discussion of the results obtained in Chapter 4 follows and places the findings in the existing literature that help to highlight areas of possible further research. Recommendations for nursing practice, nursing education, Health Care policies, universal screening, coalition building will be discussed.

The purpose of this study was twofold: first to describe, in the women's own words, their views of their health before and during a pregnancy while living in intimate partner violence, and secondly to determine what we as health care professionals can learn from these women. My hope was that this understanding would provide a new way of thinking about pregnant women who are living in these circumstances and suggestions for how more appropriate support could be provided to these women by helpers, especially nurses.

Qualitative inquiry was used in this study. Van Manen (2003) states:

Qualitative writing may be seen as an active struggle for understanding and recognition of the lived meanings of the life world, and this writing also poses passive and rhetoric dimensions. It requires that we be attentive to other voices, to subtle significations in the way that things and others speak to us. In part, this is achieved through contact with the words of others. These words need to touch us, guide us, spur us. (p. 713)

The method chosen to achieve this goal was narrative. The goal of a narrative study is to describe, as richly as possible, the meanings that people construct about their world and their experiences (Ulin et al., 2005). The way the six purposefully selected women used their words and told their stories revealed their understanding of their experiences. Providing women with a safe and supportive context for telling their stories of violence can be a powerful transformative process that leads to a journey of empowerment (Davis & Taylor, 2006).

Strengths and Limitations of the Study

Strengths

A major strength of this study is that it is based on the words of women who have actually lived the experience. The study allowed these women's voices to be heard and brought forward their unique experiences and perceptions. Actual lived experiences are a key place from which to build knowledge and stimulate societal change. Another identified strength is the design of the study in which the women were encouraged to tell their stories. Their stories provide information about the health of women who live in intimate partner violence while pregnant. This information is valuable for the health care professionals who work with women in this situation.

Limitations

One limitation is that all six of the women interviewed were born in Canada and can read and write in English. Consequently, the experiences of immigrant women who cannot speak or write the English language are not represented in this study. These women are marginalized by not knowing where they can seek help and even further by not being able to ask for help. Immigrant women may also have cultural beliefs about health that could be further compromised by living within intimate partner violence. For example, people in some cultures believe that the body needs to be in a balanced health state; if this is not the case, illness or other forms of suffering will occur.

Another important limitation is that all six women who participated in this study had left and were still living away from their abuser. The stories I received from these women were retrospective, based on what they recalled at the time of the interview. Women who are still living within intimate partner violence may recall different stories about their experiences, health and needs. Therefore, this study does not address the perspectives of women who are still living in intimate partner violence relationships.

The women involved in this study were living in an urban center at the time of the interviews. The three Aboriginal women had lived on a reserve for the first part of their lives but now live in an urban center. As a result, women who live in a rural setting or are currently living on a reserve are not represented within this study. Such women may have different perspectives, resources or lack of resources than urban woman; consequently, this is another limitation.

A further limitation is that this study was based only on male-female relationships. Different relationship perspectives might have been extracted if a female-female relationship had been included.

Discussion of Results

The analysis of the women's words and the subsequent findings of themes presented in Chapter 4 offer supporting information for current studies, along with some new understandings. Without warning, these women, found themselves in a situation of conflict. Their relationships with their abuser had started as positive; the women described their initial relationships in terms of friendship and trust. Eventually their partners changed from being attentive and charismatic to being controlling and violent. Much of the women's energy was spent on trying to maintain some control in their lives; when they realized they had none, their health suffered.

The findings from this small qualitative study indicate that these women, taking a retrospective view, knew their health suffered while they were living in intimate partner violence, both before and during a pregnancy. However, while they were living in intimate partner violence, they were so busy coping with their chaotic life that they never considered that their health was suffering. For example, Amy recalled reading in her diary about the first four months of her pregnancy, after leaving her husband. Amy had written very sad entries during this time. Her physician had noticed that she was feeling down and discussed it with her. Even then she did not grasp what her physician was telling her. This is significant for health care professionals who are concerned with the health of pregnant woman who live in intimate partner violence; women in this situation will need guidance regarding their health.

Health and the Health Belief Model

The women in this study told stories of how their health deteriorated during a pregnancy due to intimate partner violence. As discussed in Chapter 4, they described, in terms of losses, how the intimate partner violence affected their health. Although each woman told me her unique story, as a group they shared many similar experiences. The women described ways in which their body, mind and soul suffered, and it became apparent that these three areas of health were closely tied or integrated. When one area of health suffered, so did the two other areas. For example, the women described the loss of physical intimacy with their partners due to their bodies physically changing with the pregnancy. This, in turn, affected how the women felt about themselves, which led to decreased self esteem. Their sense of self or spiritual health was also affected in terms of their relationship with their partner and themselves. This finding is congruent with other authors' descriptions of optimal health as a balance of body, mind, and spirit, all intimately interconnected (Condon, 2004; Karren, 2006; O'Donnell, 1989; Olshansky, 2000, Scaer, 2007; Youngkin & Davis, 2004).

The theoretical framework used for this study is the health belief model. This model helps to explain individuals' health behavior by understanding their beliefs about health. It suggests that the probability of an individual's taking action linked to a given health problem is based on four different types of beliefs: perceived susceptibility, seriousness, benefits, and barriers (Nutbeam & Harris, 2004). In this study, the health belief model was applied to discover how women believed their state of health was during a pregnancy while they were living in intimate partner violence. The women of this study revealed that they were not in their normal state of body, mind, or spirit health

during their experiences of living in intimate partner violence when pregnant. They disclosed that they were using all of their energy trying to normalize the relationship to the outside world or surviving the abuse, and they had little energy left to care for themselves, thus affecting their health. health care professionals can use this knowledge in developing strategies for anticipatory guidance for women who live in intimate partner violence, moving them towards a state of optimum health through programming, nursing education, nursing practice, and health care policies.

Body Health

The woman in this study described a progressive weakening of their body or physical health when living in intimate partner violence during a pregnancy. The normal physical symptoms of pregnancy, such as tiredness and decreased energy, were amplified by the abuse. The themes of loss of physical intimacy, loss of physical strength, and an inability to protect their unborn babies that emerged from the data are comparable to those found in other studies (Bacchus et al., 2006; Bonomi et al., 2006; Coker et al., 2002; Martin et al., 2006; Sharps, Laughon, & Giangrande, 2007).

Mind Health

The damaging effects of physiological and emotional abuse during pregnancy are well documented in the literature (Bloom et al., 2007; Carlson et al., 2002; Golding, 1999; Jones et al., 2001; Martin et al., 2006). The theme of loss of voice and loss of joy demonstrates the mental anguish these women endured. Feelings of desperation and despair were common as women experienced the loss of their self-esteem and sense of who they were.

Lutz et al. (2006) discuss the binding process in which, for a variety of reasons, a woman makes a conscious decision to bind in to the relationship during pregnancy. This leads to a disconnection between her public and private life. Feeling tied to her decision to stay, the woman spends her energy guarding the two lives, one life for the world to see and the other a life lived behind closed doors. Doing so reduces her health or quality of life, as it drains her of precious energy that is needed for herself and her growing baby. Being pregnant and binding into the relationship clearly affected the mental health of the women of this study, as they described feelings of depression, hopelessness, and helplessness.

Grief is defined as “pain of mind on account of something in the past; mental suffering arising from any cause, as misfortune, loss of friends, misconduct of one's self or others, etc.; sorrow; sadness” (Dictionary.net, n.d.). Grief is a normal and natural reaction to any type of loss.

Bowlby, a noted psychiatrist, outlined the processes of resolving grief. The four dimensions of the mourning process outlined by Bowlby (cited in Welshons, 1999) are the following: shock and numbness, yearning and searching, disorientation and disorganization, and resolution and reorganization (p. 45). The four dimensions do not follow a set order, and a person may experience feelings from several stages at one time. An individual's past history of experiences with crisis and grief is an important determinant of how he or she will proceed through the grief process. It is important for a person to grieve and complete their relationship to the pain and unfinished business caused by a death, divorce, or any other significant loss (Welshons, 1999).

The participants in this study each clearly described unresolved grief, both in their words and in the emotions they displayed during the interviews. Amy stated, “The interview opened up cans that I thought were sealed and put away for good.” Unresolved grief tends to drain us of energy and close our hearts down, according to Welshons (1999). The women in this study confirmed this effect through their comments in their follow-up telephone calls after the interview. Brenda stated, “I couldn’t do anything all evening. I was physically tired.” Carol said that she “cried because the feelings came back.” Dani commented, “It took a piece out of me.” Elly remarked, “I was mentally exhausted but still glad I did it.” Fiona said, “I laid around in the evening, which was unusual for me, but I realized I was just really tired after the interview.”

This represents another finding for health care professionals working with women who live or have lived in intimate partner violence. Unresolved grief will need to be addressed if these women are to move forward towards improved holistic health. Questions designed around unresolved grief could be incorporated within a detailed health assessment. Health care professionals may need to access appropriate resources on dealing with unresolved grief.

Spirit Health

All of the women were affected by their memories of loss of health during their abusive relationships. Five of the six women tearfully discussed how intimate partner violence affected their spiritual health during pregnancy. The common thread or theme of the importance of relationships stands out in the women’s stories. This is consistent with the relational model developed by Surrey (1985), that women’s sense of self is primarily relational: “[Women] develop their sense of self through their ability to make and then to

maintain affiliation and relationships” (p. 3). The women discussed the loss of relationships with their partners, with a higher power, and with themselves as becoming mothers. The one participant who believed that intimate partner violence had never affected her spiritual health, which she discussed in terms of her relationship with God, stated that she believed that was one thing her partner could not take away from her. She did however discuss the loss of her relationship with her partner and how the abuse affected her as she was becoming a mother.

The women in this study also described a death of self and a sense of having no purpose in life while living in abuse while pregnant. Brenda stated in frustration that, whenever she attended a physician’s appointment, the whole time was spent on the health of her baby, and she felt like a vessel for her baby. When the health care professional never asked how she was doing or if she was safe, her sense of worth as a person decreased. This added to the death of who she was as a person and as a mother. The abuse depleted her purpose in life because it took away all her hopes and dreams of a future, and the pregnancy simply added to the destruction.

The women of this study were able to identify how the intimate partner violence they experienced during a pregnancy affected all dimensions of their health: body, mind and spirit. Our current medical model of health addresses issues related to the body and mind. With the exception of end-of-life interventions, spiritual health is almost absent from western medicine as it is practiced today (Hawks, Hull, Thalman, & Richins, 1995; Hawks et al., 2008; Vader, 2006; Wallace & O’Shea, 2007).

Nursing should ideally center on the body, mind, and spirit in order to guide people towards optimal holistic health. Health of the spirit as an equal component of

human health is still virtually unrecognized in nursing education, which currently focuses on health of the body and mind. Spirit health is included in describing the model of health; however, what is lacking is a clear definition of spiritual health and the “how to” or strategies for moving people on the continuum of spiritual wellness. Wallace and O’Shea (2007) argue that little research has been undertaken to determine how nurses may best help adults to improve their spiritual health.

By ignoring the spiritual dimension of health, for whatever reason, we may be depriving ourselves of the influence we may have to help empower individuals and populations to achieve improved physical and mental health. Hawks et al. (1995) reviewed three programs that involved a spiritual component. They found these three programs, due to the spiritual component, produced excellent improvements in health behaviors and decreased mortality and morbidity.

Quality of Life

The overarching theme that became apparent as the women were talking was quality of life. As health care professionals we concern ourselves with individuals and populations living as healthy as possible. One of our beliefs is that how one views one’s health affects one’s quality of life. Quality of life “refers to an individual’s personal assessment of subjective well being,” according to authors Mount, Boston, & Cohen, (2007, p. 373). They had studied how 21 Canadians with life-threatening illness found a sense of wellbeing and wholeness. A significant illustration of personal assessment of wellbeing is Kagawa-Singer’s 1993 study of 50 patients with active cancer (cited in Mount et al., 2007). One-third of the 50 participants considered that they were fairly

healthy, and the remaining two-thirds stated that they were very healthy, including 12 who ultimately died during the study.

The Quality of Life Research Unit at the University of Toronto's Center for Health Promotion has been developing conceptual models and instruments for research, evaluation, and assessment since 1991. Its quality of life model looks at three areas: being, belonging, and becoming (Renwick, 2009). Health crosses all three areas; therefore it is important that health care professionals address body, mind and spirit health in all health promotion encounters.

For the women in this study, health and quality of life were affected by their experiences with intimate partner violence. In general, health was not a high priority for these women. For them the need to carry out health promoting activities was overshadowed by the need to survive the relationship. Assumptions regarding the rating of quality of life for these women cannot be made; however, it may be concluded based on the data that their quality of life was changed with intimate partner violence. These women described losses of mind, body and spirit health that they experienced before and during pregnancy. They experienced a decrease in quality of life, which has a significant negative impact on everything from day to day functioning to hopes for the future.

Summary

Many of the findings of this qualitative study closely parallel the findings of previous studies of women living in intimate partner violence and their body and mind health before and during a pregnancy. The literature clearly indicates that intimate partner violence places women at substantial risk for health problems. The findings of this study support the concept that, when women live in intimate partner violence during pregnancy,

their health deteriorates. Through the stories the women told, I was able to identify themes related to losses that they experienced. The losses of body and mind health that these women described experiencing during their relationship with their abusive partners are similar to those identified in previous studies. However, the loss of spiritual health has not been identified in other studies. This omission is congruent with a finding of Hawks et al. (2008), who reviewed 2610 articles from 12 health education journals to determine what dimensions of health were being researched. They found that 79% of the articles dealt with the physical dimension, 20% dealt with the mind, and only 1% considered the spirit dimension of health.

Recommendations

Broad generalizations cannot be drawn from this narrative study, because it is based on a small sample of women from similar circumstances. However, the findings suggest possible new directions for nursing education and practice, as well as for policy making and resource planning with respect to care for women who are pregnant and living within intimate partner violence. The findings of this study may draw attention to the need for improved health care for women living in such circumstances and their need for positive experiences within the healthcare system, with the broad goal of more positive outcomes for both mothers and their babies.

Nursing Practice

As the findings indicate, these women clearly want a relationship with their health care professionals, who have an important role in assisting women who live in intimate partner violence. In particular, the women state that it is important for health care professionals to ask about intimate partner violence, but in a way that is meaningful,

respectful, and caring. Furthermore, they want to be listened to in a similar fashion. Women ultimately have the choice of staying or leaving the relationship. Health care professionals may have feelings of failure if women choose to stay with their abusers. However, health care professionals must realize that they are not there to fix the problem; instead their role is to ask questions, to listen, and to provide information and support. In particular, health care professionals can provide information and connect women with appropriate services. Listening, combined with knowing that women are looking for support, validation of their experience, and needing information but not needing to be rescued, may provide a new direction for health care professionals as advocates. As Webster et al. (2006) point out, women are not looking for the health care professional to fix their problems but rather to guide them in identifying a healthy relationship.

Public Health Nurses (PHNs) can have a considerable positive effect in this area. Their natural place in the community puts them in a position to work with women in their own environment. PHNs are dedicated to enhancing the health of individuals and communities and are aware of the resources available within the community. Webster et al. (2006) support PHNs as having a major role in working with women who live in intimate partner violence and helping them move towards optimum health. PHNs need first to assess where these women are at present and then to guide them in health decisions. The role could initially involve doing for the woman, for example by telephoning a local shelter; it could be doing with the woman, for example in developing a safety plan; or it could be supporting the woman in her decision to stay with the abuser and moving her towards optimal health choices.

According to the women in this study, education about abuse is important. They disclosed that they were aware of physical abuse but unaware of other types of abuse. They made several suggestions related to education about abuse. For example, posters, flyers, and pamphlets are one way to inform people about what constitutes abuse. Prenatal classes could include a segment covering what constitutes abuse and the signs of abuse. At every prenatal visit, physicians or nurses could ask expectant mothers about abuse. However, women also need to know that reporting child abuse is the law, and they need to be aware of the possible consequences of disclosing.

Nursing Education

Intimate partner violence is a delicate issue and may be uncomfortable for the beginning health care practitioner. Nursing is dedicated to building a body of knowledge in order to develop an evidence-based practice and has strong roots in holistic health. Educating nurses about the role that intimate partner violence plays in women's lives involves the entire spectrum of health and wellness. The results of this study showed how these women felt their health and wellness were affected by intimate partner violence while they were pregnant. Health care professionals will encounter women similar to these participants in their professional and personal lives. Teaching nurses to listen first and develop skills in the art of conversation, including caring, sharing and learning, will benefit all persons who come into their care, including pregnant women who live in intimate partner violence.

It could be detrimental to a woman's mental and spiritual health if her health care professional does not respond appropriately to a disclosure. Elly stated:

She'd look at me and she'd see a bruise on me. You know something happened, but then I thought well, they're not stupid, they must know. I don't know if they

wanted to ask. I'd say, "Just ask, then I can say something." I don't want to be a burden, you know. If you know something, if you think, even if you see something, ask.

The women of this study believe that, if a health care professional sees or suspects intimate partner violence, he or she needs to ask, because otherwise that person is an accomplice to the violence. This point underscores the need for universal screening for intimate partner violence.

Feder, Hutson, Ramsay, and Tacket's (2006) meta-analysis of 29 qualitative studies established consistency across studies in terms of what women living within intimate partner violence want from their health care professionals: an atmosphere of safety, support; access to resources; an attitude that is non-judgmental and respectful; taking time to listen; focusing on the women; explaining how violence can affect their health, and lastly not pressuring them. Time and support are very important when working with women who are living within intimate partner violence. In a large quantitative study of 2,465 women that took place in the greater Boston area, McCloskey et al. (2005) showed that talking to a health care professional about abuse increased women's likelihood of using an intervention for violence. Furthermore, those who received an intervention were more likely subsequently to exit the abusive relationship. These findings support the notion that discussing intimate partner violence with a health care professional is associated with a positive outcome.

Generally, health care professionals do not understand and are frustrated when women choose to stay with their abuser. Health care professionals need to understand the attachment that women have to their abuser, home and family. On-going education for students in health care programs and clinicians in practice may be necessary to improve their competence and comfort in addressing many issues, including intimate partner

violence. This could include strategies for screening, assessment and interventions, with the realization that in such circumstances it is important not to do interventions to people but rather with people. Health care professionals also need to be able to connect such women to appropriate resources within their communities.

Spirit health must be recognized as an equal dimension of health within nursing and the holistic health model. Nursing education must advocate for and include an accepted definition and health promotion strategies in relation to spirit health. Health care professionals need to understand that the intimate link to the very sense and purpose of self identity is probably the most powerful known motivator of human behavior and behavior change. Failure to evaluate and promote all dimensions of health equally and to appreciate the functional motivation that must underlie successful health behavior change substantially hinders the achievement of health education goals (Hawks et al., 2008).

Health Care Policies

Reducing the gaps between what we know (research) and what we do (policies) is key to providing evidence-based services (Findlay, 2004). Research findings should be taken into consideration in the development of health care policies. The current literature indicates that screening for intimate partner violence done by individual health care professionals without the support of the health system may not always lead to appropriate documentation, treatment, and referrals (Davis, Parks, Kaups, Bennink, & Bilello, 2003; Gerber, Leiter, Herrmann, & Bor, 2005; McCloskey et al., 2005; Thurston & Eisener, 2006). Health care systems need to develop policies and practices, supported by research, that aid health care professionals in proper screening, assessments, and referrals. Having evidence-based policies and practice in place for those dealing with women who live in

intimate partner violence can have a rippling effect that begins with the individual women and affects their families and relationships, their communities, and ultimately all of society.

Within our present health care model, the physician is the primary health lead. A person experiencing a health deficit goes to his or her family physician, who either deals with the health issue or refers to another health care professional. The family physician is expected to know a certain amount about every health issue a person presents with, and has limited time at each visit for extensive questioning. Sharps et al. (2007) emphasize that women need quality time for proper screening, assessment, and intervention during a health visit. These authors noted that half of the women murdered by intimate partner violence in the United States had sought health care in the year before their death.

A new primary care model is unfolding in Alberta. In this new model, physician clinics will house several different disciplines, such as physiotherapists, pharmacists, Registered Nurses, and Nurse Practitioners. The idea is to have a “one-stop shopping” health center in which clients can access all the disciplines they require with only one stop. This would be ideal for women who live within intimate partner violence, as often they have limited resources. One of the roles of the Nurse Practitioner is to complete a thorough health assessment using the principles of health promotion. This involves helping people change their lifestyles to move toward a healthier state. The Nurse Practitioner would have more time to work with clients, using evidence-based strategies in the workplace.

Universal Screening

Universal screening has been recommended in the literature reviewed for this study. There is consensus in the literature that women who live in intimate partner violence will not be detected without active screening (Plichta, 2007). Routine screening has been adopted in health care settings in Canada (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Janssen, Dascal-Weichhendler, & McGregor, 2006; MacMillan et al., 2006). Universal screening is not a miracle solution for working with women who live with intimate partner violence and should be used as a first step towards helping women obtain other necessary interventions.

Health care professional organizations support and direct their membership to perform intimate partner violence screening at each encounter in the clinical setting. The Society of Obstetricians and Gynecologists (SOGC, 2005), which directs physician practice in Canada, has an intimate partner violence consensus statement that includes routine screening for intimate partner violence. The College and Association of Registered Nurses in Alberta (CARNA, 2008) along with the College of Registered Psychiatric Nurses of Alberta (CRPNA) and College of Licensed Practical Nurses of Alberta (CLPNA) released a joint statement in 2008 on family violence advocating that nurses' routine screening for abuse should be a standard component of assessment. The Canadian Task Force on Preventive Health Care showed increased detection of intimate partner violence through screening (Wathen & MacMillan, 2003). However, there was a gap in evidence for screening tools, for effective interventions in health care settings once women are identified, and for a reduction in the level of abuse.

Health care professionals can act as an important gateway to healthcare for intimate partner violence. Without proper screening, intimate partner violence victims may not be identified. Studies consistently find that female patients (both victims and non-victims) believe it is appropriate for health care professionals to ask about intimate partner violence (Bair-Merritt et al., 2006; Burge, Schneider, Ivy, & Catala, 2005; Glass, Dearwater, & Campbell, 2001; Kramer et al., 2004). Furthermore, most women will disclose if they are asked (Hathway, Willis, & Zimmer, 2002; Kramer et al., 2004).

There needs to be consistency among health care professionals on the timing of universal screening. It would be simplest if screening were done with every interaction between a health care professional and a woman. This would include pre-pregnancy, pregnancy and post-partum interactions, including well child clinics. In this way, health care professionals would become more comfortable with asking, and women would learn to expect to be asked about intimate partner violence. Along with the screening, an education learning plan (e.g., Telehealth sessions) would need to be developed for HPVs to teach them how to use available tools, how to ask the questions, and what to do if the woman answers “yes” to questions about intimate partner violence.

In Alberta, all pregnant women should be asked about intimate partner violence by their health care professionals. The question is on a form called Notice of Live Birth, required by Alberta Health and Wellness. This form has three parts. The first page is about the pregnancy, and the health care professional completes it during the visits the woman makes during her pregnancy. However, when the women of the current study were asked if their health care professional had asked about intimate partner violence during their pregnancy, only one of the five women answered yes. One woman had not

delivered a baby in Alberta and had not been asked about intimate partner violence in the province where she delivered.

Coalition Building

Coalition building within communities could be the cornerstone for a cohesive approach in addressing intimate partner violence. No pill or surgery will end intimate partner violence, because it is a societal issue, not a medical one. It will take all members of society who have contact with women who live in intimate partner violence to address the issue. Women cross every sector of society, so the coalition could be a substantial one. Nursing would have a seat at the coalition along with other health care professionals, police, social service, women's shelters, women's service agencies, aboriginal services, legal services, religious community, immigrant services, and school systems. Among the most valuable members on the coalition would be those with the most intimate knowledge on the topic, that is, women who have lived the experience. Communication and collaboration to build a multi-faceted service for women living within intimate partner violence would be the key among all these stakeholders, to provide better linkages and coordination of services.

Further Research

Further research is needed to reduce the critical knowledge gap regarding intimate partner violence, women, pregnancy and health. Studies could investigate proper screening, which needs to include the "who, what, when and where," proper assessment tools and interventions. The studies would need to employ a mix of qualitative and quantitative methodology, in order to provide evidence about best practices and

approaches for those working with pregnant women who live in intimate partner violence.

The limitations of this study could suggest future studies regarding women, intimate partner violence, pregnancy and health. For example, populations of pregnant women who are still living in intimate partner violence, immigrant women, lesbian women, and rural women could potentially bring different perspectives to an already complex issue.

The narrative approach to this study brought forth honest and sincere information from the participants. This leads me to believe that it essential to listen to women when doing intimate partner violence research. The women in this study revealed that they wanted to talk, and what they talked about was very personal and unique to them. Women who live within intimate partner violence may not be open to predetermined research questions.

By the very nature of the topic, intimate partner violence raises ethical considerations that need to be carefully reviewed prior to the start of a study. The potential risk to women who choose to be part of such studies needs to be taken seriously. Connect a pregnancy to these studies and further ethical considerations need to be taken into account, such as the very real risk of further traumatizing the pregnant women. Another issue is the potential risk of pregnancy complications. It would simply not be an option to use a control group, withholding treatment or interventions.

There is a void in the literature regarding spiritual health research within the health professions. The focal point of studies regarding women, intimate partner violence, health and pregnancy has been on physical and mental health. However, preliminary

studies of other health conditions indicate that spiritual health can be the catalyst for improving mental and physical health. Studies on health promotion activities that women (non pregnant and pregnant) who are living in intimate partner violence might undertake to improve their body, mind and spirit health would contribute to the body of knowledge about health and interventions.

Lastly, there are three things I wish I had included in this study. First, I would have asked the women to rate their body, mind and spirit health individually, while they were pregnant and living in intimate partner violence, on a 10-point scale. I think this would have provided a more concrete indication of how they viewed their health. Secondly, it would have been of interest if the women had given a title to their stories. I might have gleaned more information about their innermost thoughts and feelings of being in a vulnerable pregnant state while living in intimate partner violence. Lastly I would have liked to know how the women rated their quality of life when living in intimate partner violence while pregnant since the women themselves are the only one who know the answer to this question,

Reflections and Unexpected Learnings

As I was jotting down thoughts, after conducting one of the interviews, I realized that these women trusted me enough to tell me their stories on such a delicate subject. I had spent a relatively small amount of time with them, two telephone calls prior to the face-to-face interview, which lasted one to two hours. I was thinking about how I would react if the circumstances were reversed. Would I have told a stranger the intimate details of my life? I realized that somehow they had found a level of comfort in telling their story. I had taken a personal interest in them and their life, and what they had to say was

important. This seemed to inspire confidence and trust, and they gave me the gift of their time and story.

The other realization I took away from this is that each woman had a story to tell, and it took time for each story to unfold. If the women had been rushed or if the interview had been more structured, they would not have been able to tell their stories in their own way. As a researcher I needed to let the women speak about their experiences in their words and stories, allowing them to take the time they needed.

I went on to reflect that building trust and giving time are in direct conflict with our western medical system. It is easier for the health care professional to ask about a person's signs and symptoms of a disease than to expend time and energy in trying to engage with the patient. I had time in the interview to build trust, whereas a typical health care professional encounter lasts only 10 to 15 minutes. This further demonstrates the need for a change in our health system so that health care professionals and women can develop a mutual and respectful relationship.

Conclusion

The purpose of this study was two-fold: first to describe, in the women's own words, their view of their health before and during a pregnancy while living in intimate partner violence, and secondly to probe what we as health care professionals can learn from these women. I chose to explore this topic because of my experiences in my career as a Registered Nurse. My motivation was to attempt to find new ways to work with pregnant women who live in intimate partner violence in order to help them improve their quality of life.

The process of interviewing, analyzing the data, and discussing the findings has been a significant learning experience. It became apparent that health needs to be addressed in all the domains of body, mind and spirit. The voices of women telling stories about their health when they are living in intimate partner violence while pregnant are limited in the literature. Health care professionals need to stop and listen to what these women are telling us, as this may be the key to moving forward as a just and fair society. Until we seriously address the issue of intimate partner violence, however difficult and uncomfortable it may be to us as a society, we may not see sustainable improvements in physical, mental and spiritual health. Let us have the wisdom, courage, and passion to move forward in improving quality of life for all members of society.

A wise friend told me, “If you don’t know where you are going, you will end up somewhere else.” I gave this advice serious consideration when I started the journey of writing a thesis, but it is exactly what happened through this process. I could never have imagined when I began what I would personally discover through this study. This study has forced me to rethink my nursing practice.

Epilogue

For women, living in intimate partner violence can be compared to other life circumstances where there is extreme hardship and deterioration of their health. I will finish with a story my father-in-law told me when I first discussed my thesis topic with him. I believe that the women who participated in this study may have had similar feelings at some point in their relationship with their abuser. One woman had used the metaphor of being “a prisoner of war” feeling she was in a battle for her life.

My father in law had been a prisoner in a POW (prisoner of war) camp in Germany for 18 months during the Second World War and experienced horrific events. He said that he endured many physical afflictions, such as starvation, lack of warm blankets or clothing, and mental torture including threats of being shot or having to watch his friends being shot. He was very passionate when he told me that he could endure the physical and mental torture but was adamant that he had to keep up his spirit. That was one thing he was not going to give to his captors. He described the men who did as the “walking dead.” He did return home with his spirit intact however there were many other aspects of his health that suffered.

References

- Alberta Council of Women's Shelters. (2008). *Annual statistics: Domestic violence information*. Retrieved December 17, 2008, from http://www.acws.ca/annual_stats.php
- Alberta Justice. (2005, October). *Domestic violence handbook for police and crown prosecutors in Alberta*. Retrieved February 10, 2006, from <http://justice.gov.ab.ca/publications/default.aspx?id=4373>
- Alexander, R. (1993). Wife battering: An Australian perspective. *Journal of Family Violence*, 8(3), 229-251.
- Alliance to End Violence Resource Library. (2008). *Violence against women*. Retrieved December 17, 2008, from <http://www.acav.org>
- Arnold, E., & Boggs, K. U. (2003). *Interpersonal relationships: Professional communication skills for nurses* (4th ed.). Saint Louis, MO: Saunders.
- Austin, W., & Boyd, M. A. (2008). *Psychiatric nursing for Canadian practice*. Philadelphia: Lippincott.
- Bacchus, L., Mezey, G., & Bewley, S. (2006). A qualitative exploration of the nature of domestic violence in pregnancy. *Violence Against Women*, 12(6), 588-6004.
- Bailey, P. H. (1996). Assuring quality in narrative analysis. *Western Journal of Nursing Research*, 18, 186-194.
- Bailey, P. H., & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of Advanced Nursing*, 38(6), 574-583.

- Bair-Merritt, M., Blackstone, M., & Feudtner, C. (2006). Physical health outcomes of childhood exposure to intimate partner violence: A systematic review. *Pediatrics, 117*, 278-290.
- Benbow, S. (2009). Societal abuse in the lives of individuals with mental illness. *Canadian Nurse, 105*(6), 30-32.
- Berenson, A. B., Wiemann, C. M., Wilkinson, G. S., Jones, W.A., & Anderson, & G. D. (1994). Perinatal morbidity associated with violence experienced by pregnant women. *American Journal of Obstetrics and Gynecology, 170*, 1760-1769.
- Best Start: Ontario's Maternal Newborn and Early Child Development Resource Centre. (2003). *Working with women who have experienced abuse*. Toronto: Ontario Prevention Clearinghouse.
- Bloom, T., Curry, M. A., & Durham, L. (2007). Abuse and psychosocial stress as factors in high utilization of medical services during pregnancy. *Issues in Mental Health Nursing, 28*(8), 849-866.
- Bohn, D. (2000). Domestic violence and pregnancy implications for practice. *Journal of Nurse Midwifery, 35*(2), 86-98.
- Boehm, R., Golec, J., Krahn, R., & Smith, D. (1999). *Lifelines: Culture, spirituality, and family violence*. Edmonton, AB: University of Alberta Press.
- Bonomi, A., Anderson, M. L., Frederick, P. R., & Thompson, R. S. (2009). Health care utilization and costs associated with physical and non physical-only intimate partner violence. *Health Services Research, 44*(3), 1052-1068.

- Bonomi, A., Thompson, R., Anderson, M., Reid, R., Carrell, D., Dimer, J., et al. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine*, 30(6), 458-466.
- Bullock, L. F., & McFarlane, J. (1989). The birth-weight/battering connection. *American Journal of Nursing*, 89(8), 1153-1155.
- Burge, S., Schneider, F., Ivy, L., & Catala, S. (2005). Patients' advice to physicians about intervening in family conflict. *Annals of Family Medicine*, 3, 248-254.
- Burkhardt, M., & Nagai-Jacobson, M. (2002). *Spirituality: Living our connectedness*. New York: Delmar Thomson Learning.
- Bybee, D., & Sullivan, C. (2002). The process through which an advocacy intervention resulted in positive change for battered women over time. *American Journal of Community Psychology*, 30(1), 103-132.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, 359, 1331-1336.
- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., et al. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, 93(7), 1089-1097.
- Carlson, B. E., McNutt, L. A., Choi, D. Y., & Rose, I. M. (2002). Intimate partner abuse and mental health: The role of social support and other protective factors. *Violence Against Women*, 8(6), 720-745.

- Chamberlain, L., & Perham-Hester, K.A. (2000). Physicians' screening practices for female partner abuse during prenatal visits. *Maternal and Child Health Journal, 4*(2), 141-148.
- Chinook Health. (2007). *Chinook Health Region annual report 2006-2007*. Alberta Health Services. Retrieved March 5, 2008, from http://www.chr.ab.ca/bins/doc.asp?rdc_id=6088
- Chung, D., Kennedy, R., O'Brien, B., & Wendt, S. (2000). Home safe home: The link between domestic and family violence and women's homelessness. *Partnerships Against Domestic Violence*. Retrieved February 10, 2006, from [http://www.facs.gov.au/internet/facsinternet.nsf/VIA/homesafe/\\$File/homesafehome.pdf](http://www.facs.gov.au/internet/facsinternet.nsf/VIA/homesafe/$File/homesafehome.pdf)
- Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story of qualitative research*. San Francisco: Jossey-Bass.
- Cloutier, S., Martin, S. L., Moracco, K. E., Garro, J., Clark, K. A., & Brody, S. (2002). Physically abused pregnant women's perceptions about the quality of their relationships with their male partners. *Women and Health, 35*(2/3), 149-163.
- Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., et al. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260-268.
- College and Association of Registered Nurses of Alberta. (2003). *Nursing practice standards*. Edmonton, AB: Author.
- College and Association of Registered Nurses of Alberta. (2005). *Scope of Practice for Registered Nurses*. Edmonton, AB: Author.

- College and Association of Registered Nurses of Alberta. (2008). *Joint statement on family violence*. Retrieved December 20, 2008, from http://www.nurses.ab.ca/Carna-Admin/Uploads/joint_stmnt_family_violence_web.pdf
- Condon, M. C. (2004). *Women's health: An integrated approach to wellness and illness*. Upper Saddle River, NJ: Prentice Hall.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Davis, J., Parks, S. Kaups, K., Bennink, L., & Bilello, J. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma, 54*, 352-355.
- Davis, K., & Taylor, B. (2006). Stories of resistance and healing in the process of leaving abusive relationships. *Contemporary Nurse, 21*(2), 199-212.
- Davis, R. E. (2002). The strongest women: Exploration of the inner resources of abused women. *Qualitative Health Research, 12*(9), 1248-1263.
- Dictionary.net. (n.d.). *What does grief mean?* Retrieved May 5, 2009, from www.dictionary.net/grief
- Ehrensaft, M., & Cohen, P. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 71*, 741-753.

- Emden, C., & Sandelowski, M. (1999). The good, the bad and the relative, Part Two: Goodness and the criterion problem in qualitative research. *International Journal of Professional Nursing Practice*, 5(1), 2-7.
- Espinosa, L., & Osborne, K. (2002). Domestic violence during pregnancy: Implications for practice. *Journal of Midwifery and Women's Health*, 47(5), 305-317.
- Fairbairn, G., & Carson, A. (2002). Writing about nursing research: A storytelling approach. *Nurse Researcher*, 10(1), 7-14.
- Feder, G., Hutson, M., Ramsay, J., & Taket, A. (2006). Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine*, 166, 22-37.
- Findlay, S. S. (2004). *Knowledge-brokers: Linking researchers and policy makers*. Edmonton, Alberta: Alberta Research Transfer Network of Alberta, Alberta Heritage Foundation for Medical Research.
- Fleury, R. E., Sullivan, C. M., & Bybee, D. I. (2000). When ending the relationship does not end the violence. *Violence Against Women*, 6(12), 1363-1383.
- Frank, A. W. (2000). The standpoint of storyteller. *Qualitative Health Research*, 10(3), 354-365.
- Frank, J. B., & Rodowski, M. F. (1999). Review of psychological issues in victims of domestic violence seen in emergency settings. *Emergency Medicine Clinics of North America*, 17(3), 657-677.
- Freedberg, P. (2006). Health care barriers and same-sex intimate partner violence: A review of the literature. *Journal of Forensic Nursing*, 2(1), 15-24.

- Fulfer, J. L., Tyler, J. J., Choi, N. J., Young, J. A., Verhulst, S. J., Kovach, R., et al. (2006). Using indirect questions to detect intimate partner violence: The SAFE-T questionnaire. *Journal of Interpersonal Violence, 22*(2), 238-249.
- Gainor, L. (2004). Domestic violence: Looking at an old problem in a new way. *Alberta RN, 60*(10), 8-11.
- Gerber, M., Leiter, K., Herrmann, R., & Bor, D. (2005). How and why community hospital clinicians document a positive screen for intimate partner violence: A cross-sectional study. *BMC Family Practice, 6*, 1-9.
- Giacomini, M. C., & Cook, D. J. (2001). *A user's guide to qualitative research in health care*. University of Alberta, Centre for Health Evidence. Retrieved August 22, 2006, from <http://www.cche.net/usersguides/qualitative.asp>
- Giesbrecht, N., & Sevcik, I. (2000). The process of recovery and rebuilding among abused women in the conservative evangelical subculture. *Journal of Family Violence, 15*, 229-248.
- Gillum, T., Sullivan, C., & Bybee, D. (2006). The importance of spirituality in the lives of domestic violence survivors. *Violence Against Women, 12*(3), 240-250.
- Glass, N., Dearwater, S., & Campbell, J. (2001). Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing, 27*(2), 141-149.
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132. Holloway, I. (1997). *Basic concepts for qualitative research*. Toronto, ON: Blackwell Science.

- Goodkind, J., Gillum, T., Bybee, D., & Sullivan, C. (2003). The impact of family and friends' reaction on the well-being of women with abusive partners. *Violence Against Women, 9*(3), 347-373.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C., & MacMillan, H. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*(12), 1-11.
- Hall, J. M. (2003). Analyzing women's roles through graphic representation of narratives. *Western Journal of Nursing Research, 25*(5), 492-507.
- Harrison, L. A., & Esqueda, C. W. (1999). Myths and stereotypes of actors involved in domestic violence: Implications for domestic violence culpability attributions. *Aggression and Violent Behavior, 4*, 129-138.
- Hathaway, J., Willis, G., & Zimmer, B. (2002). Listening to survivors' voices: Addressing violence against women in the health care setting. *Violence Against Women, 8*, 687-719.
- Hawks, S., Hull, M., Thalman, R., & Richins, P. (1995). Review of spiritual health: Definition, role, and intervention strategies in health promotion. *American Journal of Health Promotion, 9*(5), 371-378.
- Hawks, S., Smith, T., Thomas, H., Christley, H., Meinzer, N., & Pyne, A. (2008). The forgotten dimensions in health education research. *Health Education Research, 23*(2), 319-324.
- Hayward, K. S., Steiner, S., & Sproule, K. (2007). Women's perceptions of the impact of a domestic violence treatment program for male perpetrators. *Journal of Forensic Nursing, 3*(2), 77-83.

- Health Canada. (2000). *Family centered maternity and newborn care: National guidelines*. Ottawa, ON: Ministry of Public Works and Government Services.
- Health Canada. (2002). *The Family Violence Initiative year five report*. Ottawa, ON: Author.
- Health Canada. (2005). *Family violence in Canada: A statistical profile*. Ottawa, ON: Author.
- Hirsch, L. (2008). *Bonding with your baby*. Retrieved February 15, 2008, from http://kidshealth.org/parent/newborn/first_days/bonding.html
- Holloway, I. (1997). *Basic concepts for qualitative research*. Toronto, ON: Blackwell Science.
- Hughes, J. (2006). Violence and health: The challenges of how we talk about, conceptualize and address violence. *Canadian Journal of Nursing Research*, 38(4), 27-30.
- Hurwitz, B., Greenhalgh, T., & Skultans, V. (2004). *Narrative research in health and illness*. Malden, MS: BMJ Books.
- Janssen, P., Dascal-Weichhendler, H., & McGregor, M. (2006). Assessment for intimate partner violence: Where do we stand? *Journal of American Board of Family Medicine*, 19, 413-415.
- Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *Lancet*, 359, 1423-1429.
- Jones, L., Hughes, M., & Unterstaller, U. (2001). Posttraumatic stress disorder in victims of domestic violence: A review of the research. *Trauma, Violence and Abuse*, 2(2), 99-119.

- Karren, K. J. (2006). *Mind/body health: The effects of attitudes, emotions and relationships* (3rd ed.). San Francisco, CA: Pearson/Benjamin Cummings.
- Koch, T. (1998). Story telling: Is it really research? *Journal of Advanced Nursing*, 28(6), 1182-1190.
- Kramer, A. (2002). Domestic violence: How to ask and how to listen. *Nursing Clinics of North America*, 37, 189-210.
- Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues*, 14, 19-29.
- Kreidler, M. (1995). Victims of family violence: The need for spiritual healing. *Journal of Holistic Nursing*, 13, 30-36.
- Langford, D. R. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research* 10(1), 133-142.
- Latimer, J. (2003). *Advanced qualitative research for nursing*. Malden, MA: Blackwell.
- Leight, S. B. (2002). Starry night: Using story to inform aesthetic knowing in women's health nursing. *Journal of Advanced Nursing*, 37(1), 108-114.
- Lempert, L. B. (1997). The other side of help: Negative effects in the help-seeking processes of abused women. *Qualitative Sociology*, 20(2), 289-309.
- Libbus, M. K., Bullock, L. E. C., Nelson, T. Robrecht, L., Curry, M. A., & Bloom, T. (2006). Abuse during pregnancy: Current theory and new contextual understandings. *Issues in Mental Health Nursing*, 27(9), 927-938.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

- Lutz, K. F. (2005). Abuse experiences, perceptions, and associated decisions during the childbearing cycle. *Western Journal of Nursing Research, 27*, 802-824.
- Lutz, K. F., Curry, M. A., Robrecht, L. C., Libbus, M. K., & Bullock, L. (2006). Double binding, abusive intimate partner relationships, and pregnancy. *Canadian Journal of Nursing Research, 38*(4), 119-134.
- Lynch, S., & Graham-Bermann, S. (2000). Woman abuse and self-affirmation: Influences on women's self-esteem. *Violence Against Women, 6*(2), 178-197.
- MacMillan, H., Wathen, C., Jamieson, E., Boyle, M., McNutt, L., Worster, A., et al. (2006). Approaches to screening for intimate partner violence in health care settings: A randomized trial. *Journal of the American Medical Association, 296*, 530-536.
- Martin, S. L., Li, Y., Casanueva, C., Harris-Britt, A., Kupper, L. L., & Cloutier, S. (2006). Intimate partner violence and women's depression before and during pregnancy. *Violence Against Women, 12*(3), 221-239.
- Martz, D. J. F., & Bryson Saraurer, D. (2005). Domestic violence and the experiences of rural women in east central Saskatchewan [Electronic version]. Retrieved May 5, 2006, from <http://www.pwhce.ca/pdf/domestic-viol.pdf>
- McCloskey, L., Lichter, E., Ganz, M., Williams, C., Gerber, M., & Sege, R. (2005). Intimate partner violence and patient screening across medical specialties. *Academic Emergency Medicine, 12*, 712-722.
- McCracken, L. (2008). *Domestic violence/abuse: Implications for physical and mental health presentation*. Calgary, AB: Alberta Health Services.

- McFarlane, J., Parker, B., & Soeken, K. (1996). Abuse during pregnancy: Associations with maternal health and infant weight. *Nursing Research*, 45, 37-41.
- McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reed, S. (1999). Severity of abuse before and during pregnancy for African American, Hispanic, and Anglo women. *Journal of Nurse-Midwifery*, 44, 139-144.
- McGarry, J., Baksh, L., Blaubaum, L., Streeter, N., Fondario, A., & Brecklin, T. (2006). *Domestic violence in Utah*. American College of Obstetricians and Gynaecologists. Retrieved April 9, 2009, from http://health.utah.gov/rhp/pdf/Domestic_Violence.pdf
- Meleis, A., & Im, E. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry*, 6, 94-102.
- Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 36, 226-232.
- Mezey, G., Bacchus, L., Bewley, S., & White, S. (2005). Domestic violence, lifetime trauma and psychological health in childbearing women. *British Journal of Obstetrics and Gynaecology*, 112, 197-204.
- Mitchell, S. L., & Lacour, M. A. M. (2001). Reported interpersonal violence and disposition decisions: The impact of client and counsellor variables. *Journal of College Counselling*, 4, 142-152.
- Moloney, S. (2007). Dancing with the wind: A methodological approach to researching women's spirituality around menstruation and birth. *International Journal of Qualitative Methods*, 6(1), 114-125.

- Moore, M. (1999). Reproductive health and intimate partner violence. *Family Planning Perspectives, 31*(6), 302-307.
- Morse, J., & Field, P. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.
- Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage.
- Mount, B. M., Boston, P. H., & Cohen, S. R. (2007). Healing connections: On moving from suffering to a sense of well-being. *Journal of Pain and Symptom Management, 33*(4), 372-388.
- Munhall, P.L. (1994). *Revisioning phenomenology: Nursing and health science research*. New York: National League for Nursing.
- Munhall, P. L. (2001). *Nursing research: A qualitative perspective (3rd ed.)*. Toronto: National League for Nursing.
- Murphy, C. C., Schei, B., Myhr, T. L., & DuMont, J. (2001). Abuse: A risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal, 164*, 1567-1572.
- Nutbeam, D., & Harris, E. (2004). *Theory in a nutshell*. Toronto: McGraw-Hill.
- O'Donnell, M. P. (1989). Health promotion and optimal health. *American Journal of Health Promotion, 3*(3). Retrieved March 2, 2006, from <http://www.healthpromotionjournal.com/>
- Olshansky, E. (2000). *Integrated women's health*. Gaithersburg, ML: Aspen.
- Paton, B. I. (2005). Sustaining self: Moving beyond the unexpected realities of teaching in practice. *Nursing Inquiry, 12*(1) 51-59.

- Plichta, S. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma, Violence, and Abuse*, 8(2), 226-239.
- Polit, D. F., & Beck, C. T. (2004). *Canadian essentials of nursing research*. New York: Lippincott.
- Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of nursing research methods, appraisals and utilization* (5th ed.). Philadelphia: Lippincott.
- Public Health Agency of Canada. (2005). *National clearinghouse on family violence*. Retrieved February 10, 2006, from [www.phac-aspc.gc.ca/ncfv-cnivf/family violence](http://www.phac-aspc.gc.ca/ncfv-cnivf/family_violence)
- Public Health Agency of Canada. (2009). *What mothers say: The Canadian Maternity Experiences Survey*. Ottawa, ON: Author.
- Rees, C. (1997). Qualitative and quantitative approaches to research. *British Journal of Midwifery*, 4(7), 374-377.
- Riessman, C. K. (1993). *Narrative analysis*. Qualitative Research Methods Series, No. 30. Thousand Oaks, CA: Sage
- Roberts, G., Hegarty, K., & Feder, G. (2006). *Intimate partner abuse and health professionals*. Philadelphia: Elsevier.
- Robson, C. (2007). *How to do a research project: A guide for undergraduate students*. Oxford, UK: Blackwell.
- Rubin, H. J., & Rubin, I.S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.

- Russell, G. M., & Kelly, N. H. (2002). Research as interacting dialogic processes: Implications for reflectivity. *Forum Qualitative Sozialforschung*, 3(3). Retrieved February 16, 2009, from <http://www.qualitative-research.net/index.php/fqs/article/view/831/1807>
- Scaer, R. C. (2007). *The body bears the burden: Trauma, dissociation and disease*. New York: Haworth Medical Press.
- Seaward, B. L. (2004). *Managing stress*. Toronto: Jones and Bartlett.
- Sharps, P., Laughon, K., & Giangrande, S. (2007). Intimate partner violence and the childbearing year: Maternal and infant health consequences. *Trauma, Violence, and Abuse*, 8(2), 105-116.
- Sitaker, M. (2007). The ecology of intimate partner violence: Theorized impacts on women's use of violence. *Journal of Aggression, Maltreatment and Trauma*, 15(3-4), 179-219.
- Smith, E. (2008a). African American men and intimate partner violence. *Journal of African American Studies*, 12, 156-179.
- Smith, E. (2008b). Domestic violence in pregnancy. *International Journal of Childbirth Education*, 23(3), 22-25.
- Society of Obstetricians and Gynecologists of Canada. (2005). Intimate partner violence consensus statement. *Journal of Obstetrics and Gynecology*, 157, 365-388.
- Speziale, H. J. S., & Carpenter D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative*(3rd ed.). Philadelphia: Lippincott.
- Statistics Canada. (2005). *Family violence in Canada: A statistical profile*. Canadian Center for Justice Statistics. Catalogue no. 85-224-XIE / ISSN 1480-7165.

- Statistics Canada. (2008). *Family violence in Canada: A statistical profile*. Canadian Center for Justice Statistics. Catalogue no. 85-224-X / ISSN 1480-7165.
- Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. *Canadian Medical Association Journal*, 149, 1257-1263.
- Surrey, J. L. (1985). Self-in-relation: A theory of women's development. *Work in Progress*, 58, 1-11.
- Thurston, W., & Eisener, A. (2006). Successful integration and maintenance of screening for domestic violence in the health sector: Moving beyond individual responsibility. *Trauma, Violence, and Abuse*, 7(2), 83-92.
- Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco: Jossey-Bass.
- Vader, J. P. (2006). Spiritual health: The next frontier. *European Journal of Public Health*, 16(5), 457.
- van Manen, M. (2003). *Researching lived experience*. London, ON: Althouse Press.
- Varcoe, C., & Irwin, L. G. (2004). "If I killed you, I'd get the kids": Women's survival and protection work with child custody and access in the context of woman abuse. *Qualitative Sociology*, 27(1), 77-99.
- Wallace, M., & O'Shea, E. (2007). Perceptions of spirituality and spiritual care among older nursing home residents at the end of life. *Holistic Nursing Practice*, 21(6), 285-289.
- Wathen, N., & MacMillan, H. (2003). Prevention of violence against women: Recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal*, 169, 582-584.

- Webb, C., & Kavern, J. (2001). Focus groups as a research method: A critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798-806.
- Weber, Z., Rowling, L., & Scanlon, L. (2007). "It's like...a confronting issue": Life-changing narratives of young people. *Qualitative Health Research*, 17(7), 945-953.
- Webster, F., Bouck, M. S., Wright, B. L., & Dietrich, P. (2006). Nursing the social wound: Public health nurses' experiences of screening for woman abuse. *Canadian Journal of Nursing Research*, 38(4), 136-153.
- Welshons, J. (1999). *Awakening from grief: Finding the road back to joy*. Bishop, CO: Companion Press
- World Health Organization. (2004). *Violence against women: Key facts*. Retrieved February 10, 2006, from <http://www.who.int/mediacentre/factsheets/fs239/en/>
- World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health, outcomes and women's responses*. Retrieved May 23, 2009, from <http://un.intnet.mu/gender/pdf/Womens%20Health%20And%20Domestic%20Violence.pdf>
- Wuest, J., Merritt-Gray, M., & Ford-Gilboe. (2004). Regenerating family: Strengthening the emotional health of mothers and children in the context of intimate partner violence. *Advances in Nursing Science*, 27(4), 257-274.
- Youngkin, E. Q., & Davis, D. S. (2004). *Women's health: A primary care clinical guide* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Appendix A. Letter of Invitation

To whom it may concern:

I am seeking to access and recruit participants for a nursing study to be conducted in Lethbridge, Alberta. The study will be about experiences and wellbeing of women who have experience violence in their intimate relationships during a pregnancy. Women whose voices have previously been silent will have an opportunity to speak about their experiences. The study has the potential of informing health care professionals and could lead to the development of health care services, programs and policies.

Researcher Identifications and Qualifications: Debbie Martin, Registered Nurse (RN) with Bachelor of Nursing (BN) degree, presently a Masters of Health Sciences student at the University of Lethbridge. Supervisor: Dr. Judith Kulig, Faculty of Health Sciences @ University of Lethbridge (Telephone: 403 388-6682).

Potential Participants: I would like to access and recruit women, over the age of 18 who are currently not pregnant but who have experienced abuse in their pregnancy within the past 5 years. Participants should be able to speak English and be willing and have time to be interviewed. If you are getting treatment or on any medication that you feel might interfere with your ability to be interviewed for 2 hours you may not qualify for the study.

The study involves researcher – participant conversation like interview lasting up to 2 hours with a possible 30 minute follow up meeting to clarify or expand on information shared.

Please contact Debbie Martin at 403 388-6682 if you are interested in participating. Please leave a message on the confidential answering machine with your name and a safe contact number.

OR

Please fill out the following information and give to _____

Name _____ Safe Contact Number _____

Your time, consideration, and assistance are greatly appreciated.

Appendix B. Consent Form

TITLE: Pregnant Women Living in Intimate partner violence: What Does it Mean?

You are being invited to participate in a research study on pregnant women living in intimate partner violence. The purpose of this study is to gain an understanding of what it means to live in intimate partner violence while pregnant and in particular how it affected your health. The information you share may assist nurses and other health care professionals better understand your experiences, and has potential to develop more appropriate healthcare policies and services.

The research will require about 2 hours of your time for the initial face-to-face interview. You may be asked to participate in a follow-up interview that may take up to 1 hour. This second interview may be conducted by telephone.

By participating in this study feelings and memories about the abuse may come back. A counselor, provided by the YWCA, will be made available during the interview, if you require one. Disclosure of child abuse will be reported to the proper authorities as per legal requirements.

This study will give you a chance to talk about your experience in a non-threatening environment. By participating in this research you may help yourself and other women through potential changes triggered by the findings of the study.

Your participation is voluntary and if you decide to participate, you will receive \$50.00 cash, for each interview, for your time and trouble. At any time throughout the interviews you have the right to ask questions, refuse to answer or elaborate on any questions, or withdraw from the study without any penalties. If you decide to withdraw from the study, all information given to that point will be destroyed.

Several steps will be taken to protect your anonymity and confidentiality. No one but the researcher will know you participated in the study. A code will be used in place of your name on all transcriptions. A list that identifies your name and the corresponding code will be placed in a separate locked location along with your consent form. All tape recordings and typed interviews will be kept in a locked filing cabinet at the University of Lethbridge, accessible only to the researcher and researcher supervisor. The transcriber who transcribes the information from the tape recordings to the typed interviews will sign a statement of confidentiality prior to transcribing. All information will be destroyed after 5 years time.

The results from this research will be presented in writing in journals read by health care professionals, to help better understand the experiences of pregnant women living in intimate partner violence. The results may also be presented in person to health care professionals. At no time will your name be used or any identifying information be revealed. The researcher will contact you by telephone (your safe number) to ask if you wish to receive a copy of the results of the study.

If you require any information about this study, or would like to speak to the researcher (Debbie Martin) or the research supervisor (Judith Kulig) please call 403 382-7119 at the University of Lethbridge. Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services at the University of Lethbridge (phone: 403 329-2747).

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project on the lived experiences of pregnant women living in intimate partner violence.

I agree to participate as a participant and to have the interview tape recorded.

_____ (Printed Name)

_____ (Signature)

_____ (Date)

Appendix C. Confidentiality Agreement

In transcribing the tape recordings for the study “Pregnant Women Living In Intimate Partner Violence: What Does This Mean,” I agree to respect the confidentiality of information that I receive through the taped interviews. All information that I transcribe, tape recordings and typed interviews, will be provided to Debbie Martin, the researcher, at the end of my work commitment.

Signature

Witness

Printed Name

Date

Appendix D. Poster Invitation to Participate

**WOMEN'S EXPERIENCES OF LIVING IN INTIMATE PARTNER VIOLENCE
DURING A PREGNANCY**

WOULD YOU LIKE TO SHARE YOUR STORY?

This invitation is being extended by Debbie Martin, a Master of Health Science student at the University of Lethbridge, who is carrying out nursing research with women about the experience of living in intimate partner violence while pregnant. Your assistance will potentially help healthcare providers develop programs and services that better meet your health needs by increasing their understanding of your experiences.

Participating involves taking part in two interviews. The first interview will take up to two hours and the second interview about thirty minutes. You will receive a token payment for your time. All interviews will be kept confidential and your name will never be recorded with your answers. Your safety and privacy will be of great importance and be respected.

You can participate if you:

- are over 18 years of age
- are currently not pregnant but experienced abuse in a previous pregnancy within the past five years
- speak English
- are not on any medication or in treatment that you feel might interfere with your ability to be interviewed
- are not presently in a crisis

If you are interested in participating in this study and willing to share your experiences, please contact:

Debbie Martin

Telephone: (403 388-6682)

and please leave a message on the confidential answering machine

This study is being conducted under the direction of the
School of Health Sciences at the University of Lethbridge

Judith C. Kulig, RN, DNSc
Research Supervisor
(403 382-7119)

I look forward to meeting you and working together to better
understand your experiences.

Appendix E. Safety Protocol

A. Participant Contact:

- women call on a confidential answering machine to participate in study or fill out recruitment form and give to administration (to be worked out)
- participants to leave name and safe contact number
- messages will be left only with participants permission
- participants will be asked if it is safe to talk at the beginning of each telephone conversation
- telephone conversations will be kept to the minimum unless permission for longer conversations is given by the woman

B. Interviews:

- to be held in a public place (YWCA)
- not to exceed 2 hours
- child care to be provided (if needed)
- researcher leave at a separate time than woman

C. Confidentiality

- consent form will be read at the beginning of the interview
- copy given to participant only if they wish
- small “cash” token will be given to each participant so no way to trace money
- participants will be informed at the beginning of the interview of the researcher’s duty to report disclosure of child abuse
- woman will be informed regarding the protection of the data

Adapted from:

Langford, D .R. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research* 10(1), 133-142.

Appendix F. Interview Guide

Introduction: You are here today to discuss your experiences of living in intimate partner violence while pregnant. In particular I am interested in how you viewed your health during the relationship and during pregnancy. This interview is to give you a chance to share your story in your own words, including what is important to you.

1. How do you define abuse?
2. Where does your story of abuse start?

IF NEEDED, the following probes will be used to assist the woman. At the end of the interview, prior to final question below, check to see if these questions have been answered:

- How did you meet the partner that abused you?
- How old were you?
- When did the abuse begin?
- What types of abuse did you experience?
- Did the abuse change with your pregnancy?
- How did the abuse affect your health before pregnancy (mind, body, spirit)?
- How did the abuse affect your health during pregnancy (mind, body, spirit)?
- How did you deal with or cope with the abuse?
- How long did the relationship last?
- What is your present relationship with the abuser?
- Is the abuse still happening?
- Were any people/programs helpful to you at this time?
- Did you disclose the abuse to a health care professional (why or why not)?

ASK EVERY WOMAN in closing:

- What is the one thing you would like health care professionals to know about your experience with living in intimate partner violence during pregnancy?

Appendix G. Demographic Information

1. Name:
2. Case Number:
3. Age:
4. Education level:
5. Marital status:
6. Yearly Income:
7. Personal Contact (Safe Number)

Name:

Phone (home):

Phone (other):

Specific Instructions: