

Wilfrid Laurier University

Scholars Commons @ Laurier

Theses and Dissertations (Comprehensive)

2024

"The Most Important Thing in IPV Right Now": The Intersection of Intimate Partner Violence and Brain Injury

Halina (Lin) Haag
hhaag@wlu.ca

Follow this and additional works at: <https://scholars.wlu.ca/etd>



Part of the [Social Work Commons](#), and the [Women's Health Commons](#)

Recommended Citation

Haag, Halina (Lin), "'The Most Important Thing in IPV Right Now': The Intersection of Intimate Partner Violence and Brain Injury" (2024). *Theses and Dissertations (Comprehensive)*. 2626.
<https://scholars.wlu.ca/etd/2626>

This Dissertation is brought to you for free and open access by Scholars Commons @ Laurier. It has been accepted for inclusion in Theses and Dissertations (Comprehensive) by an authorized administrator of Scholars Commons @ Laurier. For more information, please contact scholarscommons@wlu.ca.

“THE MOST IMPORTANT THING IN IPV RIGHT NOW”: THE INTERSECTION OF
INTIMATE PARTNER VIOLENCE AND BRAIN INJURY

by

Halina (Lin) Haag

Master of Social Work, Wilfrid Laurier University, 2009

THESIS/DISSERTATION

Submitted to the Faculty of Social Work

in partial fulfilment of the requirements for

Degree in full, Doctor of Philosophy in Social Work

Wilfrid Laurier University

© Halina (Lin) Haag 2023

Abstract

The intersection of intimate partner violence (IPV) and brain injury (BI) has been almost entirely overlooked in research, practice, and policy, despite the known risks associated with the two conditions. Individually, IPV and BI are associated with elevated rates of unemployment, poverty, and homelessness, as well as increased mental health challenges. These social determinants of health, employment status, and income impact women's wellbeing through access to safe accommodations, food security, and (dis)ability supports. These determinants are also related to an increased likelihood of experiencing addictions, mental health challenges, and physical danger, potentially leaving women vulnerable to ongoing violence. This qualitative study sought to explore the complex interconnections between work environments and the needs of women survivors of IPV-related BI (IPV-BI). Semi-structured interviews were conducted with twenty-four stakeholder participants from four groups: women survivors, executive director/program managers, direct service providers, and employer/union representatives. The overarching goal of this project was to provide in-depth information about the intersection between IPV and BI, and the implications for women's employment. The research provided an opportunity for women survivors to share their lived experiences of employment within the context of their exposure to IPV and BI, amplifying their voices through a participatory model of qualitative research. The study was informed by Critical Disability Theory, Intersectionality, and the author's own theoretical advancement of the Considered Inclusive Framework. The work concludes with a discussion of the findings, including the extraordinary complexity within the intersection of IPV-BI itself, the impact of a socially derived culture of shame and stigma that shapes the experience of IPV-BI, and the recognition/consideration of the complex layers of power that survivors are exposed to, both structural and individual. A significant and serious gap

in awareness, knowledge, and understanding of IPV-BI, combined with an underfunded support system, is also discussed. Recommendations for practice and future research are presented, and the unique role of social work is considered in the context of moving toward an integrated response.

Acknowledgements

During my doctoral studies, I had an unparalleled opportunity to grow personally and professionally, and learn from, and with, some incredible people. My list of acknowledgments is long because it reflects the length of time this process has taken and the gifts from people along the way who have shaped me and this work in so many ways.

First, my thanks to all the stakeholders and community partners. Without their trust in me to honour their experiences, there would be no thesis at all. I am deeply grateful to them all for always coming to the table with passion and commitment and supporting this work.

I would like to thank Dr. Eli Teram, who always guided me on the right path. He has been my advisor and mentor always, regardless of title or position. My first reader and the one I turn to when I need clarity or a way through the complexity. I cannot imagine what it would have been like to do this without him. He once asked me why I was hesitating to sign him on as my doctoral advisor saying, “did I think there was someone better?”. The answer is, and always has been, unequivocally, no. There could not have been anyone better. I am beyond grateful to him for seeing me through this process and teaching me so much.

My thanks to Dr. Angela Colantonio. I will never know how I got so lucky to find a space in the care and guidance of such an incredible scholar and human being. She provided support, guidance, and opportunity. She believed in me when I did not see it for myself. She made me a better scholar, tempering my passion and balancing it with caution and good science. Dr. Colantonio helped me through some of the worst moments and offered me many of the best,

giving me the chance to create a career I never thought possible. I am deeply grateful and immensely proud to have worked under her supervision for all these years.

Thank you to Dr. Nancy Freymond. I have been so lucky to have the honour of learning from a friend. You have always encouraged me to reach further than I thought I was capable of. You became my champion when I needed one. Always the quiet voice, shaping the analysis, encouraging me to reach deeper and stretch farther. Because you believed I could do it, now so do I.

My thanks to Dr. Flora Hammond. To have someone you look up to say they want to work with you is an immense gift. You offered that freely, without realizing the impact it would have. Your insight and perspective from another discipline has added depth and richness to this work and I'm grateful to you for your knowledge and your enthusiasm.

I would also like to thank my colleague and co-researcher, Dr. Danielle Toccalino. I cannot imagine what the last years of this process would have been like without her to share them with. I have no idea how I got so lucky to have such a brilliant teammate in this work. I am so honoured she asked to learn with me and so grateful for her generosity and encouragement.

My thanks to Judy Gargaro for believing in me and giving us the opportunity to do this project.

To my husband: Thank you for all the cups of tea delivered to my desk, the suppers waiting for

me late at night, and the hugs when I needed them. You always understood and told me I would make it through this. I hope I make you proud.

To my brother: This was your fault! Telling me you thought I could do it because I liked to work alone and I was stubborn. It never even occurred to me that I could do a PhD until you told me that. Thank you for seeing something in the post-injury me that no one else did.

To my father: I'm sorry this took me so long Papa. Thank you for the unquestioning belief in me. Not once in all this time have you ever made me wonder if I could do it, and you know better than anyone how hard it is. Thank you for seeing me through this. I'm proud to be your daughter and I hope I bring some joy.

Lastly, I dedicate this thesis to my mother. Ten years gone, yet never far from me. Who would have believed I would follow in her footsteps: a second Professor Haag. I learned so much watching her teach, sitting with her in her office on campus, helping her grade papers, and seeing her support students. I had no idea that someday I would draw on those moments as I learned to do the same job. She always believed I could do this, even in the very early days after the injury changed everything. She told me to block everything else out, focus on the task at hand, and just keep going. She told me how much dignity I showed and that she was proud of me. She gave me the strength and courage to keep trying. It took a little longer than we thought Mama, but I got here in the end.

Table of Contents

ABSTRACT	I
ACKNOWLEDGEMENTS	III
TABLE OF CONTENTS.....	VI
LIST OF ABBREVIATIONS	X
INTRODUCTION.....	1
LITERATURE REVIEW.....	5
BACKGROUND.....	5
THE (RE)PRODUCTION OF (DIS)ABILITY WITHIN THE WORKPLACE	9
<i>Dominant Conceptualizations of (Dis)ability</i>	<i>9</i>
<i>The Impact on Workers</i>	<i>11</i>
<i>The Role of Organizational Culture.....</i>	<i>12</i>
IPV-BI	16
<i>Traumatic and Hypoxic-Ischemic Brain Injury</i>	<i>16</i>
<i>Intimate Partner Violence (IPV)</i>	<i>18</i>
<i>IPV-BI Services</i>	<i>20</i>
IPV AND EMPLOYMENT	22
<i>The Benefits and Risks of Employment</i>	<i>22</i>
<i>The Impact on Survivors</i>	<i>24</i>
<i>The Role of Legislation</i>	<i>27</i>
<i>Knowledge Gaps</i>	<i>29</i>
<i>Recommendations</i>	<i>30</i>
BI AND EMPLOYMENT	33

<i>The Benefits and Challenges of RTW.....</i>	<i>34</i>
<i>Self-Identity and Work.....</i>	<i>35</i>
<i>Gender, BI, and Work.....</i>	<i>37</i>
<i>Employment Support for People with BI</i>	<i>38</i>
<i>Individual Resiliency.....</i>	<i>41</i>
CONCLUSION.....	43
CONCEPTUAL FRAMEWORK.....	45
SITUATING MYSELF.....	45
CRITICAL DISABILITY STUDIES	47
INTERSECTIONALITY THEORY	49
INCLUSIVE RESEARCH: A CONSIDERED INCLUSIVE FRAMEWORK.....	51
RESEARCH METHODS.....	65
METHODOLOGY	65
METHOD	68
RESEARCH GOALS	69
STAKEHOLDER RECRUITMENT AND CHARACTERISTICS.....	70
EXPLORATION AND DATA CO-CONSTRUCTION PROCESS	73
ANALYSIS PROCESS.....	75
ETHICS.....	76
FINDINGS.....	77
1. THEME: WHAT IS HAPPENING AND WHAT IS WORKING AT THE INDIVIDUAL LEVEL.....	81
<i>1.1 Subtheme: What is Happening: A Glimpse into the Lived Experiences of Employment</i>	<i>81</i>
<i>1.2 Subtheme: What is Working: Strengths to be Leveraged.....</i>	<i>110</i>

2. THEME: WHAT IS HAPPENING AND WHAT IS WORKING AT THE ORGANIZATIONAL LEVEL	119
2.1 Subtheme: <i>What is Happening: Unknowing (and/or Uncaring) Workplaces</i>	119
2.2 Subtheme: <i>What is Working: Strengths to be Leveraged</i>	128
3. THEME: HOW DO WE DO BETTER?	169
3.1 Subtheme: <i>What Can Service Providers Do?</i>	170
3.2 Subtheme: <i>What Can Employers Do?</i>	188
4. THEME: BARRIERS TO SUCCESS	197
4.1 Subtheme: <i>The ‘It’s Your Problem’ Problem</i>	197
4.2 Subtheme: <i>The ‘Not My Problem’ Problem</i>	209
4.3 Subtheme: <i>The ‘Best Kept Secret’ Problem</i>	216
4.4 Subtheme: <i>The ‘We Have No Money’ Problem</i>	225
DISCUSSION	230
KEY OBSERVATIONS	230
IMPLICATIONS FOR FUTURE RESEARCH	231
RECOMMENDATIONS FOR PRACTICE	233
STUDY STRENGTHS AND LIMITATIONS	235
CONCLUSIONS	240
THE ROLE OF SOCIAL WORK	258
APPENDIX A	263
INFORMATION ON THE LARGER STUDY	264
GOAL AND OBJECTIVES	264
TEAM MEMBERS, ROLES, AND RESPONSIBILITIES	265
PREVIOUSLY REPORTED FINDINGS	266

KNOWLEDGE TRANSFER PRODUCTS	266
APPENDIX B	268
INTERVIEW GUIDE: EXECUTIVE DIRECTORS AND FRONT LINE STAFF.....	269
INTERVIEW GUIDE: EMPLOYERS	271
INTERVIEW GUIDE: WOMEN SURVIVORS	273
APPENDIX C	275
CONSENT FORM	276
UNIVERSITY OF TORONTO ETHICS APPROVAL	279
WILFRID LAURIER UNIVERSITY ETHICS APPROVAL	280
REFERENCES.....	281

List of Abbreviations

ABI	Acquired Brain Injury
BI	Brain Injury
CCAC	Community Care Access Centre
CDS	Critical Disability Studies
DS	Disability Studies
EAP	Extended Health Plan or Employee Assistance Program
EDR	Emancipatory Disability Research
GP	General Practitioner (physician)
HIBI	Hypoxic-Ischemic Brain Injury
HR	Human Resources
IPV	Intimate Partner Violence
IPV-BI	Intimate Partner Violence-related Brain Injury
mBI	Mild-to-Moderate Brain Injury
ODSP	Ontario Disability Support Program
OHSA	Ontario Health and Safety Act
OT	Occupational Therapy or Occupational Therapist
OW	Ontario Works
PAR	Participatory Action Research
PCS	Post Concussive Syndrome
PTSD	Post Traumatic Stress Disorder
RTW	Return-to-Work
TBI	Traumatic Brain Injury

US	United States
VAW	Violence Against Women
WHO	World Health Organization
WSIB	Workers Safety and Insurance Board

Introduction

Providing an opportunity for women survivors to share their lived experiences of employment within the context of their exposure to intimate partner violence (IPV) and brain injury (BI) and amplifying their voices through a participatory model of qualitative research addresses a critical gap in our current understanding of this highly complex condition. The overarching goal of this project was to provide in-depth information about the intersection between IPV and BI (IPV-BI) and employment by identifying and addressing relevant knowledge and service gaps. Moreover, the study aimed to advance both social and health outcomes by developing recommendations for service provisions that are intended to inform and facilitate improvements in the healthcare and social-support sectors dedicated to serving women survivors. I sought to achieve these goals through the following objectives: (1) exploring the intersection of IPV-BI and work, and identifying support needs, priorities, facilitators, and barriers to service delivery for women survivors; and (2) generating recommendations for targeted support approaches and for next steps in knowledge transfer and education.

The intersection of IPV-BI is complex and widely underexplored. As an emergent area of research and knowledge, there is little previous research to rely on, and there is a lack of clarity and cohesion in the extant literature. Each chapter here considers these issues and is designed to provide structure and clarity to a complex conversation. First, the Introduction presents the research project, the goals, and the intent of the study design. Next, the Literature Review begins by discussing the gap in the existing IPV-BI literature and justifies the need for reviewing a wider scope of literature to draw parallels and comment on similarities. In this chapter, I examine current relevant bodies of literature, including IPV-BI-specific knowledge and existing explorations of the relationships between IPV and/or BI and employment. I begin by presenting

the broad impacts of (dis)ability and IPV individually on survivors' employment. Subsequently, I explore how (dis)ability is (re)produced in the workplace, followed by a section that considers the intersection of IPV-BI itself, wherein I characterize the components (IPV and BI) and provide an overview of the existing, if limited, IPV-BI specific literature. The remaining two sections discuss the employment experiences of women exposed to IPV, followed by the experiences of people who are differently abled.

The third chapter, entitled Conceptual Framework, provides an examination of the theoretical positions that shape my work. I begin by presenting Critical Disability Studies and Intersectionality, and I explore how they have helped me to understand the employment experiences shared by people who identified as differently abled. I then move on to identify the paradigmatic limitations of both positions, and I show how I engaged with them to develop the expanded conceptual framework that guided my work. The fourth chapter presents the Research Methods. Here, I explain how I chose to use a blend of participatory, emancipatory, and lived experience methodologies (Barton, 2005; Danieli & Woodhams, 2005; Oliver, 1992; Stevenson, 2010). I then discuss the four different stakeholder groups, and how they were identified and invited to participate in the study. I describe individual demographic information and review the inclusion and exclusion criteria for stakeholder participation. I present the interview format and processes of data co-construction and analysis. The fifth chapter is entitled Findings and presents the main themes, their coding criteria, and supporting examples from interview transcripts.

The final chapter, the Discussion, begins by presenting six key observations drawn from the findings. The stakeholders identified many existing successes and strengths to be capitalized on, and there is much to be learned from these individual examples. Specifically, they provided the foundation for generating recommendations to enhance healthcare and social support

services, as well as for guiding future research aimed at improving these sectors. Each of the stakeholders contributed to these suggestions. Subsequently, I consider the study's strengths and limitations—what worked well and what could be adjusted to gain a deeper insight into this intersection and the experiences of others with similar circumstances. From here, I move on to situate my observations and recommendations within our existing knowledge by discussing how the study supports the existing literature. I characterize the extraordinary level of complexity within the intersection of IPV-BI itself, and I conclude that a socially derived culture of shame and stigma shapes the experience of IPV-BI. Furthermore, I highlight the role of complex and intensified layers of structural and individual power that affect the employment experiences of women survivors and show that a significant and serious gap in awareness, knowledge, and understanding of IPV-BI, combined with an underfunded support system has resulted in stakeholders experiencing a wide variety of barriers. I also highlight the new knowledge that surfaced in the findings and consider new ways to conceptualize IPV-BI. Building on these observations and suggestions, I propose a way forward with an integrated response that is rooted in a structural solution. Finally, this chapter returns to my disciplinary foundations and highlights ways in which social work is uniquely situated to lead this response.

This research is important as a tool for understanding the experience of IPV-BI and its implications for employment and employability. It could serve to influence support service design and delivery and the allocation of funds and resources, as well as to emphasize and encourage the need for further research. It could also be used as a reference tool for survivors of IPV-BI and their families, for educators and their schools, and for policy makers. Finally, the study offered the opportunity for a silenced minority to speak out regarding their own strengths and challenges in a way that directs those in a position to assist them.

Literature Review

The intersection of intimate partner violence (IPV) and brain injury (BI) has been nearly completely overlooked in research, practice, and policy, despite the known risk associated with the two conditions (Colantonio et al., 2010; Haag, Jones et al., 2022; Kwako et al., 2011; Valera & Kucyi, 2017). The lack of research on the intersection of IPV-related BI (IPV-BI) makes a review of the literature challenging as there is no singular, comprehensive body to explore. Given the limited literature on this topic, I begin by providing a background that presents the broad impacts of (dis)ability and IPV individually on survivors' employment. I then move on to review literature that explores how (dis)ability is (re)produced in the workplace, followed by a section that considers the intersection of IPV-BI itself. First, I characterize the components (IPV and BI), and subsequently, I provide an overview of the existing, if limited, IPV-BI specific literature. Because I have been unable to locate any literature that focuses on the employment challenges of women survivors of IPV-BI specifically, the remaining two sections discuss the employment experiences of women exposed to IPV followed by the experiences of people who are live with a brain injury.

Background

Current research shows a relationship between psychosocial well-being and employment status, noting that those who are unemployed and/or underemployed (defined as having employment but at a lower quality than desired or expected) report reduced overall health and quality of life (Friedland & Price, 2003; Mikkonen & Dennis, 2010). Furthermore, it has also been noted in (dis)ability research that differently abled people are more likely to be unemployed or employed at lower wages than their abled counterparts (Kulkarni & Kote, 2012; Mikkonen &

Dennis, 2010). In Canada, women who are differently abled are less likely to be employed than abled women or abled and (dis)abled men, leaving them vulnerable to increased rates of poverty, homelessness, and abuse (Mikkonen & Raphael, 2010). Only 23% of Canadian women with (dis)abilities were employed fulltime in the year 2000 compared to 37% of abled women and 53% of abled men, while 47% of (dis)abled women did not work at all compared to 22% of abled women and 13% of abled men (Mikkonen & Dennis, 2010). Due to the heterogeneous nature of intersecting vulnerabilities, as well as significant socio-economic barriers, a universal approach for providing successful employment is inadequate. Intersecting vulnerabilities and significant socio-economic barriers create complex needs. Specialized knowledge and an understanding of disadvantaged populations is required to develop and provide effective support services. One such vulnerable group consists of women survivors of intimate partner violence (IPV) with resultant brain injury (BI).

Every year, thousands of Canadian women are beaten by their intimate partners, resulting in significant personal, social, and economic implications. IPV is shockingly prevalent globally, affecting one in three women over their lifetime (Statistics Canada, 2011; World Health Organization [WHO], 2021), and presenting as a significant cause of physical injury to Canadian women aged 15 to 44. The most common injuries are from battery to the face, head, and neck (Sheridan & Nash 2007), a pattern of violence leaving women survivors vulnerable to BI. While this connection is largely unexplored, early investigation has identified elevated rates (75%–92%) of potential BI in women survivors of IPV (Haag, Jones et al., 2022; Kwako et al., 2011; Roberts & Kim, 2005; Valera & Kucyi, 2017). BI is a leading cause of disability in Canada and is more prevalent than breast cancer, spinal cord injury, HIV/AIDS, and multiple sclerosis combined (Colantonio et al., 2010). While an estimated 30% of reported cases of traumatic BI

occur among women, research that explores these women's psychosocial outcomes is limited, despite evidence identifying significant sex and gender differences (Colantonio et al., 2010; Styrke et al., 2013).

Individually, BI and IPV are associated with elevated rates of unemployment, poverty, and homelessness, along with increased mental health challenges. These factors result in substantial economic repercussions, including lost income, reduced productivity, and increased social support costs (Andelic et al., 2013; Roberts & Kim, 2005). BI can have a significant impact on the likelihood of obtaining and maintaining employment (Hofgren et al., 2010; Levack et al., 2004; Temkin et al., 2009), and violence related BI is associated with poorer community reintegration than non-violent BI (Kim et al., 2013). IPV has an impact on women's absenteeism, safety, stability, and access to benefits (Adams et al., 2013; Banyard et al., 2011), and even post abuse, these effects can last for at least three years (Adams et al., 2013; Crowne et al., 2011). As social determinants of health, employment status and income reduction impact women's wellbeing through access to safe accommodations, food security, and (dis)ability supports, and are related to an increased likelihood of experiencing addictions, mental health challenges, and physical danger (Mikkonen & Dennis, 2010), potentially leaving women vulnerable to ongoing violence. The need to understand the implications of IPV and BI on women's health and wellbeing is evident, given the extensive health, economic, and social repercussions combined with increased psychosocial barriers to social integration in areas such as employment, housing, community involvement, and personal relationships (Gutman et al., 2004; Iverson & Pagoda, 2015; Iverson et al., 2017; Roberts & Kim, 2005; Valera & Berenbaum, 2003). To obtain a nuanced understanding of the challenges, exploration of the workplace and individual

experiences is called for. My research targets this gap, exploring complex interconnections between work environments and the needs of women survivors of IPV-BI.

There is a dearth of research examining the organization's role and impact in relation to employment access and stability for women who are differently abled (Zanoni & Janssens, 2007). The limited literature exploring (dis)ability in the workplace leaves a gap in our understanding of how dominant ableist discourses are maintained and continues to marginalize differently abled women's voices (Williams & Mavin, 2012). While critical (dis)ability scholars advocate for research focusing on the interconnections between the body and the social world (Goodley, 2013), existing research utilizes an individual, deficit model of (dis)ability (Spataro, 2005), focusing on the impact of IPV or (dis)ability on the organization or women's job performance (Banyard et al., 2011; Fejedelem, 2008). This lack of knowledge about organizationally based challenges and employment implications seriously inhibits our ability to design services that consider the complexity of IPV-BI and/or deliver them in such a way as to be accessible from a (dis)ability perspective and a trauma-informed one. This gap leaves women vulnerable to ongoing unemployment, homelessness, and poverty. Equally key to understanding the nature and extent of employment-related challenges faced by women exposed to IPV-BI is consideration of the intersecting conditions themselves and how they impact employment. The overlapping conditions of IPV-BI create complex needs for survivors, and specialized knowledge and understanding is critical to develop much needed support services.

In the sections below, I review the existing literature that has guided the conceptualization and development of the research project. I begin with a macro-level exploration of how organizations (re)produce (dis)ability, their accompanying rationales, and the impact on differently abled

individuals. From there, I move to a micro-level consideration of the intersection of IPV-BI and the accompanying implications on women's ability and opportunity to work.

The (Re)Production¹ of (Dis)ability Within the Workplace

Dominant Conceptualizations of (Dis)ability

Even though considerable research into (dis)ability within the workplace and the role of work for people with different abilities has been done, workplace organization is still decidedly unequal (Barnes, 2000; Williams & Mavin, 2012). Acker defines organizational inequality based on difference as “systematic disparities between participants in power and control over goals, resources, and outcomes; workplace decisions such as how to organize work; opportunities for promotion and interesting work; security in employment and benefits; pay and other monetary regards; respect; and pleasure in work and work relations” (2006, p. 443).

To look at the myriad ways in which organizational practices and procedures (re)produce (dis)ability, it is helpful to identify the dominant conceptualization of (dis)ability. Organizations tend to consider different abilities from within an individual, deficit-driven model with essentialist, fixed, binary categories of either abled or (dis)abled (Acker, 1990; Dobusch, 2016; Riach & Loretto, 2009; Williams & Mavin, 2012). (Dis)ability is seen as a personal issue to be addressed by the organization through individual fixes, with very little mention of change on a broader level (Dobusch, 2016; Roulstone, 1998). Williams and Mavin suggest that the embodied reality of living with different abilities needs to be considered as “legitimate, organizing requirements rather than individualized problems” (2012, p. 160). In Dobusch's 2016 study, participants reported individual practices designed to aid their adaptation rather than the entire

¹ The use of brackets here is intended to represent the inseparable amalgamation of production and reproduction of disability as an identity category.

organization receiving (dis)ability education. Only during the concerted effort to address physical accessibility challenges in the 1980s and 1990s has there been a recognition of the structural role in the experience of marginalization. Unfortunately, the installation of automatic doors, ramps, and elevators seems to have solidified the notion that accessibility has been addressed.

Assumed ableism, (i.e., using the able body as the normative standard around which to structure organizational practices) is still the prevalent approach (Acker, 1990; Dobusch, 2016; Williams & Mavin, 2012). Dobusch's 2016 study found that the common organizational approach to including people with different abilities is to fix individual issues rather than focus on institutional practice and culture, despite a discourse suggesting otherwise. Marginalized individuals are often discursively constructed as being difficult and uncooperative regarding how they work and what they accomplish rather than the organization being unreasonable and inflexible in its expectations and processes (Gotsis & Kortezi, 2015). The dominance of the deficit model can be seen within abled co-workers, who discriminate and exclude, and in people with difference, because they display a lack of confidence or skills, and self-exclude (Dobusch, 2016; Riach & Loretto, 2009). As organizational discourses perpetuate the normative binary, the "right" way of being is, in turn, (re)produced (Bendl et al., 2008; Foster & Wass, 2012), and then enforced by both abled and (dis)abled workers. These discursive constructions, focused on individual deficits, lend legitimacy to policies privileging those who fit the normative standard, thereby re-enforcing and perpetuating it (Gotsis & Kortezi, 2015).

The Impact on Workers

Social inequities, norms, and stigmas play out in organizations through various forms of control (Gotsis & Kortezi, 2015; Spataro, 2005). Using internal power and control mechanisms, organizations shape workers based on a desired ideal, capable of peak efficiency and productivity, thereby creating an ableist norm (Alvesson, 2008; Gotsis & Kortezi, 2015; Jack & Lorbiecki, 2007; Spataro, 2005).abled individuals still enjoy the “privilege of invisibility”, while people with different abilities become “hyper-visible”, as the normative abled are left unidentified (Dobusch, 2016, p. 9). As there is no need to attach a label to an abled person, the lack of label itself identifies that position as the desirable norm. Rules and processes within the organization are not inherent but thought out, often perpetuating inequity and protecting privilege (Harlan & Robert, 1998).

Employers use a variety of tactics to maintain control: “denying the need for accommodation, renouncing responsibility for providing it, withholding information about legal rights, denying requests, and using intimidation and fear to force individuals to assume responsibility for fitting into the organization” (Harlan & Robert, 1998, p. 427). Controls, characterized as micro-expressions of macro-level power dynamics, are used to maintain the status quo through worker compliance and self-policing. Overt forms of control, such as bureaucratic rules and regulations, punishments, and wages, are used in addition to such covert ones as monitoring phone and internet communications, selectively relaying information, hiring vulnerable workers who can be bullied, and achieving worker buy-in, so they engage in regulatory behaviours. Normative strategies can develop into mechanisms of control when they become so accepted and ingrained that they are left unchallenged. Equally effective, these norms are also internalized by the individual as they self-police in their effort to fit in or be seen as a

productive and valuable employee (Acker, 2006; Gotsis & Kortezi, 2015; Janssens & Zanoni, 2005; Stone-Romero et al., 2006). Making visible how organizational culture and practice (re)produce (dis)ability in the workplace, and how it impacts on the individual, can provide insights into these mechanisms of control.

The Role of Organizational Culture

Organizational culture—from managerial attitudes, co-worker stigma, and appropriate expectations, to corporate flexibility and an overall view of individual value versus accompanying challenges—is critical to the overall success of the differently abled worker (Ely & Thomas, 2001; Golub, 2006; Gotsis & Kortezi, 2015; Lerner et al., 2004; Spataro, 2005). It also plays a key role in the (re)production of inequality, because it permeates how diversity practices are, or are not, put in place and maintained (Gotsis & Kortezi, 2015; Spataro, 2005). While practices shift and change, reflecting the temporal and cultural nature of their context, Dobusch (2016) found that the label of (dis)ability is all encompassing, serving to define the individual, and is almost always viewed as a negative. When, on the rare occasion, it is seen as a positive quality, it usually ends up being essentialized into a “master status”, overriding all else. Managers assume problems will accompany the differently abled worker, problems that will need to be dealt with, causing time and expense challenges (Barlow et al., 2003; Cavanagh et al., 2016; Donnelly & Given, 2010; Foster & Wass, 2012; Harlan & Robert, 1998; Kulkarni & Valk, 2010; Stone-Romero et al., 2006).

Management is key, as personal attitudes can override policy. Lacking knowledge about supports and strategies, seeing differently abled workers as a liability rather than an asset, and viewing accommodation as a threat to authority are not uncommon (Cavanagh et al., 2017;

Gotsis & Kortezi, 2015; Harlan & Robert, 1998; Lerner et al., 2004; Yang & Konrad, 2011, as cited in Cavanagh et al., 2017). Many authors report that managers still hold preconceived notions of differently abled workers as being incapable, dependent, and poor employee prospects (Cavanagh et al., 2017; Jones & Schmidt, 2004; Lengnick-Hall et al., 2008; Shier et al., 2009). These negative attitudes can impact a differently abled worker's ability to do their job, ultimately re-enforcing the notion that they are not capable in the first place (Jones & Schmidt, 2004). This outcome is particularly relevant to the choices around disclosure, which remain a major concern for differently abled workers, as they have fears around job security and personal safety (Cavanagh et al., 2017). Conversely, if the worker feels accepted and supported, they are more comfortable with disclosure and support seeking behaviours (Charmaz, 2010; Spataro, 2005). In an interesting conundrum, it has also been noted that management will show more confidence in a differently abled worker if the worker displays confidence in themselves, causing a spiral cycle that can be positive or negative (Charmaz, 2010). Management who display deficit models of (dis)ability may also serve as permission for subordinate workers to take up similar notions, perpetuating stigma and marginalization (Cavanagh et al., 2017). Determining negative attitudes in management is difficult, making it even harder to change them (Chan et al., 2010) and adding complexity to the issues at hand.

How the organization goes about “doing diversity” has a direct impact on how it is experienced. Official policies and practices, underlying assumptions and attitudes, and apparent/actual engagement are all key aspects of outcome (Gotsis & Kortezi, 2015). Social stigma and isolation remain significant barriers to positive employment experiences for differently abled workers (Brown et al., 2009; Cavanagh et al., 2017; Scheid, 2005; Schulze & Angermeyer, 2003). Rather than a pro-active effort to create and foster an inclusive environment

(Lengnick-Hall et al., 2008), the response is typically re-active, since human resource management strategies and policies regarding differently abled employees are, in large part, rhetorical with no real teeth to protect and support (Cavanagh et al., 2017; Gotsis & Kortezi, 2015).

Organizations engage in a variety of discriminatory practices regarding the employment of differently abled people. Some of the most common practices include failure to hire or to provide adequate supports once hired, stringent demands for performance and increased supervision requirements, lower pay scales, and lack of consideration for advancement (Cavanagh et al., 2017; Graffam et al., 2002; Hartnett et al., 2011; Schur et al., 2005; Shier et al., 2009; Stone-Romero et al., 2006). Discriminatory recruitment and selection processes, combined with a lack of understanding of the needs of differently abled employees, result in significantly reduced opportunities for employment (Cavanagh et al., 2017; Jones & Schmidt, 2004; Stone-Romero et al., 2006). Differently abled people are more likely to be under- or unemployed than any other disadvantaged group (Foster & Wass, 2012; Jones & Wass, 2011, as cited in Foster & Wass, 2012; Spataro, 2005). Management frequently lacks an understanding of the complexities of being differently abled and places unreasonable expectations of productivity and advancement of skills and output on workers. Equally, employers, if they do anything at all, attempt to fit differently abled workers into an existing job, despite it being designed for an abled worker (Foster & Wass, 2012). Accommodation is framed as “special treatment” and is seen as unfairly favouring someone who is not deserving, allowing the “if we do it for one, we have to do it for everybody” defence of inequity. Making it difficult for the worker to ask for accommodation accomplishes the end goal of doing nothing, since it silences those who require assistance (Harlan & Robert, 1998).

Under the business case model of diversity, the organization only hires differently abled employees when they see a direct benefit to the company, usually related to profit (Luecking et al., 2006). Dobusch (2016) found that organizations are more likely to support existing employees who become differently abled than to hire them in the first place. When they do hire differently abled personnel, there is an unwillingness to invest in worker development, leading to lower pay, reduced job satisfaction, and higher rates of employee turnover (Schur et al., 2009). The preference to view it as an individually based problem to be addressed on a case-by-case basis leaves it “open to negotiations and organizational prioritization” (Dobusch, 2016, p. 13). Able-normed organizational practices force differently abled workers to adapt to be eligible to participate in work (Foster, 2007; Harlan & Robert, 1998; Roulstone et al., 2003, as cited in Williams & Mavin, 2012).

People have a desire to work, as it provides dignity, inclusion, worthiness, and status as a citizen (Brown et al., 2008). Additionally, working is a key piece of how we define ourselves (Riach & Loretto, 2009; Killackey, 2010). Individuals constantly shape and reshape their identity, either to resist or conform to normative controls (Brown et al., 2008; Riach & Loretto, 2009; Zanoni & Janssens, 2007). The requirement to constantly shift identities to belong and succeed can create many difficulties for a differently abled worker. Conflicting contexts and shifting expectations often put the worker into potentially contradicting identities; action in one setting is seen as compliance and in another as emancipatory (Zanoni & Janssens, 2007). People frequently put themselves at risk to compensate for perceived deficits (Harlan & Robert, 1998), and the focus is consistently on how the (dis)ability impacts work performance rather than how organizational culture impacts the differently abled worker (Spataro, 2005). Doing (dis)ability, particularly through work, is critical to a differently abled person’s identity construction, since

interactions define and re-define notions of the self as abled or (dis)abled (Brown et al., 2008; Riach & Loretto, 2009).

Exploring the broader literature that discusses the ways in which (dis)ability is constructed, experienced, and perpetuated within organizations provides insight into the role of the workplace in the individual's experience of work and serves as a useful foundation for this work. However, as this research was focused on women survivors of IPV-BI, I will now shift from this mezzo-level conversation into a micro-focused one, first by providing a brief introduction to each condition, and then by reviewing the limited literature considering the intersection of IPV-BI.

IPV-BI

Traumatic and Hypoxic-Ischemic Brain Injury

There are two forms of BI that can be caused by exposure to IPV: traumatic brain injury (TBI) and hypoxic-ischemic brain injury (HIBI). TBI is defined as an injury to the brain comprising an alteration in brain function, or other evidence of brain pathology, caused by an external force or an acceleration–deceleration–rotational force (Menon et al., 2010). Motor vehicle collisions, sporting accidents, falls, and being struck by an object or person are the main causes of TBI. The level of severity (mild, moderate, and severe) is usually diagnosed through tests measuring loss or alteration of consciousness, post-traumatic amnesia, and post-incident deficits. During physically violent IPV, blunt force trauma to the head or face or violent shaking can cause neurological deficits, loss of consciousness, TBI, and death (Haag, Jones et al., 2022; Kwako et al., 2011; Sheridan & Nash, 2007). Strangulation is frequently part of physical IPV and can cause HIBI, due to oxygen and nutrient deprivation in the brain (Haag, Jones et al., 2022;

Jacob et al., 2020; Monahan et al., 2020; Toccalino et al., 2022b). While the two types of brain injuries (TBI and HIBI) are classified separately, there are significant similarities between them and both are medically treated and socially supported in much the same manner (Cullen & Weisz, 2011). Because both are highly likely consequences of IPV, I have included them together here simply as BI, as have others (Campbell et al., 2018; Haag, Sokoloff et al., 2019; Kwako et al., 2011; St. Ivany & Schminkey, 2016; Valera & Kucyi, 2017; Valera et al., 2018). It should also be noted that for the purposes of this study, the term BI included *only* TBI and HIBI, excluding other forms of brain injury.

People coping with BI traditionally present with higher incidence rates of mental illness, such as depression and anxiety, suicidality, substance misuse, as well as other consequences including divorce, unemployment, homelessness, and poverty than their uninjured counterparts (Mateo & Glod, 2003). The effects of BI are not just experienced by the brain-injured individual, but also by families, local communities, and nations as a whole. Not surprisingly, BI has been identified by international governments and the World Health Organization (WHO) as a significant health concern (Simpson et al., 2002). Approximately 18,000 people are hospitalized annually in Canada with BI; however, research suggests that this number omits a significant proportion of those with mild-to-moderate injury levels (Laforce & Martin-MacLeod, 2001). This omission is particularly concerning, because even mild-to-moderate BI (mBI) is associated with permanent cognitive, physical, psychological, and social challenges and carries major personal and economic repercussions (Bazarian et al., 2005). While mBI is a relatively new area of investigation, it is known to be under-reported, with often inadequate or non-existent supports for survivors (Folzer, 2001; Marschark et al., 2000).

Historically, the lack of BI knowledge and understanding has led to widespread misdiagnosis and inadequate treatment and support, even though it is associated with permanent cognitive, physical, psychological, and social dysfunction, including elevated rates of mental illness and substance use. BI also has major personal and economic repercussions, including medical costs, lost income, and reduced productivity (Bazarian et al., 2005). Because research has focused on moderate to severe injury, this information is particularly relevant for mild injury levels. Furthermore, 70% of reported BI cases are in men, resulting in more male research participants and male-dominated information (Colantonio et al., 2010; Faul et al., 2010; Saverino et al., 2015; Toor et al., 2016). Despite an estimated 30% of reported cases of BI occurring among women, and evidence identifying significant sex and gender differences, little research exists exploring their outcomes (Colantonio et al., 2010; Colantonio, 2016; Harris et al., 2012; Mukherjee et al., 2003). Additionally, to date, researchers have concentrated on privileged populations, such as professional and university-level athletes, military personnel, and individuals receiving top-level care in teaching/research-oriented healthcare facilities. However, since recent investigations have noted high prevalence rates of BI in women survivors of IPV (Haag, Jones et al., 2022; Kwako et al., 2011; Roberts & Kim, 2005, Valera & Kucyi, 2017) the need for more targeted information is critical.

Intimate Partner Violence (IPV)

IPV refers to actions committed by a spouse or intimate partner, which can be physical, sexual, or psychological in nature, and can result in significant emotional and bodily harm to the victim (WHO, 2021). According to recent statistics, it is a significant cause of injury among Canadian women between the ages of 15 and 44, with self-report rates ranging from 4% to 8%

(Statistics Canada, 2016) and one in three women will experience IPV over their lifetime (WHO, 2021; Sinha, 2013). Across Canada, 42% of known violent incidents involving women were committed by an intimate partner (Statistics Canada, 2016). Although IPV has an impact on many different individuals, the majority of survivors are women, including both cis- and trans-gender women (Bukowski et al., 2019; Garthe et al., 2018; Statistics Canada, 2015). Such an increased vulnerability directed this study to focus on women survivors.

The majority of physical injuries sustained by women as a result of IPV are from battery to the head, face, and neck, including strangulation (Sheridan & Nash, 2007). In the IPV context, an external force, such as blunt force trauma to the head or face or violent shaking is enough to sustain neurological deficits, loss of consciousness, brain damage and even death (Monahan, 2018). As a result, BI is a pervasive, debilitating, and very real consequence of exposure, but there has been very little investigation into this intersection. Research examining the intersection of IPV-BI has traditionally been scarce and limited in scope. There is a significant knowledge gap among frontline service providers and healthcare personnel alike regarding the risk of IPV-BI. As a result, it is often overlooked and/or misdiagnosed, despite the potential debilitating effects on survivors' overall function and independence over the long-term.

IPV-BI

The complexity of symptoms and individualized nature of BI can add to the challenge of identification and further complicate the issue, as can the silencing challenges of stigma and shame that often accompany IPV. More recently, an increase in awareness and research in this intersection has begun to emerge, although it is still scarce and almost completely concentrated within the United States. The most recent scoping review (Haag, Jones et al., 2022) noted a total

of 42 published articles, of which only 22 were reporting original research. A variety of topics were noted in the literature, with four main areas of focus on issues such as (1) prevalence and reporting (Iverson et al., 2017; Roberts & Kim, 2005; St. Ivany, Bullock et al., 2018; Valera et al., 2018); (2) screening and identification (Ackerman & Banks, 2009; Amoroso & Iverson, 2017; Baumann et al., 2018; Campbell et al., 2018; Corrigan et al., 2003; Davis, 2014; Farley et al., 2018; Iverson et al., 2017; Valera & Berenbaum, 2003); (3) recommendations for practice (Banks, 2007; Campbell et al., 2018; Davis, 2014; Iverson & Pagoda, 2015; Jackson et al., 2002; Roberts & Kim, 2005; St. Ivany, Bullock, et al., 2018; St. Ivany & Schminkey, 2016; Valera et al., 2018); and (4) future research priorities (Goldin et al., 2016; Kwako et al., 2011; St. Ivany, Kools et al., 2018; Valera et al., 2018). Much of the literature focused on the critical need for increased awareness and education regarding the unique characteristics of IPV-BI, highlighting a near total gap in targeted IPV-BI services and supports (Ackerman & Banks, 2009; Amoroso & Iverson, 2017; Bauman et al., 2018; Farley et al., 2018; Haag, Jones et al., 2022; Hunnicut et al., 2017; Hux et al., 2009; Linton & Kim, 2014; Kwako et al., 2011; Monahan & O’Leary, 1999; St. Ivany & Schminkey, 2016; Valera & Berenbaum, 2003; Valera & Kucyi, 2017; Zieman et al., 2016).

IPV-BI Services

To address this gap in knowledge and services, it is important to understand what is already known. While many studies identify a critical need for an improved understanding of BI among IPV-direct service providers (Ackerman & Banks, 2009; Anderson et al., 2015; Baumann et al., 2018; Campbell et al., 2018; Farley et al., 2018; Haag, Jones et al., 2022; Hux et al., 2009; Iverson et al., 2017; Kwako et al., 2011; Linton & Kim, 2014; Linton & Perrin, 2017; Monahan,

2018; St. Ivany, Bullock et al., 2018; Valera & Berenbaum, 2003; Zieman et al., 2016), very limited data exist that examine the implications of IPV-BI for support service provision and uptake are, with only three known studies exploring this issue (Haag, Sokoloff et al., 2019; Nemeth et al., 2019; Nicol et al., 2021). Taking the first step in this process in a 2016 pilot project, my colleagues and I surveyed frontline service workers supporting women survivors of IPV to determine (1) existing knowledge of IPV-related BI in their client populations, and (2) what, if any, BI-sensitive services were being offered to support these women. During phase one of the study, based in Toronto, Canada, 68 agencies providing IPV support services were invited to complete an anonymous online survey. Survey response rate was 28% (Haag, Sokoloff et al., 2019). In phase two, national stakeholders (including survivors, IPV and BI service providers, researchers, advocacy and legal professionals, and decision makers) were invited to attend a workshop held to disseminate existing knowledge, develop a national knowledge-to-practice network (K2P Network), and determine next steps in research and practice. Phase one survey results highlighted a general lack of BI awareness and understanding among IPV service providers. These results were reinforced during the phase two workshop, where all attendees resoundingly reported on this gap, identifying it as a high priority to be addressed through the creation of tailored educational resources (Haag, Sokoloff et al., 2019). Nemeth and colleagues (2019) and Nicol and colleagues (2021) further supported these findings during similar studies conducted in the United States and Canada, respectively.

Specialized knowledge and understanding are particularly critical for groups with intersecting vulnerabilities, as they often have complex needs and face significant barriers to well-being and successful psychosocial outcomes. Because each injury is unique in presentation and resulting challenges, BI resists simple identification and a universal approach to care. It is

further complicated by its hidden nature and widespread lack of understanding. Additionally, the literature identifies a significant gap in understanding the impact of BI on the ability to work, particularly for women (Corrigan et al., 2007; Mukherjee et al., 2003). Equally, the experience of IPV is known to negatively affect women's ability to obtain and maintain employment (Matjasko et al., 2012; MacGregor et al., 2017; Moe & Bell, 2004; Showalter, 2016; Swanberg et al., 2006). Even though the role of stable employment in positive outcomes for both groups has been well documented (Banyard et al., 2011; Bould & Callaway, 2012; Donker-Cools et al., 2016; Giesbrecht, 2020; Moe & Bell, 2004; Shafi & Colantonio, 2021; Wathen et al., 2018), the implications for women experiencing the combined condition of IPV-BI has not yet been explored. Since I can find no existing literature that explicitly explores employment challenges for women survivors of IPV-BI, the final sections focus on the micro-level employment impacts of IPV and BI individually.

IPV and Employment

The Benefits and Risks of Employment

Intimate partner violence is associated with low income, unemployment, and poverty (Matjasko et al., 2013) and can have a significant impact on survivors' employment status through several pathways. For women who are employed while experiencing IPV, many barriers to maintaining employment exist (Adams et al., 2013; MacGregor et al., 2019; MacGregor et al., 2020; Maskin et al., 2019; Moe & Bell, 2014; Showalter, 2016). Equally, for those not employed, or who have lost their employment, seeking employment is also challenged by exposure to IPV. While there is limited literature exploring this intersection historically, consideration of this area has been increasing (MacGregor et al., 2017). There are four main types of research exploring

employment concerns for women experiencing IPV: (1) how perpetrators use the workplace as a location for continued violence; (2) how perpetrators interfere with women's capacity to work; (3) the impact on a survivor's efficacy; and (4) possible ways to ameliorate challenges (Banyard et al., 2011; MacGregor et al., 2020).

Generally, employment is thought to be beneficial for women exposed to IPV for a variety of reasons. Employment is an important source of financial independence and stability that can lead to increased safety, it can provide critical social support connections that may otherwise be missing, it offers an element of control over one's own life course, and it can provide a sense of identity and a source of self-esteem (Giesbrecht, 2020; MacGregor et al., 2020; Maskin et al., 2019; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020). Since poverty increases exposure risk (Moe & Bell, 2004; Wathen et al., 2018), and physical severity of violence was found to increase with job loss compared to employed survivors of IPV (Swanberg et al., 2007), employment is suggested to be protective against IPV. However, the issue is complex, and employment may also lead to violence under certain conditions. It has been noted that the engagement in an activity that provides the benefits listed above may, in and of itself, threaten an abusive partner, encouraging them to use violence as a means of control (MacGregor et al., 2020; Moe & Bell, 2004).

Adding another layer of risk, the workplace itself is often a site for IPV, because it may be the only place a perpetrator can predict the whereabouts of their partner, particularly post-separation, and it can offer a variety of abusive mechanisms (Giesbrecht, 2020; MacGregor et al., 2020; Moe & Bell, 2004; Zorn, 2017). Many of these mechanisms are those we would expect: abusive partners turning up at the workplace, following women or conducting surveillance through windows, entering the building or hanging out in parking lots (Adams et al., 2013;

Giesbrecht, 2020; MacGregor et al., 2017; MacGregor et al., 2019; MacGregor et al., 2020; Maskin et al., 2019; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006). Abusers also “cyber stalk” women using email, phone, or text messaging, and monitoring web or social media usage (Giesbrecht, 2020; MacGregor et al., 2017; MacGregor et al., 2019; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006). Partners intent on control often interfere with a woman’s ability to get to work by making her late or refusing to take her there, hiding keys or work-related materials and equipment, or explicitly threatening the welfare of children or pets, should she leave (Adams et al., 2013; Banyard et al., 2011; Giesbrecht, 2020; MacGregor et al., 2017; MacGregor et al., 2019; Maskin et al., 2019; Moe & Bell, 2004; Showalter & McCloskey, 2020; Swanberg et al., 2006). Other challenges are less immediately apparent, but they are no less intrusive and can have significant impacts on women’s ability to work and maintain their employment.

The Impact on Survivors

The literature discusses how episodes of IPV can reduce a worker’s capacity if they are tired, injured, or unwell. Stress-related challenges occur, and women have difficulties concentrating or need extra time off to cope with legal, housing, or health matters (Adams et al., 2013; Banyard et al., 2011; Giesbrecht, 2020; MacGregor et al., 2017; MacGregor et al., 2019; MacGregor et al., 2020; Maskin et al., 2019; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006; Wathen et al., 2018). Mental and physical health-related challenges are also discussed, with rates of anxiety, depression, and post-traumatic stress disorder (PTSD) being the most commonly experienced (Banyard et al., 2011; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020).

The immediate impact of IPV episodes can have far reaching consequences for women survivors, in many cases long after the actual abuse occurred (Adams et al., 2013). These impacts range from immediate economic effects, such as reduced or lost wages and healthcare benefits, and limited access to education (Adams et al., 2013; MacGregor et al., 2017; Moe & Bell, 2004; Swanberg et al., 2007), to more long-term disadvantages, such as episodic or unstable employment, under-employment, and chronic unemployment (Adams et al., 2013; Banyard et al., 2011; Crowne et al., 2011; Giesbrecht, 2020; MacGregor et al., 2020; Maskin et al., 2019; Mighty & Leach, 1998; Moe & Bell, 2004; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006; Swanberg et al., 2007; Wathen et al., 2018). In some cases, women receive reprimands or are disciplined for IPV-related negative work behaviours, such as absenteeism, excessive phone calls, or in-person interruptions, which can impede a woman's likelihood of career advancement (Giesbrecht, 2020) and even lead to termination (Giesbrecht, 2020; MacGregor et al., 2017; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006). Some of the literature discusses women reporting a positive impact on their employment, because they saw work as a respite from IPV (Giesbrecht, 2020; MacGregor et al., 2020; Maskin et al., 2019; Mighty & Leach, 1998) and increased their work time and effort to protect their jobs. Often though, the negative impacts are cyclical in nature: because IPV impacts employment, making it more precarious, it increases unemployment, making leaving the abusive relationship harder and, ultimately, raises the risk of exposure to more IPV (Maskin et al., 2019; Moe & Bell, 2004). All of these challenges to employment and employability means that critical assets, such as financial independence, savings, Registered Retirement Savings Plans, sick days, and vacation are denied (Adams et al., 2013; Maskin et al., 2019), usually to the very women who are most likely to need them.

In many cases, women report quitting their jobs, sometimes for safety reasons, but at other times because they believe they are about to be fired anyway (Giesbrecht, 2020; MacGregor et al., 2017; MacGregor et al., 2020; Moe & Bell, 2004). They report a fear for safety from direct physical assaults to themselves, but also to their clients, co-workers, or children and pets (Maskin et al., 2019; Mighty & Leach, 1998; Moe & Bell, 2004). Survivors discuss how trying to hide the IPV is emotionally and physically draining, and employment is no longer worth the effort or costs involved as fear, guilt, and shame become overwhelming (Giesbrecht, 2020; Maskin et al., 2019; Moe & Bell, 2004). These factors lead to a negative effect on survivors' self-esteem and feelings of self-worth, as they can no longer perform their job tasks to their full abilities (Giesbrecht, 2020). Potentially even more concerning is that IPV interferes with the process of forming and nurturing interpersonal relationships in the workplace (Banyard et al., 2011; Mighty & Leach, 1998), relationships that have been shown to be protective for survivors' health and wellbeing, as well as supportive in maintaining employment. Women who disclose IPV exposure to their workplace generally do so to friends or managers. For the most part, they report positive experiences from having done so (MacGregor et al., 2017; Swanberg et al., 2006), with one study reporting an association between disclosure and maintaining employment (Swanberg et al., 2007).

With early investigation highlighting the value of workplace interpersonal relationships and the positive impact of disclosure, more research is badly needed on whether women disclose, to whom, and why or why not (Swanberg et al., 2006; Swanberg et al., 2007). During a recent review of current literature, MacGregor and colleagues (2017) reported workplace disclosure rates ranging from 30%–65%, supporting Swanberg and colleagues' 2006 finding of 67%. Giesbrecht (2020) reports a disconnect between co-workers expressing a desire to help survivors

and women thinking that others will not care and therefore remaining silent. They go on to note that women report co-workers and/or employers failing to notice or intervene in cases of IPV, stating that “no one asked”. Other studies report that women disclose to gain support and express safety fears or explain work-related challenges, poor performance, interference tactics, and health concerns (Swanberg et al., 2006; Swanberg et al., 2007). Conversely, they highlight women’s reasons for not disclosing as the perceived stigma, accompanying shame, the work environment, and safety fears (Swanberg, et al., 2006; Swanberg et al., 2007). Considering the limited literature that exists on this topic, and with workplace culture being important in the decision to disclose or not (Giesbrecht, 2020; Swanberg et al., 2006; Swanberg et al., 2007), further consideration of the challenges faced by the organization in the context of IPV is warranted and discussed below.

The Role of Legislation

The effects of IPV are felt by everyone in the workplace, not just by the individual experiencing it directly. These impacts are far-reaching, they can be long-term in nature (MacGregor et al., 2017; Swanberg et al., 2006), and they can involve safety concerns for survivors, co-workers, and employers themselves (Fejedelem, 2008; Giesbrecht, 2020; MacGregor, 2017; Moe & Bell, 2004; Swanberg et al., 2006). Additionally, with economic impacts through decreased productivity and increased administrative costs, IPV within the workplace can become costly for employers (Fejedelem, 2008; Giesbrecht, 2020; MacGregor et al., 2019; Maskin et al., 2019; Moe & Bell, 2004; Swanberg et al., 2006; Zhang, 2012). Giesbrecht (2020) extrapolates from Zhang’s (2012) figures and suggests that the total economic cost of IPV to Canadian employers is \$93,037,087 in 2019 alone. Startlingly, with this level of

economic impact, most provincial governments have failed to act, including a lack of federal legislation in this arena. Ontario is one of the few provinces that has legislation dealing with this situation, with a June 2010 amendment under the Occupation, Health & Safety Act (OHSA) that requires employers to “assess risks of workplace violence and harassment, to develop corresponding policies and procedures for investigating and handling complaints and incidents, and to implement proper communication and programs for protecting workers” (OHSA, 2021). The amendment also specifically identifies IPV (in this case referred to as “domestic violence”) to be included in the definition of “workplace violence” if it is “likely to expose a worker to physical injury, where the employer is aware or should reasonably be aware” (Minken Employment, 2021; OHSA, 2021).

Challengingly, MacGregor and colleagues (2017) report that many employers (54% of Ontario-based respondents) who took part in their study were unaware of the obligations laid out in the Ontario legislation. In their study, 66.2% of respondents reported that they did not receive information or support from their employers, and 63% reported similar concerns with a lack of union-based support. When supports were available, they were most often in the form of written materials or broad-based education sessions, with information on extended health plans (EAP) coverage, any available IPV-related legislation, and general workplace-related policies (MacGregor et al., 2017). In some cases, survivors report workplace policies and employer decisions being made without any consultation or inclusion of their voices in the process (Giesbrecht, 2020). Despite these issues, some survivors still report receiving support via the workplace upon disclosure. Examples of these types of support include coworkers offering emotional support, employee security programs, access to EAP benefits, schedule flexibility, and screening phone calls. Swanberg and colleagues (2007) report that these workplace supports

were associated with survivors maintaining their employment and increased disclosure rates. Therefore, support offered may reduce employee absenteeism and turnover, as well as increase productivity. Clearly, the role of workplace culture, stigmatization, and interpersonal relationships within the environment are of critical importance, yet there are still more gaps in the literature than known information.

Knowledge Gaps

With little known about the intersection of IPV and employment, authors have made a clear call for expanded investigation and reporting (Banyard et al., 2011; Giesbrecht, 2020; Maskin et al., 2019; Moe & Bell, 2004; Showalter & McCloskey, 2020; Swanberg et al., 2006). In particular, there are substantial gaps in our understanding of the impact of IPV. Specifically, authors note a need for research exploring approaches to support and intervention (Adams et al., 2013; MacGregor et al., 2019; MacGregor et al., 2020; Showalter & McCloskey, 2020; Swanberg et al., 2006), available resources (MacGregor et al., 2017; Swanberg et al., 2006), the implications on mental health (Crowne et al., 2011), and the benefits and drawbacks of work for women exposed to IPV (MacGregor et al., 2020; Moe & Bell, 2004). In Showalter and McCloskey's 2020 review of current literature, they were able to identify only six qualitative studies that explored women's experiences of IPV in the workplace. Not only does this lack of research limit our knowledge of the subject, thereby hindering the development of effective, much needed support, it also serves to continue silencing the voices of women survivors. Finally, in their 2004 study, Moe and Bell highlight the lack of scholarship within the organizational management body of literature, noting that management tries to argue IPV is a private issue, rather than a company matter, despite economic indicators to the contrary. Disturbingly, this gap

is again raised in more recent commentary, as other authors discuss the still-limited knowledge identifying organizational policies and procedures that address IPV (Showalter & McCloskey, 2020; Swanberg et al., 2006; Wathen et al., 2018). This knowledge deficit translates into a general lack of embedded IPV policy and procedures in the workplace (Giesbrecht, 2020; Moe & Bell, 2004; Showalter & McCloskey, 2020) and a distinct lack of the legislation needed to require workplaces to formally provide much-needed supports (Giesbrecht, 2020; Showalter & McCloskey, 2020). This deficit has led a number of authors to discuss a wide variety of recommendations to address these challenges and provide better support for women survivors.

Recommendations

Many of the recommendations put forward in the literature are focused on education. Some authors discuss the need for IPV-educated frontline staff, employment counsellors, and employers (Adams et al., 2013; Giesbrecht, 2020; MacGregor et al., 2017; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2007), while others focus on the need for mandatory, repeat training for all workers (Giesbrecht, 2020; MacGregor et al., 2017; Showalter, 2016; Showalter & McCloskey, 2020; Swanberg et al., 2006; Swanberg et al., 2007). Giesbrecht (2020) notes that basic information and support in the workplace, along with in-house policies, should be made easily accessible to all employees. Additionally, authors suggest that there is a critical need for workplace culture change through policy, education, and leadership (Giesbrecht, 2020; MacGregor et al., 2017; Swanberg et al., 2006; Swanberg et al., 2007). Interestingly, some authors note that there is an opportunity for widespread education through the workplace. They suggest that we should see the workplace as an opportunity for community-based supports, public education campaigns, and a safe access point for IPV-related information (Banyard et al.,

2011; Giesbrecht, 2020; Moe & Bell, 2004; Swanberg et al., 2007). Murray and Powell (2007) propose a “partnership model” whereby local IPV-support workers do in-house workplace training and offer specialized supports, an idea echoed within the literature (MacGregor et al., 2019; Swanberg et al., 2007).

Other key literature recommendations focus on specific services that can be offered, such as paid leave, flexible work hours, and EAP supports that are trained to assist IPV survivors (Giesbrecht, 2020; MacGregor et al., 2017; Mightly & Leach, 1998; Moe & Bell, 2004; Showalter, 2016; Showalter & McCluskey, 2020; Swanberg et al., 2006; Swanberg et al., 2007). Useful accommodations identified by women survivors themselves include switching work locations, having an escort between the parking areas and workstations, being able to use family leave or emergency leave to cover needed time off, flexible work time, re-routing incoming phone calls through a main reception to screen out abusive partners, and individualized safety protocols (Giesbrecht, 2020; MacGregor et al., 2017; Moe & Bell, 2004; Showalter & McCloskey, 2020; Swanberg et al., 2006). MacGregor and colleagues (2020) note the importance of individualized solutions that offer multiple options, while Giesbrecht (2020) notes that it is important to make sure that solutions are universal and can be accessed no matter where an individual resides. Authors suggest that safety planning must be individualized, tailored specifically to the risk levels involved, include the workplace and the commute, and include women in all discussions and safety planning (Giesbrecht, 2020; Showalter & McCloskey, 2020; Swanberg et al., 2007). Additionally, it was noted that employers and coworkers need to remember that survivors can experience additional challenges in access and uptake of services, and that they should not withdraw or penalize the survivors when they do not do what is expected, particularly around disclosure and leaving an abusive partner (Banyard et al., 2011;

Giesbrecht, 2020; Showalter & McCloskey, 2020). Some authors discuss the need for specialized skills training and career counselling for women survivors and note that more research towards effective interventions and programming is needed (Maskin et al., 2019; Moe & Bell, 2004; Swanberg et al., 2006). In particular, Swanberg and colleagues (2006 and 2007) discuss the role of social workers and their unique capacity to support survivors with employment-related challenges via tailored interventions, detailing support options, rules, and legislation. The authors suggest engaging in roleplay activities and educational sessions, as well as supporting clients through the disclosure process by providing helpful information and preparation ahead of time and even acting as an intermediary between the client and their employer, when appropriate.

As workplace supports may well protect a woman's ability to maintain employment (Swanberg et al., 2007) and support her overall health and wellbeing (MacGregor et al., 2017), it seems critically important for workplaces to develop and implement effective IPV policies, educational programs, and workplace training in a combined effort to address this growing concern. The literature clearly identifies the need for legislation to mandate a pro-active approach to supporting survivors of IPV-BI and rings the bell for targeted knowledge and interventions to better support employment for women exposed to IPV. However, before this task can be done effectively, the consideration of a resultant BI is important. With so many survivors at high risk of this debilitating injury, combined with some of the unique employment-based challenges experienced by individuals with BI, overlooking the intersection of IPV-BI is a critical mistake. Since there are no previous studies exploring employment implications of IPV-BI to date, I will include a section on BI and employment in the general population. Regardless of whether the injury is obtained through IPV, a fall, or a motor vehicle collision, many of the resultant BI specific challenges (e.g. communication difficulties, impaired cognitive function,

emotional lability) are the same. As such, much can be learned from existing BI knowledge and practice in this area.

BI and Employment

As noted earlier, BI is a global health concern that results in complex challenges experienced over a lifetime. As people are often work-aged at the time of injury, many of these challenges can significantly interfere with employment capacity (Franulic et al., 2003; Graff et al., 2021). BI-related issues can include: (1) cognitive based challenges, such as executive function impairment, memory gaps, slower processing speed, and attention deficits; (2) physical sequelae, such as headaches, fatigue, chronic pain, balance issues, and sleep challenges; and (3) emotional/psychological difficulties, such as anger management, emotional lability, depression, anxiety, and post traumatic stress disorder (PTSD) (Alves et al., 2020; Franulic et al., 2003; Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020; O'Reilly et al., 2018; Richard et al., 2021; Shafi & Colantonio, 2021; van der Vlegel et al., 2021; Watter et al., 2021). Challenges associated with BI are frequently complex, long-term, and misunderstood or underestimated, particularly within an employment context (Hooson et al., 2013; Stergiou-Kita et al., 2016; Watter et al., 2021). Those who are unable to maintain employment face significant challenges, including reduced income, fewer social connections, lower community integration, and increased likelihood of depression and anxiety (Bould & Callaway, 2021; Franulic et al., 2003; Hooson et al., 2013; Libeson et al., 2020; O'Reilly et al., 2018; O'Reilly et al., 2021; Stergiou-Kita et al., 2016; Watter et al., 2021). Unsurprisingly, “better” jobs equal more access to higher income and quality benefits, and maintaining employment is often easier, because accommodations are more likely (Corrigan et al., 2007; Fleming et al., 1999; Lefkovits et al., 2021; Watter et al., 2021).

Return-to-work (RTW) is often the number one goal of rehabilitation, since it is considered as a key indicator of quality of life post-injury and a means of recovery (Bould & Callaway, 2021; Donker-Cools et al., 2016; Franulic et al., 2003; Fleming et al., 1999; Glintborg et al., 2017; Hofgren et al., 2010; Lefkovits et al., 2021; Levack et al., 2004; Libeson et al., 2020; Nalder et al., 2016; O'Reilly et al., 2018; Shafi & Colantonio, 2021; Stergiou-Kita et al., 2016; Watter et al., 2021).

The Benefits and Challenges of RTW

The goal of employment is high among survivors of BI, regardless of their capacity to achieve it (Watter et al., 2021). Disappointingly, relatively few manage to maintain current employment post-injury, return to previous employment post-recovery, or even secure a new position. Most studies report a RTW rate of less than 50% for participants (Alves et al., 2020; Bould & Callaway, 2021; Lefkovits et al., 2021; O'Reilly et al., 2018; van der Vlegel et al., 2021). Studies note that RTW is very hard to achieve (Hooson et al., 2013), and even if it initially takes place, sustaining it is even harder (Alves et al., 2020; Hart et al., 2006; Hofgren et al., 2010; Libeson et al., 2020; Shafi & Colantonio, 2021; Watter et al., 2021). Part of the difficulty with a sustainable RTW is the challenge to maintain a healthy work/life balance post-injury. Many survivors report that the personal toll is too high, and they must choose between their health and the financial gains of employment (Libeson et al., 2020). Libeson and colleagues (2020) note that even those survivors who RTW successfully and can sustain it, few earn pre-injury salary levels, and many are unlikely to advance in their career. Part of the challenge is that RTW involves a very complex process that requires individualized supports (Stergiou-Kita et al., 2016; Temkin et al., 2009; Watter et al., 2021), and as a result, unemployment and

underemployment remain very high in survivors of BI (Corrigan et al., 2007; Donker-Cools, 2016; Franulic et al., 2003; Hofgren et al., 2010; Lefkovits et al., 2021; Libeson et al., 2020; Nalder et al., 2016). Studies also show that the impact on employment is often long-term, with fewer than half of survivors employed three years post-injury and many still unemployed at ten plus years after sustaining a BI (Ahman et al., 2013; Graff et al., 2021).

Previous research suggested that predictors of successful RTW include being male, having a lower level of injury severity, and having a higher pre-injury education level (Alves et al., 2020; Corrigan et al., 2007; Franulic et al., 2003; Fleming et al., 1999; Glintborg et al., 2017; Hofgren et al., 2010; Libeson et al., 2020; Wehman et al., 2005). Interestingly, some studies show that the severity of impairments post-injury is more important for RTW than the severity of the original injury itself (Corrigan et al., 2007; Fleming et al., 1999; Ownsworth et al., 2004; Wehman et al., 2005). Some studies report that pre-injury employment status is an indicator of successful RTW, noting better outcomes if pre-injury employment can be maintained (Corrigan et al., 2007; Donker-Cools et al., 2016; Libeson et al., 2020; Hooson et al., 2013; Stergiou-Kita et al., 2016; Watter et al., 2021). Compounding the challenges, unemployment itself may actively increase BI-related symptoms, through increased stress, cognitive strain, and physical effort for example, thereby making it harder to obtain new employment and creating an ever-expanding problem for survivors (Franulic et al., 2003).

Self-Identity and Work

Some studies report participants feeling pushed to RTW too quickly for a variety of reasons, such as feeling obligated to employer or co-workers, experiencing financial hardship, and having feelings of low self-worth (Graff et al., 2020; Libeson et al., 2020). This finding is

particularly important, because a negative RTW experience can set an individual back or even entrench a poor outcome (Graff et al., 2020; Libeson et al., 2020). An important factor in achieving a desirable post-injury outcome is the development of a positive self-identity (Glintborg et al., 2017; Hooson et al., 2013; Libeson et al., 2020; Watter et al., 2021). Our socially constructed notions of (dis)ability still conceptualize it as a tragic burden to be overcome. (Dis)ability is still presented, and often experienced, as being located in the individual rather than as a by-product of an ableist society that constructs binary categories of being: the abled norm and the (dis)abled other (Goodley, 2013; Goodley et al., 2012; Williams & Mavin, 2012). With the additional neo-liberal emphasis on the value of productivity and independence—characteristics seen as best achieved through paid employment—the role of work may therefore be particularly important to the creation of a positive post-injury self-identity. Authors have commented on the importance of work in the development of self-identity and have noted that, for people who fall outside of the abled norm, this factor becomes even more significant (Dunn et al., 2008; Killackey, 2010; Riach & Loretto, 2009). For many, work is tied to a psychological quality of life (Glintborg et al., 2017; Libeson et al., 2020) and to their sense of self-identity (Glintborg et al., 2017; Hooson et al., 2013; O'Reilly et al., 2021; Stergiou-Kita et al., 2016; Watter et al., 2021). Some authors note that the difficulties experienced during the transition from pre-injury identity to post-injury can be ameliorated through employment (Glintborg et al., 2017; Klinger, 2005; Levack et al., 2010). Hooson and colleagues report participants describing the RTW experience as “difficult and painful...[with] a distinct grief reaction in the process of exploring re-engagement in occupation following TBI” (2013, p. 19).

Certain aspects of BI can exacerbate that experience. For instance, Lefkovits and colleagues (2021) discuss the challenges of a hidden disability: people do not understand the

impacts of a BI, thinking that because they look “normal”, they should be able to function “normally”. Franulic et al., (2003) identify that psychological and cognitive-based challenges are viewed as harder to cope with than physical ones. Additionally, studies have noted the importance of gender roles and the ways in which men and women have different experiences of RTW, particularly as it relates to access to employment-specific rehabilitation, as well as the implications of domestic roles (Corrigan et al., 2007; Haag et al., 2016; O’Reilly et al., 2018). Little literature exists exploring the employment experiences of women post-BI, and much of what does exist has mixed results with some reporting positive experiences while others report negative ones (Cancelliere et al., 2016; Corrigan et al., 2007; Shafi & Colantonio, 2021). Corrigan and colleagues (2007) suggest that an overall lack of sex- and gender-specific BI research in general, small sample sizes of women, and differing injury characteristics may be clouding the picture.

Gender, BI, and Work

Corrigan and colleagues (2007) found that women with BI are more likely to decrease or stop work post-injury than men, while married women are even more likely to stop, and black women or women with lower pre-injury education levels are most likely to become unemployed. They also note that parenting children may further interfere with successful RTW, as it can be difficult to juggle both roles. Some authors have considered the employment experiences of women with BI, noting reduced life-satisfaction (Haag et al., 2016; O’Reilly et al., 2018). Others note that women with BI are more likely to experience and/or report poor health overall and (dis)ability (Colantonio et al., 2010; Nalder et al., 2016; Styrke et al., 2013), prolonged concussive symptoms (Graff et al., 2021; Permenter et al., 2022; Styrke et al., 2013), and

increased mental health challenges, such as depression, anxiety, and PTSD (Colantonio et al., 2010; Corrigan et al., 2007), all of which can interfere with their ability to maintain/obtain employment.

These findings are particularly relevant here, as women survivors of BI have a higher risk of mental health challenges, including PTSD, as do women exposed to IPV, and research has shown that combined, PTSD and post concussive syndrome (PCS) exacerbate each other (Bryant, 2001; van der Vlegel et al., 2021) and can significantly interfere with RTW (van der Vlegel et al., 2021). Additionally, PTSD can mask a BI, further confounding an accurate diagnosis. For women exposed to physical forms of IPV, this is a serious concern, since they are more likely to experience both conditions and, with so little awareness about the intersection of IPV-BI, quick and accurate diagnosis is unlikely. Until IPV-BI specific, employment-related knowledge is readily available, it is useful to rely on what we do know about successfully supporting RTW for people living with BI. The following section explores this further.

Employment Support for People with BI

Research suggests effective employment supports for people living with BI: workplace accommodations, such as quiet spaces, ergonomic equipment, flexible work hours, work-from-home options, and rest breaks can all be beneficial (Alves et al., 2020; Graff et al., 2021). Accommodating an existing employee to facilitate successful RTW is a valuable approach for all parties involved. Aside from the obvious financial and individual benefits to survivors, employers will also benefit from retaining employees, boosting worker morale, and supporting an individual, as well as the local community (Shafi & Colantonio, 2021). However, while workplace accommodations can help initially, they may, in the long-term, also act as a restrictive

force, because they prevent the individual from learning new skills and taking on new tasks, and they may even interfere with career advancement (Libeson et al., 2020). Lefkovits and colleagues (2021) highlight that part of the reason for the mixed success around RTW post-BI may well be attributed to the mixed environments in which people find themselves: not all workplaces are equal in terms of knowledgeable employers and co-workers and a willingness to accommodate. A supportive work environment and positive workplace culture have been shown to be critical to RTW success (Bould & Callaway, 2021; Graff et al., 2021; Libeson et al., 2020; Shafi & Colantonio, 2021; Stergiou-Kita et al., 2016; Watter et al., 2021). Supporting employer and co-worker relationships can have a significant positive impact on outcomes, while a lack of support is seen as an additional barrier to success (Libeson et al., 2020).

Studies suggest that it is important to include employers and co-workers in determining what accommodations are useful, but caution they often lack knowledge about what supports are effective and, as such, may be reluctant to engage in this process (Bould & Callaway, 2021; Graff et al., 2021). Watter and colleagues (2021) suggest having mandated requirements around workplace accommodations and policies would address this issue, and many Canadian provinces, including Ontario, already have such requirements in place. Supporting employers and co-workers through education (Bould & Callaway, 2021; Donker-Cools et al., 2016; Hooson et al., 2013; Watter et al., 2021) and taking an interdisciplinary, team approach to developing a flexible, individualized RTW plan are key recommendations in the rehabilitation literature (Bould & Callaway, 2021; Donker-Cools et al., 2016; Graff et al., 2021; Hooson et al., 2013; Libeson et al., 2020; Watter et al., 2021). Many authors highlight the importance of a long-term strategy, with a case manager or navigator in place, as challenges and needs may change over time (Bould & Callaway, 2021; Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020).

Workplace mentoring, a buddy system, peer- and/or group-support systems have also been noted as beneficial to RTW viability (Bould & Callaway; Hooson et al., 2013; Lefkovits et al., 2021; Watter et al., 2021). Some studies identify that it is helpful to have a rehabilitation professional, such as an occupational therapist or a social worker, available as a contact person to explain specifics (Libeson et al., 2020; Watter et al., 2021). However, they caution that, to be effective, RTW professionals must be trained in brain injury, be knowledgeable about the specifics of any given workplace, and focus on the client's self-identified needs and challenges to put together an individualized program (Graff et al., 2021; Libeson et al., 2020; Richard et al., 2021; Watter et al., 2021). Survivors with early access to formal, BI-specific RTW supports tend to report favourably, even if RTW was unsuccessful in the long-term (Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020; Richard et al., 2021; Watter et al., 2021). Despite this awareness, such services remain limited within the BI context (Watter et al., 2021).

Specialized recruitment strategies are suggested, and employers are encouraged to be proactive through a range of application and interview styles, online human resource (HR) systems, pre-employment trials, and on-the-job training with lists of tasks instead of a job description (Bould & Callaway, 2021). Offering pre-vocational skills training or making use of volunteer opportunities can support individuals in becoming work-ready before formally re-entering the workplace, where meeting expected obligations can become more challenging (Bould & Callaway, 2021; Donker-Cools et al., 2016; Hooson et al., 2013; Libeson et al., 2020; Watter et al., 2021). Glintborg and colleagues (2017) also agree with the value of this approach, but caution that it needs to be meaningful work to support the rehabilitation process. Libeson and colleagues (2020) suggest that the individual must feel the workplace is a good fit for them, and that their roles, responsibilities, modifications, and co-workers are supporting them in RTW for it

to be sustainable. It is important that RTW rehabilitation professionals work to provide individualized options to assist the survivor in adjusting, while still feeling productive, through suggesting other ways of contributing, rather than assuming previous employment roles (Hooson et al., 2013; Watter et al., 2021).

Individual Resiliency

Self-determination, inner strength, and personal motivation have been identified as key factors in supporting successful RTW (Lefkovits et al., 2021; Libeson et al., 2020; Watter et al., 2021). Achieving these factors can be challenging, as BI itself can interfere with an individual's capacity to self-assess, leading them to take on too much too soon and causing setbacks. This process can become damaging to a survivor by increasing depression and anxiety, which will only exacerbate the challenges experienced. Additionally, engaging in RTW too early can put the employee at risk of termination for lack of competency in the role (Libeson et al., 2020; Watter et al., 2021). To avoid this risk, it is particularly important that realistic, measurable goals be agreed upon (Hooson et al., 2013), that more emphasis is placed on cognitive strategies and workplace assessments ahead of RTW, and that adequate time for adjustment is provided (Libeson et al., 2020; Richard et al., 2021). Individual adjustment to a "new normal" is critical to successful outcomes, and individuals must be given the time and space to recognize and grieve their loss (Hooson et al., 2013; Libeson et al., 2020; O'Reilly et al., 2021; Watter et al., 2021). In light of this information, it has been suggested that RTW rehabilitation programs include a focus on increasing resilience (Lefkovits et al., 2021) and psychological support, particularly around grief and loss (Glintborg et al., 2017; Hooson et al., 2013; Libeson et al., 2020; Prigatano & Schacter, 1991; Shafi & Colantonio, 2021; Watter et al., 2021). Such support should also include the

individual's family and personal support network, as it has been shown that family support is critical to their overall success (Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020; Watter et al., 2021). Lefkovits and colleagues (2021) highlight the need for an active approach to family support through education, information, and counselling as a necessary component of the adjustment process. Not only is this approach seen as helpful to a successful outcome, Libeson et al (2020) note that without it, RTW is actively hindered. This conclusion is particularly concerning for survivors of IPV-BI, because they may well have no access to family support or may have significantly negative family relationships in the case of an active violent-home environment.

While much is known, as discussed above, still more remains unexplored and critically important. Many authors note an overwhelming gap in knowledge and practice around employment needs and supports for people living with BI. Some highlight the lack of high quality studies from which to draw any significant conclusions (Alves et al., 2020; Bould & Callaway, 2021; Donker-Cools et al., 2016). Others discuss the need for standardized guidelines for RTW rehabilitation professionals (Graff et al., 2021; Richard et al., 2021). Some authors highlight the lack of research exploring ways in which to support survivors in maintaining their pre-injury employment (Stergiou-Kita et al., 2014; Shafi & Colantonio, 2021) and suggest that further investigation to determine effective supports are much needed (Alves et al., 2020). Too few studies focus on workplace-related factors or on the role and impact of vocational rehabilitation best practices (Hooson et al., 2013). Even more challengingly, while so little is known about RTW for moderate-severe BI, an even bigger gap exists in knowledge around RTW for people with mBI (Shafi & Colantonio, 2021; Temkin et al., 2009), the category most likely to contain survivors of IPV-BI.

Conclusion

The current lack of specific knowledge and understanding of the issues faced by women survivors of IPV-BI as they intersect with, and impact, employment has significant implications for social work, in practice and theory. First, the gap inhibits service design and implementation, potentially leaving women vulnerable to ongoing violence and increased rates of unemployment, homelessness, poverty, mental illness, and engagement with the criminal justice system. This consequence is highly problematic, since the exposure effects of brain injuries are not only cumulative, but also exponential, putting survivors at high risk of long-term, permanent damage. Additionally, because differently abled women are at higher risk of IPV, they are also at higher risk of permanent brain injury. As a known social determinant of health, employment offers women a chance at financial independence, thereby allowing them access to a safe living environment and healthy food for themselves and their families. It also offers them access to mental and physical healthcare that may be lacking otherwise. However, without IPV-BI sensitive services, women survivors' access to employment is severely compromised, and they are often left to cope in a disabling world with no knowledge of their condition and no means of ameliorating its effects. Second, the combined effect of these two conditions creates a new IPV-BI identity that is complex and defies simple solutions. The challenges associated with each condition exacerbate the problems created by the other, making the situation more complicated, and increasing the level of difficulty when attempting to support survivors. Adding still more to the complexity, the hidden nature of each condition serves to isolate and marginalize survivors, while the lack of understanding among support providers means that their resultant impairments are frequently misunderstood and interpreted as unwanted behaviours or bad choices instead of

being more appropriately attributed to a medical condition. Finally, from a theory perspective, the gap fails to address a continued silencing, or disappearing, of (dis)ability from our understanding of the work world. Until we engage with this continued silencing and disappearance, we maintain the positioning of the abled worker as the dominant, and desirable, standard. We must bring these voices forward and make visible the experiences of differently abled workers, in this case survivors of IPV-BI, to unpack and problematize workplace practices. These gaps provide a context for this project, leading me to look further into the employment implications of IPV-BI for women survivors and develop recommendations for support and next steps in knowledge transfer.

Conceptual Framework

Situating Myself

My doctoral research developed out of my academic, professional, and personal experiences of the psychosocial challenges that frequently accompany BI, particularly for women. As a woman living with a BI, I bring a unique combination of lived experience and academic knowledge to my research. In 2002, I was injured in a car crash that resulted in a permanent traumatic brain injury. Like many others, I faced significant health challenges as I attempted to recover from my injuries, develop a new sense of self, and rebuild the personal and professional facets of my life. Reconstructing my life post-injury, I became keenly aware of the gaps in knowledge and understanding of BI, particularly in the intersections of gender, health, and work. While reaching out for professional assistance during recovery, I noted an unexpected lack of information, accompanied by a significant lack of services, for this unique and complex injury. Therefore, I was left to rely on myself, family, and friends to learn about my injury and work towards rehabilitation. While reasonably successful overall, much of what I learned required a long and frustrating process of trial and error.

Ultimately, this experience led me to resume academic study, focusing on the intersection of (dis)ability, gender, and socio-economic status and their impact on people living with BI. As I worked in the master's and doctoral programs, clients and research participants living with brain injury repeatedly expressed their experiences of alienation and marginalization, and their struggles to achieve and maintain positive psychosocial outcomes post injury. These accounts reinforced my own experience that people living with BI were being chronically misdiagnosed, under supported, and overlooked. I began my studies exploring the lived experiences of people with brain injuries as they adjusted to life post-injury and attempted post-secondary education

and/or employment. Exploring the experiences of women with brain injuries heightened my awareness to the role of sex and gender in their lives post-injury. While assisting a colleague, I became aware of the prevalence rate of BI among women exposed to IPV and the unique challenges faced by these women. As someone who has lived with a BI, I have an intimate understanding of the accompanying difficulties. As an educator in the field of Social Work, I am conscious of how little BI training is provided to professionals, particularly in the context of IPV. Moreover, as a practitioner, I am keenly aware that a significant portion of the IPV support sector is coming from a social work background. These intersecting locations quickly made me realize the magnitude of the issue and the seriousness of the gaps in knowledge and support. From there, my work focused on the unique challenges faced by women exposed to IPV with resultant BI.

My commitment to transparency and openness regarding my own identity as a differently abled woman leads me to disclose my brain injury to research partners and stakeholders. It is important for voices of lived experience to recognize and support each other, and it is a choice well supported in the literature and in my own experience throughout my academic career. As a differently abled scholar engaged in bettering our understanding of the experience of (dis)ability, I sought theoretical positions that could explain the experiences shared by people who identified as differently abled. The following sections discuss Critical Disability Studies and Intersectionality, two conceptual foundations that shaped my work. However, while I find them both valuable, I also see limitations, particularly on a paradigmatic level. Following is a discussion of these foundations, my engagement with their limitations, and the resulting expanded conceptual framework that guided my work.

Critical Disability Studies

The last forty years or so saw the inception of the field of Disability Studies (DS); the subsequent epistemological and ontological debates; and its development, through a series of turns, into its current identity of Critical Disability Studies (CDS). Epistemologically speaking, it has been characterised as a field with “more disagreement than consensus” (Danforth, 2006, p. 337). Its multi-disciplinary foundation of ontological, epistemological, and methodological frameworks conflict, and the resulting debate has not always benefitted either the discipline or the disability community (Lubet, 2009).

Historically, (dis)ability was conceptualized from within a traditional “individual” or medical model, which “locates the ‘problem’ within the body” (Stone & Priestly, 1996, p. 699), and makes the individual responsible for coping with, adapting to, and overcoming their imperfections. The social turn came in the early 1980s when the Disability Rights Movement became an influencing force with academics and researchers, such as Mike Oliver, Colin Barnes, and Vic Finklestein. Influenced by materialist theoretical arguments drawn from neo-Marxist and Gramscian ideas, these theorists coined the term “social model”, as they reconceptualized (dis)ability as external to the body (Barnes, 2003; Goodley, 2013). In 1986, Oliver argued that while impairment may be an internal, corporeal state of being, (dis)ability is created through socially situated barriers and culturally constructed ideas of ability (Lubet, 2009). Researchers situated within the social model suggest that (dis)ability emerges from social, political, economic, and environmental interplay, and that the individual experiences should be located within this collective (Barnes, 2003; Danforth, 2006; Oliver, 1992; Stone & Priestly, 1996). The social model also saw the development of participatory research methodologies intended to privilege the voices of people who are differently abled and shift the balance of power. This

model remained dominant until early in the 21st century when (dis)ability researchers and activists begin to question its theoretical and methodological validity and efficacy.

In his 2006 work, Tom Shakespeare, previously one of the leading proponents of the social model, began to question its viability. He recognized that (dis)ability scholars risked becoming dogmatic by excluding other theoretical frameworks and approaches. Even more problematically, the social model was, in effect, silencing the very people whose voices it had sought to amplify. By essentializing the differently abled experience as a strictly social phenomenon, the conceptualization rendered the lived experience of bodily impairment irrelevant and immaterial. This silencing became a concern to many (dis)ability theorists. Scholars identified the need for conceptualizations of disability that recognized the dialectical relationship between the individual impairment (physiology) and the social world (culture) in the experience of being differently abled. Where the social model had set aside the embodied experience of difference, this new shift, referred to as “the cultural turn” (Goodley, 2013), now saw the interplay between the body and the society in which it existed as the crux of the issue. Spurred by the debate around a more inclusive epistemology, CDS emerged.

In CDS, we now have a discipline that embraces the concept of intersectionality (Crenshaw, 1993) and seeks new ways of conceptualizing and exploring the experiences of (dis)ability through the problematization of ableism. The field developed as a space in which various theoretical perspectives, including post-colonialist, post-modernist, and post-structuralist, could be utilized to explore the constructions and experiences of being differently abled. Drawing upon the work of feminist and gender studies authors, CDS scholars added new dimensions to the field. Once again, bodies became an integral part of the debate, contributing a realist conceptualization, carnal sociology, and research methodologies, with the goal of

emancipation (Goodley, 2013). Interestingly, it has also been noted that “The awareness of disability theory continues to lag behind that of other transformative arenas...disability theory has not had the sweep and global interest...due to the stigma that disability still carries, despite years of legislation and struggle” (Goodley, Hughes & Davis, 2012, p. 1).

Intersectionality Theory

Intersectionality (Crenshaw, 1993) is a theoretical framework that provides a means of understanding how complex social identities, such as race, gender, (dis)ability, sexual orientation, and socio-economic status, intersect with each other on a micro level of the individual lived experience and with macro level systems of privilege and power, such as racism, sexism, ableism, heterosexism, and classism (Bowleg, 2012; Olesky, 2011). It is predicated on post-modern notions of fluid individual subjectivities and embraces complex conditions and ambiguities. It tends towards an open-ended quality in conceptualizing these complexities, suggesting that there is no end of possible intersections but that they continue indefinitely (Olesky, 2011). Instead of positioning the impacted individual as being marginalized through gender, ability, and as a survivor of violence in a “one-plus-one-plus-one-equals-three” equation, Intersectionality conceptualizes a new identity and demands that we engage with that new identity as a separate and distinct lived experience (Bowleg, 2012; Tolhurst et al., 2012).

Although it has traditionally been used in feminist, race, and legal studies, Bowleg (2012), noting its absence in health studies to date, suggests that Intersectionality is particularly well suited to the field, proposing it an ideal framework for the investigation of social inequalities across intersections. She argues that Intersectionality speaks to distinct gaps in current healthcare literature by potentially providing a unifying language, encouraging conceptualization and analysis to take place in complex and multidimensional ways, supporting a

macro consideration of what has traditionally been seen as a micro level problem, translating well to social policy development, and looking beyond race and gender. Tolhurst and colleagues (2012) call for a theory that links multiple levels in the field of health studies, while Malacrida (2009) notes that (dis)ability is not a homogenous condition and therefore requires a framework that engages with those intersections that produce different identities.

There are well-deserved critiques of this theory, the first one being *what is it?* Theory, framework, method, methodology, and approach are all descriptors that have been used in the literature. Here, it has been used as a framework through which the project is shaped, influencing the development of questions, the process of engagement in co-construction of narrative, as well as a lens of analysis to understand the experiences shared by the stakeholders. Another challenge put to Intersectionality is that it is grounded in, what is referred to as, the “intersectionality paradox” (Bowleg, 2012, p. 1269), meaning that not all members will experience all intersections, and not all intersectional points are disadvantaged. It was important to remember this paradox when speaking with stakeholders in this project, particularly since each individual experience of the intersections of gender, (dis)ability, and employment was unique. Lastly, Intersectionality has been interrogated as to its ability to bring about actual positive change for those marginalized individuals (Olesky, 2011), and it is here that I see its main challenge. The differently abled community has long noted that, historically, those who have benefitted the most from (dis)ability research have been those in positions of power to begin with. As a scholar who is both a member of the differently abled community and one who conducts research alongside it, I find CDS and Intersectionality highly appealing; however, I also see their limitations. The following section discusses those limitations and my solutions, building on Burrell and Morgan’s (1979) and Goodley and Lawthom’s (2005) discussions of paradigm.

Inclusive Research: A Considered Inclusive Framework

As discussed above, the epistemological and theoretical debates taking place within DS over the last 40 years have resulted in a paradigmatically divided field with confusing and conflicting theoretical concepts. Some within the field attempt to erect and maintain strict barriers between opposing ideas, proposing that only one paradigm, with all its accompanying theoretical and methodological ideas and practices, can be positioned as the “right” way to conduct (dis)ability research. For instance, some in the education and rehabilitation areas of DS position themselves at one extreme end of an epistemological and methodological continuum, advocating the use of the medical model as *the* theoretical foundation for DS, along with its positivist methodological approach to research (Barnartt & Altman, 2001; Harrison et al., 2007). For me, the traditional research model has conceptual and practical problems. Most of these challenges centre around its epistemological view of the nature of (dis)ability, its theoretical views of the experience of impairment, and its methodological practices of alienation and isolation. This model is based on the individual or medical conceptualization of (dis)ability and has little or no value to members of the differently abled community, while predominantly abled researchers have been the chief beneficiaries of the knowledge produced (Barnes, 2003; Kitchen, 2000; Oliver, 1992; Whalley Hammell, 2007). The term “rape model” has been utilized in the literature for research of this nature, suggesting that “expert” researchers take what is needed for their work with little regard for the needs of the participants (Oliver, 1992; Whalley Hammell, 2007).

Morris (1992) recognized that positivist-based research views participants as objects, adding to the experience of isolation and individualization. The literature has examined power imbalances inherent in this paradigm, suggesting that positivist epistemology and ontology have

allowed for the dominant culture to continue oppressive practices and policies (Danieli & Woodhams, 2005; Oliver, 1992). Oliver (1992) points out that positivist-paradigm research results do not bring about policy changes, even when governments agree with the findings, and he asks whether participation in such research should even be considered. Following this position, others situate themselves at the opposite extreme, stating that only strict adherence to Emancipatory Disability Research (EDR) principles and practices can be seen as engaging in anti-oppressive research, and that all other practices are little better than previous positivist approaches (Danieli & Woodhams, 2005).

This debate has been long, unfruitful and, in some ways, damaging to DS and the people that it attempts to serve (Danforth, 2006; Lubet, 2009). Unsurprisingly, it created confusion and distraction as I attempted to identify the “right” way to proceed in DS, leaving me dissatisfied with the available choices. The absence of unity, understanding, and acceptance of other ways of thinking within DS challenged me to locate myself paradigmatically and theoretically within the field. I am troubled that a field that promotes acceptance of difference as a key principle in the struggle for equality for its members fails to do so within its academic community. This issue led me to ask: “What would it look like if the DS academe were as accepting of difference in the theoretical arena as they demand of the abled towards the differently abled in the community?” In attempting to answer this question, I began with Danieli and Woodham’s (2005) suggestion that good research should focus on epistemological and ontological transparency, rather than methodology, and room for variety should be made. Other scholars have agreed with this call for pluralism within DS, noting that the experience of (dis)ability is complex, variable, and heterogeneous in nature, and DS should reflect these factors in its ways of thinking, researching, and educating (Barton, 2005; Shakespeare, 1996).

Danforth (2006) suggests that the solution lies in the absence of epistemology. He argues that, as the debate has failed to supply an answer in 30 years, the search has become redundant. He suggests there is no need for DS to adopt this type of foundation, and that research and intervention can be done from a position of pragmatism. If the outcome benefits persons who are differently abled, the work is deemed to be both sound and ethical. If pragmatism is applied, and “truth” measured by the success of outcomes, DS could get down to the business of bettering people’s lives instead of becoming mired in a philosophical debate. He proposes that research and theory become “sources of creativity and innovation” (2006, p. 340). Richard Rorty’s notions of pragmatism (i.e., usefulness rather than truth) are also relevant here. He moves towards productivity rather than the search for a single truth, proposing rather that the experience and understanding of process should be the goal (Moosa-Mitha, 2005; Skirbekk & Gilje, 2001). However, this approach can raise new challenges, as some appear to have either ignored or misunderstood foundational underpinnings, leading to sometimes ill-considered intermingling and misappropriation of theory and methodology. For me, pragmatism’s removal of ontological and epistemological foundations is, perhaps, a step too far, because it removes the very structures that can guide and shape the production of knowledge and its usage. I do not see a solution in the absence of these foundations, but quite the opposite: I seek a solution that recognizes a variety of ways of knowing, and that seeks ways to learn from one another, working from a place of pluralism rather than pragmatism.

There has been discussion in the literature regarding the adoption of a more open model of research referred to as Inclusive Research (Stevenson, 2010; Walmsley & Johnson, as cited in Barton, 2005; Whalley Hammell, 2007). Inclusive Research is pluralistic in nature, with wider goals that seek to balance political change and individual needs. Its principles state that

researchers should attempt empowerment through knowledge, skills, actions, and social change via understanding. The participant's voice is not only valued in this model, but also seen as the means through which credibility is achieved. There is still a focus on the social contextualization of the individual experience, so as not to other and marginalize. Researcher transparency regarding epistemology and methodology is still seen as critical, but there is no one "right" way to conduct research. Researcher self-reflexivity should be an ongoing process, and there is always a need to be critically aware of power imbalances and the potential for patronization within the process. Inclusive Research practices maintain the critical awareness of power and privilege and seek to improve the experiences of people with disabilities, while accepting the uncertainty of not having one right epistemology or methodology. This approach allows for the possibility of changing the way we think about "research", and of replacing old notions of what research should be with such goals as illuminating and amplifying voices, educating through examples, drawing attention to (rather than explaining), and asking questions (rather than seeking answers). The model also allows for the combination of methodologies and a pluralistic approach to the research process. In short, it allows for studying (dis)ability in a manner that aligns well with my own position.

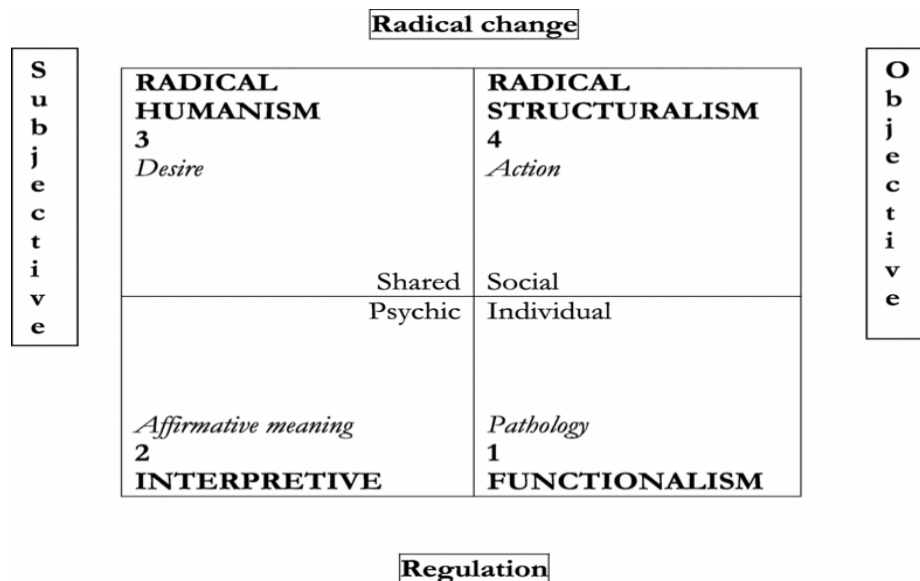
This background led me to develop what I termed the *Considered Inclusive Framework*: a rethinking of how we conceptualize difference and how we unpack and make sense of its experience. I use the term *Framework* rather than epistemology, theory, methodology, practice, approach or model because I envision it to include all these things. *Considered Inclusive* refers to an active consideration of various positions, their underlying assumptions, and their paradigmatic foundations before using them to guide research to avoid inappropriate intermingling and misuse of theory and method. It is not a completed idea, and space has been purposely left open for new

ideas and perspectives as I encounter them. This framework is intended to be the start, rather than the culmination, and I anticipate continued evolution.

I began this process by considering the work of Goodley and Lawthom (2005), as they sought to “make sense of the research process” within DS (p.140) by providing an epistemological map. Adapting Burrell and Morgan’s (1979) schematic conceptualization of Kuhn’s (1965) notions of paradigm allowed Goodley and Lawthom to organize the confusion and surface the epistemological and ontological underpinnings of various DS theoretical positions and methodological choices. Their resulting schematic (shown below in Figure 1), while valuable to a degree, also has distinct limitations.

Figure 1

Goodley and Lawthom’s (2005) Adaptation



The first limitation I see with Goodley and Lawthom’s (2005) adaptation is the challenge of incommensurability. Their schematic retains the solid boundaries of Burrell and Morgan’s original work and its foundational assumption from Kuhn that “communication is possible within

a paradigm, but not so easily between different paradigms” (Skirbekk & Gilje, 2001, p. 434). Much debate regarding the incommensurability of Burrell and Morgan’s paradigms has taken place in organizational studies, in what has been referred to as the “paradigm wars” (e.g., Deetz, 1996; Gioia & Pitre, 1990; Schultz & Hatch, 1996; Shepherd & Challenger, 2013). During this debate, many positions have been discussed—maintaining the original structure’s incommensurability (Jackson & Carter, 1991, as cited in Shepherd & Challenger, 2013), an integration approach (Pfeffer, 1993, as cited in Shepherd & Challenger 2013), a multi-paradigmatic solution (Goia & Pitre, 1990), and a pluralist position, referred to as “interplay”, because it allows for movement between paradigms (Schultz & Hatch, 1996).

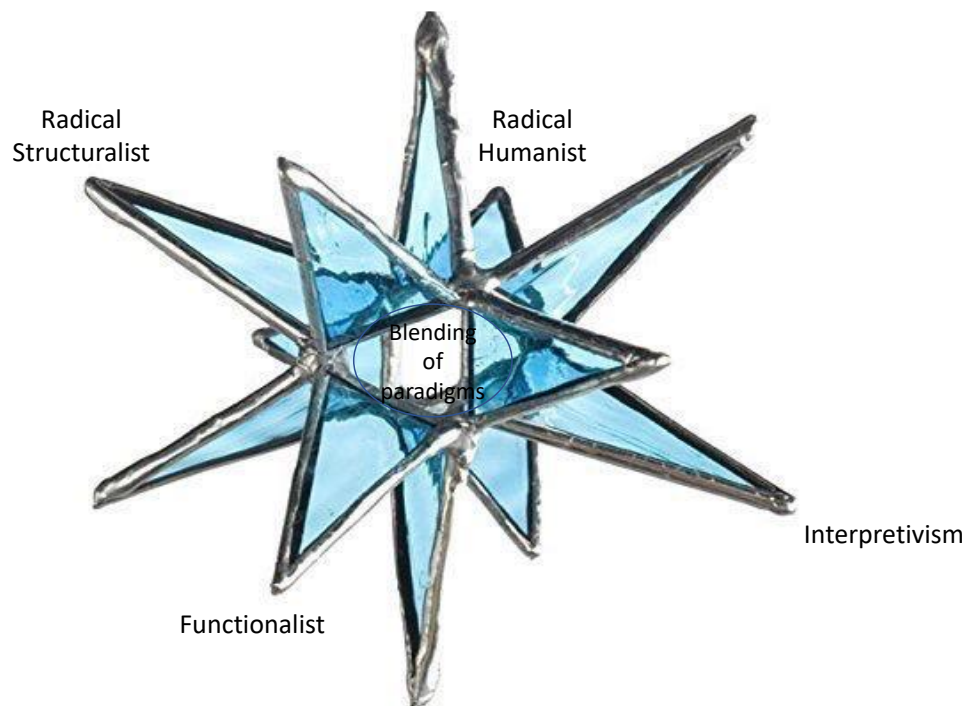
The second limitation I perceive is the conceptualization of theory on a two-dimensional linear continuum. I see this as problematic, because it allows for the exclusion of the other. A barrier can be erected along the line at any point, and no further consideration given to those on the other side. Last, both Burrell and Morgan’s original schematic, and Goodley and Lawthom’s adaptation, are limited to four paradigms. While that may be sufficient currently, room for expansion should be left open as new ways of thinking are developed. Together, these challenges encouraged me to envision a different way of thinking about paradigms. Payne (1997) reminds us that social work attempts pluralism in its recognition of the value and subsequent blending of theories from other disciplines. While he identifies challenges to this eclectic approach, he ultimately proposes that an educated, considered blending is of great value to the discipline.

I agree with the post-modern positions that argue against incommensurability and conceptualize the boundaries between paradigms as permeable. I propose that, with careful and knowledgeable consideration, one can practice inclusivity and generate discussion and learning between different paradigms in DS, deriving benefit both from the position of the other and the

process of the conversation itself. Equally, I want a three-dimensional conceptualization; one that allows for inclusivity, adaptation, and expansion. In the end, I am drawn to a three-dimensional star, as shown below in Figure 2, a shape with multiple planes that allows any point along the star to still be visible to, and influenced by, any other.

Figure 2

Considered Inclusive Framework



Embodying a pluralistic approach, each plane of the star houses a different paradigm containing multiple theoretical lenses, methodological foundations, and choices of method. Equally important, the centre holds an open space where the consideration and integration of different ways of thinking and acting can take place. Valuable knowledge situated within opposing paradigms can be of great use, but only if there is room for the practice of considered inclusivity. The centre of the star represents this space, within which I locate my work. It is here that conversation between paradigms can occur and where the integration of different levels of

thinking and acting can take place. As discussed by Skirbekk and Gilje (2001), Habermas' postulation that the conversation between conflicting ideas is, in essence, the only rational option against relativism left to us supports my conceptualization. Habermas suggests that we need the other position to contextualize our own plurality (Skirbekk & Gilje, 2001). Rosenau's (1992) description of the skeptic post-modernist's perspective suggests to me a wiping clean of the slate. Modernity and all its promises are to be discarded, and the post-modern relativist position is to be adopted. I find this position counterproductive to DS's goal of improving the lives of people with different abilities.

Following Payne's (1997) thought, embracing multiple ways of knowing is key to my framework. For this approach to be applied successfully, it must be understood that there is no one "right" way; instead, there is value in the "other" position, and knowledge can be gained by engaging in conversation between paradigms. However, the researcher must engage in this inter-relational process from a place of knowledge and understanding, of the ideas and of herself, or she runs the risk of misappropriation and oppressive practices. The Considered Inclusive Framework respects difference and values plurality by creating space to incorporate these concepts into a means of helping and understanding. Therefore, the framework can alter the way we conceptualize and approach (dis)ability in theoretical and practical contexts, using the multitude of epistemologies and theories available to us. An inclusive approach that creates conversational space and encourages the growth of understanding and knowledge can be beneficial. The interconnectedness of the star shape allows for the transmission of knowledge and ideas in a two-way flow: ideas move downwards into the centre space but also return, having a transformative effect on the originating concepts. Using the star's unique shape with its equal positioning of paradigms to draw from, and the centre space in which to consider their

similarities and differences, provides a pluralistic framework that addresses these limitations. Starting with Goodley and Lawthom's (2005) adaptation of Burrell and Morgan's (1979) work, I considered the various paradigms available, their underlying assumptions and accompanying research methodologies, and what each of them could contribute to my work.

The Functionalist paradigm espouses an objective ontology and regulatory purpose and situates the nature of the “problem” within the physical body. This paradigm maintains that both the natural and social worlds have external, measurable realities that can (and should) be objectively studied. The resulting knowledge is factual and can be applied universally for the purposes of amelioration and progress (Oliver, 1992). Traditionally, knowledge in the field of DS has been produced within this paradigm using a positivist-based methodology (Barton, 2005; Danieli & Woodhams, 2005; Stevenson, 2010), with (dis)ability seen through the medical model lens—a problem located in the individual, to be diagnosed, treated, and cured. Researchers within this paradigm are deemed to be “experts” within the field, regardless of their own experience or ability. This external expert is critical in the evaluation and identification of (dis)ability and is placed in a position of unquestionable knowing, while an individual's perceptions of being differently abled are discounted as irrelevant and/or tainted.

An opposing plane represents the Radical Humanist paradigm, which claims a subjective ontological perspective combined with the goal of radical change. In this paradigm, meaning is found within social discourses, and the world is seen as fluid and changeable (Goodley & Lawthom, 2005). Here, social change becomes a driving force behind research design and implementation, challenging the intersections of privilege and power. Affirmative post-modern ideas, as discussed by Rosenau (1992), can be seen as influential in this paradigm— notions of subjectivity and the dismissal of the positivist notion of external expert are evident. Arendt's

comments on the loss of being with nature in the effort to gain control over it are relevant here (Skirbekk & Gilje, 2001). This paradigm values the individual's experience and seeks to bring about change through inclusivity and respectful interaction with members of the disability community. A shift backwards and "being with" the experience as the means of bringing about social change can be identified within the paradigm. Critical thinking is a cornerstone: power, knowledge, and claims of truth must be scrutinized with the understanding that the social world is contextual in nature, and (dis)ability must be examined using a social lens.

An adjoining plane denotes the Radical Structuralist paradigm, balancing an objective perspective with a goal of radical change. This paradigm sees an objective reality within the social world: "some groups are always at risk of alienation and oppression" (Goodley & Lawthom, 2005, p. 139), suggesting that elements are fixed and rooted in conflict. This paradigm's position of an objective social reality that can be observed and altered is rooted in the notions of oppression and alienation found in Marxist ideology, as discussed by Moosa-Mitha (2005). The skeptic post-modernist's position, as presented in Rosenau's (1992) discussion, is also present, specifically the notion that there is no external truth except that of oppression. DS scholars in this paradigm see the social world as being constructed with inherent power imbalances and oppressive practices that are institutionally perpetuated. To bring about social change and improve the individual experience, these social structures must be identified and altered (Danieli & Woodhams, 2005). The paradigm also considers (dis)ability within the marketplace and the impact of its commodification on the individual. The old "welfare" system has resurfaced as a way of determining the deserving and undeserving need for allocating funds to support those who are deemed worthy of pity and intervention (Camilleri, 1999; Hough, 1999), thereby perpetuating a hierarchy of (dis)ability.

In this paradigm, activism becomes the key purpose for research and knowledge, from a macro perspective in terms of policy changes, and in a micro context in the transformative, power-balancing methodology designed to turn control over to the differently abled community. Anti-oppressive practices are frequently at home here (Barton, 2005; Danieli & Woodhams, 2005; Moosa-Mitha, 2005; Shakespeare, 1996), with Marxist and Feminist ideology evident, as well as the influence of post-colonial and structuralist thinking. Notions of hegemonic practices in the continuation of power, and privilege in the hands of the white, abled, heterosexual male can be seen as influencing the ideas of DS scholars who locate within this paradigm.

Emancipatory Disability Research practices, designed solely to shift the balance of power and control into the hands of people who are differently abled, are closely linked to these ideas.

Moosa-Mitha (2005) refers to knowledge as a socially constructed tool of power and reminds the reader that critical thinking is required to “disrupt essentialist thinking” (p. 64). EDR principles require that researchers not only seek ways to educate the abled but also provide people who are differently abled with the knowledge produced to support transformative change processes.

The counter-plane represents the Interpretivism paradigm, holding a subjective ontology and regulatory purpose (Goodley & Lawthom, 2005). Scholars in this paradigm believe there is a co-construction of (dis)abled identity, but that this occurs between individuals rather than as a by-product of the social world. Here the “post-positivists” suggest that, while the natural world has a distinct external reality, the social world is context and culture specific (Barnes, 2003).

Notions of individualism are present here (i.e., Locke’s ideas that the state’s purpose should be to protect the rights of the individual, but without interfering in social problems). His thoughts on the social construction of norms and on the role of language within that process are also evident in this paradigm (Skirbekk & Gilje, 2001). One can also see the influence of theorists, such as

Rawls, as discussed by Moosa-Mitha (2005). Rawlsian notions regarding the creation of social reality through individual relationships are evident within this paradigm in its conceptualization and confrontation of (dis)ability.

Danieli & Woodhams (2005) write that there is no one right way to research; instead, an awareness of social nature must be present, with an understanding of the complexity involved. Stone and Priestly (1996) assert that all research is theory based, while Barnartt and Altman (2001) expand upon this assertion suggesting that “good research” (p. 1) must rest upon theoretical and epistemological foundations. Goodley (2001) suggests the underlying epistemological belief about the nature of (dis)ability and impairment is a key issue with direct implications for research opportunities, partnerships, and practices. Equally, I have no wish to remove the epistemological and ontological foundations of my research; I seek to include more not less. Within each paradigm are many theories, methodologies, and methods to be brought to use. Depending on the paradigm, DS theories are derived from a wide range of historical influences, including Enlightenment thinking, such as Darwinism and positivism, and modern thinkers, such as Freud, Durkheim, Marx, and Weber. DS is also influenced by Role Theory and Structural Functionalism, as well as scholars of the post-modern school, such as Foucault, Butler, and hooks, and by Feminist, Shame, Organization, Anti-Oppressive, Critical, and Realism theories. I envision these as interchangeable, so that, for instance, shame theory could be applied within a functionalist and a radical humanist perspective, provided that it is a considered adoption. Methodology, or the reasons why the researcher chooses the methods she does, can be linked to the paradigm within which she situates her work, and methods are interchangeable when grounded within appropriate epistemology (Danieli & Woodhams, 2005).

Researchers in the Functionalist paradigm often choose positivist methodology, as they believe in the possibility of, and need for, an objective observation of the individual to determine the cause and effect of (dis)ability. Pragmatists lean towards methodology that is based on outcome: if the intervention produces a positive outcome, it is deemed successful. A grounded theory methodology might be employed by someone in an Interpretive paradigm, because it provides the means of understanding the subjective experience of the individual but is not seen as a methodology of change. Researchers from a Radical Humanist paradigm commonly adopt a participatory model, since it is an inclusive methodology that centres on individuals and their relationship to the social world. Taking the next step, a researcher from a Radical structuralist paradigm is more likely to choose an emancipatory approach, as it is considered to be more transformative for those experiencing oppression and powerlessness.

As noted earlier, when using the Considered Inclusive Framework, the boundaries between these paradigms should be viewed as permeable. I see my work as moving along the planes of the star. Unsurprisingly, the fluidity found in the underlying epistemology influenced both the methodology and the methods. The Radical Humanist paradigm's objectives of social change moulded the research process, design, and implementation. The fluidity of meaning found within social discourse, as noted in the Interpretive paradigm, is given priority within my research, but the existence of systemic barriers, as identified within the Radical Structuralist paradigm, are also recognized and addressed. Other components of the Radical Structuralist paradigm directed some choices, such as providing the knowledge gained for the purposes of education and activism, and offering a transformative, power-balancing approach designed to turn some control over to the survivors themselves. Additionally, intersections of privilege and power, such as sex and gender, race, and socio-economic status, as conceptualized within a

critical paradigm, have shaped this project. The methodology for this research relies on Critical Disability Theory and Intersectionality Theory, as discussed above. Critical Disability Theory provides a way of understanding the experience of being differently abled through an ableist lens, while Intersectionality Theory allows me to apply a range of theoretical influences (e.g., Gender Theory, Queer Theory, Feminist Theory) to assist in understanding the complexities. The following chapter discusses the methodology in detail and outlines my specific research methods.

Research Methods

Methodology

For there to be radical social change, the methodologies, epistemologies, and ontologies on which research is based must fundamentally shift (Danieli & Woodhams, 2005; Morris, 1992). Goodley suggests that considering the social production of (dis)ability and its heterogeneity, recognizing the need for an activist approach to theory and practice, and employing a critical analysis and deconstruction of power are “key foundations of an epistemology of impairment” (2001, p. 225). Kitchen notes that there is a choice to be made between “consultancy or partnership” (2000, p. 45) in the research process. Zarb (1992) discusses the distinction between participatory and emancipatory research, noting that, while participatory must be a part of emancipatory, they are not always the same thing.

While the methodological choices for this project (i.e., Lived Experience Research, Participatory Action Research, and Emancipatory Disability Research) are discussed here as separate and distinct entities, it should be noted that, in practice, they overlap. Lived Experience Research as discussed by Stevenson is “used to illustrate the complexity of the process of disablement” (2010, p. 40) and is best aligned with the Interpretive paradigm. Participatory Action Research (PAR) is an activist methodology, focused on the goal of restoring power and control to participants, all of which is complimentary to the Radical Humanist position. It is seen as collaborative, with the differently abled community driving the research process. Participatory research models consider real-life problems, while trying to minimize power imbalances through collaboration between the researcher and the participant. By attempting to reach a new understanding or generate a new meaning, the goal is one of social action and change (Eckhardt & Anastas, 2007; Levin & Greenwood, 2001; Lincoln, 2001; Swain et al., 2003; Westhues et al.,

2008). The literature suggests that participatory models can be an excellent means of closing the gap between the theoretical and the practical (Eckhardt & Anastas, 2007; Patten et al., 2006).

Focus groups are often utilized as a good way to share power and control with participants, while actively seeking to reduce isolation and individualization (Barnartt & Altman, 2001; Danieli & Woodhams, 2005; Goodley & Lawthom, 2005; Stevenson, 2010).

Emancipatory Disability Research (EDR), considered by many (dis)ability scholars as the current “best practice” of research within the differently abled community (Barton, 2005; Barnes, 2003; Danieli & Woodhams, 2005; Stevenson, 2010), also informed the development of the project. Since Oliver (1992) presented the idea of EDR, it has become heavily favoured and has been adopted, at least in name, by many leading DS scholars. EDR methodology conceptualizes (dis)ability as being created by inequalities within the social world, such as the workplace, and seeks to shift the balance of power from the researcher to those experiencing disablement. The following list of EDR principles has been compiled from numerous sources (Barnartt & Altman, 2001; Barnes, 2003; Barton, 2005; Danieli & Woodhams, 2005; Goodley & Lawthom, 2005; Oliver, 1992; Shakespeare, 1996; Stevenson, 2010; Stone & Priestly, 1996; Whalley Hammell, 2007), but remains unchanged from Oliver’s original ideas for the most part:

- Respectful, non-colonial, collaborative
- User/participant driven
- Contributes practical, valuable knowledge that can be used by the (dis)ability community to further their own empowerment
- Epistemologically rooted in the social model of (dis)ability
- Recognizes intersecting oppressive realities (e.g. colour, gender, economics)
- Ensures personal experience is framed within the collective narrative

- Critically deconstructs current notions of (dis)ability
- Political in nature (action/change-driven with meaningful outcomes)
- Transformational in nature
- (Dis)ability-driven throughout the entire process, including the evaluation of the process itself
- Shifts control and power to the differently abled community
- Recognizes that “researcher objectivity” is a false premise, and that the researcher *should* care about the impact on the lives of people with impairment
- Amplifies marginalized voices
- Maintains transparency of process and researcher epistemology, methodology, and ontology
- Challenges and deconstructs dominant power structures
- Is accountable to the differently abled community, specifically participants and co-researchers
- Accepts plurality of methodology

While both PAR and EDR address many of the historical challenges to conducting research within a (dis)ability context, they each have limitations for which they have been criticized. Discussions challenging the underlying assumptions around power and control (Barnes, 2003; Danieli & Woodhams, 2005; Kitchen, 2000; Shakespeare, 1996; Stevenson, 2010; Stone & Priestly, 1996), who benefits from the research process (Barnes, 2003; Barton, 2005), and political interference in what is deemed valuable knowledge (Danforth, 2006; Lubet, 2009; Stevenson, 2010; Stone & Priestly, 1996; Whalley Hammell, 2007) are all present in the literature. Considering these limitations and associated discussions allowed me to include aspects

of each within the project, thereby privileging the voices of the lived experience and seeking to empower participants through the process itself. Not only should participants have an active voice in the research design and influence over the researcher, but ultimately, they should have ownership of the process and the knowledge generated.

Method

Research that involves consideration of those who are oppressed should be focused on the goal of liberation (Shah, 2006). “Qualitative research challenges the ‘hierarchy of credibility’ which gives more credence to the experiences and opinions of those with greater power...[and is] particularly suited to giving voice to the ‘underdog’ in society” (Becker, as cited in Shah, 2006, p. 210). Eckhardt and Anastas (2007) write that qualitative research methods are particularly effective when used in the field of (dis)ability studies as they are particularly adept at uncovering how people make sense of their experiences and understanding a previously unknown phenomenon. Additionally, because feminist epistemology supports amplifying women’s voices through the qualitative method, it has been seen as particularly viable for similar studies involving women exposed to IPV (Moe & Bell, 2004). In keeping with the Considered Inclusive Framework discussed above, multiple methods were incorporated to best meet the following goals: learning about the lived experience of work for women exposed to IPV with resultant BI; amplifying the voices of a group of women who have been traditionally marginalized; and beginning a process intended to lead to social change for survivors.

Following the tenets of the Lived Experience model discussed above, research needs to include the voices of those with lived experience to gain insight from the unique position rather than the preferred one, and to engage with individual and corporate attitudes, diversity practices,

and existing barriers and supports for people with different abilities. Most importantly, research must have the intention of leading directly to better standards and not just report on the status quo (Campbell, 2009; Cavanagh et al., 2017; Williams & Mavin, 2012). Using a participatory model, I ensured the inclusion of multiple stakeholders and perspectives, leading to knowledge-transfer materials that are meaningful, sustainable, and responsive to the needs of women survivors. Building on PAR methods, I also incorporated those principles of EDR that demand a project be transparent, inclusive, and (dis)ability driven. Another key project goal was to provide women survivors of IPV–BI with information that can be used to improve their own lived experience, an aspect that is seen as critical in the EDR practice (Oliver, 1992).

Research Goals

This study was part of a broader project that sought to provide in-depth information about the intersection between BI and IPV, and its implications for women’s employment and mental health and explore COVID-19 implications for survivors of IPV-BI and their service providers.² By identifying and addressing relevant knowledge and service gaps, and developing recommendations for service provision and knowledge translation strategies, my aim was to inform improvements in healthcare and social support sectors serving women survivors. The research was also intended as an opportunity for women survivors to share their lived experiences of employment within the context of their exposure to IPV and BI and to amplify their voices through a participatory model of qualitative research.

² More information about the larger study is provided in Appendix A

Stakeholder Recruitment and Characteristics

This project explored employment challenges for workers who are differently abled from the perspectives of four different stakeholder groups: (1) survivors of IPV who self-identify as a woman (cisgender and/or transgender); (2) frontline staff engaged in direct service provision for women survivors of IPV (e.g., intake, counselling, outreach, or other emotional, physical or health-related support services); (3) support service providers in either a management or direct service position in an organization directed to support women survivors of IPV and/or BI and/or employment services; and (4) employers or representatives of employers or labour unions able to speak to their organization's policies and practices supporting women employees exposed to IPV and/or BI.

Stakeholders were purposively recruited from the national informal network of professionals and individuals with a vested interest in IPV/BI, previously established by my colleagues and me in 2015, called the K2P Network (Haag, Sokoloff et al., 2019), or through snowball sampling. Women survivors were also recruited with the assistance of community-based partners and frontline workers, using an approach previously recommended as being better situated to judge and protect a survivor's safety and privacy (Haag, Toccalino, et al., 2022; Showalter & McCloskey, 2021). This approach involved frontline workers identifying appropriate clients from their organization and then speaking with them directly to provide initial information regarding the study and the opportunity to participate. If the client expressed interest in providing an interview they were instructed to initiate contact with a member of the research team or to instruct their worker to do so on their behalf. To participate, stakeholders had to speak, read, and write in English, be over the age of 18, and be able to provide legal consent.

Twenty-four individuals participated: six women survivors, six executive director/program managers, seven direct service providers, and five employer/union representatives.

Compensation was provided to women survivors in the form of a \$100 gift card of their choice.

The majority of interviews were held with one stakeholder individually; however, two group interviews were conducted at their request, one with direct service providers and one with employer/union representatives. While efforts (e.g. targeted snowball sampling and specific recruitment requests) were made to attract stakeholders representing diverse groups, all but one identified as a woman and most identified as Caucasian or of European origin. The average age of stakeholders was 48.5 years, and nearly everyone had completed some post-secondary education. Complete stakeholder demographics are reported in Table 1.

Table 1

Participant Demographics

Education Level	N=24	%	Ethnicity	N=24	%
Some high school	1	4%	Indigenous	2	8%
High school diploma	0	0%	African origin	1	4%
Some post-secondary education	3	13%	South Asian	1	4%
College Degree	3	13%	Black	1	4%
University Degree	17	71%	Middle Eastern	1	4%
Age (mean, standard deviation)	48.54	12.73	European origin	18	75%
Sex at Birth (Female)	23	96%	Multiple visible minorities	1	4%
Gender Identity (Woman)	23	96%			

As identifying BI among survivors of IPV is still an ongoing challenge, and prevalence rates are noted as very high (75% – 92%), a formal diagnosis of BI was not required to participate. However, as this information was thought to be useful in advancing the discussion around Canadian statistics, survivors were asked a series of questions intended to identify if they had sustained injuries consistent with known causes of BI and/or any symptoms of BI, resolved or ongoing. All survivors who were interviewed reported experiencing hits or injury to the head, face, or neck during IPV, and all but one noted a resulting loss or alteration of consciousness, a key diagnostic criteria for BI. Interestingly, the survivor who did not report a loss or alteration of consciousness did note several ongoing common BI symptom-related difficulties from the list provided. As the vast majority of survivors are unaware of the risk and likelihood of BI as a result of exposure to IPV, and/or may have memory deficits around recollection of events, it has been suggested that an anticipation or assumption of BI, based on exposure to hits to the head, face, and neck, and an endorsement of typical symptoms, may be recommended (Haag, Jones et al., 2022; Monahan & O’Leary, 1999; St. Ivany & Schminkey, 2016; St. Ivany et al., 2018a; St. Ivany et al., 2018b; Valera et al., 2018). As such, survivors were asked if they experienced any of 16 challenges commonly experienced with BI. The list of 16 challenges was compiled by the research team, taken from a cross-section of the literature characterizing BI (e.g. Bazarian et al., 2003; Franulic et al., 2003; Hooson et al., 2013; Mateo & Glod, 2003; Monahan & O’Leary, 1999). They reported an average of 13 challenges, with headaches, memory problems, fatigue or tiredness, trouble concentrating, difficulty multi-tasking, and problems organizing tasks being the most commonly noted. Table 2 provides the complete reporting on these health-related characteristics.

Table 2

Health and Healthcare Reporting of Survivors

	N	%
Have you received formal healthcare services for something related to IPV in your lifetime?	6	100%
Have you ever experienced hits or injury to your head, face, or neck?	6	100%
Did you lose consciousness, see stars, or feel dazed or confused during or after hits or injury to the head, face, or neck?	5	83%
Did you and/or do you notice ongoing challenges with any of the following after hits or injury to the head, face, or neck?		
Headaches	6	100%
Memory problems	6	100%
Fatigue or tiredness	6	100%
Trouble concentrating	6	100%
Difficulty multi-tasking	6	100%
Problems organizing tasks	6	100%
Sleep problems	5	83%
Flashbacks	5	83%
Depression or Anxiety	5	83%
Light or sound sensitivity	5	83%
Nightmares	5	83%
Dizziness	4	67%
Ringing in your ears	4	67%
Mood swings or anger	4	67%
Hard to follow conversations	4	67%
Loss of taste or smell	1	17%
Total Challenges (mean, SD)	13	1.67

Exploration and Data Co-Construction Process

I facilitated all in-depth, semi-structured interviews in conjunction with another team member³ and explored: (a) IPV/BI women survivors' lived experiences of work; (b) perceived employment-related support needs for women with IPV-related BI; (c) existing programs,

³ More information on research team members and role assignment is provided in Appendix A

policies, and practices intended to support women survivors; (d) characteristics of healthcare and social support services that are valued and/or helpful; and (e) challenges that need to be overcome in the system, from the perspective of individuals with lived experiences, service providers, and/or workplace representatives. In keeping with a qualitative methodology (Denzin & Lincoln, 1998; Denzin & Lincoln, 2000; Braun & Clarke, 2006), and to encourage an unstructured discussion (Moe & Bell, 2004), we asked broad, open-ended interview questions. The use of a semi-structured format when interviewing women exposed to IPV has been identified as beneficial, as it provides a breadth of information, while allowing survivors to maintain personal safety and comfort boundaries and make individual decisions regarding the level of detail they wish to provide (Moe & Bell, 2004). Interview guides were designed to identify (a) existing barriers/facilitators to obtaining and/or maintaining stable employment; and (b) knowledge gaps regarding impairments associated with IPV-related BI and current employment support practices. Copies of the interview guides is provided in Appendix B.

Individual or group interviews lasting 60–90 minutes were done using video conference technology, as in-person interviews were suspended during the pandemic. Written consent forms and a study information package were sent to all stakeholders prior to their interviews. Once signed consent forms were returned, an interview was scheduled. At the beginning of each interview, the purpose of the study and the consent form were outlined verbally, and further verbal consent to proceed was obtained. With stakeholder consent, all interviews were audio-recorded (with no video component included) and transcribed by an independent professional transcription service. All audio-recorded data, signed consent forms, and demographic information was stored in locked facilities, as per approved ethics protocols. Sample sizes for each stakeholder group was consistent with recommended homogenous subgroups in qualitative

research (Denzin & Lincoln, 2000), and recruitment and interviews continued until no new information surfaced. Informed consent was obtained prior to the interview being scheduled and confirmed verbally at the outset of each interview. A copy of the consent form has been attached in Appendix C.

Analysis Process

Transcripts were analyzed by four members of the research team, using a thematic analysis approach (Denzin & Lincoln, 1998), established as a method of “identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). This approach allows for flexibility during analysis to encourage a broad understanding of a previously under-examined area, while staying close to the data, but not being restricted to a single theoretical position (Denzin & Lincoln, 1998; Denzin & Lincoln, 2000; Braun & Clarke, 2006). This concept was particularly important, because the topic is very new and previously unexplored. Using a manual process, descriptive codes were attached, which were then grouped into broad, topic-oriented categories (e.g., stigmatizing attitudes, discriminatory practices, organizational policies). To enhance rigour, several strategies were used, including memoing, reflexivity, and triangulation (Lincoln & Guba, 1990). Immediately after each interview, researchers engaged in reflexive note taking and met to discuss reactions and responses to the data. During the coding process, multiple meetings were held to identify and interpret findings, discuss interpretations, and create a list of themes with supporting data. Trustworthiness was maintained through debriefing, analyst triangulation, regular meetings to discuss and ensure code consistency, and development of an audit trail. I also did another, independent analysis after the completion of this initial process to develop the final themes and sub-themes presented herein.

Ethics

Approval was granted by the Research Ethics Boards at the University of Toronto (Protocol #39175) and Wilfrid Laurier University (Protocol #6611). Copies of the protocol approvals are provided in Appendix D.

Findings

Four themes surfaced during the analysis, each of which contained numerous subthemes with a variety of comments to support them. Many of these themes overlap, creating a highly complex overview of the experiences of, and barriers and facilitators to, employment. This process was guided by a ‘findings map’ that is included below in Table 3 to provide clarity.

The first theme, *‘What is Happening and What is Working at the Individual Level’*, focuses on the micro context. This first subtheme in this theme presents a glimpse into the lived experiences of women survivors, discussing the importance of work and what it means to them, practical challenges to obtaining and/or maintaining employment, abusive behaviours and how they impact their employment. This is followed by the second subtheme which explores what is working, with comments discussing the value of peer support and, what I have termed, the ‘guardian angel’ effect.

The second theme, *‘What is Happening and What is Working at the Organizational Level’*, in a mezzo context, presents the realities of an unknowing (and/or uncaring) workplace. The first subtheme here discusses identification, silencing and stigma, increased risk, expectations tied to notions of an ‘ideal worker’, and survivors’ experiences of dominant workplace cultures. The second subtheme explores what is working, covering compassionate organizational cultures that provide safe spaces, flexibility, and a destigmatized, proactive approach to support. Conversations also include the importance and impact of education, exploring interdisciplinary cross-pollination as an example of what is working, and the ‘Ah-Ha moment’. Last, this subtheme explores existing employment support programs, including comments on local programs and what contributes to their success.

The third theme, *'How Do We Do Better'*, presents stakeholders' own suggestions for improvements. This theme includes two subthemes: 1) micro-level suggestions that can be enacted by social support providers in an IPV or BI context, and 2) mezzo-level suggestions focused on actions employers can take to improve outcomes for survivors. The micro level includes conversations around empowerment, various service models, the importance of training, and the value of supportive employment programs. The mezzo level contains comments around accommodations, the benefit to a proactive approach, potential in-house supports, the need for training and education, and opportunities for community engagement.

The fourth and final theme, *'Barriers to Success'*, presents four groups of 'problems' as its subthemes: 1) the 'It's Your Problem' problem; 2) the 'Not My Problem' problem; 3) the 'Best Kept Secret' problem; and 4) the 'We Have No Money' problem. These subthemes explore micro-level challenges, such as complexity, survivors left on their own, and problems with access to supports, as well as mezzo level obstacles, such as motivating employers to change, and tensions between what is private versus public. While this thesis focuses on presenting micro- and mezzo- level experiences, macro-level barriers also surfaced in this theme and have been briefly covered here to provide a glimpse into the underlying systemic issues that play a significant role.

Table 3

Themes and Subthemes

Theme	Subthemes
1. What is Happening and Working at the Individual Level	<i>1.1 A Glimpse into the Lived Experience</i> <ul style="list-style-type: none"> ● Importance of work ● Practical challenges to employment ● Mechanisms of abuse and their impact on employment <ul style="list-style-type: none"> ○ Physical ○ Cognitive/emotional ○ Maintaining employment vs. seeking a job ○ Grief and loss

	<p><i>1.2 Strengths to be Leveraged</i></p> <ul style="list-style-type: none"> ● Peer support <ul style="list-style-type: none"> ○ Survivors at the center of support ○ Different ways of knowing and knowledge ○ Paid work ● Guardian angels
2. What is Happening and Working at the Organizational Level	<p><i>2.1 Unknowing Workplaces</i></p> <ul style="list-style-type: none"> ● Identification ● Shame, blame, and silencing ● Increased risk ● Expectations of the ‘Ideal Worker’ <p><i>2.2 Strengths to be Leveraged</i></p> <ul style="list-style-type: none"> ● Compassionate organizational culture <ul style="list-style-type: none"> ○ Safe spaces ○ Flexibility ○ De-stigmatization ○ Proactive approach ● Interdisciplinary cross-pollination <ul style="list-style-type: none"> ○ Importance, how, and impact for workers and survivors ○ The ‘Aha moment’ ● Employment support programs <ul style="list-style-type: none"> ○ What aspects work ○ Examples of local success
3. How Can We Do Better?	<p><i>3.1 What Can Service Providers Do?</i></p> <ul style="list-style-type: none"> ● Empowerment ● Service models <ul style="list-style-type: none"> ○ Long-term ○ Holistic ○ Client-centered ○ Navigators/peers ● Training ● Supportive employment programs <p><i>3.2 What Can Employers Do?</i></p> <ul style="list-style-type: none"> ● Accommodations ● Proactive approach ● In-house supports ● Community engagement ● Training and education
4. Barriers to Success	<p><i>4.1 Subtheme: The ‘It’s Your Problem’ Problem</i></p> <ul style="list-style-type: none"> ● Complexity

	<ul style="list-style-type: none"> ● Survivors on their own ● Access to care and supports <p><i>4.2 Subtheme: The 'Not my Problem' Problem</i></p> <ul style="list-style-type: none"> ● Motivation to change ● Private vs. public <ul style="list-style-type: none"> ○ Safety vs. surveillance ○ Disclosure <p><i>4.3 Subtheme: The 'Best Kept Secret' Problem</i></p> <ul style="list-style-type: none"> ● Awareness ● Larger context awareness gap ● Training ● Policy <p><i>4.4 Subtheme: The 'We Have No Money' Problem</i></p> <ul style="list-style-type: none"> ● Staffing/training ● Direct support services ● Employment-related supports
--	--

Additionally, to provide further clarity and allow for possible insight across and within stakeholder categories, each quote has been assigned an identification code. For those who participated in an individual interview, the letters denote which stakeholder category they belong to (S = survivor, E = employer, ED = executive director, FL = frontline worker), followed by a number that represents their identification number assigned at the time of the interview. For those who contributed via a group interview, the initial letters denote which group they belong to (either FG1 or FG2), the next letter identifies their stakeholder category, and the final number represents their identification number assigned at the time of the group interview (three stakeholders in FG1 and two in FG2).

1. Theme: What is Happening and What is Working at the Individual Level

1.1 Subtheme: What is Happening: A Glimpse into the Lived Experiences of Employment

Much of the literature reviewed earlier in chapter 2 discussed the ways in which workplaces are built on ableist constructs that focus on a deficit-driven model and continue to (re)produce the experiences of (dis)ability as being situated within the differently abled individual, leaving them to bear the brunt of adjustment and adaptation. Structures of power and control are used to maintain a normative-abled standard to which employees are expected to comply. The importance of organizational culture and its impact on the individual was presented as being critical to the overall success of the employee. The literature reviewed here also explored the risks and benefits of employment for survivors of IPV, as well as the impact of IPV on employment. The analysis here surfaced many similar conversations, highlighting the importance of bringing these experiences to the forefront. I begin this subtheme by presenting conversations that explore the importance of employment and what it brings to survivors' lives.

Importance of Work Unsurprisingly, employment is seen as important in a variety of ways ranging from practical implications for financial stability, independence, and access to benefits to more personal ones, such as an impact on sense of self-worth, identity, and dignity. Some stakeholders discussed the advantages of employment while others highlighted some drawbacks. One of the more obvious positive impacts of employment is the financial aspect, since women need resources to have access to safe and stable housing, food, and healthcare. One stakeholder noted:

I think for a lot of us, the only way for women to actually leave and not to feel that they have to get involved in another relationship is to be financially independent. I think a job is really important in terms of women feeling like they have some options. A lot of women feel like they have no options: 'I'm going to go into a

shelter, I'm going to leave, how am I going to pay the rent? I don't want to be on welfare.' (ED-12)

Another stakeholder spoke of how lucky she felt to have established employment in a supportive environment, saying, "I think that's probably why I started out saying I feel so privileged because I don't know how I would have ... continued to pay rent or whatever, all those types of things." (S-1) One stakeholder talked about the challenges for women trying to leave when they are unemployed, noting:

Some of these women, when they leave, they have nothing, same as me, I left with nothing. And some of them don't have a job, so with the system prolonging everything like that, what are they going to live on, where are they going to live? You know they have nothing, and they get nothing, or they rack up a bill to live and that takes away all the money when they finally do get it. They can't buy a house; he's got the house. (S-4)

The impact of not having choices when you are financially dependent, and the increased risk this puts women in was noted by one stakeholder, who commented on frontline workers "noticing this link between women who have experienced trauma and returning into situations that were really unhealthy for them because of a lack of choices. So, they [workers] saw trauma and employment really connected." (FL-19)

Shifting further from the practical aspects of earning money, stakeholders also discussed personal implications. Some noted the importance of work as part of our identity and the difficulty when being asked about it:

My work, when I was working, was my identity. Some days were harder than others to get up and go to work, but I could say 'I'm a supervisor' ... I could say

this is what I do instead of ‘Where do you work? Nowhere. You’re awful young. How come you don’t? Oh yeah, now I remember, you have the brain injury. You still can’t get back to work? No, still can’t work.’ (S-11)

Another stakeholder spoke of the impact on mental health and overall wellbeing:

Having a job is very important to me ... in terms of your mental health, having a purpose, having something that you're doing that's outside of yourself. I was good, I was really good at my job in so many ways. (S-2)

Stakeholders identified the link between earning a paycheque and the independence this provides by saying, “And honestly, if I hadn’t had a job, if I hadn’t had supportive employers that allowed me to take that time off. If I hadn’t had a home where I could go. I don’t know what someone would do.” (S-1). Another stakeholder spoke of the power of financial independence and women’s assumptions around what they thought they were capable of:

I think what I've seen is a variety of women who never thought they could be economically independent. I think there was just this assumption. Some of them, kind of, grew up with that, kind of, as a gender role. Others, I will say it quite literally, got beaten into them their sense of worthlessness and such. (FL-14)

Other stakeholders continued this conversation, noting, “And it also is about the paycheque because it’s a very powerful thing, right? It’s like, ‘oh I’m getting acknowledged’, like there’s some worth that’s shown.” (FL-19) They spoke of how their sense of self-worth shifted to a more positive place when they were able to earn their own wages either in the relationship or after they left:

I think that, when they found that they could get their own paycheque, when they found that they could have that sense of independence and not have to rely on

someone else to help pay those bills, there was just a great deal of a combination of surprise at times, but also, again, that sense of self-worth, that ‘Yes, I can do it’. Especially for women that have a lot of shame, that is really based on that assumption that one cannot do something. Then, all of a sudden, to have that sense of ‘Oh, I can do it, and look how I either helped this person or I produced this product or was able to participate in something’, you know, it was very rewarding. (FL-14)

Some stakeholders went so far as to note that the monetary gain was not as important to them as the personal one:

It’s not even the financial side of it. The financial side doesn’t matter. ... It gives them a sense of value, whether it’s working as a volunteer and helping other women, or even working in a food bank. There are so many things. (S-5)

Building further on this, stakeholders discussed the sense of purpose and validation experienced through a contribution via paid and/or unpaid work, saying, “There’s something, this real connection that these women have, something vital that they can give, [that] they offer our whole society.” (FL-19) Another stakeholder described the importance of working:

It was important to have a job. First, I needed it for money, but I think it gives you a sense of purpose and it gives you your own money. It allows you to use your brain and your skills and feel productive. (S-4)

Survivors spoke of the personal value of doing something right and the sense of validation it achieved:

It gives you a personal sense of value, and a personal sense of validation that you're not wrong, you're not crazy, you didn't deserve this, and this is something that

happened to you, and it wasn't your fault. ... And very often, because these women are in these terrible relationships, that's the only sense of self they have. They're constantly being told they're a bad parent by their partner, they're constantly being told they're a bad housekeeper, they're a bad wife, they're a bad this, they're a bad that. But the only thing that they—the only positive reinforcement is if you work, you get a pay cheque, and you possibly get a promotion. Then you know you can't be all bad. (S-5)

Even though I'm retired, [and] I'm not actually working, all the committee work I did for the last six or seven years was more fulltime than a job. If I couldn't have done that, I would probably be depressed. I think it gives you something in your life, being able to work or to give back or whatever you want to call it. It's fulfilment, interest, it's social too, so it's a whole big circle of things that are beneficial. (S-4)

Some stakeholders noted the value of volunteer positions, particularly if paid employment was not possible. One stakeholder noted the structure it brings, saying, “But I have been very [engaged] with a lot of volunteer things and stuff like that too, so ... it helps. ... I do have some sort of purpose through that.” (S-2) Another spoke of the value of being busy, “Oh yeah, I volunteer a lot for different organizations. I'm always looking for something to do,” (S-11) when unable to engage in paid employment.

Stakeholders discussed the challenges of employment as well, particularly around safety and personal capacity. It is worth noting, however, that despite these risks, the need and/or desire still overcame the challenges in many cases. One stakeholder noted:

You know, there was a woman at the shelter who really wanted to keep her job, and he found her, and he murdered her because he knew her route. You can tell women this is not safe, but a lot of them are, like, ‘I’ve given up everything, I’ve given up my home, I don’t want to give up my job; it gives me some sense of responsibility, some sense of [control]’. (ED-12)

Another stakeholder discussed the challenge of safety, in terms of a survivor’s physical safety, as well as their overall health:

Women that are trying to leave the violent relationship or really suffering from the consequences of that, they continue to try to go [to work] because of the economic dependence even though it might be dangerous and/or, from a health perspective, they’re really struggling and maybe not doing a very good job. (FL-14)

One stakeholder went further, noting a negative impact on her wellbeing when considering employment: “Not anymore. [Employment] used to be [important to me] but it’s not anymore. Because I don’t trust people. I’m terrified of people after the experiences I’ve had. No, it would just cause more stress.” (S-13)

Some stakeholders identified the difficulty experienced by survivors when there is a disconnect between the desire to work, which was high, and the capacity to do so, which was often impaired. One stakeholder highlighted that the effort put in by survivors was to no avail, saying that “There are other clients who work like crazy to try to get themselves work ready. But there’s still a gap between what is reasonably out there for work and what they’re capable of doing.” (FG1-FL-1) Another spoke of survivors’ desire to work, and the effort being put into achieving that:

They want to work, and they want to find jobs, and we are at that stage where it's, 'Okay. Let's look at the skills. Let's look at what you want to do'. All over the internet looking at what's available and talking about fit. (ED-10)

Another stakeholder spoke of the experience of trying to regain what had been lost as a result of her injuries during exposure to IPV:

And I always thought I could go back to work, if I could just relearn how to do math again, that maybe I would be able to go back to my job that I had before. Because I was well-paid and doing well, and I went from a high income to nothing, instantly. (S-5)

Others spoke of the impact of having to accept a new reality, and the pressures they put on themselves, saying that "These women are in a place of employment that they've spent a long time getting to, working up to. They will have an expectation of themselves to be able to maintain that." (FG1-FL-3) There was a recognition of the difficulty in aligning old and new capacities:

I think that's really hard for them to figure out, not only what they can do but to go from something where they're making, you know, a decent wage down to minimum wage. ... Some of them still want to work, and how are they going to? I don't think they've found anything really satisfactory as far as figuring out what they can do. (FG1-FL-2)

Regardless of these challenges, there was a clear statement of the desire to work. Stakeholders identified this desire, noting a "huge desire and drive for work" (FG1-FL-2). Stakeholders spoke of wanting to work and the motivation it provided: "having that purpose that's doing something for somebody else is what was getting me up in the morning" (S-2), and "it's given me a drive, a

function.” (S-5) One stakeholder identified the value of striving for and achieving paid employment:

I think it also helped them, again sort of from a psychology perspective, of kind of developing their sense of self outside of survival and, perhaps, their kids or their partner. That sense of ‘I can exist and contribute to society’, or ‘I can buy my own car’, just lots of those kinds of things that [give] someone a sense of ‘I can do it’, and that's the first time they really felt that they could. And really start taking in positive feedback as opposed to negative: ‘You can't do it, you'll never amount to anything’, that kind of emotional psychological crap. (FL-14)

Some stakeholders identified the importance of maintaining existing employment. By staying employed, survivors avoided having to seek new employment. One survivor noted the importance of her employment, saying, “I don’t know what I would have done, honestly; I don’t know how I would have gotten another job or anything like that. I feel very fortunate and privileged that I already had a really well-established employer and employment.” (S-1) Another stakeholder saw the dual need to support survivors in maintaining employment and re-training or changing fields, when necessary:

I think it's easier that we figure out a way to keep them employed, because if you lose your job, then a whole world of trouble follows you. Poverty is a huge issue, so let's not wait until the horse has left the stable, whilst they're in there, let's figure out ways that we can wrap them with supports, so that they are able to continue to live productive and meaningful lives. However, having said that, recognizing also that there might be, for that population of women, times when they need to retrain, because the work that they were doing before, they realistically can no longer do it.

But you have to have mechanisms in place to sort of track and understand that. (ED-6)

The importance of employment for women survivors of IPV-BI is unmistakable; however, many barriers to employment and employability remain. The next conversation in this section details some of the practical challenges experienced by these women when trying to achieve employment and employability.

Practical Challenges to Obtaining & Maintaining Employment Many survivors experience very practical challenges to obtaining and/or maintaining employment, ranging from access to education, existing language barriers, and availability of resources, such as housing, transportation, and appropriate clothing. However, the most notable challenge faced by a single mother with limited resources is childcare: “The realities for women working are very much interconnected with their access to quality childcare. I think that's a big factor.” (ED-8) Stakeholders discussed these challenges, noting:

The women that we’re serving, half of them are parents, young parents. Of those 50% that are parents, probably 80% of them are young parents with multiple children. So, there is a whole other element there. There’s no break. They are on all the time, because as a parent, you are also expected to, and presented with, a need to multitask all the time. There’s no downtime. ... So, the parenting piece is overlooked and the lack of childcare, and access to childcare, and the fact that she needs funding for childcare. ... Lots of our moms just can’t work, because their kids are home. (ED-10)

We've seen lots of disruptions with employment, it being very challenging for a single mother to work. You know, whatever your circumstances, it can be very challenging trying to get childcare, affordable childcare, getting yourself ahead. We have women that literally would be further ahead if they were on income assistance, because by the time they work fulltime and pay their childcare bills, they're taking home less. I think that factors in hugely. (ED-8)

If they have children, it's further complicated because there's the difficulty of finding childcare, getting through that process of arranging childcare. And then making sure that what they earn is enough to pay for the childcare. So many levels of challenge for somebody who is in a [state] of disorganization. (FG1-FL-2)

There was a single mother once who had to go back to retraining, and childcare was on the top of my list. How do I get the kids away from her so she can retrain and be ready for work? (FL-15)

One stakeholder described a particular survivor's challenges and the need for their own organization to develop adequate support services to assist:

One woman who worked at Old Navy, a woman in her forties, had really struggled, really wanted to keep her job and was sort of trying to figure out what to do around childcare. She had childcare during the day, but on Saturdays and Sundays, it became difficult. But she really wanted to keep that job, because for the first time in over twenty years, she actually had a job that was meaningful, and she wasn't cleaning houses anymore, so she really wanted to keep that job and wanted to move

out. So, how do we, as an organization, support her? The day care was during the day and in all honesty, there is no childcare on weekends, so she had to rely on family and friends. (ED-12)

Stakeholders also discussed the challenges around education for women survivors, noting that many of them had not had access to adequate education prior to seeking services. One stakeholder considered her own client group by saying, “Education has come up over and over again as a barrier to employment. I think one client I'm working with right now finished high school, and the rest have not.” (FL-7) Another Stakeholder highlighted the link between education, employment, and financial independence:

Part of it simply is that lack of opportunity to develop some [education] post high school that would allow for some decent wages. ... I'd say the vast majority of women that line up in shelters have not, or have had limited access to college or university or some sort of training that would enable decent employment, something above poverty line minimum wage. (FL-14)

Stakeholders discussed a variety of challenges connected to resources, such as housing, transportation, and clothing, all of which were needed when considering interviewing for a new job and/or providing the stability needed to keep an existing one. Stakeholders discussed the need for reliable transportation and safe housing, noting:

In terms of finding a job, you know, I think it's easy to think that everybody can apply and have fair opportunity for a job, but there are [advantages] that we have, whether it's a car, or transportation to get to the workplace. (E-18)

I'm also working with women who don't have the safety and security of a home,

with a couple of them being homeless. Lots of them are parents whose brains are also functioning trying to raise and keep alive and provide quality of life for their other humans, and not able to care for themselves as much. Or don't have the time to. (ED-10)

But when it comes to the bare basics of, do you have a home, do you have a way to get to work? Do you have an employer who can be flexible and understand that you have kids to care for? Do you have an employer who understands what a brain injury is and can be flexible when you forget, or struggle? That's nowhere. (FL-7)

Another stakeholder discussed the paradox of increasing the complexities and challenges faced by women when they are doing what we ask them to do while making a move toward safety and independence:

We also know when women leave, they have a stack of responsibilities that they have to deal with, they need to deal with lawyers, they need to deal with police sometimes, they need to find housing, they need to figure out what to do with their children. I think that we found employment is disrupted very frequently when IPV takes place, especially when she's leaving. Because you literally can't keep working and do all the things that need to happen to keep yourself safe. (ED-8)

Some stakeholders discussed the internalization of some of the barriers and how survivors can feel overwhelmed and need time to adjust:

I think for many of my clients, the anxiety about communicating with somebody and the emotions that come from that, can be kind of debilitating. I think that is a big hurdle for a lot of people—"how do I manage that situation?" Just preparing for

it. It goes back to that preparation stage. How do we help somebody prepare and go through the scripts and talk about the words and talk about what questions you might be asked, so you feel more prepared going into that? (ED-10)

I think a lot of women just don't even—it's so overwhelming to try to know where to start. ... There's certainly a lot of steps that go into just actually even being able to get to the point where you're putting yourself out there and applying for jobs. (ED-8)

Lastly, one stakeholder noted the need for, what they referred to as, a 'recalibration period' (ED-8), a significant period of time during which survivors could adjust to their new lives, seek out new education and training, find housing and transportation, and develop pathways to successful integration into society without pressures and expectations being put on them:

I think that there is, for survivors, pressure for them to be at a certain point and be able to go 'Okay, now you're two years post brain injury, you should be able to work and you should be back to work.' I do think there needs to be that recognition that there is just going to be a period where employment is not a realistic goal for people who have experienced IPV and BI. We need to hold out the possibility always that it will be, and not just go 'Oh well, this is never going to happen.' But I think we have to be realistic that there is almost always, with very few exceptions, going to be some kind of a break that has to happen. So. ... there's healing and there's preparation. There's a recalibrating to the new reality. You may have been trained in something and you can do it, but you could do it [before] because you weren't a single mother. Now, you're a single mother, so that has to change, so that may mean you can't even do the job you were trained to do. Or it might mean you have to do

it differently. I think that those things take time to put together. ... That preparation needs to happen ... even for women that don't have children, there's a whole new reality that they're living in a post-abusive relationship with all kinds of factors that need to be worked through before she can work again. (ED-8)

Practical challenges, such as childcare, access to education, housing, transportation, clothing, and legal and medical responsibilities, create new barriers for women survivors in seeking or maintaining a job at a time when employment is critically important to their health and wellbeing. These challenges are further complicated by the expectation of a quick recovery, when, in reality, a longer 'recalibration period' is required. The next conversation explores some of the abusive behaviours in which partners engage and how these behaviours interfere with women's employment. The subsequent impact of exposure to IPV-BI on survivors is also explored as the focus begins to narrow, and the conversation considers the unique ways in which the intersection of IPV and BI increases the complexity faced by women survivors.

Mechanisms of Abuse & Their Impact on Employment Even the fact that a woman is at work can increase her risk, as noted by one stakeholder: "We know that the place of employment can be a very dangerous place for women who've experienced IPV. Because, he knows where she works, and he may have some connections with that." (S8) Stakeholders also commented on the variety of abusive behaviours used by survivors' partners. They included physical violence, overt and covert manipulation, fear tactics, and outright interference in a woman's ability to attend the workplace, as required. One front line worker noted:

I've worked with several women that have had some sort of employment over the years but have found often that their abusive partners have really interfered in that, sometimes at the more extreme of actually showing up at work, threatening

behaviours. I'm currently working with one woman [where] the partner sent some other women to her place of work [who] assaulted her in the parking lot. (FL-14)

A manager discussed the unequal access to resources that is often characteristic of abusive relationships, noting some of the more subtle mechanisms of control applied by an abuser:

One of the things about most abusive relationships is that there's a significant economic, unbalance in terms of women having access to resources. And him being very intentional about undermining any sort of independence that she might have, and economic independence being one of those things. Women do hear all the time, 'You're stupid, you could never support the kids on your own. You don't know what you're doing, you can't get a job.' This is the messaging that they may have been exposed to for years and years prior to leaving. (ED-8)

Another survivor discussed her abuser's requirements around her work environment: "It was like, he wanted [me] to be isolated. I had to work around whatever he wanted, work in a job he wanted, but there's only certain things I could do with my brain injury." (S-11). She went on to describe the barriers put in place:

The barriers were that he didn't want me driving, so it was me taking a cab, and he didn't want me leaving the dog alone for extended periods of time. I had to be home when he got home from work, so if he got home at three o'clock in the afternoon, I had to be home at three o'clock in the afternoon. (S-11)

Other survivors also discussed their experiences of partner control around their attempts to engage in work. One woman spoke about the ways in which an abusive partner might try to intimidate survivors: "A lot of men who are abusive will do anything they can to prevent that woman from speaking. They'll soothe them, they'll try and take their kids away, they'll do

everything to silence them.” (S-5) These behaviours have significant impacts on women survivors’ ability to maintain existing employment or seek new positions. The next conversation explores some of these impacts, as described by the stakeholders.

Stakeholders identified a connection between ongoing exposure to IPV and challenges with employment:

Those who reside in a shelter who've gotten to the point that economics are an ongoing issue and typically have been for an extended period of time, for a variety of reasons, these are women that have struggled to access and maintain employment. (FL-14)

Some note an equal distribution between women who have employment and those who are unemployed: “If we’re just speaking about domestic violence, it’s probably fairly evenly split,” (ED-3). Others identify a preponderance of unstable employment situations: “The women I've worked with have more precarious employment and fall more into that category,” (FL-9) and “It’s my experience that most are not employed. And if they are, it’s very precarious work—under the table, low wage, things of that sort.” (FL-7) Interestingly, this distinction between maintaining existing employment versus seeking new positions was also raised by stakeholders who described the impact of exposure to IPV-BI on employment.

One stakeholder identified the difficulty in maintaining employment and/or advancing in their career as some of the most significant challenges survivors face:

The biggest challenges that I see ... [is] around number one, maintaining their job, maintaining employment. Secondly, being able to rise in terms of promotion and thirdly, being able to, sort of, navigate between the personal and their professional lives. I think the lack of information around traumatic brain injury in this population

is a huge barrier. So, women lose their jobs because they are not doing the job. (ED-6)

Another discussed the severity of her injuries, which prevented her from returning to her previous position, and the implications for her career:

I was severely injured during the attack, and I lost my job that I had prior. And with the brain injury, there was not a hope in hell I was ever going to be able to do that job again, because I was a contract manager handling multi-million dollars, and I couldn't add, so you can't really do that. (S-5)

Another survivor highlighted her inability to cope with work-related stress such that she was forced to leave her employment:

I had to shift employment a lot. I had a good job and then ... I was having migraines and I was a supervisor and ... there was a lot of stuff going on. So finally, the migraines got so bad I quit, that was the stress of it all. (S-4)

Stakeholders spoke of negative repercussions when having to explain why they were experiencing difficulties in performing work-related tasks, saying, "And then they want to know why, what's wrong. So then, you have to explain and then they don't want you because of your TBI or IPV." (S-11) She went on to discuss how she would try to keep the reality of her situation from her employer, "I would [say], 'I can't work that day. I have to be home.' I didn't let them in to that side of my life, I just said that I had to be home for whatever reason. Or I called in sick." (S-11). Others also noted the need to keep the truth hidden: "You see nobody knew he was like that and of course you're trying to hide it. And so, you try to deal with both and keep everybody happy and that doesn't always work." (S-4) One service provider noted:

And then of course she's going to minimize it, usually. So, that's the other piece, right? So even if you were quite frank in asking questions ... they're not going to tell you. Even if she remembers or knows herself. (ED-3)

Stakeholders also identified a variety of challenges faced by women survivors when trying to seek employment. Some focused on the difficulty experienced by survivors when trying to put together a resume. "Because resumes are one of the things that can be very disturbing to people. They may feel like they have done nothing in their lives, and so, they have nothing to put on a resume." (FL-19) Another said, "When you put the fact you haven't worked for years and that your last employer was ... a gym, and you take your resume in to an employer they're going 'What's wrong with you?'" (S-11) Other stakeholders raised challenges around interviews:

I think it does change the dynamics, ... the comfortability with a male employer or whether they're going in for an interview alone with a man in the room, that maybe our male survivors would never even have to think about ... Because not only will you [not] understand me, but now also coming with this trauma and history of violence and some real trepidation around what that looks like in a workplace. (ED-10)

One stakeholder felt the impact of isolation and control on survivors held them back from seeking employment. "I think a lot of women who've experienced IPV have experienced such profound isolation in the months and years leading up to leaving, that there's so much that needs to be done to support them to get to that place." (ED-8) Some survivors noted they did not feel capable of engaging in paid work in a workplace environment and, therefore, did not even attempt it:

I think the best way to put it is I gave up even trying to find anything ... because I've talked to everyone I can talk to that I know to talk to and it's just nothing that I'm physically able to do or emotionally capable of. (S-11)

In the state that I'm in now ... from being in a really abusive relationship, there is no way I have the emotional stability to perform any work. I have trouble sitting for any length of time, I have trouble standing for any length of time, I have trouble walking. And anytime I overdo it, I end up paying for it for at least three days, it will put me three days in bed. So, I honestly don't see that there are any support programs that actually work for somebody in my situation. (S-13)

Another stakeholder identified the challenges in learning a new job and the impact that has on performance, particularly around employer expectations:

It's definitely no easy task when you've got someone who is looking at getting back into the workforce but knows that trying to build their stamina is going to take time. And going up to potential employers and saying, 'Hey, I've got all this experience, this is all the stuff that I can do, but I need to start slow. I need to start one or two days a week for two or three hours and see how that goes. And I need to have the same job until I can get that part—that job down pat, then I can incorporate other pieces of the job.' Yeah, trying to ask for that kind of stuff is nearly impossible. (FG1-FL-1)

Even retraining can be problematic for survivors as one frontline worker commented:

They go from one course to another, looking for, you know, the perfect fit that they can do. And it seems they go through one course, and they can't quite make it work,

and then they go to another one and can't quite make that one work, and [it just] keeps going. (FG1-FL-2)

In both cases, stakeholders saw the direct impact of an abuser's behaviour as being a barrier: "So that's really where some of that kind of power and control from the abusive, especially the more obsessive partners, comes in and really interferes in their capacity just to kind of maintain a job." (FL-14). One survivor discussed that level of control in her life and the impact on her job performance, noting "I was not very good at that, meeting deadlines, mainly because I would be not able to leave my home or have my own time." (S-2) Another spoke about the impact on her career path:

I couldn't progress in my life like I could have if I didn't have him holding me back.

He wouldn't allow me to work extra hours or long hours or weekends, that kind of thing. And then when I was at work, he was constantly phoning and interrupting, so that doesn't go over well. (S-4)

Other stakeholders discussed the challenges brought on by exposure to trauma, noting: "And because some of the ways that trauma shows up is, you know, it's like a difficulty in maintaining employment." (FL-19) The unpredictable nature of BI and the impact it has on survivors' employability was also highlighted:

I'm sure all recovery of any kind is two steps forward, one step back type of thing, but brain injury is so much like that that I think the idea that someone can predict how they're going to feel from one day to the next and make a commitment based on that is very, very challenging. We know that survivors of brain injury can be doing really well for a few days or a few months and then, there will be a trigger, or a setback of some kind, and they may find themselves unable to be [at] the same

level of productivity. And I think that makes it hard for, sort of, the traditional job.

(ED-8)

Many stakeholders discussed survivors' difficulties with cognitive function and the effect on their employment. A service provider noted that "there's often so much disorganization in their life that although there's this huge desire and drive for work, the disorganization gets into the way of them getting to step one practically." (FG1-FL-2) Another noted the challenges they face within the shelter system and commented on how that translates into a workplace:

Organizational things [like] scheduling, being late, remembering what to do when, I see that as a really big barrier, especially in our shelter where the managers try to streamline things. ... It's just that it's a really complex skill to be able to fill out a form, remember who to hand it in to, by what time, on which day? And when I see that as a barrier in the shelter, I imagine it would be a huge barrier when being employed as well. Even something, as I said, remember a schedule, what they do at work, at what time. (FL-7)

Other stakeholders were able to further extend this awareness to include the existence of a brain injury and how cognitive capacity might be compromised:

Almost like they do just in learning to identify with a newly acquired brain injury to understand that something as simple as making sure that you show up for your shift on time, that's no longer just something that's naturally in them. There's now a process that has to go into finding that structure again. And learning how to maybe manage potential conflict or being able to advocate for themselves. Because not only are they dealing with the BI stuff, but they're also dealing with repercussions

and the trauma from dealing with abuse and feeling like they don't have those voices, so it's very complicated. (FG1-FL-3)

So, I go meet with the woman and we talk. I said, 'Tell me a little bit about what you're dealing with. Tell me about what you find challenging and how.' So often, those challenges are the same. 'I get overstimulated. I can't finish a task. I can't multitask. I can't fill out a form. I can't remember anything. I write something down and then I lose the piece of paper.' Those are so common. (ED-10)

One survivor discussed the cognitive challenges she faced post-injury and the lasting impact they have:

And I lived like that for almost a year and a half, with Post-It notes everywhere, and books, keeping track of everything. ... Reading a book was a big love of mine. Now I can't read more than a page at a time because my eyes don't focus properly on the page, and by the time I finish the page, I can't remember what happened. (S-5)

Another survivor noted the cognitive challenges she experienced within a workplace environment by saying "When you're at work, you need to be able to do all of that stuff. And it does impact your ability to think, coordinate, organize, and multitask. I find now I can't multitask very well at all." (S-4) One survivor spoke about their difficulty with communication and processing speed, and the challenges those create in the workplace setting:

I think a big underlying factor is IPV-TBI sufferers and survivors have a hard time communicating, they have a hard time getting their story out, and getting their

thoughts in order. They need to have time to gather their thoughts before they can talk. (S-11)

Survivors and service providers spoke about the difficulty experienced by women trying to compartmentalize their experiences to maintain their focus while at work:

And then the challenge of maintaining this work–life balance is complicated by the traumatic brain injury. So, you're at work and you can't separate the worries that's happening at home; you're at home, and you can't separate the stuff that is happening at work. So, your work and your home becomes commingled in ways that people who don't have brain injuries are able to sort of silo off [from] their work. (ED-6)

After those arguments, after those fights, after the violence, to be able to switch your brain off to then be working on something that seems trivial in comparison to what you just survived. That questioning 'Should I be connecting to the police, how do I get out of here, should I be going to the hospital?' (S-2)

It's hard to go from a night of violence into the workplace and act like nothing happened. Especially [if] some of it was pretty traumatic. Some of the hits in the head were pretty rough, so I ended up with headaches at one point for five years, and they developed finally into constant migraines. (S-4)

One employer also recognized these challenges, commenting, "It's hard when you're faced with challenges at home to come to work and fully function. So, it affects your ability to focus; it affects your attendance or absenteeism from work." (E-16)

Some stakeholders discussed the emotional challenges experienced by survivors and their impact on employment stability, noting:

Because of their hyper vigilance, they're always on alert; that impacts their work performance, and again, it's going to depend upon the boss and the colleagues in terms of their capacity to provide either some sort of support or accommodations or something. (FL-14)

I notice a lot of anger, [which is] to be expected in working with women who are fleeing violence. They're really angry, and they're really upset. And there's this phenomenon that happens where things are taken really personally [by survivors], but that's not necessarily the case. (FL-7)

Other stakeholders expressed the challenges of coping with mental health difficulties as a result of the IPV-BI:

I think ... it melts together. When you have the TBI, you lose a lot of yourself, and then, you lose a lot of self-confidence and self-esteem, because you realize what you've lost. Then you add the IPV, and you lose even more. So, it's like a cumulative effect, and you just keep getting pushed down ... and you're so anxious and so depressed and so wound up and you can't think. And you just don't know which end is up; you don't know how to get up. So, it's like a dual thing. (S-11)

One stakeholder highlighted the role of anxiety, noting "The anxiety piece intersects all aspects of somebody's life. ... In the employment piece, I think it can be a real hindrance." (ED-10) This stakeholder went on to give examples of how anxiety can prevent women from active engagement in social relationships, noting how workers can misunderstand and question a

survivor's behaviour by asking:

‘Why didn’t you call those numbers that I gave you? Why didn’t you reach out or do those things? Why did you cancel all your dates with your friends just last week or two weeks or three weeks?’ You know, often its anxiety driven. (ED-10)

One stakeholder discussed the impact of IPV on survivors’ self-esteem and confidence: “I see self-esteem and self-confidence as a barrier. I have trouble with wanting my clients to dare to dream, to seek out a job that they actually want, versus them, kind of, falling back into the familiar.” (FL-7) Others also discussed these internal barriers:

And I know there are all these home-based businesses out there, and don’t think I haven’t looked into many of them. ... But you’ve got to put so much money up front and you have to have the technology to be able to do it. And I have lost my self-confidence that I could actually do that. (S-13)

Most women are hearing messaging about themselves that's intending to undermine their sense of confidence and their sense of independence. So, there are so many layers to just getting to the point where you even put out your resume to apply for something. (ED-8)

Some stakeholders discussed challenges of a physical nature and their implications on survivors’ employment. Stakeholders discussed the impact of fatigue on survivors: “The fatigue for any woman is tough, let alone somebody who is dealing with, you know, brain fatigue and fog constantly.” (ED-10) Another noted the impact of fatigue on communication:

“Communication is hard for people ... language barriers and just general fatigue and trauma. It’s

complicated.” (FL-9) This stakeholder went on to provide an example of how this complexity can challenge a survivor’s employability:

She is working an entry-level labour position that is extremely hard on her body and makes her very tired, which impacts her mental health, obviously. And then makes her more vulnerable to having a seizure. And she also just finds the work a bit degrading and that impacts on her mental health. So, she doesn't find the workplace to be the most respectful or accommodating. (FL-9)

Other stakeholders highlighted how physical limitations can create challenges within an employment context. One stakeholder discussed being triggered, saying that “there was a period of time because of the triggers, I was having panic attacks, to the point of heart palpitations and things.” (S-2) Others discussed physical impairments that interfered with their skills and ability to perform their job tasks:

I think of one person who was an office manager with great typing skills and all sorts of abilities and now can’t move her fingers in a way that she could even type 20 words a minute. And no organizational skills, so obviously can’t run an office. (FG1-FL-1)

There’s the loss of the job, but then also, it took a really long time rehabbing, because I couldn’t walk properly, I couldn’t think properly, it affected my left side, so I was walking with a walker, and couldn’t really do a lot of things on my own completely. (S-5)

Many stakeholders discussed survivors’ difficulty in adjusting to their altered capacity and ability:

What I've seen is that after a head injury, the women that I have worked with don't seem to be capable of their previous level of employment. And I think that's really hard for them to figure out, not only what they can do, but to go from something where they're making a decent wage down to minimum wage. And some people—they're almost incapable of employment. Some of them still want to work but I don't think they've found anything really satisfactory, as far as figuring out what they can do. (FG1-FL-2)

They kind of create their own barrier because it would mean kind of going back to the drawing board and learning how to do that job all over again, taking into account the fact that they're now trying to navigate a brain injury. And in my experience, there are a lot of women who will say 'Well I've already done my four years of education and I've already done my graduate [work].' And the idea of having to go back and relearn those skills doesn't seem feasible, or it's just something that they're not interested in doing. (FG1-FL-3)

Some stakeholders focused on the lifetime impact, noting that there are no quick fixes for the situation:

These things take a lifetime to resolve. Like, if you experience violence, it's not an easy fix; it's never going to be within a year fixed. It's going to affect you. You're going to get triggers. You're going to get incidents where you're more vulnerable, so you cannot frame it that it needs to be fixed within a specific time. And you can't expect me to deliver as much as someone who's healthy or who's just treading through life without many problems. (E-16)

Because it doesn't just end in terms of the impact of the brain injury, but it also doesn't end in terms of the trauma. I wish that I could say that there'll be a time that I would be the same as I was prior to. I'm never going to be. (S-2)

I never considered [BI] until after he ran me off the road and I can notice a difference after that for sure. Trying to do my studies, I gave up after that, I did my exams and I never went back to it, because I just can't focus long enough. I can't retain and keep it there and keep going like I used to. (S-4)

I have to prepare myself days in advance just to get out and go grocery shopping. And then you know I do as much as I can. And I try and get through two to three weeks without even having to leave the house to restock. (S-13)

One stakeholder identified the challenge of socially derived expectations of what women are 'good' at, and what they should be able to do, and the disconnect between expectation and capacity experienced by survivors:

And it is the thing that all the women that we're working in IPV-BI say they struggle with. 'I cannot multitask. I cannot multitask.' Yet it continues to be this expectation that women are great at multitasking, and it's not a problem. Now you have somebody who's really struggling with scheduling, completing an application, remembering an appointment, all these types of things, and there's just this societal expectation that she can. So, I think that is a real challenge. (ED-10)

Finally, stakeholders highlighted the feelings of loss and frustration experienced by survivors:

But there's still a gap between what is reasonably out there for work, and what they're capable of doing. And I think, in every case, it's pretty tough to be able to navigate that [gap between desire and capability] and to be able to emotionally cope with the frustration. (FG1-FL-1)

That's a huge loss to realize that maybe you can't run an office anymore. And maybe the next capacity you have is becoming a cashier somewhere, or maybe it's doing something completely different like landscaping and being able to have that process. (FG1-FL-3)

They went on to discuss the difficulty of how some survivors are painfully aware of their limitations, noting, "Some don't think they can ever work again, and they're very aware that their capacity has diminished" (FG1-FL-1), while others need to learn through trial and error:

Sometimes the people that we work with have to go through that process of trying what worked before to prove to themselves that either it's doable or it's not doable. Which can be quite crushing for a lot of people when they realize that that's not reality anymore. (FG1-FL-3)

Perhaps the most powerful statement on adjustment and loss was provided by a survivor who noted, "I was just so outraged that this person didn't kill me, but at that point he might as well have, because it was such a struggle." (S-5) Clearly, the impact of abuse on women and their employment cannot be understated. Conversations highlighted the inherent danger that women survivors faced in the workplace itself, because it is a known location to the abuser. Stakeholders discussed various ways in which abusers sought to control their partners, ranging from physical assault, manipulation, threats, making demands around workplace characteristics, or interfering

with transportation. The unequal access to resources was also highlighted, with an abusive partner using it as a means of control. Stakeholders also identified differences between the challenges associated with maintaining existing employment vs. obtaining a new job. These included internalized challenges of shame, stigma, and silencing experienced in existing workplaces, and practical challenges around interviewing, resume writing, childcare, and retraining when seeking new employment. Many stakeholders spoke about the physical, psychological, and cognitive impacts of the abuse, noting the impact on their employability. Poor job performance because of impaired cognitive capacity, memory, and organizational skills, combined with fatigue were discussed, as were physical limitations due to injury. Mental health difficulties associated with traumatic events, such as anxiety, depression, and anger were also raised. Stakeholders also identified the pressures of coping with anxiety, loss, and frustration. The next group of conversations provides a glimpse into the workplace environment, social and employment norms, and expectations, and the impact these have on women survivors.

1.2 Subtheme: What is Working: Strengths to be Leveraged

Several survivors noted the value of shared experience and the importance of access to peer supports. One stakeholder commented that “peer [support] has been more helpful than any other organization or expert” (S-13), while another noted, “We need peer support, but we do not value it at all enough. We don’t recognize experience as an asset. We don’t recognize experience as knowledge. We don’t recognize all that stuff as things that are teachable.” (S-1) Frequently, stakeholders identified the need to privilege the voice of survivors and value their knowledge, saying, “You have to ask the people who are the community that you’re trying to support. This is important, asking survivors what they need; that’s number one.” (ED-6) Some saw the

importance in an employment context, noting, “I think that what needs to happen is, instead of just looking at what's easiest for the department or for the employer, making those hard decisions, those hard choices. And involving victims with those discussions.” (S-2) Particularly when trying to develop or offer support services, the voices of those with lived experience are to be brought forward:

There’s nobody who knows how it feels, other than the people who have lived it.

That was my biggest argument with the [support organization] when I first joined was, you aren’t listening to the victims. You have to listen to them, you have to, because they're the ones that it’s happened to. They can give you some guidance on how to avoid it, how to remedy things, how to make things easier, how to help them.

(S-5)

Many of the stakeholders actively engaged in this activity in one way or another, expressing a sense of giving back or finding value in their experiences through the process of offering support. One stakeholder noted, “I think you’ll probably find—at least I have found in talking to other victims — that almost every woman wants better for the next woman; they don’t want them to have to go through what they’ve gone through.” (S-5) She went on to describe her willingness to open herself up to judgement and blame, if sharing her story could inform: “I go around to all the different police [forces]. I’ve trained all of the detectives there, and I let them ask me all those stupid questions ... like, ‘Why did you stay?’ How could I get out?” (S-5)

Another survivor commented “I thought, well, if I can make it better ... make the services a little better for her, then all that shit I went through for 20 years—something good will have come out of it.” (S-4) Not all stakeholders consciously shared their experiences of IPV in this way. One stakeholder prioritized brain injury support by noting:

That's what I have done in my community. I'm kind of the peer facilitator, and any time anyone, you know mainly brain injury, some of the IPV, they will come, and they will talk to me, and we will talk it out, or I will call them. I have for years. Just not on the IPV side, but on the brain injury side. I always left out the IPV side before. (S-11)

Regardless of whether the focus was on IPV or BI, the value of a peer assisting survivors to navigate systems and identify and gain access to resources was evident. One survivor described a peer navigator's role and what that could look like:

They are just there to be your navigator, advocate, how amazing would it be if everybody had one of those for everything. ... That is a role too for volunteers who are not getting paid, and that's another thing; we still don't value investing in them. (S-1)

Interestingly, despite many engaging in this role, only one stakeholder described being offered paid employment for her expertise:

They reached out to me to ... sit on an advisory board. ... I've been doing that now for thirteen years. I advocate for victims and sometimes I'm sure I irritate the government people, because I don't care what their problems are, I want something for the victims. ... I go anywhere in [the province], and get people resources and I talk to them and give them positive feedback, that there is light at the end of the tunnel. (S-5)

Building on the value of peer support, the final conversation at the individual level considers what happens when a survivor comes into contact with, what I term, a 'guardian angel': someone

who makes a positive difference by offering knowledge, support, understanding, or opportunity but does not see themselves within a 'saviour' role.

The guardian angel appears in many different forms: they can be a co-worker, a supervisor, a friend, a support worker, or a medical professional. What unites them is that they each play an important role in improving the experience and outcome of women survivors in some way. One stakeholder described their role in educating others in the community, noting that they found value in helping others as well as becoming more aware of the realities of IPV:

The only thing I am thinking about is, at first, when they ask me to do the training, 'Is there anybody else who wants to do it?' But after, I was really happy to have done it, and it really changed me for the better about domestic violence. I had never been in close contact with these kind of problems. So, now it's the sensitization for the rest of my life, and I'm sure that we had that positive impact also on other people. I already have maybe five or six people that I know that we've helped since the beginning, that maybe would not have been helped, so I'm really happy about what we've done. (FG2-E-2)

Another stakeholder described using her role as a union representative to provide support to a co-worker:

I don't think it was addressed in the best manner. I had to intervene as a union rep because I was concerned about the co-worker. She came one time to work, and she was bruised. All along I could see her deterioration, becoming unreliable, not showing up for meetings, and she was very experienced, but the quality of work—you could see that it's lacking, and the focus. There was a pattern, but what made it very clear is the abuse symptoms that showed up on her body. And she wasn't ready

to leave a relationship or to speak about it or to take time to look after herself. ...

So, I just intervened from a union perspective and a co-worker who cares. (E-16)

Some guardian angels spoke of their role as an advocate for others who might not feel safe to speak out:

I feel like I've had lots of courses that have been offered to me in past roles prior to this that make me comfortable helping. And being a more vocal and visible person within not just our hall, but the industry as a whole; being female in [a male environment], I feel like I'm confident enough to handle, or at least find answers, if someone comes to me with an issue. And I'm not worried about what happens to me if I have to shake some trees down to find those answers. (E-17)

One stakeholder described the challenges of trying to educate others while obtaining adequate access to medical care for a client:

We've had experiences where women have been victims [who have] severe symptoms, like where she was strangled. And it's obvious to me, who's a non-medical practitioner, that she had endured a traumatic event to her above the shoulders. She was discharged back to police for statements and then we stepped in. She was actively vomiting and experiencing some other symptoms of what I would say was concussion or brain injury. Again, not a medical professional, but from all the screening tools we have access to, I had concerns, but the hospital had discharged her and weren't willing to re-admit her at that time. So that's another barrier. In that case, we put her in a shelter, and the shelter sent her back [to the hospital], and she was immediately sent back to them [the shelter]. (ED-3)

Other stakeholders discussed the support they can offer clients because of professional training or special interests:

The number one thing I hear, 'I'm crazy or I just can't do it. You know, I'm kind of slow. That's what he always told me, or my mom told me: I'm just kind of slow; I just can't do it.' It's kind of helping them understand that information, that experience in a different way. ... It is something that I can uniquely offer at the shelter. ... Some of my training as a clinical psychologist does have to do with executive functioning ... so, I kind of come to the table with some skills around that. But I must admit, there was never any training I ever had, it was just sort of personal interest. I started looking at the issue around head injury and the implications or working with this kind of clientele. (FL-14)

I write support letters often, I can't diagnose PTSD, but I can say that based on the experiences of my client and the symptoms that they're exhibiting, I believe that they're showing signs of post-traumatic stress disorder. And often that letter, when I write it to whomever, does carry some weight—as much weight as a social worker can provide. (FL-9)

Survivors spoke of the positive impact a knowledgeable person in the right place at the right time had on their experiences. Many of them gave these individuals credit for providing life-changing support. Some survivors spoke of healthcare professionals who made a difference in their lives. One described being helped to understand what had happened to her and how to accept the consequences in her life:

The biggest gift that she gave me: I always thought that I could relearn how to read. Reading a book was a big love of mine. Now I can't read more than a page at a time ... and she explained how to accept that. And I always thought I could go back to work ... I can remember how to do something and see it in my head, but I can't get it to work on paper, or to actually produce anything from it. And she was very, very kind and very gentle in telling me that was a memory I was having, and the pathway just isn't there now. (S-5)

Another survivor spoke with gratitude about a medical specialist who tried to make it clear to her that her life was at stake:

He said 'You know if you go back, you're signing your own death certificate.' I saw him here a month or so ago and he asked me the same question. He said, 'Did you go back?' And I said 'No.' ... Every year, he asks me the same question. ... I know some women don't have that chance, and a lot of them are [dead] now. And that's where I would have been had I not had the chance I had. (S-11)

Survivors also found guardian angels in community organizations with individuals who advocated with them and offered support:

I consider myself extremely fortunate in that I had people who would advocate for me as I was coming through the process. I don't know where I would be today if it hadn't been for them, or the shelter. They carried me, they literally carried me, because I was not able to do it myself. (S-5)

I had a counsellor with the brain injury association who witnessed some of the abuse. She put me in contact with the local women's shelter. ... She took me to the

women's shelter, and we worked with the women's shelter in getting me an apartment, in getting a safety plan and everything set up. (S-11)

Some survivors also found guardian angels in the workplace, individuals who were willing to accommodate or offer new information:

[My boss] was pretty lenient when it came to me, she accommodated me a few times. There'd be times when it was just like, 'I can't take this anymore, I just need a break, I need a couple of weeks off.' And she'd say 'Go have your break, let me know when you want to come back to work.' And she would give me that time. (S-11)

I didn't know. I was strangled and my boss at the time was the one who told me that's actually a huge thing. I think at the time he said something like 'You know, you're six times more likely to end up killing your partner if you strangle' or something like that. Right off the bat, he was very caring and supportive. 'This is serious, don't just try to be a tough girl you know', he would sort of say ... and so, I learned a lot and I feel kind of lucky that way. (S-1)

Stakeholders were also able to describe the qualities needed to shape and replicate guardian angels. Some spoke about the need for an individual to be motivated to go beyond the norm, saying, "There needs to be, basically, an extraordinarily generous person that is willing to go outside of what they're legally required to do and to accommodate," (ED-8) or the need for them to seek further education to provide effective support: "I think it really comes down to the worker to do their due diligence, to educate themselves as the situation comes up." (FG1-FL-1).

One stakeholder commented on the capacity to see survivors' experiences as assets instead of deficits:

I think it's the person receiving the information: the supervisor, or the boss, the hiring manager, it's their awareness and education around brain injury and what that means. And whether they look at that as a negative and something scary and unpredictable. Or whether they look at that from a strength-based perspective and say, 'Well, this person can bring a really unique perspective and skillset that maybe no one else on our team can have.' (ED-10)

While the guardian angel is clearly of significant benefit to survivors and can be found in a wide variety of sectors and roles, the challenge is that, for the most part, they are random. There is no formalization of this role in most spaces, and women either come across them or they do not. In most cases, it is luck rather than design. One stakeholder raised this point by noting:

What we hear from a lot of women who reach out to us is that it's not a direct route. It's been ... by the grace of God that they've met someone who's actually asked the question, actually asked the question. Because for years they didn't ask the question—no one ever asked 'what's going on here?'. (ED-12)

So, how do we replicate the concept of a guardian angel within the life of a survivor? How can we shift this random event to a predictable one? When asked about the best mechanism to provide support to a survivor, a stakeholder responded:

Having someone who cares, who's willing to say, 'You know what, I care. Are you okay? I am seeing some changes. I'm concerned. Is there anything I can do for you?' And then they offer resources. They don't need to be counsellors, but they need to have an eye and a heart, and not be judgmental. (E-16)

Clearly, the guardian angel can have a significant impact. It is often someone who says or does the right thing at the right time, and who can be integral in supporting a survivor to move forward toward safety, financial security, and a sense of wellbeing. However, the randomness of the interaction is problematic because cannot be predicted or replicated, leaving some women to benefit while others will not. In the case of employment, it is worth considering if the guardian angel role can be formalized, thereby providing a pathway to more consistent support. An examination of workplace functions and their impact on women survivors of IPV-BI can highlight possibilities to foster and replicate these guardian angels.

2. Theme: What is Happening and What is Working at the Organizational Level

2.1 Subtheme: What is Happening: Unknowing (and/or Uncaring) Workplaces

Comments here highlight the importance of workplace culture in a variety of ways: identification, protective vs. unprotective employment sectors, employer expectations around productivity and the support they offer, and an overall environment that fosters shame, blame, and silencing. Many stakeholders described the challenges associated with workplace environments that had little or no understanding of IPV-BI. Both worker and employer highlighted the importance of identifying survivors of IPV-BI and the difficulties in doing so. The unknowing workplace is experienced as unsupportive, and, in some ways, uncaring. It is, unfortunately, all too common, and carries with it the potential for increased risk to survivors' safety and wellbeing.

Overall, stakeholders noted the importance of employers having a general understanding of IPV and BI individually, as well as the potential relationship between the two, making identification itself difficult. One stakeholder noted, "How do you recognize those situations, and

what is the best way to approach them with that individual? What is the best way, who is the best person to reach out to on those matters?” (E-18) Another commented, “I think a lot of employers just don't get it at all. They don't really understand brain injury and they figure ‘this happened two years ago, I don't really get why this is such a problem for you today’.” (ED-8) Combined with this lack of awareness of the intersection, there also appears to be a general lack of policy that might provide specific guidance on how to identify and support employees who are experiencing IPV. One stakeholder noted, “There are no policies in particular in my union. The only policy is ‘duty to accommodate’, but for accommodation, the person has to say she has a need.” (E-16) Another stakeholder also highlighted this gap in policy:

We don't have a set of procedures per se. We do have policies in the workplace regarding violence in the workplace, bullying in the workplace, etcetera, and also within our health and safety policies and procedures, which talk about external threats. But not specific enough to talk about a spousal abuse situation. (E-18)

Other stakeholders identified the challenges employers face when a lack of training or education leaves them unsure of how to proceed:

How do you, as an employer, begin to sort of bridge that ... gap. That there might be things that have happened to this individual that have impacted their ability to function in the way that they used to function. And that thing could be a brain injury that she sustained as a result of violence at the hand of her partner. (ED-6)

How do you navigate those discussions? What can you ask that is safe from a legal perspective, maintains their dignity—which I think is incredibly important—protects their privacy, but also provides them with the support that's needed? I think

any time you roll out any sort of training, or new knowledge topic, I think it's, 'Where can I learn more? What can I and can I not do, or should I and should I not do? And if I'm lost, who can help me?' (E-18)

One stakeholder discussed the potential impact of their organization's education program:

Some of the leaders will probably think back and realize that there may be some people that had some performance issues. [But they didn't know] because they didn't have that tool in their toolkit: that it's possible that the performance issue is because of domestic violence at home. They will think back and think, 'Oh my God, you know, maybe that's what happened with this person, and they're no longer with us now.' (FG2-E-1)

This lack of knowledge and subsequent unwillingness to address the topic can quickly translate into shame and stigma for individuals experiencing IPV-BI and can easily have a further silencing effect on everyone involved. Notably, most stakeholders reported exposure to a negative, uncaring environment, where shame, blame, and silencing were often felt. One stakeholder shared her experience of being left on her own, because her supervisor did not feel comfortable approaching her: "I think she knew about it, but she didn't know how to approach it." (S-11) Other stakeholders recounted how their employer chose not to see or acknowledge the obvious, maintaining productivity expectations and failing to offer support:

When I was doing my graduate work, I had an extension, and I couldn't meet it. I went to meet with my advisor, and he said 'Well, you know, we arranged for this time.' And it was at that point that I actually said, 'I don't know if you can notice, but I have a black eye, because I tried to go to the library to work on my stuff.' (S-2)

Oh, they knew, because that was just after my ex [ran me into] a tree, and he beat me up, so there was a lot of stuff that went on that night. And they all knew about it at work, because I had to take some time off ... and they didn't have any supports at that point in time. (S-4)

Another related that it was made to be her responsibility to control the situation:

I was going through this stalking thing, and then to have [my boss] on me about, 'Well, you have to get him out of the parking lot.' How am I going to do that? I keep calling the police, that's all I can do. (S-5)

Other stakeholders discussed feeling silenced, noting, "There is something to that, protecting someone and making sure they aren't judged because ... they're on the employee assistance program ... that's got this taboo bad connotation to it still. This huge stigma." (S-1)

One stakeholder raised the difficulty speaking out in this environment:

They struggle to explain to their employer—how do you tell somebody 'I'm not functioning the way I used to because he kicked me in the head?' There's this whole mystery around your new normal, your new life that you, as a survivor, are finding difficult to articulate, because you no longer have the language. (ED-6)

Some were directly told not to speak out: "But at the same time, my boss was very much 'Don't talk to people about this, don't tell people about this. Don't integrate this experience into your work.'" (S-1) Others discussed the lack of response when they did tell someone: "There were a lot of other times where I would say things, where things didn't feel right in my relationship, and I would say something, and it was never really picked up on." (S-2)

The unknowing workplace environment can lead to increased risk for survivors. Some may

feel unable to remain, either because feelings of shame and stigma are internalized or they wish to avoid them all together, and need to seek new employment elsewhere:

I was harassed and threatened by the company, not just the other employees, but from the supervisors, I was just constantly threatened every day. And I got to the point I had to quit; I couldn't do it anymore. ... Because who wants to walk in and be identified as the woman who got the shit kicked out of her and has some mental health issues. (S-13)

I'll say it's much more the social pressures there and just the fear of other employees. You know, other colleagues, co-workers that might be scared of what's going on, and the woman feels pressured, sometimes internally or just socially, to leave the environment and to leave their work. (FL-14)

It's about getting the employer on board and identifying that these are the limitations we're having at present. Some people are not okay with speaking to their employer, because they didn't have a good relationship with the employer to begin with. Then, readiness takes longer, because you have to figure out, 'Do you want to go back to the same job? Or do you want to go back to a different job?' (FL-15)

Some stakeholders identified that some sectors would inherently offer more protection and support to women experiencing IPV-BI while others would have cultures that would increase the challenges, and that this factor should be considered when seeking employment:

I think the imposter syndrome brain is so heavy in these halls [within the construction industry] because you're constantly challenged about why you're

there, more so than many industries, so I think that added mental health element to someone coming in might be challenging as well. When you're already dealing with a disability, you're dealing with the minority aspect [of being differently abled], and now there's going to be a lot of people who might want to make you feel like you don't belong there. ... I think a big portion is culture, and where to direct employment, if you are going to look into construction industries as a viable option for women who have undergone these challenges or these hardships. (E-17)

I think working in tech is inherently flexible. I don't think an employer who is not flexible, would be able to retain their employees, because most tech companies are flexible. So, if you couldn't offer that flexibility, somebody else would, and it's just that competitive in tech that there's always going to be somebody that can do it better than you. (E-18)

There's already kind of a built-in system within the school setting, [for example] there are security cameras. Schools are just locked because of people intruding into the building, and some of the threats and such that have happened. So, those are things that those women don't have to deal with, and I'd say having a bit more of that empathy and social context is already part of a school setting. (FL-14)

Some stakeholders raised concerns about the workplace environment:

I think many workplace cultures are not particularly healthy or safe, so it's oftentimes very unclear: who do I disclose information to, how do I know that information will remain confidential, or not be used in a way that will limit me in

the workplace. (FL-9)

First and foremost, you have to have an employer who is compassionate enough and willing enough to accommodate somebody with special needs. If they're having an anxiety attack, could take some time to go and calm down or take the day off. (S-13)

There were times where I would be sitting in my grad classes and we'd be talking about, you know, the abused woman and 'why doesn't she just leave?' Or using it as a thought experiment. And there I was sitting with a charley horse, I was limping into class, and nobody even really knew. (S-2)

Others highlighted the potential for survivors to be othered by saying, "Quite frankly, that's another huge thing too, that the whole system and, a lot of my bosses and even my best friend, basically they infer their judgement upon you." (S-1) One stakeholder discussed the impact of being faced with workplace insensitivities:

It might not be the challenge of finding a job, it might be more maintaining it, and probably wanting to be fairly private about what's going on in their personal life, to seem normal or okay, when other people are celebrating Valentine's Day or other things. Maybe they just didn't get hurt that day, and that might be enough of a celebration. (E-18)

Construction is a more male-oriented industry and ... the culture changes aren't quite there. I think ... for women who have been put through various challenges in

domestic partnerships, it's going to be a challenging environment for them to work in. It's not even older journeymen that it comes from, it's ... the guy that's just made it through an apprenticeship that ... was treated poorly, and then they feel the need to almost perpetuate that. Like 'You're an apprentice, you're going to do this, you're going to do that.' Whereas you're lucky when you get one of the older guys ... and he's like 'Come here, I'm going to teach you how to do this properly.' I think there could be a power struggle for someone that's had a domestic violence aspect in their life. It could be an uncomfortable position, depending on who you end up with. (E-17)

Some stakeholders recognized the protection available through 'good' jobs as opposed to entry - level positions, part-time work, or unskilled labour by saying, "I currently have clients who are working in factories or warehouses, and it just seems that those jobs don't offer flexibility, because there's so many people looking for jobs, and it's an easily replaceable position." (FL-9) Another noted that organizational size of the organization was important: "[Accommodations] depend on the employer. If it's a big employer they have their own health and safety people in place, and they overlap, they facilitate, they help out. But if you have a family business, they don't." (FL-15)

Employer expectations were equally important to the overall experience of the workplace for women survivors. Stakeholders noted the challenges of a fast-paced environment with high demands on employees: "We have a very 'productivity' [based approach]: you get your deliverables, and you get this done, everything's about speed and efficiency." (ED-8) Others noted the negative impacts on survivors, costing them their employment status. "It [occupational support/accommodations] wasn't offered to me. I was thinking about it. I ended up being let go

before I knew that I was struggling.” (S-2) Lack of occupational support/accommodations also led to feelings of personal failure:

This habit of working in North America that’s super go-go-go: inadequate break times, super-fast pace, and this expectation to be so high-performing all the time. ... I feel it’s just setting someone up for failure if you do have a brain injury; it’s just too much. ... It’s so inaccessible. (FL-9)

Alongside these issues, stakeholders noted the lack of support offered to survivors who might be experiencing difficulty in achieving these expectations, even when there were clear indicators of the challenges they were facing. One stakeholder described her experience by saying, “There was never a conversation of ‘What’s going to make you feel safe, what needs to happen?’ ... there was nothing in terms of those things.” (S-2) Another spoke of the difficulty she experienced when trying to request support: “I did have to disclose to my employer, and it was awful, really, really awful. Because it turned out that my boss had a son who had been charged with abusing his wife.” (S-5)

One survivor described her being forced to go to work against her physician’s orders to keep her job:

They ordered me to work, even though the doctor put me on bed rest and had me on OxyContin. I was not supposed to drive, I was not supposed to work, I was supposed to be on bed rest. They said it would be my job if I did not go to work. My job was an hour and a half away. I wasn’t supposed to even be out of bed. They made me drive to work an hour and a half one way, and I couldn’t work. I had to sit in a chair all day and count screws. (S-13)

Here again, the type of job held, and the associated implications, were noted. One stakeholder stated that it was even difficult to obtain a position when “a lot of the jobs that they're accessing are entry-level positions and labour positions, and I find there's not a lot of compassion or accommodation provided in certain areas. So, more accessible hiring and interviewing processes would be helpful.” (FL-9) Another stakeholder described the value of having access to built-in benefits and resources within a professional position compared to those in unskilled labour jobs:

Typically, those women [in professional jobs] are going to have access to short-term leave and some other pieces so that if they do need to take a week or two off either to manage their own mental health and/or court proceedings etc., they have that financial network, that support system. But unfortunately, a lot of the women in the shelter, they're in jobs that, if they don't show up they don't get paid. They're financially a lot more dependent, and they wind up putting themselves in situations that, at the very least, feel a lot more dangerous. (FL-14)

Even though much of what is happening has negative implications for survivors, stakeholders also discussed examples of valuable interventions. The remaining subtheme explores some of those successes.

2.2 Subtheme: What is Working: Strengths to be Leveraged

A Compassionate Organizational Culture There are many ways for an organization to build a compassionate space: focusing on improving physical safety for survivors and their colleagues; providing and fostering opportunities for emotional support through trust, sharing, and recognition; being understanding of a survivor's need for time off and flexible work hours. Working to destigmatize IPV-BI within the workplace and being proactive with policy and

initiatives were seen as key to overall success. One organization demonstrated this approach to a level beyond the norm, and, as such, it is frequently put forward here as an example to be learned from.

Safety is a critical concern for women exposed to IPV and can be experienced in different ways. Stakeholders noted the importance of physical safety and recognized the challenges in addressing it within the workplace:

I think cameras in the parking lot are incredibly helpful. What's hard is that once someone leaves your premises, or the coverage of surveillance, what happens then? How do you protect people? What can you say to somebody when they come to work the next day, and clearly something has happened. Or you know, maybe you see increased absenteeism from that individual, which is not normal. Maybe they are more introverted and do not spend a lot of time talking to other individuals, so people might not know they're in a new relationship or may have a problem at home. Or maybe not even at home; maybe the individual has left that abusive partner, but it is still very much a part of their day-to-day. As an employer, I don't know how you protect people from that. You can protect them when they're within the four walls, and you can provide services to help them cope, but from a prevention perspective, I think that's probably a very difficult thing to do. (E-18)

We show them, in the training, how to recognize a victim, but also how to recognize an aggressor. Because ... [we hire] 95% men or more in some sites, it was good for the supervisor and the staff to understand also how to recognize the aggressor. (FG2-E-2)

Other stakeholders discussed how their organization put safety protocols in place in an attempt to offer support to their employees:

We've put in place, especially through COVID, keywords that people could write in an email. And if they use a certain keyword in that message, then the people who receive that message would notify and dispatch the champions saying, 'Hey you know, this person, either they need someone to talk to, or they're at a point that they need some help.' (FG2-E-1)

And thankfully, she has a good employer who has been quite—I'll say active—in terms of maintaining safety for her. And so, she's maintained that position. I think there's been some good things about that particular place of employment that has taken employee safety seriously once it's brought to their attention. So, in terms of security protocols at work, if these particular people [abusers] are seen at all, police are automatically contacted. You know, they've done a variety of things to maintain her safety once it was brought to their attention. (FL-14)

Another stakeholder spoke about their experience when their in-house protocol was accessed by an employee:

I remember when it happened. I got the email that somebody had reached out to us [and used] the code word. At first I thought 'Oh no, what do I have to do?' But the great thing is that we helped the person and the system worked. The feedback from the people we trained was really good, everybody says it is a good thing. (FG2-E-2)

Stakeholders also noted the importance of emotional safety and discussed what that can look like in a compassionate workplace. One stakeholder noted, “You create an environment where there is a sense of community, and trust has been built. That way, people don’t feel reticent to tell you what’s happening. That to me is critical ... fostering a community of trust and engagement.” (ED-6) Another spoke of the importance of trust, saying, “Trust is very important because there is already a vulnerability, and you have so much going on, and your focus is very little, so you don’t want to get hurt more or you don’t want more betrayals.” (E-16) One stakeholder recounted the support they received from their employer around memory challenges:

I don’t think they understood how difficult things were for me. But they got it because I would go many times to the office and I knew that step by step, it was okay. [I would say] ‘Who did you tell me to call? What did you tell me to do?’ And they’d say ‘Okay, we told you to call [whoever]’, and I’d have to write it down or put it on my phone. (S-11)

These acts of care and compassion were recognized by survivors and appreciated, “It was probably a protectionism thing. It was probably a bit paternalistic, trying to take care of me and protect me and all that sort of stuff. And it is probably wise.” (S-1)

Another way in which organizations demonstrate a compassionate culture is through providing a supportive work environment that is capable of flexibility to accommodate individual needs. One stakeholder discussed the ways in which their organization offers support to employees experiencing IPV: “All the things that are available, like ... paid leave, somewhere where you can live in security, maybe with your children if you need, you can have budget for that and everything.” (FG2-E-2) Others highlighted options available in their union or in their broader industry:

My union did something amazing. They negotiated 10 days of leave for people who experience violence at home or even a family member. That gives you support, and it doesn't need too much investigation or interrogation of why and who and ... it's accessible. That's very important to have the support and to be able to take the time to get better if you're leaving a relationship, or until you settle, that you're not affected financially on top of physically and mentally. It's very important. (E-16)

Within our industry there's the "Construction Rehab Industry Plan", which is like a help phone for any, it's not just for mental health, it's not just for addictions, it's also for any mental health challenges that people are having, they can phone and talk ... and as far as I understand they'll take on any counselling and not just for the member, but also for their family including children that are dealing with struggles. (E-17)

Another stakeholder described the environment in their organization, noting how it can promote communication between employees and managers:

The organizations that I have worked for have been extremely flexible. Whether it's your routine doctor's appointment, going to a lawyer, taking your pet to the vet, or your kids to the doctor, fortunately, all the organizations that I've worked for have been very flexible, including being able to work from home prior to, or after the appointment. ... Fortunately, we do have that flexibility, and generally speaking, it's always been, talk with your manager, and your manager needs to be aware of where you are at all times, more so from a safety perspective. (E-18)

One stakeholder discussed how simple it can be to offer this kind of flexibility: “Accommodation can be really simple. ... It doesn’t have to be hard. It doesn’t have to be another job to create accommodations. They can be simple and have big impact.” (ED-10) These small acts of compassion through flexible work environments can make a significant difference to women experiencing IPV-BI. Stakeholders highlighted the importance of that flexibility and how crucial it was to wellbeing and overall success:

No questions asked, take time off, don’t even worry about that ... there was no pressure that way, which was incredible. ... It was super important for me to have a job, to be able to maintain that job, to be given the flexibility to actually take some time and heal. (S-1)

Women we have worked with who have maintained their job through leaving their relationship have almost always said to us, ‘You know, my boss was amazing to me. My boss let me do this or do that, he gave me a paid day off, he let me take a week off unexpectedly’. And that those are the type of circumstances that need to be in place for someone to keep their job. (ED-8)

Some stakeholders discussed the possibility of relocating within organizations, and what that might look like, if needed:

Would an employer say, ‘Okay, you can switch to that manager, because [another colleague’s] cologne smells like your ex’s.’ Where and how do we even begin to understand that as an employer, and still maintain the need to carry on as a business. In a large organization, it may be easier to move people around to different teams,

because you might have several teams that do the same thing but focus on a different area. But in smaller organizations, that might be more difficult. (E-18)

For unionized employees, sometimes we can relocate them in jobs if they cannot do the job they were doing before the accident. So, I have one example that we have: there's a woman who was a supervisor at the facility and she had a big car accident. She had big headaches and difficulty to concentrate and things like that. We took her from a job as supervisor to another job where she was less active ... so, we can relocate people from different jobs if they have brain damage. (FG2-E-2)

While stakeholders from different categories noted the importance of taking a proactive approach to support women survivors of IPV-BI through de-stigmatization and policy development, one organization embodies this approach beyond any others. This particular organization has created and implemented a multi-level approach to supporting employees experiencing IPV that is embedded into their community engagement strategies, their workplace culture, and written into their policies. This approach is implemented around the world throughout their many locations. As there is much to be learned from their example, they were heavily relied upon as these stakeholders discussed the importance of taking a proactive approach, embedding practices into policy, and providing transparency on multiple levels. They described these policies as follows:

That's one of our core values, one is the safety and then within that, it's the safety at home, the safety around in your community. We do a lot of work with communities and it's always in the news, what people, different sites are doing to

help the community. Even during COVID, there were a lot of initiatives, that's part of our culture. (FG2-E-1)

For my part, I would say that the important—one of the most important things that we've done is to talk about domestic violence and make publicity around it, make sure that everyone knew what was [our] engagement in the cause. (FG2-E-2)

They describe pathways embedded in the organization for survivors to request assistance:

We're known as a 'champion', but if you go in the system, it won't say I'm a champion. The people from HR know. We're under the assumption that the leader who has an issue, and they don't feel comfortable dealing with the issue, would go to HR. If HR doesn't feel comfortable dealing with the issue, then they would reach out to the champions. There is a formal policy that's on the intranet ... and we refer to either a leader or HR. (FG2-E-1)

These stakeholders highlight the importance of actively working to de-stigmatize IPV through open conversation, saying, "I'd say that the [policy] is important, but what's most important is to talk about it and make sure that everyone knows what it stands for." (FG2-E-2) and "It's ... the fact that we're talking about it so openly, it's ... not really a taboo subject in the organization."

(FG2-E-1) They go to describe the impact on survivors, noting:

From my point of view, [what is important], is just to have the conversations. It's amazing. When someone demonstrates that they're seeing there's something wrong ... all of a sudden, the person feels like, 'oh my God, I'm not crazy, I'm not the only one thinking there's something wrong going on.' So, the open-the-door approach, just making sure that the person knows there's a possibility to even talk

about it. And that they realize they're not crazy in thinking that something is wrong, that it shows for other people as well. (FG2-E-1)

They also recognize that working to help an aggressor can also support survivors, as one stakeholder commented:

But are we going to support [the aggressor]? Men or women can do domestic violence, but we know that it's more often men. And we have, maybe 80% men in [our] business, so we have more chance to have an aggressor than a victim. So, the people asked the question, and I thought ... the policy should be changed. Because first, my reflection is that if you help the aggressor, at the same time you help one victim or maybe two or three, because you can help the whole family. And I think ... even if the policy doesn't show that, I'm pretty sure that we would help, we'll help him and apply the policy just as if it was a victim. (FG2-E-2)

These stakeholders discussed how their organization has built-in mechanisms to address IPV through support for an aggressor:

In the policy, what we say is that there are other mechanisms of help for the aggressors. We're not going to give him paid leave, we're not going to pay for emergency accommodation. But there are other mechanisms like the education assistance program ... they can ask for unpaid leave and for sure they'll be listened to if they want to talk. And the community referrals that we give they can be used as well by the aggressors. Even though they might not support them directly, they would know which resources can support them in the community. (FG2-E-1)

The last two conversations build on the previous discussion about what a compassionate workplace culture looks like, exploring ways such cultures can be developed and encouraged.

The first looks at the value of a community-based approach to sharing knowledge and information, while the last one considers existing employment support programs to see what is working locally.

Interdisciplinary Cross-Pollination Stakeholders discussed the importance of a widespread understanding of the intersection of IPV-BI and the benefits of education via interdisciplinary pathways and collaborations. While much of this conversation focused on direct support services rather than the workplace, it is clear that raising awareness and understanding of the intersection and the implications for women survivors is critically important and much can be learned from the successes in any context. Some stakeholders came from organizations that had never engaged in these kinds of knowledge-sharing approaches, while other organizations have been actively working on cross-pollination efforts for some time. Many spoke of their own ‘Ah-Ha moment’ when they first realized the intersection existed and began to understand the implications for their clients and their workplace. I start here with examples of individual Ah-Ha moments to provide context and highlight their significance, before moving on to explore the importance of cross-pollination, how to engage in it, and the subsequent impact on the client and the worker.

For many stakeholders, the moment when they first understood that exposure to physical forms of IPV can frequently result in a BI is a key point in their professional and personal lives. Stakeholders spoke of this moment, saying:

The idea kind of took my breath away, the whole idea of brain injury and how we’re encountering that. I think it was my biggest Ah-Ha moment when I came to [work here]. And it was like, of course, it makes perfect sense. (FL-19)

I don't think that these people are thinking brain injury at all. I just don't think it's top of mind, I don't think it's something that people recognize as being the epidemic that we know, those of us that have had our light bulb moment around this, which is literally how almost anyone that I've ever talked about this topic with has described it: like a light bulb going off, like 'Oh my God'. (ED-8)

We had a couple follow up questions: 'Have you ever lost consciousness due to overdose? Have you ever had your head repeatedly battered?' ... It turned out that every woman I asked said, 'Yeah, I did.' ... And it wasn't until further in the conversation that we flushed out how that happened, and that the challenges are related to that injury, ... and the connection happened. ... It wasn't until flushing it out and making the Ah-Ha connection moment of, 'I think these challenges that you're saying you're having now that you didn't before, might be related to this specific injury or injuries that were continuing to happen to you.' (ED-10)

When I was at that conference, and I've done this for three years, the light went, 'Oh my God, a lot of women we're working with have had a brain injury because of the abuse, and I didn't know about it.' It's kind of embarrassing. I've been in the field for years, and I didn't know about it. It's like 'Wow.' (ED-12)

One stakeholder had their Ah-Ha moment during the interview itself:

I feel it goes back to what I was saying about knowledge. You know, I had no idea it [IPV exposure] was one in three. That's more prevalent than cancer, I think. And

so, you know, putting it into those terms, I think is really important for people, because most teams are three-plus people, regardless of organizational size. Most teams are three people or more, which means at least one person on that team is at risk. (E-18)

Stakeholders spoke of how these Ah-Ha moments became important, because it shifted their thinking and encouraged the development of new ways to support survivors:

I really think that so-and-so might have a brain injury. Now this makes sense. Why she's missed all these appointments. Or why I give her the card and she's never reaching out to that person. I don't understand why she never wanted the help. Whereas, these were more cognitive challenges that were holding them back from performing these tasks. (ED-10)

I think what we've learned from [the BI] team is a lot about timeline and the patience that it takes day-to-day, and just the expectation that our BI folks have, that they just expect that it's going to be a very rocky road with lots of setbacks. I think we've learned a lot about trying to alter our expectations a little bit and not feeling 'Oh, we've put all this work into it, and now it's getting derailed'. I think we have had that feeling sometimes, 'Well, why is she sabotaging all the stuff we've been working on?' And not recognizing that there's a brain injury there that really is a huge component of that. (ED-8)

So I think the police here are trying to look at more screening, and what they should be doing, and I think the training last fall really opened up a lot of people's minds

that if we start going through a list of clients, there's probably a very high correlation of BI in that population that we're seeing, and this has never been identified. And so, what's our responsibility now that we know this? (ED-3)

Now there's also some base for us to link with the brain injury worker and have group conversations; that is very, very helpful. I have to say, that over the last few years, coming from a place where we assume everything is just psychological trauma, to recognizing that, 'Oh my gosh, there's something much, much more here', has been quite eye opening. And then, to continue down this road with the brain injury workers is very, very helpful. (FG1-FL-1)

You know, I'm just sort of thinking, what other possibilities are there where employers could provide better support? Yeah, I mean, before I knew what I learned today, I already felt that this was an important topic. ... I am shocked and saddened by those numbers and what you shared here today. And reflecting back, I do think there's more that we can do. (E-18)

These examples provide a picture of what can change for survivors and supporters alike after the lightbulb goes on. Many stakeholders discussed the importance of bringing the intersection forward, raising awareness and strengthening the knowledgebase through interdisciplinary collaboration. Stakeholders discussed the challenge of a general lack of awareness and the added difficulty it can bring to supporting survivors:

I think those tools, or those things that we've provided in the past to leaders, helps them get more comfortable with the subject matter. So, it might be just knowledge

sharing. It could be an online training course, it could be questions to ask if you suspect someone is encountering violence at home. ... I would say, unless someone close to them has encountered something, I don't think people would have a general awareness of it. It's not something that's talked about. (E-18)

The key message that frontline workers need to hold about survivors with brain injuries is just being aware that it is a possibility a woman might be experiencing. That is super important. I think for a lot of people, it doesn't even enter into their mind, and so there's a lot of frustration or misunderstanding that could be avoided if you entertained that is potentially what is happening. And then, being equipped with some tools to support someone who might have a brain injury. (FL-9)

What we found over the whole time was ... there are people who know brain injury and there are people who know IPV. And as much as we cross-train—super important for the recognition and awareness piece—the women that [they] were working [with] would still need both. They need their Women Outreach worker for long-term. They need to have somebody to go to, to talk about rebuilding new relationships, trauma that continues to manifest in different ways. And then they need their BI worker to go [to and say], 'Okay, I still struggle with this form.' (ED-10)

When you think of employment [supports], like Job Start, how many of their staff are integrating VAW [violence against women] into their programming? And I don't

know the answer. I think ... people don't take that all into account. It doesn't become a very holistic approach to stuff, right? Then you've got the brain injury stuff, so you've got these two huge factors. And a lot of staff are [thinking] "It's too much for me." Well, it actually isn't too much. If you can just ask those couple of questions, you're much better ahead. (ED-12)

The adjuster needs to be onboard. The lawyer needs to be onboard. The employer needs to be onboard. The medical team, including the GP, needs to be onboard. If I'm called in for a return-to-work, and there's an occupational therapist on file and a psychologist on file and a physiotherapist on file, they need to appreciate that I'm coordinating the return-to-work, and I get to [make] the calls and we're all understanding each other. And if they don't agree with the return-to-work component, then either I'm out of the team or they're out of the team. (FL-15)

Stakeholders working in an IPV-support capacity noted the importance of having brain injury specialists to supplement their services and increase their own understanding of a survivor's support needs:

They are coming and ... directing the care in terms of bringing in physio and the team that needs to rehab that client. They ... [are] coming into your home and identifying where are your deficits, physical, emotional, whatever, and how we do compensatory strategies. This is a huge thing they talk about all the time, compensatory strategies, so that you can actually do life on some level, so that you

can get to your appointment, you can take care of your children and have food, make a meal. (ED-8)

Yeah, I find it very helpful as well ... I work in IPV so I personally find myself still very short on the expertise of the brain injury side of things. It's really helpful to have my clients plugged in with the brain injury professionals and learning. Even the clients will tell us what's going on and what we need to know. (FG1-FL-1)

When we're doing safety planning, I've been a really big advocate around talking about acquired brain injury because it's not something that has been traditionally spoken about around here. And we're searching for ways to communicate that or to pass that on to women: 'you're taking in a lot right now'. This is big: the police maybe are involved, the children are involved, maybe children's aid services. How can [we provide] something that they can remember and check in on their brain health after the fact? (ED-3)

I think it's acknowledging that, if you're working with the women and things are not going away, do you understand why they're not right? And to have those resources. I think it's always people's comfort level, how to deal with mental health issues, and I think people, sometimes staff or management, doesn't feel very comfortable, because they think mental health is really scary. (ED-12)

I see it within my own organization, when you get into an argument with a woman

in the dining room and you're frustrated because she's not understanding what you're trying to say. If you had better training to understand what might be going on here, then your communication is going to go more smoothly, and you're not going to have to repeat things. It might take a little bit of extra work at the beginning and a little extra time, but then, you will ensure that both parties have an understanding, and then things move more smoothly. (FL-9)

Equally, stakeholders who support people living with brain injuries spoke of the unique challenges brought on by exposure to IPV. They highlighted the importance of having ties to experts in parallel areas, such as mental health or addictions, to complement their own support efforts and the need to become trauma informed:

We have to take that time to really tease out exactly why [clients are struggling]. Because my work is more specifically on the BI stuff, and I know that sometimes, there are these self-imposed barriers that just come with whatever has been going on for them. So, being able to have those real conversations with them and saying 'Tell me why this is not working for you.' (FG1-FL-3)

And that's where the communication with the IPV and BI workers has been helpful. They're saying, 'Something's not right and everything I'm trying isn't working. What am I missing?' And now, they're saying this to a BI worker. And the BI worker is [speaking to the IPV worker] saying, 'Wow. Maybe I'm just feeling really uncomfortable about accessing that [trauma piece].' ... Being able to ask the questions, if it's a bit out of our wheelhouse. ... I would love to see more agencies

able to join forces and not have to work as a silo ... I feel like the informal connections between teammates are crucial, especially those working in separate sectors. I can't tell you how important it has been for me. (ED-10)

There are many ways to engage in cross-pollination efforts, and stakeholders discussed a variety of them, including cross-training within the organization's staff compliment, bringing in outside trainers, providing training within the community, and building relationships with other organizations to share expertise. There was an interesting selection of organizational types represented in the sample, some which had little to no experience of cross-pollination on IPV and BI, some of which support IPV and/or BI survivors individually and had some knowledge of the intersection, and some that were actively offering IPV-BI services within their communities. Stakeholders shared examples of the benefits of interdisciplinary communication:

I think for me, it wasn't so much how we integrated the clients into the two programs, but definitely, a lot about the work that I get to do with the ladies from the IPV side. Just really understanding their perspectives and being able to balance what was said about [the client's challenges]. Sometimes there's this automatic 'go to' because of the psychological effects that they're dealing with. (FG1-FL-3)

It needs to be a two-part system: you're going to have a BI Team, who's going to look at your challenges through this lens, and you're going to have an IPV worker who's going to look at it through this lens. And one of the big learnings was that we need to make sure that there's also funding for those teams to communicate. Because they need to each know what the other one's doing, so we're not double-duty-ing, but we're not missing anything, or doing something opposing. (ED-10)

I know we had employment programs and they had shelter programs, but we did a lot of training together as staff, because that's one of the things that I wanted as a manager, ... I wanted us to integrate all that. So employment staff were trained on VAW, VAW staff were trained on employment stuff so ... that VAW is not separate, it's integrated as part of the organization. (ED-12)

When I was giving the training, I always had with me one person that was taking care of men who have a violent [history]. And I had one other community service [worker] that was taking care of women who were a victim of domestic violence. (FG2-E-2)

The previous two quotes also begin to highlight the importance of the community. One stakeholder identified the shift toward a collaborative approach to care by saying, "Like what we're seeing in youth justice ...[with] talking tables or wraparound circles. It's basically care teams and so, we all come together, we all communicate, we all share." (E-16) Many stakeholders noted the value to be gained from developing strong interdisciplinary ties with other organizations in the community:

We're saying you should have someone from the community. ... Here we invited them to the training, so that if people in the room had questions, [they could answer]. We're saying that everywhere they should do that, so that at least there is a connection, there is a link, and the community service [worker] also knows that we're doing that. (FG2-E-1)

How do we cross-train so that you know who to call and ask these questions to? And once you have those connections, how much easier it is to pick up the phone and help someone. We've tried to be really low barrier that way. There's not a large criteria or eligibility checklist. If you say that you've experienced IPV, and you believe you have a brain injury and/or are open to the conversation you might then say, "Let's talk about it. And how can we help?" (ED-10)

I've actually got a connection with one of the women that I'm working with and our addiction services. And we were talking about, when she goes into her supportive housing, having a case conference, so that we can have me come in with the brain injury perspective. He's going to come in with the addictions perspective. So that we can make sure that when she goes into this housing that they understand what the realities of her situation are. That she's not being aggressive, or complicated, or naggy, or anything. She's literally crying for help. But the help has to be delivered in a specific way. She can't have nurses coming in and hammering questions at her and she's unable to even process the first question before they ask her 20 other questions. And then get mad at her because her response is to get mad and tell them to stop. And then, in turn, it turns into this whole other thing. Because now, all of the students, the nurses are thinking that she's being aggressive when, literally, she just needs everybody to stop talking for 30 seconds. But that's just such an unheard-of tactic. (FG1-FL-1)

They were really happy to participate, and it was a great thing, because they were able to answer the questions, because as we were saying, we're not specialists in domestic violence. And one other thing that was really interesting also for them coming to the training, is they were able to share things that they have seen in real-life in the same community that the people are living in. They were really connecting with the people, because everybody will say, 'There is so much more than we thought', and everything like that. (FG2-E-2)

One stakeholder noted their contribution back to the community, describing how their cross-pollination efforts were viewed as valuable by others:

The people from the community were also really asking to be at the training with us, because they said, if [your company] does it, then maybe that others will do it. They said it will give really good visibility to the cause, so they were pretty happy about that. And they also invited me to give a speech at one of their fundraisers. (FG2-E-2)

Knowing what to do is often simpler than actually doing it; however, many stakeholders provided specific examples of how they integrated this knowledge into their direct practice. Some stakeholders described conversations they might have with clients:

I say [to the client], 'Well, have you ever thought about it maybe being a brain injury and that maybe some of this violence that you've experienced in your life is impacting these new challenges?' That's usually the conversation. [And they reply:] 'Yeah. Actually, now that you've said that, I've had my head smashed multiple times, and I was strangled a few times, and then I was in a car accident. Yeah, I guess. I mean, no doctor ever told me that. But that would make sense, because it's

been really different since this one last incident.’ [Then we follow up with] ‘So, you’re not alone in that. A lot of people that we work with have similar challenges, and I have a team of people that might want to come and talk with you about how we can make some of that stuff easier.’ That is almost how every conversation goes. (ED-10)

They don’t come in, rehearsed, saying, ‘These are my impairments and this is what I know about TBI, this is what I don’t know about TBI.’ I don’t expect them to know all of it. Because they have to contextualize their impairments based on what their life is. And my job is to help educate them in that regard, even though they’ve read everything on the internet about TBI. It’s about really taking those fundamental pieces and saying, ‘This is how it applies to your life. That’s why you were challenged when you started playing chess and listening to the TV at the same time. That’s what was happening.’ So, let’s take a step back and say, ‘Where do we need to start at so you can meet that goal if that’s really where you want to be at. And why do you want to be there, what’s the goal?’ (FL-15)

As a psychologist I kind of talk a bit more about executive functioning and how to organize some things there. It is typically the first time they have heard that even for those women that have been identified with a concussion. (FL-14)

Stakeholders also described the interaction possible between interdisciplinary teams and how it improved client support:

We were even at certain points talking about having an IPV-BI worker that somehow was some brilliant master in both areas. And then we [thought] ‘Well, why are we doing that, that's stupid.’ We've got people who know IPV, and we've got people who know BI, can't we just put both of those programs together rather than trying to come up a renaissance person? (ED-8)

I act as a case manager, really, when I'm running this program, except for the training and the physical component where I need a kinesiologist, or I need a physiotherapist to really do the physical strengthening programs ... I do the cognitive remediation portion of things, I take over every aspect with respect to return-to-work. But the physical I don't. The mental-behavioural I don't. There are lots of privately funded psychologists who are really good and I'll refer them out. (FL-15)

BI rehab is very practical. The skills, the interventions, the strategies, can be very practical. And they can be really individualized. Like scripting for instance: you can script with anybody. How you script and what you talk about is going to look really, really different. I think that individualized piece, and the practicality of BI rehabilitation and strategies, is appealing for an IPV worker. I think that's been often where they've sought out support on the other side. It's saying, ‘None of the things are working that I'm trying, and I'm missing something here.’ ... It's saying, ‘I want to reach out so we can do better. So, we can serve this person better.’ And then having maybe a different lens, a more practical lens. (ED-10)

Sometimes, through the intake information that's been gathered already by staff, they do have a pretty good picture of what has happened from a domestic violence perspective, what were the injuries, what were the assaults like? Sometimes, it's been very clear and you know they were strangled to the point of unconsciousness three times, or they were hit multiple times, or their head was hit against the wall. Sometimes that information is fairly clear, and then I might more directly ask questions about head injury. 'Well, are you having a headache, how's your vision, how are you organizing things, what's your concentration stuff like?' In part, trying to gather information for them and organize it for them so they understand 'this is an injury rather' than 'I'm crazy'. It's helping them understand that information, that experience in a different way, so. (FL-14)

The last piece of this conversation explores the impact of engagement in cross-pollination, specifically how it changes the task of supporting IPV-BI and the experience of being supported. In this section, I have chosen to present first the voices of stakeholders who did not identify as having lived experience, leaving the last words on the subject to those who did. I wish to amplify the voices of survivors here as they speak about the experience of working with someone who understood the implications of IPV-BI. Stakeholders noted that increasing awareness through cross-pollination assisted with identification, allowing women survivors to be seen and supported more effectively:

Cross-training happened in January, where our BI Team and our IPV Team came together. Anybody who was going to be working in that field potentially with any of these clients, and I did a big BI spiel, and my colleague did the big IPV spiel.

After that, I had a 300% increase in phone calls from anybody in that field [identifying BI as a possible concern]. (ED-10)

I think coming from the BI side of stuff, it was awesome to see the perspective that the IPV workers come from, because they're completely different from where we kind of come from in the BI stuff. Although our goal at the end of the day is always the same. But I did feel like it wasn't earth shattering. Because when you're working with people specifically focused on brain injury, a big part of that is managing mental health, managing substance misuse, managing unhealthy relationships and potential for violence, either from the partner or from the individual, because emotional regulation is a really big piece of BI. (FG1-FL-3)

You know, if people aren't telling you about [their challenges] then you can lose them in between. That's how I assess mental health/wellbeing, how functional they are and is it affecting their personal life? They're doing everything for me, but they can't spend an hour with their children? That's mental health and wellbeing. So, if they tell me after 6:00 I just napped, I had dinner and then went back, or I smoked a cigarette and I watched TV, and it's not in sync with what they used to do before, then I'm cognizant of that. (FL-15)

And again, I'm more familiar, more adept with the PTSD, with the clinical factors than I am sometimes with more executive functioning pieces. But I think I am quite willing to refer to a physio or someone else to assist with some of those things. I do

talk about it as an overlap, in terms of how it looks and how it might feel for the client or how it might look to an employer or to your partner or to your kids. But again then, what do we do about it? Because I do find the women appreciate a different frame of understanding of these things rather than the “I’m crazy” frame. Anything is better than that I guess, but [best is] to help them move forward and say ‘Okay, this is really related to an injury, whether it be a physical or a psychological injury, and there is something else I can do about it.’ (FL-14)

I just think if women are telling you, who are fleeing violence and have a brain injury, they’re telling you as a staff person or as an agency what they need, please take those statements at face value and figure out how you can do something about them. You don’t have to take them all on but think of the ones that will have an impact on the women that you’re working with. (ED-12)

Some stakeholders also discussed their impression of the impact on women survivors:

There is that common phrase. “Something just happened.” ... What I hear when they’re telling me that, is “I know something is different. My brain is different. I can’t do the things I used to do before.” So, there’s an identification that ‘Yeah, something in my brain is different’, but the connection between that [and what] you are challenged with now seems to take some time to unpack. And I think a little bit of a validation that they’re not alone in that, often that is comforting. I haven’t actually met a woman that hasn’t become comforted when I’ve said, “We work with a lot of survivors that struggle with that same thing.” ... There’s some validation that [what is happening is] a result of your head being injured. It is interesting

because most of them will say, “Something’s different, I do identify with having a brain injury,” and I don’t have to do the other follow-up questions. (ED-10)

The effects of concussions or strangulation and stuff like that, some of those symptoms can manifest really much the same. And trying to go in and look at it from a symptoms perspective instead of trying to figure out where that symptom is manifesting, sometimes that can be really, really challenging. So, it’s nice to have both sides of the coin, where you can have the BI looking at it a little bit more from a medical perspective, and then you’ve got the IPV side that come from a very ground-level, very personal, kind of, perspective. (FG1-FL-3)

I’d say that the majority of the women that I’ve worked with are probably not aware that they have a brain injury. They have, primarily from their partner, gotten the message that they are crazy, stupid, can’t do it, etc., etc. They have a whole litany of the name calling but they’ve clearly been given the message that this is about them, that it’s nothing to do with what has happened to them. And it’s a very pejorative perspective. And again, they are crazy, they are psychopaths, they’re this, they’re that. ... And just that practical support that even just validates ‘Yeah, you know, when I was in that fight that headache I had for some time is one of the reasons I’m having problems organizing myself now.’ (FL-14)

I want to be able to partake in screening and assessment in some way, because I really, really think that knowledge is really powerful. You know, sometimes when

a client receives a diagnosis, they think ‘That makes so much sense.’ ... It’s so important for people to have the opportunity for someone to tell them: ‘Hey, this might be what’s going on for you, so maybe you can feel less ‘crazy’, you know; there’s an explanation for what you're feeling. There’s an explanation for why you're here. You didn’t do anything wrong.’ (FL-7)

The remaining comments come from stakeholders who identify as having lived experience of IPV-BI. Positioning them at the end of this conversation allows them the last word on this subject and permits me to amplify their voices. These stakeholders commented on the impact of receiving support from individuals who were aware of the intersection of IPV-BI:

The services I received from them were from visiting elders who came in and did counselling and support. And they were far more supportive than anybody I’ve found to date. Because they were there to talk when you needed it. And they were able to give direction, and they have healing modalities. (S-13)

I'm lucky, I do have a doctor, and I've had numerous doctors, I guess, over the time. Most of them have been pretty supportive and understanding. The one I have right now, she's young and she's very much keen on supporting [violence against women organizations] and all that stuff. I think she's behind women who are being abused to try and do what she can. And she's very knowledgeable, so that’s a good thing. (S-4)

And the Brain Injury Association, I managed to find them through my family doctor, and they put me back together. Literally, they put me back together. They

sent out an outreach worker, who worked with me for almost two years and arranged for my physio, like, to speak with my physiotherapist and occupational therapist ... they arranged that and did testing for that and arranged for the neurological testing at the hospital. And they literally saved me, because I was lost, I really was lost. (S-5)

The last conversation here looks to existing employment support programs to see what is working locally and can be expanded upon.

Existing Employment Support Programs Community-based employment support programs exist widely, many of which are subsidized by public funds. However, few of these have specialized supports for (dis)ability or IPV-related challenges, let alone someone with both. Some organizations assisting survivors of either IPV *or* BI include some form of employment support but for most, services are not IPV-BI specific and are very limited. Many of the stakeholders here spoke about the benefits of employment supports programs put forward either in their own organizations or community-based agencies. This conversation highlights successes that can be learned from: in-house programming addressing practical needs, psychological challenges, safety, and organizational culture; efforts to de-stigmatize IPV-BI through communication and training; expanded access to services via (dis)ability assistance programs; and the use of existing community-based employment supports. While very few of the supports being offered are tailored to IPV-BI specifically, learning what is working for either group individually can be highly valuable.

Various types of in-house programming were discussed by stakeholders, but the most common ones addressed practical considerations. One stakeholder noted the importance of job-readiness when attempting to return to work post BI:

I think return-to-work is often perceived as a singular process. You wake up one day, you think you're going to go back to work, and you implement it. And based on my practice, a lot of work happens [first]: the planning, the preparation, the readiness to work is far more critical than the return-to-work component. And I think when you're trying to facilitate re-entry in any gainful employment or volunteer situation, you really have to think about readiness. You really have to think about how you've prepared all stakeholders, not just the person who survived, but where they're going to go, their family, their providers, as to what is expected. (FL-15)

Another discussed the need to help with basic tasks, such as filling in forms:

It's still about strength and fit, I think, more than anything, and coaching them through that whole application/interview process. And some of them, it's just the paperwork, even. ... Filling out forms and paperwork universally is tough for our clients. Sometimes just completing a resume and sending in the application and reviewing interview questions is a month's worth of work. And sometimes that position doesn't ever require you to fill out a form, but the application process for them to get the job that they may never have to do paperwork in again, is a challenge. (ED-10)

Stakeholders described supports offered within their organizations that seek to support clients in aspects of job seeking:

Then we move into a job search aspect of it and it's all trauma-informed. We do work with people around resumes, but we also talk about resumes in a way to help them really understand. Because resumes are one of the things that can be very

disturbing to people. They may feel like they have done nothing in their lives and so they have nothing to put on a resume. (FL-19)

The counsellors hold the case management piece for our clients, and so, part of the case management is us assessing where they are in terms of employment and what they want to do. Then if we can't [support] that, we get them connected with an organization that can. We've recently hired for an Equity and Access position and her role is to support women in what they want [for themselves]. She hosts drop-in resume and application support. It's very informal at this point, but we do have some employment support. (FL-9)

The support tends to be at the beginning, more coaching and mentorship around getting the position, let's find what the right positions are. Talk about your skills. Let's look at what kind of positions are best for the skills and strengths that you have and recognize where some of your challenges and limitations are to avoid. ... And again, this is an individual who is identifying with having a brain injury and maybe at a different spot in their acceptance of their brain injury, ... that can be a real challenge. Often that's where counselling or mentorship and support is coming from: how do we identify what that is and match you with the right position. And then it's kind of coaching them through that whole interview process and it's kind of scripting and how do you perform in an interview? And what do you wear? And those types of things. Often that's a relearning for people. Or they haven't had to do a resume or go to a job interview in decades. (ED-10)

Stakeholders also discussed the need for these supports to be available to survivors on a long-term basis:

One of the things that we've fought for is the length of our program. ... If we had a shorter program, then people would maybe meet their outcomes sooner. That was an initial thought and [then we thought] 'no, no, no'. Because six months, on some levels, may sound like a very long time, but healing journeys take time. ... There has to be longer programs for women to really do work on their healing journey. And we cover a lot in six months. [We need] longer programs for really understanding how trauma works. One of the things that we tell clients all the time is, 'you know, the fastest way is slow'. (FL-19)

I think the critical piece that I find most practitioners miss is the preparation part, where everyone's on the same page, where you've communicated with everyone what the expectations are, where you've communicated what the timelines are, where you've got the medical clearances. And then, you initiate a return-to-work process. So, by the time you initiate a return-to-work process, people are sick and tired of hearing about return to work and they really don't want to start return to work. Literally, some stakeholders. And that tells you that everyone's ready. We're ready to go. (FL-15)

Once they've landed their position, there's still a little bit of coaching required. I think if there was an opportunity for us to stay connected with clients really long-term [that would help]. We do linger – our organization lingers. We'll hang around

and they know where to find us. And if somebody was stuck, they'll come back.

We'll bring them in and talk about it. (ED-10)

Equally important to addressing practical needs is supporting survivors on a psycho-social level. One stakeholder highlighted the importance:

It's very informal, it's very intuitive, it's saying, are they still motivated? Are they still interested in doing these things? And then, I often – every two or three sessions will bring up return-to-work again to make sure they are where we started off, and they haven't changed their mind, because now they feel overwhelmed because they're working three hours a day and they feel tired and they take a nap before dinner. (FL-15)

Other stakeholders discussed different approaches they take in supporting survivors with these challenges:

The champions are those that, we were the trainers and then in each region, each site we would train some champions. So, you know, we're training other people, for the keyword initiative, you know, we're the resources. ... Let's say, there's a situation on a site, we would be the ones if HR needs to reach out. Because ... when you hear about something happening, everybody gets really nervous and forgets everything. So, we would be the resource people to help direct ... where to find the right resources and supporting basically ... when there's a need. (FG2-E-1)

A lot of our strategies around [anxiety] are scripting, talking about scripting, role playing – maybe not active role-playing, but talking out a scenario and in your head you're like, "Well what would you do if somebody said that to you?" And then,

“What words would you use? How would you talk about that? Or, what if somebody says something you didn’t like? What might you say? Or what might you be able to do to manage that situation?” A lot of it is just scripting. It seems to be a really good strategy for a lot of the clients. Being put on the spot is a real scary thing, I think for a lot of them. They’re just not sure how they’re going to react, or how their body is going to react and that’s scary. And so, a lot of it is just trying to mitigate feeling put on the spot. (ED-10)

When we do career exploration, one of the things that we do is ask them to do a presentation on a career. Presentations are ... triggering. It’s such a hard thing to do. They’ll go to their counsellor and say, ‘I don’t think I can do this’. The counsellor really works on settling and that kind of thing, and we do that within the group as well. (FL-19)

Some stakeholders identified workplace disability benefit programs as a potential pathway to extra supports for survivors:

Well, [IPV-BI] would most certainly be supported through our disability program ... We have a short-term disability program of up to one year, depending on where you are in the organisation, depending on what collective agreement you’re under. ... We [also] have long-term disability, so if it’s determined as a disability, you would be supported. (FG2-E-1)

So within, the industry as a whole, if you have a brain injury, if you have an injury of any sort there’s always that workers comp [option of going] slowly back into

work. It's like a change in duties, task rotation to something that's more within the scope of work that the employee is able to manage or handle. (E-17)

Stakeholders also noted the need for survivors to feel safe in their workplace, physically and psychologically:

We're trying to make more respectful workplace policies so that there are those routes for people to look for support. Right now the support is basically these women's committees which we have opened up to be accessible to anyone that's kind of an ally. [That's] how we put it, but anyone that feels there is a need for a more inclusive culture and to start pointing out the flaws in some behaviors that have been acceptable. (E-17)

Screening phone calls. If she is to take any kind of phone call, they have to be very aware of who the caller is. And if there's any question at all that [the caller] is not an identified customer or someone that she has [previously approved], then they ask her first. (FL-14)

Where things tend to go from an employer perspective, is the safety of the worker and the safety of fellow workers. So, if there was an individual whose spouse presented an immediate threat to them, we would do everything we can to ensure their safety in the office, and limit the impact that it would have on others. [That would include considering] is there a risk that that individual would enter the front doors, and what safeguards are in place to protect that individual, but also that person's co-workers. A lot of companies have key-card passes, which means if you

don't have a card, you can't get past the front entryway. ... We also have visitor logs, you can track who's coming in and out. And you have to provide a piece of identification, so you can't be lying about who you are either. ... Most of the companies that I've worked for have not only security footage once you've entered the building, or right in front of the entrance, but also throughout the parking lot.

(E-18)

Interestingly, one stakeholder identified additional challenges that can be caused by these safety measures:

There are pictures of her abuser by certain entries to the building so that if anybody sees this person trying to enter the building, they're immediately to call 911 just to notify and to contact her. She said that is a big trigger for her just to see pictures of him, but she appreciates too that that's the reality because there are other people in the building who don't know what he looks like. So for her safety, that needs to happen. (FL-14)

Some organizations are making a concerted effort to reduce stigma within the workplace through communication and training. Stakeholders highlighted the process of in-house communication, including successes and challenges. One stakeholder noted the importance of communication by saying, "So, the [policy] is really interesting, and I think what was really important was to communicate to everyone in the business what was going on." (FG2-E-2)

Another commented on the organization's approach of raising awareness around new accommodations negotiated for survivors of IPV:

It was a huge negotiation, so we advertised it to all the members. And it was in the news and it's on our website. Then it was negotiated with the employer so the

employer sent emails as well to the employee to let them know this is happening and where you could access it. And we got a different time code in our time mechanism to access it, and it talks about it – where [to find it] in the agreement.

(E-16)

One stakeholder commented on the challenges of approaching difficult conversations within the workplace:

We have to recognise that it's not easy to have these conversations for an employer, a leader, or as colleague ... So, there's an openness, but there's also the fact that, wow, this is not something we're used to dealing with in our day-to-day life, and when it happens, it's stunning. (FG2-E-1)

Other stakeholders described the importance and value of training in their efforts to reduce stigma and create more compassionate workplace cultures:

We try to reach every employee, but we do the big training with all the leaders. For the unionised employees, we give maybe 30 minutes training, online because we have so many employees. So we did it too, but it was a different format. I think it's always a good thing to try to reach the larger group. It's like when we talk about suicide or something like that, the more you talk about it, the more you 'sensibilize'⁴ people, the more chance you have to reach different people. ... It was really an engagement from the top, and that's why the impact really [worked]: everybody had to do it. Maybe sometimes people were questioning some things, but at the end

⁴ The stakeholder meant 'sensitize' but I have left their original comment here as I think, while unintended, it is actually a clever combining of sensitize and sensible and it suggests that what is needed is for people to display more of each quality in the workplace.

everybody thought it was a good thing and was saying, the business should do more of these kinds of things. (FG2-E-2)

When you get into this industry you realize that there's not as much meat to the bones of the words that are being said or the promises that are being made [about supporting women employees]. So now we're trying to give [management] reasons why they should actually follow through [on their promises]. That's the education and information services we're trying to find right now. To show [management] this is what hiring women and supporting women [looks like] ... or even just changing your culture for the next generation coming that's not going to put up with this bullshit ... this kind of culture. To bring [that information] forward to the business managers that we have access to and have that as a course so that they can actually buy into it and not just say that they're doing it because it's a promise that's made for the public. (E-17)

Pre-COVID, we had an employment coordinator, somebody who [asked] 'What clients out there are looking for work and what fields are you looking in?' This person was acting like a liaison [and considered] 'how do we go out and educate employers about the strengths that our [IPV-BI] clients can bring and maybe accommodations that would make their employment successful, so they can give their best?' And also allow [employers] to ask some questions and maybe request some training or request some further information? So, that was very valuable. (ED-10)

Not all organizations are able to offer services targeting employment challenges faced by women survivors. Many stakeholders identified locally available community-based support options and discussed their value:

We have a program that is our main not for profit employment program here. We often refer there and they do second career-type things and they have, resume building and those standard pieces. ... There's another place ... if somebody ... needs more life skills, that talks more about trauma and the impact of that, a little more of a group-like session. They do a 12-week group. We might refer to them. So, they're technically an unemployment program, but it comes at it from a much different place than [the first option], which is more the standard 'do your resume, cover letter, and start applying to jobs'. The [second option] does talk about trauma and uses more of a peer support model. (ED-3)

There's an organisation ... that offers coaching and support and development specifically for women who've experienced violence ... And then there's another organisation ... that helps women get into the trades, and a paid apprenticeship programme, and helps them move towards quite stable and well-paying employment in the trades which is also great. (FL-9)

We certainly have had some success with some of the local programs that have really focused on helping women get employed. ... They have been really good about servicing women who were, I'll say quite vulnerable, in helping them develop some skills so they can get something above minimum wage and certainly carry

some pride with that. ... And I've heard several examples from clients around very practical support that they get right down to writing the resume, practicing job skills, those kinds of things, interview skills, kind of the employment counsellor. (FL-14)

One stakeholder identified a particularly interesting organization within their community that offers services to women survivors of IPV only:

So, we have a really wonderful agency that does work with women who've experienced violence and helps them with employment and at the same time is also helping them with some trauma work. And that is one of the most powerful programs because it does really recognize that we can't just expect women to be prepared to go out and get jobs without a lot of support. And there are so many factors and variables that go into getting a woman to that place. (ED-8)

The organization referred to here also participated as a stakeholder in this study and are relied on here more usual in order to share 'what is working' in the community so others can learn from their success. When asked about their programming, this stakeholder explained:

If we think about the idea of violence against women and, you know, first, second, and third stage, we offer third stage services. So women are in relatively stable environments. ... They're not recently out of an abusive relationship, that kind of thing. Because if they're unstable, they can't really do what they need to do to go through the program. The program is six months long. It has several phases in it. It's really kind of understanding about how trauma has affected a person, recognizing the impacts of trauma on a person's whole life. We do psycho-educational parts at the beginning covering topics like boundaries, assertiveness,

anxiety, grief and loss, those kind of things. And then as you move along in the program, we have a career exploration part where we begin asking questions like, well actually ‘who are you’, and ‘what might be some of your strengths’, and those kind of questions, so really looking at career from the inside-out perspective. And I love asking that question and I love hearing it too, that question about ‘who am I’, it’s a question that accompanies us our entire lives. And it is the place to start when we think about career. We explore what ideas they have and new possibilities of career. (FL-19)

They noted the importance of supporting survivors using a holistic approach:

People are going through the group in a peer environment. Lots of validation around their normal reaction to an abnormal situation. And we also offer them counselling. When the clients work with staff, half are facilitators and half are counsellors. So, they work one-on-one with counsellors. And as things arise [with their counsellors], it also offers an opportunity [to support job-seeking]. (FL-19)

This stakeholder was not aware of the intersection of IPV-BI before participating, but quickly thought about the implications of BI and how that might well be relevant in their work:

Our counsellors may be noticing something and then they say, well you know, maybe you need to get some further help. So, a big one is about learning and that could totally be related to brain injury. Part of our program too is we connect them to our local college to do upgrading. And that can be a triggering thing because they don’t think they can learn, or they’ve been told a lot of stuff ... about their [capacity to] learn. (FL-19)

Lastly, they spoke about the importance of funding stability and what that could mean for their clients' overall success:

When we were part of [provincially funded programming], they actually had something very cool where you could get some psycho-educational assessments, so people could actually really look at their learning abilities and be able to work with that. We could actually get those assessments done and then ... make a plan for when they did go to school, how to work with their abilities. (FL-19)

While there are lessons to be learned from these examples and strengths that can be carried forward, there were many specific suggestions for improvement provided by stakeholders. The next theme reports these recommendations, grouped into two subthemes: (1) what can service providers do; and (2) what can employers do.

3. Theme: How Do We Do Better?

Stakeholders provided many suggestions for possible improvements to services and support programs. These suggestions have been grouped into two subthemes: (1) those from a micro perspective, focused on what service providers can do; and (2) those from a mezzo perspective, highlighting what can employers do. The first subtheme provides discussions around empowerment, various types of service models, training suggestions, and how supportive employment programs could be beneficial. The second subtheme considers accommodations, how to take a proactive approach, potential in-house supports, ways to engage with the community at large, and suggestions for training and education.

3.1 Subtheme: What Can Service Providers Do?

Many stakeholders discussed the importance of empowering survivors, noting women should be given the knowledge and support required to allow them agency and self-determination. A variety of ways to achieve this goal were put forward, starting with knowledge of the intersection of IPV-BI itself. One stakeholder noted the importance of self-knowledge for survivors to allow them to recognize that they are not to blame:

It's so important for people to have the opportunity for someone to tell them, 'hey, this might be what's going on for you, so maybe you can feel less "crazy", you know; there's an explanation for what you're feeling. There's an explanation for why you're here. You didn't do anything wrong.' I think people need to hear that, because otherwise there's so much self-blame and confusion. And then you don't know how to help yourself, because you don't know what's going on. (FL-7)

Another highlighted the value of understanding what might be interfering with their cognitive function, allowing them to reframe their sense of self as injured rather than deficient:

I think when I typically ask them 'Just tell me about your concentration,' or 'When you try to organize something, what happens or when you listen to something, can you remember it? Or When you try to read the instructions on that, can you remember them or implement them?', and that sort of thing. They're often kind of pleasantly surprised, like, 'Oh I hadn't thought of it [their challenges] that way.'

(FL-14)

Some stakeholders recognized the need for knowledge to allow survivors to have more agency in their own lives and make informed decisions about their futures. One survivor noted, "You have to be empowered, you have to be knowledgeable, you don't know what you don't know. So, it's

very difficult to, sort of, instruct or direct these things.” (S-1) Another survivor also acknowledged the need for knowledge to empower others by saying, “There needs to be an accessible resource base that survivors can access. That has advocates that have knowledge of where the resources are that the survivor can go to.” (S-13) Frontline workers who were able to provide IPV-BI specific services noted their value:

It’s really helpful to have my clients plugged in with the brain injury professionals and learning. And even the clients will tell us what’s going on, and what we need to know. But now there’s also some base for us to link with the brain injury worker and have group conversations that are very helpful. (FL-FG1-1)

Some stakeholders discussed this topic as it related directly to employment:

My brain immediately went to not focusing on the employer and focusing more on the woman, to know what to ask for and when, to know what her rights are as an employee. To know about human rights around disability and access. That’s where my mind went to. (FL-7)

One thing that would be valuable is if there was something there to help employers and people working with women who have experienced brain injury to hear some of the success stories that have happened when you get employers partnering with not-for-profit service providers. There's been some really great partnerships that our brain injury services have had with local employers. Telling that story and talking about how that happens and what the benefits are on both ends could be really powerful. (ED-8)

Some of the same qualities that make a person a survivor are qualities that an employer would want. Like really sticking through some tough situations. ... If you think about all the single parents and what they've modelled for their children. Even by leaving a tough situation, they're modelling something really strong. I think, if we can sort of think about ... the resiliency, the strengths that women have demonstrated through their survival, [these] are things that would really make them the best employees. (ED-19)

Building on this need for knowledge and support, stakeholders spoke of the need for women to develop a positive sense of self-identity and see themselves as capable and deserving of more:

Empowering women about what to take and what not to take, when to draw the line, ... and when to speak up. Teaching people that they matter, that they care, but, at the same time, having rights to support them while they're going through this so they don't add more and more complexity by losing income on top of all of this. What's important is having a system that supports them, not just resources. ... You've got to empower people to take action. (E-16)

It is very exciting when they start looking at education and getting jobs that pay more than minimum wage. Often, some of the women that I've worked with have six and seven children. You cannot, on minimum wage, there's no way you can support your family through that. So, really looking at themselves as: a) what they can offer, and they have lots to offer, and b) that you know, they deserve to have a well-paying job. (ED-19)

I don't think the people I work with are asked enough questions about themselves as they move through these institutions. It's more: 'here's a thing, take it'. I would love to see more of, 'What do you like, have you ever had a big dream? What is that dream? What are you good at? I know that it's commonplace for us to set you up with [welfare support] and housing, but what do you want?'' (FL-7)

Stakeholders discussed the importance of individualized services to support survivors in this task by saying, "I think for each individual woman that you have to, kind of, figure out what is the most helpful for her and, in her own self perception, what's going on." (ED-8), while also recognizing that it is important not to do it for them, but to assist them in doing it for themselves:

That's what women need to see: to be able to see a way forward and to have assistance to get them on that path. We don't expect you to hand-hold us all the way, but just at least point us on the pathway we need to go, and give us a little nudge; that's it. (S-5)

One stakeholder highlighted the importance of helping survivors see themselves in a positive light, even in the face of unwanted change:

If you have to find a different job, as long as you have pride in it and it's something that you enjoy doing, then it's OK to say goodbye, cherish, and celebrate what you were able to do. And look at it in the sense of having a new chapter. Getting a second chance to maybe try something else that you otherwise wouldn't have been able to try. And just trying to have a positive spin on what could otherwise be a really upsetting and you know heart-breaking scenario to have to go through. (FL-FG1-3)

The last piece of the conversation around empowering survivors focused on using a strengths-based approach to support. One stakeholder noted the importance of this approach while recognizing the difficulty in accomplishing it: “How do we help ensure that all members of our community have access to employment and are supported in that? We all have strengths and weaknesses. How do we continue to promote the strengths?” (ED-10) Others presented ways to shift the image of a survivor from someone who is damaged or in trouble to someone who has much to offer:

It’s really important for us to show, you know, their resilience, the skills, the strengths that they have tapped into throughout the whole process. ... they need to know that they have a lot to offer and ... there are so many ways that they can contribute to the world. It’s a lot around belief, I think ... shifting the belief systems. (ED-19)

I think it would have to be attractive to employers, why they would want to make the changes and do the work. I can say a lot of the women that I've worked with are incredibly hard workers, that have lot of experience, and a lot are looking for long-term stable employment. ... If they’re given that [flexibility], then many of them say “I would stay here for a very long time,” but not if they’re being mistreated. (FL-9)

We do have programs in place for people to voluntarily participate and [gain] employment skills. But the way that I see it, [it’s about] being able to show appreciation for their time and realize that what they’re doing is important and

being able to provide some kind of compensation so that it also encourages them to keep going and shows that we value their time. (FL-FG1-3)

Many stakeholders discussed service techniques and models, noting ways to improve overall delivery. Some raised the issue of the need for services to be available over the long-term, highlighting the need for an “accessible system that is going to be there all along, not just in the very beginning, and drop them after. Because this is an incident that’s going to take time and may come back in a year or two.” (E-16) One stakeholder described this as a “recalibration phase”:

I think just kind of normalizing this idea of ... reframing the whole conversation around women and employment when there's brain injury and intimate partner violence, that there is going to be this recalibration phase. That's the narrative we need to get more comfortable with and we need to start expecting and planning for and not going into like ‘we’ve got to get everybody jobs, and we’ve got to do all these partnerships, and oh my god no, where are we at in the stages, where is she at?’ And then what's the appropriate response at that point? ... I think those things take time to put together. (ED-8)

Some stakeholders noted that rehabilitation from an injury takes time:

How do we make sure that these services can be long-term? Rehabilitation is a long journey. Some tasks and some goals can be achieved quicker than others and there’s going to be some challenges that are long-term – lifelong even. And so just having somebody to walk alongside you to do some of those things that may be simple for so many people, are game changers for some of our clients. We just can’t put a timeline on recovery. (ED-10)

It all depends on what they've had before the readiness. How long have they had rehab for? What is their functional status at the time? Are they mentally prepared to go back to work? Do they have the insight to understand their limitations? Are they motivated enough to go back to work or are they very comfortable where they are? And then, in terms of physical and mental capacity, cognitive capacity, have they reached maximum medical recovery to be able to re-initiate that readiness? ...

Their readiness can take anywhere from six months to two years. (FL-15)

Not only was the length of time for rehabilitation and recalibration noted, the timing of what was offered when was also discussed:

It's not just about getting that person back to work for three to six months, it's also being able to say, 'OK, we'll follow-up in six months. Or, if there's a problem, you follow-up with us.' And I think that's not only reassuring for the person who's gone back to work, but also for the employer. (FL-15)

It's hard to try and serve women in the Transition House in 30 days. That time is really intense for women. They're just getting connected to services. They're very fresh from leaving a traumatic situation. Even though the workers were calling saying, "I'm recognizing this person is presenting with some BI. I'm wondering if we could have that conversation." And I would go into the house. I met a few women. But none of the services stuck for the women that I met in the Transition House. It was all in the second stage, where they're there for maybe three years or something like that. ... So how do we make aware, provide some insight and

strategy, but then respect the fact that everybody will come around in due time and that time is different for everybody? And where will they be when that happens?

(ED-10)

A key consideration of these discussions is the need for individualized, client-centred care. Many stakeholders commented on the importance of taking a flexible approach to supporting survivors. One stakeholder highlighted this key point by saying, “I think the thing that’s really important is that you have to be where women are at and take their direction first rather than assuming that you know what’s best. That’s been proven to me over and over again.” (ED-12). Another commented on the need for flexibility, saying, “So, it’s just being kind of fluid about that for sure. That client-centered approach of being individualists is so important.” (ED-10) Another noted the complexity and the need to support women through the process “We can’t just expect women to be prepared to go out and get jobs without a lot of support. And there’s so many factors and variables that go into getting a woman to that place.” (ED-8) The following conversations consider some of these factors and variables. Some stakeholders considered this aspect from a rehabilitation perspective:

Functional recovery is dependent on where they’re headed. So, functional recovery for someone who is an accountant is very different than a functional recovery for someone ... who’s going to go into physical labour and sit on a machine all day and end up with low back pain at the end of the day. (FL-15)

So, that can be doing a big whiteboard schedule or setting up an app on your phone that reminds you when to take your medication. One of our women has a sight deficit, and so, it was like ‘Oh, we have to reorganize your kitchen and put

everything on the left side, because you actually have visual neglect, and you're not going to see things as much on the right side of the kitchen'. So, setting up their space and working with them. (ED-8)

One stakeholder put this concept into the context of returning to work:

I try to have a couple of things that somebody might enjoy. If somebody was a cook at one point but they can't quite handle the stress of being in a restaurant, ... but they still had this drive to cook, find a different way of including cooking. Whether that means that maybe it just starts by having weekly dinners at their house to buildup confidence so they can do this at a different level. (FG1-FL-3)

Another spoke of the importance of re-affirming a survivor's strengths and skills, underlining their capacity, while supporting their return to work:

We always say things like: 'You know, you have been learning here. You actually have the skills to deal with this, you know. And you have the tools and all this. We've been talking about the theory, now you get to practice it. And you get to practice it in a safe environment.' That happens when we talk about resumes then, because it, sort of, brings up so much, and we say, 'Actually you have the skills to deal with it.', and you know, just really affirming. (FL-19)

The timing of offering support also surfaced during these conversations with stakeholders, who noted the need for timely intervention: "If you need somebody, you need somebody then. And with some people, if you don't get them in then, the impetus is gone. If you have to wait six weeks, they say 'Ah, everything's fine, I don't need to go.'" (S-4) Stakeholders also noted the need for frequent check-ins:

You don't wait for six months to evaluate progress; you do it as you're going along, saying, 'Okay, this is our goal, have you achieved it? It hasn't worked this week, why not? Let's talk about strategies.' Next week, 'Have you met the goal? No, you haven't met the goal, why not? Let's talk about strategies. What am I missing? Is the goal too big? Do we need to modify our [approach]?' ... I'll often use an example with patients: 'You never eat the whole cake at once. You break it down into slices. So, we're going to take the smallest slice possible and make sure we can eat it at the end of the day.' (FL-15)

One stakeholder summarized this conversation with a clear statement to position survivors at the centre of their own care:

I think it's really important to listen to what women are saying. Women have every right to ask for whatever they want ... are we not trying to model women to be independent and to actually ask for more than what they've ever been given? And yet, when they do it to us, we don't want to respond to that, we want them to be in a certain place. (ED-12)

Stakeholders also discussed the need for a holistic model of care, highlighting the complexity and interconnectedness of the challenges that survivors face. Stakeholders noted the importance of assessing the needs of a survivor and being prepared to support in a variety of ways:

[We need] somebody to do an initial intake, identify medical, emotional, psychological, employment, education, all of the different areas of a woman's life that are falling apart that she needs help to redirect her life and make healthy

changes and healthy choices. And that includes counselling, you know medical and even lawyers. (S-13)

I guess one of the things that I find challenging is really unpacking that and knowing when something's happening, where a woman is struggling. Where do we start to try to address this or get things back on track? Do we need to call the psychiatrist, do we need to call the neurologist? Do we need to call the counsellor? Do we need to just come in here with some practical supports and go 'Yeah, we'll clean your bathroom and we can make you some lasagnes.'? It can be all of those things. I think for each individual woman you have to, kind of, figure out what is the most helpful for her. (ED-8)

Stakeholders commented on the value of a 'one stop' approach, i.e., having multiple services combined in one location:

So, you'd have to have certain rehab vocational centres within hospitals or rehab centres that will facilitate those [RTW] programs, but be funded through a full-time occupational therapist, a full-time case worker, a full-time kinesiologist, that'll facilitate some of those components. I don't see it happening any other way. ... I know that there are certain supported employment shelter programs in each [US] state, and sometimes multiple centres within each state, that are funded by the government. They're publicly funded centres, they have a full staff, anyone can walk into it saying they got injured, they need to go back to work, and there is a rehab component to it, there's a supported employment component to it, and there's a follow-up component to it. (FL-15)

So a central agency does the initial intake and identifies areas of assistance for a person—I shouldn't keep saying woman, but for a person. And is willing to actually—and has enough staff and enough funding for staff. Because that's a real huge issue. (S-13)

It's hard enough when you have a brain injury, to try and find one right person to help you, when you are constantly looking for other [things]. It would be so nice to have it all linked. And that was what the Brain Injury Association did for me, was, it was all linked, and then I also had the CCAC, because I was so physically injured, they would have a case conference and it would be all the doctors and everybody there, and the Brain Injury Association was there. It was great because I felt like I had some control over what was happening. (S-5)

One survivor likened this concept to that of 'wrap-around' care with interdisciplinary teams, noting, "Talking tables or wrap-around circles or you know. It's basically like care teams, we all come together, we all communicate, we all share." (S-1) Another highlighted the need for a knowledgeable referral system for this model to be effective: "And then make the referrals, because that's the biggest thing, is getting the referrals to people that can help them." (S-5)

The value of an effective referral system was carried forward into discussions centering on the need for a key 'navigator', often a peer, who could support survivors trying to move through the various systems they encounter as a survivor of IPV-BI. Stakeholders discussed the role of a navigator:

Somebody to move people through the process in a healthy way. You know, when you feel lost, and you can't function. Handing somebody a pile of phone numbers or some resources and saying, 'Here, go sit on the computer and find it and figure it out,' isn't helping anybody, because you sit in that comatose state, and you just don't move from there. There needs to be somebody or some agency who have the resources in place and they can just help you manoeuvre through it to figure out what you need. That they can actually have somebody who is an advocate for that woman, who can hold their hand through the process, and make the phone calls and the connections for that woman until she's ready to stand up and able to do it on their own. Because sometimes you need that hand hold. (S-13)

Some stakeholders saw this as a formalized role:

Without [case management], I don't think you can do a successful return-to-work. ... I think effective communication, for me, is timely, and effective communication to all stakeholders is such a key, and it's so difficult to do it if you're working in silos. There needs to be one person that needs to understand the process. (FL-15)

Others conceptualized it as a peer and/or volunteer role:

I would argue we need brain injury-informed practice where women are receiving education, support, skill development, mentorship; these are all, kind of, key parts of this program. They're experiencing that from other women, not just some white man that's telling you what to do, but women who are survivors that have gone through it. There's a huge peer component to it. (ED-8)

One person, like a volunteer care support person, who's basically assigned to you, and they go with you, and they follow, and they are just there for you. They are just there to be your navigator, advocate, whatever you call that. How amazing would it be if everybody had like one of those for everything, for all their stuff. (S-1)

One of the characteristics that is repeatedly mentioned when discussing these navigators is the need for them to be knowledgeable about systems and existing supports, like a guide through an unknown landscape. Stakeholders noted that cross-disciplinary training and a team approach offered opportunities for support:

Having the skills to be able to go through that process with somebody, which would involve a pretty diverse team. Making sure that you have the frontline workers because we're the ones who are with them every single day. And having some very specialized counsellors, and all of that kind of stuff, to help them navigate that. (FG1-FL-3)

I think lots of education, but over and over again, and it has to come from management, to be honest. ... If there can be this really deep dive into learning about brain injury, weaving it through how we work all throughout the staff, all throughout the shelter, I think that can be helpful. It's also a very tall order. (FL-7)

Some stakeholders discussed the lack of existing knowledge of IPV-BI and the importance of addressing that, particularly as it shapes how survivors are identified:

I'm kind of surprised that no one is doing any kind of cognitive assessment, executive functioning. That is just not part and parcel of how we understand what's

happening for the client. I think it does have to do with agency intake and screening procedures, training, and broader sensitivity to the subject. ... I'd say, it really needs to come right down to basic training, you know, medical training, nursing training, psychology training, where these kinds of screening questions need to be asked. And it's not just the 'Have you ever had a concussion?', it really needs to be 'Did you ever have a hit to the head?' (FL-14)

That's it, yeah, to make sure that they [family doctors] are aware of them as well, because they can make referrals. I think it almost needs to be an advertising blitz with the GPs, because they're the key to getting assistance, they're the first person that sees you, other than the neurologist or whatever. (S-5)

Others focused on the value of investing in the community and sharing their specialized knowledge with key groups:

I think it kind of goes back to the knowledge that the community has. Because we have a lot of clients that can present ...[with] lots of expression or none, or talk really loud, or sometimes slur their words. And it's not because they're impaired. It's not because they have been using, it's because that's part of their brain injury and how they present, and there's very low risk. But it's hard to make sure that [employers] know that in advance and are prepared to welcome somebody. (ED-10)

That sort of training would be incredibly beneficial just internally. I have a client who has epilepsy, and there are processing issues that I believe exist sometimes.

And so, in terms of the ways that staff communicate with her, I think a deeper understanding and training for staff on how to support clients who might need additional assistance in communication due to acquired brain injuries [is needed]. (FL-9)

Building on the conversations around the value of training, knowledge, and cross-pollination, stakeholders highlighted the importance of supportive employment programs and discussed some suggestions for practice improvement. One stakeholder noted the value, saying, “It would be nice to have that long-term connection with people and their employment. Like they do in supportive housing. To have almost like a supportive employment.” (ED-10). Another commented on the need to support women in their existing employment: “I feel like we could do more in terms of having more support for women who are leaving and want to keep their job.” (ED-8). This sentiment was repeated by others:

[Supporting survivors] isn’t just about programs [that support physical] healing. There’s ... something vital that they can give, they offer our whole society. And so, the idea of having a [practical focus in an] employment program actually makes a lot of sense to me. (ED-19)

I do wish that there were ... better ways of assessing what [survivor’s existing skills] are, or where they want to go, and really supporting people in obtaining stable employment that is better paying and utilizes the interests and skills of the people they are serving. (FL-9)

Stakeholders also discussed what those programs might look like and ways to offer specialized supports:

I think the important component is to provide that support at work, that the return-to-work should include a supportive component, that the training needs to happen at the workplace. The literature, since the 80s, has said that over and over again. It just hasn't translated into practice. If you try and train someone in what you think is a work task and then you put them at work, the transferability isn't there. Versus you train basic components, but the task training actually happens at the workplace.

I find that results in sustainability of that work for a longer period of time. (FL-15)

One stakeholder identified the value in being proactive when working with a client, and problem solving through a step-by-step approach potential issues that might arise in the workplace:

So how do we submit a complaint? How do you work through that? What does that look like? What are the interpersonal skills that we need to look at for this type of a situation? ... Again, it goes back to that preparation stage. How do we help somebody prepare and go through the scripts and talk about the words and talk about what questions you might be asked, so you feel more prepared going into that? (ED-10)

Once again, stakeholders identified the need for supports that address multiple, interconnected concerns: "So, like I said, the initial life skills coaching, which will help identify resources, education, retraining, and finances to achieve any of those things." (S-13) Some stakeholders saw value in a job coach or shadow role, saying, "Job shadowing, job coaching, that's also offered through the Ontario Disability Support programs, most of them, for the employment support places, so anyway, just wanted to put that out there, because that definitely should go into your report." (S-2). This sentiment was reiterated by others:

I think some form of job shadowing, whether they would check with the employer ‘How did she do today?’ Or they would have a mock run through of what a day could look like before you actually went to work. Because sometimes, if a survivor knows what they’re going into, they’re more comfortable when they actually go into it. (S-11)

Others discussed the importance of monetary support and benefits of financial independence for survivors:

If there were some more programs in place that were more accessible in working with people to develop different kind of employment skills, that weren’t [volunteer] based. Where you go and spend eight hours for a couple of weeks learning how to use a cash register, or how to use a Restaurant Squirrel or getting Food Safe [specific food service training]. So that people who want to go back and try different things, it doesn’t become this [volunteer] thing where they’re just using their time to build these skills, but that their time is acknowledged as important. And being able to pay them to go through these training processes. (FG1-FL-3)

If it were easy for women to have some kind of interim financial support, easier for women to get on income assistance or disability. When women are at the place where their basic needs are taken care of, and they're able to access a program like [that], we just see that is a transformative experience for them. (ED-8)

3.2 Subtheme: What Can Employers Do?

The second subtheme presents the remaining suggestions for improvement, focused on actions that employers could take to support women survivors, including accommodations around scheduling and recruitment, how to take a proactive approach, potential in-house supports, ways to engage with the community at large, and suggestions for training and education. Stakeholders identified the importance of workplace accommodations:

With a little bit of accommodation, flexibility, and support, I think employers could find that they have very long-term dedicated employees. It's just to put in a little extra work at the beginning to accommodate would be helpful. A lot of the women that I support ... have children to support, so they're looking for something very stable. (FL-9)

They discussed the need for flexible work hours, saying, “That would be great if you had the flexibility; if you had the flexibility to work when you can.” (S-13), pointing out that parenting with a brain injury raises added complications:

If they were a little bit more flexible about parental duties and sick kids, because all of a sudden you have a brain injury, and then, you're trying to cope with work and everything else, and then, you have someone who is sick. Either you're sick or your child is sick. So, a little bit more flexibility around vacation and sick time. (S-5)

One stakeholder discussed the need to accommodate survivors seeking to obtain a new position, suggesting the interview process could include accommodations: “I think also asking ‘What is the most comfortable method of communication for the interview?’, or breaking the interview up

into two parts if that's easier. Providing interview questions beforehand so people can prepare.”
(FL-9)

Following from this conversation, stakeholders commented on the benefits of a proactive approach to support survivors of IPV-BI instead of reacting to a problem once it surfaces:

When you catch a problem in the beginning, it's way easier to fix it. When it's complicated, there are so many layers, and it requires time and effort. And if you're already exhausted, it's harder on the person as well, not just on the employer. ... The employer tends to be reactive rather than proactive. Part of the problem is they don't keep an eye on the employee, part is the confidentiality piece, part is that member doesn't talk about it. (E-16)

Stakeholders presented open lines of communication within the organization and policies that clearly outlined procedures as examples of how organizations could become more proactive:

In a workplace, who do you speak to? Do you speak to your supervisor? But do you work alongside your supervisor, and if you disclose that to your supervisor how does your supervisor conduct themselves in terms of communicating with other staff that you work alongside? If employers said 'This is our clear process for disclosing accessibility needs; this is our policy on how your medical or accommodation needs are kept confidential; this is the process if your confidentiality is breached.' [it would be helpful]. I think it's a lot of work on the part of the employer so I don't have high expectations. But I think that would add a lot of safety. (FL-9)

Stakeholders highlighted the need for identifiable individuals to whom survivors could disclose their exposure to IPV-BI safely saying, “So there should be somebody that you can go to, you

know, that they would be the person.” (S-2) noting that transparency around this role (identifying who holds the position, how to contact them, and what to expect after disclosure) is critical:

A lot of companies have annual [reviews and evaluations with their employees] of ‘thou shalt and thou shalt not’, so maybe it’s included in there. Maybe it’s in [the company’s] core value [statement]. I think if you’re going to use a word or a phrase or a site or a person as a contact, it shouldn’t be hard to find, it shouldn’t be hard to know about. (E-18)

One stakeholder discussed the link between accommodation and ease of disclosure, commenting that without an easy way to disclose, asking for accommodations becomes much more difficult:

I do think that it would help a lot if there was ... a sense of safety to disclose to the HR department, if that exists in the company, of what health challenges you might be experiencing and to request accommodations for that. (FL-9)

Another reiterated this need, discussing her own experience of having to disclose to co-workers:

I had to tell fellow employees what was going on, because there was this weird guy in the parking lot, watching everybody. It would be [ideal] if [employers] had a human resources person available, who is schooled in domestic violence. ... [Survivors would] get access to services earlier too, because it takes a long time before you actually start disclosing. To be able to reach out would be [great]; the earlier you could reach out and get assistance [the better], and it wouldn’t be known, necessarily. (S-5)

Stakeholders commented on the need for trust between the employer and the employee:

I think an important thing is to learn to speak about things and trust that if you speak about it no harm that is going to affect you, that the employer won’t think you’re

unreliable or [question if] you can perform your work and put you under more of a microscope rather than support you. (E-16)

What kind of supports are there if there is a miscommunication while someone's working? Or if someone becomes emotionally dysregulated at work, is there support or understanding or flexibility? Or is it just unilaterally 'That's inappropriate behaviour,' or 'You missed a day at work, and now you're fired.'? (FL-9)

Another stakeholder raised the challenge of supporting employees as they become the touch point for staff members to disclose:

What support could we provide managers with if you do suspect something is going on, and who should broach it? Would it change that manager's view of the employee [if they] go right to HR, when the manager is the one that interacts with that person all the time, or sees the absenteeism, or is impacted by it. I think those are all challenging questions that, as an employer, it would be helpful to understand how to best navigate it, besides just handing them an employee assistance brochure and saying, 'Those people are available, should you need anything.' And I think you need to go the full enchilada. I think you need to provide it in Day 1 orientation; I think you need to provide it in your manager training. I think you need to have reminders. (E-18)

The need for supports was discussed in different ways. Some stakeholders focused on suggestions for 'in-house' supports that could be offered through the workplace. One stakeholder presented the value of a safe space to talk at the workplace saying, "Having a place where

women can just talk about it and work it out and just try to keep safe. That's all they can do, because maybe the option of leaving is not an option.” (ED-12) Other stakeholders took this idea further and discussed workplace-based support groups and mentoring programs:

We've got lots of support groups for, you know, employees. You know, a lot of companies have [addictions supports]. Is there a benefit to having a similar group, or something anonymous for people to come together? You know, I'm just sort of thinking, what other possibilities are there where employers could provide better support? (ED-18)

I've heard of some companies having a mentor for the women, because they are aware sometimes those kinds of social things happen. You know, other people get kind of scared and think, 'We don't want to hang out with her, because who knows what's going to happen to our safety.' And she winds up ... alone. ... I've heard of other agencies providing more of a mentor to help people more socially within that context, provide them with some support and sometimes just a listening ear about how to navigate some of those social implications. (FL-14)

Similar to the first subtheme, stakeholders highlighted the need for training and education of appropriate staff in the workplace and the benefit and opportunities for community engagement. Discussions focused on the need to provide information and training widely within an organization, with one stakeholder saying, “If it was only up to me, we would train everybody in the company, not only the leaders to recognize the signs ... and I think it would help.” (FG2-E-1) Another noted the need for employers to take some of the responsibility for this task instead of leaving it up to survivors: “I would say training opportunities for employers, so that the work

can fall on somebody else for once. Instead of it always falling on our clients to have to do.”

(FG1-FL-3) One stakeholder identified the importance of employers having an underlying knowledge base in order to offer appropriate support:

They could have, they should have known a little bit more about [how to support survivors]. I think that just even having a conversation about what's going to make you feel safe, how can we make sure that you still feel that you can be successful in [your employment role]. (S-2)

Other stakeholders spoke about the breadth of professionals within any given organization who would need to become more informed about the unique needs of women survivors of IPV-BI:

I would have the toolkit in the hands of HR professionals. And particularly people who are dealing frontline with the business, so your generalists, your business partners, your admins: people who are generally in contact with the employees in your organization. And then I think managers need to be aware of it, they need to have the toolkit. ... I think if employers were provided with a toolkit, some helpful suggestions, questions, ways to navigate things that would maintain someone's dignity, and offer them support without prying, I think people would feel more comfortable broaching the subject. (E-18)

I think that it's important for [everyone] to have training in what domestic violence or intimate partner violence looks like. It would be hard to have just one person, because you never know who the victim is going to connect with, right? Because it could be a colleague that they're going to disclose to. (S-2)

It was less of ‘How do we train IPV workers in BI?’ and more ‘How do we ensure everybody can recognize and see that this might be a BI issue, or this might be a trauma issue, or we might be looking at something completely different, like addictions, or mental health, or various other things?’ ... It’s more of a marrying of [IPV and BI specialists], as opposed to trying to train one to be the other. (ED-10)

Stakeholders commented on the depth of knowledge that was needed and the commitment required of the organization:

You can’t say we will only train you on what’s in the workplace. Even in the workplace, there are people who have baggage which affects their behaviour. You cannot separate it from each other. You can’t give technical [job task] training only. (E-16)

I think the toolkit is awesome and having the resources to go to and draw from is incredible. I think of how time-stretched frontline workers often are. I believe that employers, organizations like ours, have to commit to making that a priority, and carving out time where staff are paid, and it's during work hours, and perhaps regular trainings. (FL-9)

Some stakeholders identified key learning opportunities to be leveraged when trying to engage employers in taking up this responsibility:

Maybe through existing conferences where the executives go, try to get ... a slot there to talk about what’s new, what’s been suggested. Go through HR conferences to maybe try to have it added to the curriculum. (FG2-E-1)

Employers are very tricky. You don't know which one's going to be more receptive to the idea of the return-to-work, because they don't want an injury happening at their workplace. One. Second, they know what traumatic brain injury is, but they don't understand the implications. 'Why does this person need a separate room? Why do we need to now buy new headsets? Why do we need to look at this? I thought he had recovered, I thought he had rehab.' So, it's really trying to educate them quite a bit, and sometimes, that education isn't well-received from me as an occupational therapist; it's well-received from a GP. And that's why I think the important piece is educating the GP and getting them to correspond, getting them to do my dirty work, for lack of a better word, because it comes across better if it comes from a GP. End of story. (FL-15)

Stakeholders identified other community engagement opportunities to strategically encourage employers to become more IPV-BI sensitive and increase supports for survivors:

I should be very well versed in all employment standard acts and these kinds of things, but I would expect that employers do have a certain requirement to accommodate. And I would think that an acquired brain injury would count in that sense, so just holding employers to those standards. And, [knowing what] recourse we might have supporting a client who is not being treated fairly in their workplace or is not being accommodated appropriately. It's a conversation with employers about how they're upholding their obligations that already are in place, I think. (FL-9)

If there was communication with employers effective enough to help them understand the special needs of people who've experienced intimate partner violence, and the desire for them to do the work, if there was a way to set people up with these employers through technology, so they can work at home. (S-13)

I think what needs to happen, and I'm no expert, is you need to have a network of employers who are willing to recruit IPV survivors. You need to establish who those might be. Do you put an ad out and say we're looking for employers who will retain women survivors of abuse? And they might do it more on emotional grounds, or they might have certain values in their organization that speak to those things. It'd be nice to have a network. (FL-15)

How do we go out and sort of educate these employers about the strengths that our clients can bring and maybe accommodations that would make their employment successful, so they can give their best? And then also allow them to ask some questions and maybe request some training or request some further information? (ED-10)

Many of the suggestions provided by stakeholders are simple and could be implemented with little cost or effort; however, barriers do exist. The last theme to be explored highlights some of those barriers.

4. Theme: Barriers to Success

Stakeholders discussed many different types of barriers to success. These comments have been grouped into four subthemes. The first two are again sorted into micro and mezzo experiences: (1) the ‘It’s Your Problem’ problem on the micro level; and (2) the ‘It’s Not My Problem’ problem on the mezzo level. The remaining two contain broader concerns, underlying the micro and mezzo, and influencing the capacity to improve outcomes: (3) the ‘Best Kept Secret’ problem; and (4) the ‘We Have No Money’ problem. The first subtheme provides discussions around complexity, survivors left on their own, barred access to care and supports, and the lack of a standardized approach. The second subtheme considers motivation to change, and the difficulty of separating what is thought private from the public. The third and fourth subthemes explore challenges around knowledge, awareness, and training, as well as policy and funding.

4.1 Subtheme: The ‘It’s Your Problem’ Problem

The first subtheme to be discussed is the ‘It’s Your Problem’ problem: the challenges experienced by survivors on a micro level. One of the most challenging barriers experienced by all stakeholders in one form or another is the complexity of the intersection itself. One stakeholder noted, “It’s really hard to tease out what’s important or what is the key piece; it’s almost impossible to tease that out because of the complexity,” (FG1-FL-2) while another highlighted how the complexity fundamentally affected their ability to offer support: “I can’t help but get bogged down in how complex it is. It’s so complex, it’s hard to even talk about.” (FG1-FL-1) Other stakeholders also identified this issue, often from different perspectives, but the overall sentiment was the same:

I find in IPV-BI, every time I have a conversation about it, there are ten more things that are like ‘Oh no, we need to look at this, we need to look at that, we need to look at this.’ You know, it's like ‘Oh my gosh, containing it and being okay, what am I actually going to do, what's my piece of this versus another?’, that's been one of our biggest challenges. (ED-8)

Sometimes I have a hard time sourcing where the challenge is coming from. And the only thing I found to counteract that is just to try things. To say, ‘Here are some strategies. I’ve got a toolbox full of strategies that we can try and implement and see if it makes a difference for you. And if it doesn’t, then we’ll try something else.’ ... That’s something I’m continuing to navigate. Because there are so many intersecting pieces. Parenting, trauma, addictions, mental health, BI. There are a lot of pieces there. So, it’s just continuing to try things until something makes it better. (ED-10)

Even getting the residents into their own home. Even though we have special priority, it takes so long to get a home, and it’s burdensome, the paperwork. ‘Do you have this document, do you have that document?’ It’s a lot for somebody to do. (FL-7)

You can’t make those decisions; you have to make them along with the client. And that can be challenging sometimes. Because you don’t want to put your foot down on certain things, but you don’t want to give them that much freedom, because they

don't know what they want sometimes, given their impairments, given lack of insight or given their inability to see what their memory or executive function limitations might be, and that you really want to educate them, as well. I think it's multiple tiers that you really have to consider. (FL-15)

That's a tough one because it is very subjective; it is very personal. ... It's all very, very confusing and convoluted and kind of complicated and subjective, and it really is very personal. ... Well, it is a whole big ball of altogether-ness, isn't it? So, it's hard to pick it apart. (S-1)

I think the medical community at large has to recognize that when you have an injured brain, it affects every aspect of your life. And they need to always remember that the brain is how everybody functions; it keeps you alive or it doesn't. (S-5)

Some stakeholders tied these challenges specifically to the impact on survivors' capacity to obtain and maintain employment:

Employment is going to be super important, and we want to get there. We need to house you first and we need to get you to a place where you are stable and have a good recovery plan. Sometimes we have to back track. And ... recognize that there may be three huge hurdles to overcome before we even get there. (ED-10)

It's not just their impairment, it's also their environment before work. It's 'What circumstances are they in? Are they in a family that's supportive? Are they by themselves with no support systems at all?' Before you even go to the employment

piece. And then, ‘What’s the work environment like? What’s the employer like? What are the job demands like?’ Which is nothing to do with the employer, if you can isolate it, which sometimes you have to in saying, ‘You won’t be able to do this, because you’ve got tinnitus, you’ve got ringing in the ears, and [when] the alarm goes off, it’s going to aggravate your headaches.’ It’s not a realistic return-to-work option. So, a lot of components. That’s why it’s such a moving target, because you really have to come back, problem solve, and say, ‘Okay, what’s the next step?’ (FL-15)

I would say training can’t be this fricking band-aid that’s going to solve it all either. It’s not just about retraining and giving someone a three-hour course and then, like magic. It’s not that simple. I think it’s one piece of a much bigger thing, and it is systemic. (S-1)

Adding to the challenge of the complex nature of the intersection itself is the experience of survivors being left to cope with their circumstances on their own. One survivor identified the impact of this feeling of being alone:

It’s, ‘What do I do? Where do I go? How do I fix what I know the problem is?’ Because you know what the problem is and you’re confused, you finally just give up. It is what it is, it’s what it’s going to be. I can’t fix it anymore. (S-11)

Other stakeholders commented on the reality of IPV-BI intersecting with other marginalizing conditions which then serve to further limit their access to support saying, “There are a lot of folks that are living more on the margins that, for a variety of reasons, have some brain impairment, brain injury that really need that support.” (FL-14). They recognized the

problems that go along with it, noting, “Especially with the marginalized population that tends to be transient. You kind of hand out things [information brochures] to folks, and you think this may not even make it to their next locale.” (ED-3)

Another noted the impact on survivors’ ability to move through the challenges they face under these circumstances:

There are a lot of these things that are helpful, but women don’t know about them, because it's sort of trial and error; what works for some person might not work for another person. I think it depends on how much you want to heal. You do what you have to do, and you try to find resources. But some women aren't proactive like that, or they don’t have the money, so they see the price, and they just drop it right there. (S-4)

Some stakeholders commented on the need for survivors to be their own advocates, often under circumstances that are new to them:

I wish someone had just told me in life, “You’re just going to have to be persistent and follow-up on everything all the time.” It’s a full-time job, it feels like sometimes, to follow-up on things, but that’s just it. So, it’s not taking no for an answer, questioning things, challenging things, asking why. Asking for rationale and trying to gain an understanding, that’s really important for anybody to know or keep in mind. (S-1)

And then, the expectation that women with brain injuries have, at that time, the ability to keep taking on more and more, because you really have to, almost, be an advocate for yourself, or have someone to advocate for you, to get anywhere. (S-5)

Because I worked in Behaviour Therapy for over 15 years, and I have a brain in my head, and I can be tenacious at times, I had the wherewithal to just keep going. To keep looking on the internet and phoning people and digging up what I could to help myself. So, the internet provided a lot more assistance than any human being did for the longest time. I don't know what women who do not have that background do, I don't know how they stay sane or even alive. (S-13)

Other stakeholders discussed the need for financial and physical resources when seeking employment:

If I want a job, what do I need? Do I need retraining, do I need higher education, how do I get the money to do that, where do I get the training? You need somebody who actually understands that and has the resources. (S-13)

They may not have a resume; this might be the first time they've ever even had to work in the last ten years, or whatever. She may not have any, you know, even things like just being— feeling that sense of confidence and safety to go and be interviewed and have the right clothes and know what to do and what to say. (ED-8)

One stakeholder identified the role that families can take in providing these types of resources and the critical function they can play in a successful return to work:

I think families are a very important component of the readiness. Because, if you have support from home [it helps]. Readiness entails a lot of restoration activities that people do before they go back to work. I literally have them do [six to eight]

hours a day while they're still at home to see how much tolerance they can sustain before I put them in the workplace. ... I follow up with them [and] the family every week. Is it really happening? They're good insight into whether things are actually happening the way they're telling me at the end of the week or are there challenges. Family can be an important facilitator, or a barrier [when] you're getting people ready for return-to-work. (FL-15)

However, the reality for these survivors is that family is often either non-existent or unsafe, as commented on by other stakeholders, "I think I was too scared, because I was living out there essentially by myself with just him and so, I had no family support myself," (S-11) and, "It gets more complicated when you're dealing with violence at home, because you can't really recover at home. You don't feel safe at home. There is no escape. It's the harder place to be." (E-16). The lack of family support was not the only aspect of survivors being on their own that was raised. Some stakeholders also noted the ways in which systems of care abandon survivors:

They just didn't listen at all. They do what they're going to. You get a call from the Victim Witness Assistance Program saying, 'Oh, it's all over, it's all over. You know, congratulations, we did great.' And I'm asking, 'What's all over?' Your court case is all over, but it's not all over. There's still a no contact order for at least a year, and I still have to live with this shit, and I still don't know if this guy's beating women or not, even if he did his ten weeks again for the third time or not. (S-1)

I went to all the organizations, I went to the person who coordinates all the organizations that deal with domestic violence, told him my experiences and what

happened to me, who I tried to access and what their responses were to me, and all [the coordinator] did was hang his head. (S-13)

Systems of care and their failure to support survivors of IPV-BI were discussed in a variety of contexts. Relevant here are the ways in which these failures shape the experiences of survivors, ultimately impacting their capacity to maintain or seek employment. One such aspect is the need for a formal diagnosis to gain access to employment-based support services (e.g. income replacement, re-training opportunities, resume and interviewing support), thereby acting as a gatekeeping mechanism. One stakeholder identified access as a critical issue, saying, “The thing that, I think, is probably the most challenging is the burden of medical proof for a [person with a] brain injury to get services.” (ED-8) An employer also highlighted this concern, saying, “So, the employee has to go see their own doctor and after that, we receive at the plant the diagnosis and everything, and we [respond to] the case, and it’s all confidential, of course.” (FG2-E-2) However, while this stakeholder was confident about the confidential nature of the process, others noted the risk to confidentiality embedded in the process, along with other limitations:

They always tell you EAP is available, Employee Assistance Program, but at the same time, you have to declare it on your timesheet: you’re seeing an EAP person. And there are only five sessions available. And if they send you somewhere, it’s a short-term counselling. (E-16)

EAPs have always been a really big component of all the companies that I have worked for. There are some plans in which the number of sessions or hours are limited, in terms of for free and included. So, if that individual couldn’t afford to,

or didn't want their spouse to see that they were engaging in conversations, I guess that could be a barrier, if they hit that limit in working with the provider. Or, of course, if there is anything under a benefits plan where they are obviously incurring the expense, and then having to get reimbursed. If there was concern or sensitivity regarding their spouse, I would imagine that that would be a barrier. (E-18)

Even more concerning is that to access these services, women need to be employed already, and many survivors of IPV-BI are not. Stakeholders discussed the increased barrier to diagnosis for women survivors of IPV-BI and its impact on employability:

So right now, as part of our IPV-BI initiative in the agency that I'm at, we're doing, sort of, coordinated services [where] our IPV and our brain injury programs are working together with 10 women that are accessing our services. They come in through the IPV door, we do the screening and the recognition, and then, we approach 'Do you want some BI support?' and we put it in place. None of those women—actually, I should say one woman, I think, has a diagnosed brain injury, medically diagnosed brain injury, one of the 10. And even she's not eligible for brain injury supports. (ED-8)

It's really hard when you don't have an employment counsellor, and you live in an isolated community, to narrow something down, and look for places that can help. When you find a place that can help, they're saying 'Okay, you have to go for a [neuropsychological assessment]', and the [assessment] is saying 'Well, no, you can't do what you want to do, you have to do something else.' (S-11)

Our largest urban centre has very few services, and the ones I found were completely ineffective. I tried to access services 20 kilometres away and they refused me service. ... I asked for advocacy assistance as well, and they said, 'You'll have to find that in your own area.' (S-13)

Stakeholders identified the role that healthcare providers play in this barrier, acknowledging that the issue is systemic and needs to be addressed on a broader level:

We have to change the way that we medically treat [survivors] and the expectations that we have because right now, if you don't have all the scans and the pictures to prove this is where your brain injury is, then you don't get the support. And I think that's just not realistic for women who have experienced intimate partner violence. (ED-8)

Maybe half of the women have a physician, and even within that half, [fewer have] a physician they can actually talk with. For some of these programs and such, there is a requirement around having some sort of medical documentation verifying that there was a head injury in the first place. ... I think it's great if you do have medical documentation but unfortunately, there are a whole lot of folks who I work with, especially at a shelter context and [IPV] context, that don't have that. (FL-14)

And another piece to the mess is the fact that it's hard to get a doctor. If they have no doctor, they can't get Ontario Disability Support Payments or Canada Pension Disability, because you have to have a doctor fill out a form. So, where do you go with that piece? (S-4)

The neurologist, he never talked to me at all. He kind of tested all of my reflexes and all that kind of stuff, but really never even asked whether or not I was having any symptoms of a brain injury. (S-5)

These observations left a stakeholder wondering where survivors go for support:

Sometimes I think, ‘Where are most of the women where this has happened? Where are they getting services? Is it through a hospital emergency service? Is it through their doctors? Where are they going? Are they going nowhere to acknowledge that something’s happened to them?’ ... I mean, there’s a lot of women who are working who have a brain injury and are fleeing intimate partner violence. Tons of women. Teachers, principals, bank managers, tons and tons of women who are survivors of all this, and they’re just trying to juggle it all and hoping to God everything’s going to work out okay. (ED-12)

While another commented on the challenge of needing money to access resources to improve your health so you can become employable and make money, a system they refer to as being ‘front end loaded’. They question how survivors manage to afford services that fall outside of provincially funded healthcare programs, particularly in light of the fact that they are frequently unemployed or underemployed:

Those kinds of resources, you have to have the money to pay for it, and then the time to take off work, ... it really has to do with, do people have access to the physio, to the OT, to the taxis. This is all very front-end loaded in terms of getting people connected with different services. (FL-14)

Stakeholders recognize that the system is operating beyond its capacity with one survivor saying, “As far as counselling and the sexual assault crisis centre, they're so overloaded, which is hard for anybody that’s coming out of the system.” (S-4) The need for more supports and better access is clearly identified, particularly for survivors of IPV-BI whose circumstances rarely fit the mold:

More brain injury support for women who aren’t diagnosed and don’t necessarily fit the category medically, but have had brain injury because of the partner violence, and getting that piece of support for them from that perspective without having to exactly fit the box. (FG1-FL-2)

In addition to the scarcity of services and the overloaded capacity, stakeholders noted a lack of a standardized approach to identification, diagnosis, and supports, and challenges associated with this lack:

So, that definitely continues to be a common theme. We have experiences with both. We have experiences where sharing [information about having] a BI has left somebody very vulnerable, and they have not received the support they’re looking for. Then, we have others who have shared that they have a brain injury and may require some accommodation and they have been accommodated. And because of sharing that, there’s been a lot more compassion and patience in understanding and training and mentorship. (ED-10)

There needs to be more cohesion between agencies and services. There needs to be a central resource group that a woman is initially directed to. Say by the police, or even self-identifying to them that she needs assistance, that is aware of, and has contact with, all the other groups. (S-13)

We don't have access to police records, and we don't need to know nitty-gritties. We're not going to re-traumatize her by asking her to tell us. We might just get told 'It's intimate partner violence, he's been arrested and is awaiting a bail hearing.' So, if we can't visibly see any injuries, we're not always asking. We're not screening specifically, because we don't want to re-traumatize her with that piece. And we don't need to know that stuff. She doesn't need to disclose that to another stranger. So, unless she does, or we have some visual indication or the officer has told us something, we might even miss the fact that there's been a potential for a BI. (ED-3)

4.2 Subtheme: The 'Not My Problem' Problem

The next subtheme to be discussed is the 'Not My Problem' problem: mezzo-level challenges associated with encouraging organizations to change their policies and practices, and the realities of navigating the conflict between what is seen as belonging in a public space and what is considered private. The challenge of combatting the socially created norms of silence and stigma around IPV and disability was raised by a number of stakeholders in a variety of ways:

Nobody wants to live in silence; survivors live in silence because they have been silenced, and they've been silenced because of the system, the work. Society is structured in such a way to ... see no evil, hear no evil: 'I don't want to know, I don't want to know.' (ED-6)

The only thing is that most employers and most people back away from partner violence. They don't want to get involved, they don't want to hear about it, they don't know how to deal with it, they don't even know how to react when you talk to them about it. So, you're left out on a limb. (S-4)

I don't know how you can change people to think differently. Some people don't want to invest and/or don't know how to be human. I don't know how you can teach that. It's just, right now, for example, because of COVID, the employer came and said we're going to teach you empathy. We're going to give you empathy training. Sure, it's good to educate me, but if I'm not a caring person, I'm going to go to the training and come out and make fun, 'Oh, these people are using the system.' (E-16)

And the other [pushback] was, 'If we have to choose a wellbeing or mental health subject, why domestic violence?' Some people were saying to me that maybe intimidation in the workplace or things like that are more of a big problem for our business. (2)

Stakeholders continued with this conversation, commenting on the lack of motivation for change within a workplace:

And then getting them to—this sounds really simple and crass—but getting them to care. Getting the employer to just care about their staff, and that it's not about bottom-line. You know, you come in nine to five, you do your job, I'm paying you,

so you bloody well do what I'm asking you to do. But [instead], to be empathetic.
(ED-6)

I don't think the workplace is going to do much involvement. The employer, what they care about is: are you fit to work, are you able to come, are you able to deliver. They don't dig deep, and they don't invest and take time to care about your mental state. (E-16)

To prepare to give the training, she sent me different articles about the impact [of IPV] in the workplace because, let's not lie to ourselves, in general, if a business doesn't see what's in it for them, it's more difficult for them to ... put a lot of resources in something. (FG2-E-2)

It's about getting people on board, and it's about getting the employer on board, that these are the limitations we're having at present. ... I think I've had more understanding employers than non-understanding employers, and when the employer isn't on board, more often than not, the return-to-work isn't successful.
(FL-15)

We find that ... some leaders say, 'Well you know, I'm not a community service, you know, it's not really my role, you know, to be like a psychologist'. And that's part of that training, we're making sure to tell people, 'We don't expect you to be taking the whole ... problem on by yourself. What we're saying is, you need to just

open up, make the other person aware that you're seeing the signs and saying there is help. There is help and here is where you can go and we're really concerned, and if there's anything that we can do, we'll follow up.' (FG2-E-1)

Some stakeholders associated this lack of motivation with a concern over costs or difficulties associated with accommodations:

There are some employers that are more welcoming to that information than others. Some are like, 'That just sounds like too much work. It sounds like too much more of an investment. And we're a small business, or whatever, and we don't have time for that.' That still happens quite a bit. ... And I think it's scary sometimes for employers, the word 'accommodation' is a big umbrella word. But accommodations can be very simple and can make a huge difference. (ED-10)

You know, employers don't have the time. If I throw a lot of homework their way, I don't know how that would go. So, I've always tried to say, "I'm the resource person. Come to me, whoever needs to come to me." So, it's really trying to take work off them. ... Even when I'm talking about chairs and headphones and computers, I'm speaking to the insurer or the defense council and saying, "I need a budget for this," so the employer doesn't feel like they have to give extra equipment. Whatever I can take off them, I do, so they can be as accommodating as possible. (FL-15)

First and foremost, you have to have an employer who is compassionate enough and willing enough to accommodate somebody with special needs. So, somebody

who, if they're having an anxiety attack, could take some time to go and calm down or take the day off. ... But you also have to have an employer that has confidentiality. And it's pretty hard in a place of employment for that confidentiality not to be breached. So, it's not safe, ... going into the employment field, especially a new one, with those needs, it's not a safe environment. (S-13)

One stakeholder described the challenges they faced when trying to implement training within a workplace saying, "The [pushback] I got at first were ... 'Oh, we have so much to do just to run our business', so it's, like I said, it was maybe six, eight months of preparation." (FG2-E-2)

Stakeholders commented on the need to 'make it personal', citing this approach as a way of increasing motivation:

Honestly, I think you have to make it personal. When somebody can see that a thing can, and does, influence their personal life, I think you have more buy-in. ... Why would anybody engage in learning, which is a lot of work, unless there is something emotional attached? That's what politicians do, they make it emotional about family and this and that. I think it can become less of this, 'Whoa, acquired brain injury', like, science-y brain thing, and be brought down to the personal, maybe that could be a way to help. Also, sometimes I think, maybe people just shouldn't have the option. (FL-7)

You almost do need exposure to something for you to really understand. ... Is there something we can do that basically says 'think about a time that you had an issue'? Or ... 'is there something in your life that's happened'? Or 'what if this was your daughter or your son' [would] you would react differently? ... Unless we're

smacking people in the face with it ... it's not touching them. How can we get them to internalize it almost and make that real transformation inside. (S-1)

These discussions continued as stakeholders discussed the challenges organizations face when trying to decide what is public and what is private: which conversations should take place at the workplace and which should not, and how to engage in those conversations in a safe and confidential manner. Some stakeholders discussed this issue from the perspective of safety and comfort to disclose, saying, "I selectively chose who I was going to tell. Only a couple of people. ... You have to feel safe with those particular people." (S-1) and "Survivors will tell you this for a penny or for a pound, if the space was safe, they will tell, they will disclose." (ED-6). Others saw this from the employer's perspective and discussed the complexity of the situation and how to navigate that:

Because the employer doesn't want conflict, [they don't want someone] to say, 'Okay, we're pushing, or, there is still confidentiality, there's still a barrier of how much can they ask.' For example, if you're sick at work, they can never ask for the diagnosis, but they need to make sure that the limitation is okay, but they don't go there, even. They wait very long, and people get affected until that bridge is crossed. (E-16)

Right now, as an HR person, you do the dance of, 'Is everything okay, and I just wanted you to know, we have services that are available to you.' And that's, kind of, where it stops. And unless that person divulges further, and even if they do divulge further, what can you do to help them? You know, where's the line of starting and stopping? ... Because that has always been the difficult part:

intervening when people don't feel like you should be, and it's their personal business. But also feeling, as an employer, a responsibility to help that individual and protect that individual, it's a really hard balance to strike. (E-18)

They also highlighted the difficulty faced if an employee chooses not to disclose at all:

We put all these policies in place, but as I said earlier, it's up to the person who is the victim of violence to come forward. We can't force it, we can indicate to leaders or to all employees what are the signs to look for, and then to mention that they see these signs. But it's up to the person to take up the offer, and open up, and make the step forward; it's something that's very personal. But the whole infrastructure is there for them to do that. Also, we have to recognize that it's not easy to have these conversations for an employer, for a leader, as a colleague. (FG2-E-1)

And all of the [safety protocols and supports] are predicated on the individual sharing that there is a risk to them and their safety. Which, in my experience, is not prevalent; they don't talk about it. Usually, an incident needs to happen in order for people to understand, or a fellow co-worker, who is aware of it is coming forward and sharing the risk and concern for the impacted employee that's in that relationship. (E-18)

The line between public and private is not an easy one to define. Some stakeholders spoke about the issue in terms of safety vs. surveillance:

People are also nowadays very sensitive about surveillance, and their privacy, and so even when you look at video surveillance, whether it's entrance ways or parking lots or that kind of thing, some people are really against it. And so, even though it's

for your safety and your protection, there are a lot of people who are against it, even if there's nothing going on in their lives that could come to the office. So, I think that's a challenge and a balance that employers would need to strike between safety of people, but not surveilling them. And where do you step in as an employer? (E-18)

We had a staff member, who was a receptionist, whose husband was really abusive and kept phoning her and phoning her, and eventually the boss got on the phone and said 'If you ever call again, you know there will be a restraining order against you at the agency.' But you have to be careful with that, because as a staff member, she was freaking out about that and was really worried about losing her job. She was told very clearly that she was not going to lose her job, but she also really worried about setting him off more. So, it's a very delicate balance. (ED-12)

While the discussions so far have been presented as they relate to micro and mezzo contexts, they are, in reality, strengthened and perpetuated by currents running underneath and around them in a more macro-level vein. The remaining two subthemes explore some of those barriers, highlighting how they influence the micro- and mezzo-level-related experiences of women survivors of IPV-BI.

4.3 Subtheme: The 'Best Kept Secret' Problem

Stakeholders frequently commented on the lack of general awareness about the intersection of IPV-BI, noting that this underlying gap leads to many of the identified barriers: one cannot begin to address a problem until one recognizes that the problem exists. One

stakeholder captured the severity of the issue succinctly by saying, “I think that really puts it into context for HR professionals, for leaders, for supervisors. And it’s terrifying to think that we’re not talking about it, or not focused on how to support those individuals.” (E-18) Another noted the significance of this gap on employment experiences:

I think it does matter, the employer side of things. I think that’s a big factor ... their awareness and education around brain injury. ... We have a local grocery chain that often hires people with disabilities and has an excellent accommodation program and are very celebrated. ... And then, we have other people looking for positions where there’s just a lot of resistance. There’s a lot of uncertainty. There’s a lack of education and understanding and awareness around what brain injury is, and a bit of fear, I think, from the employer, and needing a lot of coaching. It does matter, I think, who’s on the other side of the conversation and what they know. (ED-10)

Comments that contributed to this conversation highlighted the role of this gap, the importance of education, and the significance of the Ah-Ha moment that was discussed earlier. Some commented on the importance of raising awareness:

I think the first thing is for anybody who works in an agency to understand that intimate partner violence can also coincide with brain injury and vice versa. That’s the first important thing to identify, to be able to support women better. I think it’s again that comprehensive training. We’ve done a really good job in terms of acknowledging intimate partner violence. People are pretty good. They’re better than when I started years ago. So now, it’s the next step, which is that there are consequences—the impact of intimate partner violence can be a brain injury—it’s [about] acknowledging that. (ED-12)

I think there is quite a large gap of that being common knowledge. I don't find that women are coming to me and saying, 'I think I might possibly have a brain injury, and what services are there to support that.' And then, staff are not [saying], 'I wonder if this woman has a brain injury and what service ...' I think that it needs to become more understood and more common, and then to build services that specifically support that. [Services that consider] how do brain injuries impact people, and what are tools to support people in their learning or in their day to day to manage that. It should become a more central and common conversation. (FL-9)

I do find that even amongst professionals, usually when you hear brain injury, you think of sports, that's where a lot of the funding is. ... I'd say the popular conversations I have in the community, people would never think of women or children that have been abused [as having a brain injury too]. It does surprise me that there's not more awareness and an assumption that this is part of what's going on [in IPV]. (FL-14)

The lack of general awareness extends to the survivors themselves. Stakeholders identified that women are not aware of the intersection and, therefore, dismiss the challenges they might be experiencing or accept them as their own failures:

I never considered I had a brain injury. I just figured it was the stress I was dealing with all the time. I put it down to that more than anything. And I think most women do that in those situations. It's not been something that's been talked about much in the circles until recently. (S-4)

I'd say in terms of the women I work with, the vast majority are unaware that they have some sort [brain injury]. They are aware they have some headaches since they got hit in the head yet again, but the implications of that have not been identified and certainly not validated. ... So [we need to] just broaden [awareness], so people can start including themselves in that understanding. Because with the women in the shelter, it comes down to 'Oh, I just can't focus, I just can't do it' if they even articulate it there. Because sometimes, they just sort of assume 'This is just the way I am.' (FL-14)

One stakeholder commented on the lack of awareness among employers, saying, "I think that we don't have proper workplace stuff around domestic violence; it's not something that employers really understand very well." (ED-8) Another noted this gap while engaging in IPV training sessions within their company:

That was a big eye opener for people, thinking, 'Okay, maybe we think it's not that big a deal, because we don't see it, and we don't recognize it; we don't see the signs.', so we had a lot of talk about that. (FG2-E-2)

The difficulty in getting employers to accept the need for accommodations when they lack awareness of the intersection itself was also noted:

They don't understand the extent of the implications that certain impairments might have, and it's not surprising. They're not trained in that. So, they don't foresee the challenges that might come. In fact, if you can identify challenges before they can, that helps build rapport with employers, because they know that you're looking out for their wellbeing, as well. (FL-15)

As was the challenge of not knowing where to find information:

I think, the biggest challenge is not having information and not knowing where to go to find information. ... I think it's about awareness, it's about knowledge, and it's about getting people comfortable talking about it. ... When you give people little tidbits on how to bring it up, or where more resources can be found, that can be a really powerful tool for people. Because I have found, in my experience, that it's not that people don't want to help, it's that they don't know how to help. (E-18)

This lack of awareness among service providers, employers, and survivors alike is hardly surprising when one considers the equally pervasive gap in the broader society itself. It would be remarkable if either human service organizations or workplaces did not reflect the larger contexts in which they operate. While this thesis does not include an exploration of macro-level experiences, it is necessary to include a small selection of some of the conversations. Not doing so would be a failure to accurately represent the situation. Stakeholders identified multiple contexts in which these larger, macro-level gaps created barriers that were felt in micro and mezzo experiences. One stakeholder identified the lack of awareness within government saying, "Now, I'm in a position of the employers here, and the government just doesn't understand brain injuries and very little IPV," (S-11) while another highlighted the impact of the gap among police:

When the police came, and I had a concussion and was staggering around, they took him away. They told me he would be held overnight and have a bail hearing the next day. They released him two hours later to his ex-wife. And when they charged him, they listed it as slapping and shoving me, because that's what he said he did. (S-13)

Other stakeholders pointed to a significant lack of awareness among healthcare providers. While issues related to healthcare have been covered elsewhere, it is worth noting again briefly, as this underlying gap in awareness plays a critical role in the barriers to care and support discussed earlier:

I think another huge thing that's in my back of mind with this is that the medical system is set up around brain injury to think 'Okay, brain injury happens on a highway or on a football field, it's not happening in a bedroom for a year before anybody even knows about it and maybe a year after it stops is when you actually first talk about it.' (ED-8)

I kept on wanting somebody to ask me. I mean, right after you give birth, it's not something that you're going to be disclosing outwardly. But when he refused to be in the hospital at the same time that my family was visiting, there were signs. And this was also the same hospital that I went to a year previously because of an incident where he hit my head off the phone. So, there really needs to be more interaction, more follow up by medical professionals with that. To this day, nobody, no medical professional has ever asked. (S-2)

When I was assaulted, he almost killed me. He smashed my head up against the wall over a dozen times. And I wasn't even allowed to go to the hospital. I called the police. And when I phoned my family doctor she said, 'Just go to emerge.' I said, 'I can't drive.' So, after a week I phoned her and said I had finally gone to emerge and they said just go to your family doctor. I said I wanted a scan. And [was

told], “No, we don’t do that; I’m sure you’re fine. Here, do you need some antidepressants; do you need some sleeping pills?” That’s not helping. It took me two months to get to see my family doctor, knowing what happened to me, two months. And all she did was dismiss it. (S-13)

Sometimes, when I do ask someone to talk with their healthcare provider, with their physician (if they have them), the physicians themselves have said, ‘Well, I don’t know what to do with them.’ So, what do we do? (FL-14)

These gaps in awareness of the intersection itself feed directly into the barriers experienced by survivors: if people in any context are not even aware that IPV can, and frequently does, cause brain injuries in survivors, they do not seek adequate training on how to effectively support them. Stakeholders working in a direct service capacity commented on the impact these training gaps had on their ability to offer services:

I would have to say this is an area I still don’t have a lot of knowledge about. I know that a lot of the clients that we work with have brain injury ... but it’s a little bit beyond me at this point to know how to work with all that together. ... I think it would be helpful to understand that a little bit better, because even in this situation where we have brain injury [professionals working here], it’s hard to know what is my piece to work on with that and what is their expertise in that area. There’s no point in me doing what they’re going to do unless it’s to back up and support what they’re going to do. But it’s not helpful to be running off in different directions. (FG1-FL-1)

Just from the little bit I know about chemistry, there are significant interactions. But I'm not sure how to apply that to this connection between brain injury and intimate partner violence, and employment and substance use to bring all of those pieces together. It's a big question mark. (FG1-FL-2)

I don't know a lot about brain injury, but I've heard pieces around concussions, and I know that one reaction, or a consequence of a concussion can be difficulty managing anger, and so I imagine that could be what's happening here. (FL-7)

I just wonder how often we're maybe not helping our clients, because we're thinking 'Oh, there's a mental health issue here, and we're using all our mental health tools', but it's not. It's impacting a person's mental health, but we're not equipping them with the right support, so we're having a talk therapy group about something, and they're saying "I actually just need a way to remember certain things." I just wonder if we're spinning our wheels, because we're not actually using the right tools and addressing the right issue. (FL-9)

Many stakeholders identified this dearth of training as a significant barrier to employment for women survivors of IPV-BI:

People don't know what they are doing, whether it's the people who experience the violence or people who are supportive to the people experiencing the violence. Which makes it hard, because you want to act with decency and compassion, but you don't know how. And it's just too hard. (E-16)

How can you recognize the signs? Are there typical things that you see or that people say, or situations that they avoid, that maybe employers or managers or human resources professionals might recognize? What could we do to make workplaces more inclusive and safer for these individuals? Are there certain opportunities or environments that would make them feel more vulnerable or less vulnerable, or safe? I'm trying to think about those situations, and in the course of my day-to-day interactions with employees, how would I know? And if I did know or did suspect, what could I do to help that individual? (E-18)

I think that for brain injury survivors, they often need a little bit more support, time, and they may need a little bit more communication and more simple—you know, it might take you twice as long to direct a person with brain injury, because you need to speak more slowly, you might need to repeat yourself more. I think those are certainly barriers. (ED-8)

I think it's the middle supervisor that really needs to know, to understand. The person who that employee is going to directly go to and say, 'I'm fatigued', or 'I'm having a tough time with my schedule', or 'I've been scheduled four days in a row instead of every second day', whatever it is. It's that person that needs to know. ... It's going to be the supervisor or the person that does the scheduling. So, how do we get to those middle managers and supervisors? We need buy-in from the top, but it's the people in the middle, the direct supervisors [for whom] accommodation is going to be most important to understand. (ED-10)

I think employers need to recognize that IPV is a power and control situation, it's not just about removing somebody from the physical side of things. They do have to recognize that power and control, because that is what is going to be affecting how somebody's making those decisions for their safety as well, which I think is key. (S-2)

Just as this gap acts as a barrier to training, it also prevents effective policies from being devised and enacted. Unless there is an awareness of the problem, it is not possible to create proactive policies to address it. It is barriers like these that undermine the suggestions for improvement made earlier that spoke directly to employers regarding the need for proactive, effective in-house policies around supports for survivors. The last subtheme discussing barriers experienced by women survivors also explores challenges faced on a macro level.

4.4 Subtheme: The 'We Have No Money' Problem

As is so often the case in operating human service organizations within a neo-liberal context, funding underlies many of the barriers to providing effective support. Again, while this dissertation does not explore the macro level of discussions in any detail, to not touch on this aspect of service delivery and experience would leave a vital part of the conversation unsaid. One stakeholder summed the issue up well:

There needs to be more support around helping women to stay employed or to get back into their job after a couple of weeks off or something like that. We just don't have the funding, and we would love to be able to do that. (ED-8)

Many stakeholders expressed frustrations with the lack of funding support for women exposed to IPV-BI in a variety of contexts. As such, insufficient funding and the impact to staffing, support programs, and, ultimately, employment-related services are briefly highlighted below. One stakeholder identified challenges with adequately training staff in the area of IPV-BI by saying, “If you’re working with the women, and things are not going away, do you understand why they’re not? And do you have [funding] for those resources?” (ED-12) Others highlighted the realities of limited staffing budgets and the impact on services:

In our shelter, there's generally one child and youth care worker on during the daytime hours. That's not enough to be able to say ‘Yes, children of this one family, with four kids—I'll care for you all day’, because you're trying to juggle with all the other moms. It really does come down to lack of funding. We're really fortunate in our agency, we have a childcare centre with a very compassionate manager who often will shuffle our people to the top of the list. But that means that mom has to have the ability to pay for the childcare. Sometimes we pay for a period of time, we use donation funds to pay. (ED-8)

I think organizations understaff routinely, and regardless of how well-trained you are, if your organization is understaffed, you will never have the capacity to support someone who’s incredibly emotionally dysregulated while you’re supposed to be serving lunch and running the front desk. ... That’s about funding, and maybe larger things, but I think it's an incredible irresponsibility on management of organizations to understaff the very frontline workers. ... Understaffing people makes them

resentful, and resentful people can't appropriately support clients who are emotionally dysregulated. (FL-9)

Some stakeholders tied the issue directly to programs and services designed to support employment, highlighting a demand for funding to better address the needs of women survivors:

For me as a professional, it becomes a real, legitimate [problem]: what do we do now about this? There's a minority of the women that I work with, that have access to economic supports that could allow them to take some time off to recover at least a bit from this concussion or kind of have some accommodations specific to that, but the vast majority of women I work with do not have access to those kinds of supports, from a workplace perspective. ... [And] if they don't go to work, they don't get paid. There isn't that kind of safety network ... for a lot of jobs. (FL-14)

Paying for those courses is sometimes a bit of a challenge too. While they're in our program, sometimes we have access to some funds sometimes that can help them pay for it, but that isn't always the case. And there aren't always free courses out there that they can access, so. (FG1-FL-2)

And so, I remember when that legislation came down thinking like I do about most legislation: 'What dollars are being attached to those bills of legislation?' I always think that because we do all these things, and then, there's nothing to actually do it right. So, how are we empowering employers and tooling up employers and all the rest of it to do that work? (S-1)

That's where the challenge will be in trying to get people back to work who are IPV survivors, because they're not supported by WSIB, they're not supported by a private insurance company, so who's going to fund all that? It takes a lot of energy and resources to be able to get a person to the readiness state, you know, do worksite assessments, do functional restoration assessments, do capacity assessments, before all of that happens, before the actual return-to-work happens. And it doesn't stop when someone's gone back to work. (FL-15)

Lack of funding is an ongoing issue in social service organizations. Addressing it requires government buy-in and a general political will to support survivors. It is not a popular idea, as highlighted by one stakeholder's comment: "The government needs to open up their purse and find the money, because the government doesn't like to do that." (S-13). Without adequate funding, women survivors of IPV-BI are falling through the cracks and receiving sub-standard services that are funded off the side of someone's desk:

These brain injury workers that are coming in and doing this, they're not getting paid through the typical stream that they would with all their other clients. We are using grant money, donor money, coffee can money to do that, to put this program together. So that's where it's, like, this wouldn't even be happening or possible without us going; forget the medical diagnosis, screw that, we can't even go down that road, we're never going to get anywhere on that road. We need to find money somewhere else for the BI stuff. (ED-8)

This situation continues to put women exposed to IPV-BI at high risk of repeated violence, unemployment, and poverty.

This chapter has provided a glimpse into the lived experiences of women survivors of IPV-BI, the importance of work, the challenges they experience in obtaining or maintaining it, and their experience of workplace culture. It has also covered what is happening in the workplace, the impact of the pervasive lack of knowledge, and the complexity of the situation. The conversations have provided examples of what is working, as some organizations have begun to address some of these challenges in different ways. In addition, stakeholders have provided suggestions on how to capitalize on existing strengths and how to address some of the challenges they experience. Finally, the chapter has explored four groups of problems that act as a barrier to achieving the proposed solutions. Many of the problems are intricately connected in what quickly becomes an overwhelmingly complex situation. It resembles the rhizome pictured below in Figure 3, with many of the connections hidden underground until a crucial event causes them to surface in a seemingly random manner.

Figure 3

Rhizome Theory Visual



The remaining discussion chapter seeks to bring some clarity to the messiness of this intersection by presenting clear suggestions to address some of the challenges and highlight where to focus our future research efforts.

Discussion

As previously noted, the existing body of literature that considers IPV-BI as a distinct intersection is very limited. Despite prevalence rates in Canada that rival those of breast cancer, we still have fewer than 75 original studies exploring IPV-BI to date, and only a handful of researchers around the world are focused on expanding this knowledge base. This study is the first to explore IPV-BI within an employment context. As such, it can add much to our understanding of the employment and employability impacts that IPV-BI has on women who have been exposed. In this chapter, I begin by providing six key observations I have drawn from the themes presented here. I then suggest implications for research and recommendations for practice. Next, I consider the study's strengths and limitations. In the final sections of this chapter, I offer my insights, discussing the importance of each conclusion, situating it within the broader literature, and highlighting what I see as necessary steps forward that can, and should, be explored. I conclude by coming back to social work to consider the unique role that we, as social workers, can play in moving the needle forward.

Key Observations

Because the field of IPV-BI is in its infancy, nearly any new research is, by definition, ground-breaking, and will address existing gaps. However, it also means that, as researchers, we have an obligation to start at the ground floor and seek to understand the basics before we rush ahead. Therefore, while my observations may appear to state the obvious, their simplicity provides essential groundwork for addressing the challenges faced by women who have been exposed to IPV-BI.

1. The intersection of IPV-BI is uniquely and extraordinarily complex. Each component individually presents significant challenges on multiple fronts: medically, emotionally, psychologically,

economically, and socially. Each brings with it layers of externally produced shame and stigma which become stored internally; each becomes a marginalizing and oppressing condition; and each circumstance of the condition is unique—no two survivors are alike.

2. There is a widespread gap in IPV-BI knowledge, resulting in a critical need for extensive campaigns to increase awareness, develop practice guidelines and protocols, and implement training among all professions who connect with women exposed to IPV-BI.
3. The socially derived culture of stigma and shame around IPV and the medical model approach to (dis)ability still make up the dominant discourse and continue to shape the contexts in which these women live, work, and seek support.
4. Workplace culture plays an important role in successful employment for women exposed to IPV-BI.
5. Women exposed to IPV-BI are subjected to complex and intensified layers of power and control, in particular as experienced within the workplace.
6. Adequate funding is essential if we are to offer effective support to women exposed to IPV-BI.

Implications for Future Research

The relatively few authors who have published in this field before me have already provided some guidance for future IPV-BI-related research. However, as none have focused on the employment needs of women survivors of IPV-BI, I will take this opportunity to focus on these specific gaps, which frequently take the form of questions rather than answers:

1. We need to better understand the condition of IPV-BI and how its presentation interferes with women's employment and employability. Of particular importance is to increase our knowledge of the implications of intersectional identities, such as Indigenous, Black, LGBTQ2S+, and newcomer. Many of these identities are further marginalizing, and women identifying in these

categories often carry a higher risk of IPV and/or reduced access to appropriate care and support.

There is much more that we need to know to develop adequate supports.

2. To develop these supports, more information is needed on the help-seeking behaviours of women survivors, including their capacity to prioritize self-care, their access to care services, and the pathways with which they make use of available services. How survivors are identified and how they seek support, particularly around employment, are key questions to be answered. It is not enough to develop appropriate programming; we also need to identify points of intervention in which to situate these services and how best to facilitate survivor access and uptake.
3. More consideration must be given to strengthening community capacity through effective engagement in cross-pollination techniques. We need to answer such questions as ‘How do we build bridges between organizations to enable resource sharing and leverage existing knowledge?’ and ‘How do we maximize interdisciplinary community partnerships to build effective IPV-BI support structures?’. With so little existing experience of IPV-BI service delivery to go on, more research is needed to explore what works. It is important to bring the voices of lived experience to this process. Priority should be given to participatory models that include an emancipatory or empowerment component for women, enabling their contribution through advocacy and knowledge-building, while also serving to diminish isolation and stigmatization.
4. To develop effective models of support, the voices of survivors need to be included. We need to better understand how various models of care, such as holistic, client-centred, and peer-based approaches function for survivors of IPV-BI. What delivery models are useful? How do we determine eligibility? Where do we focus our areas of recruitment? What are the key areas of difficulty for survivors, and what existing techniques and resources can we build from? What do they want, when do they want it, and what works best for them?
5. We need to have clarity around the complexities of screening, diagnosis, and access. What are the risks and benefits of each for women survivors? Are there ways to make use of workplace-

related, (dis)ability-specific supports that could benefit women exposed to IPV? Are there existing provincial or federal supportive employment programs that could be expanded to include women exposed to IPV, if it were seen as a form of (dis)ability?

6. To advance an agenda of workplace equity, we need to understand how to motivate employers to change. This study found examples of successful strategies to change workplace culture and create a more proactive approach to supporting employees who are experiencing IPV and/or BI. Much could be learned from a deeper exploration of these successes and the creation of guidelines for effective support.
7. More scholarship is needed to unpack the socially constructed norms around IPV-BI and their impact on survivors' employment. Critical disability, feminist, intersectional, and organizational theories all provide insight, but until we understand how survivors see themselves post IPV-BI and why, we cannot begin to address the widespread issue of underemployment and unemployment. More investigation into the lived experiences of women exposed to IPV-BI in general is needed, but I would argue that the relationship between their lived experience of IPV-BI and their experience of employment is of particular importance. Access to financial independence, a healthy self-identity, and the opportunity to contribute in a meaningful way are vital components to the overall safety and wellbeing of these women.

Recommendations for Practice

While the literature offers recommendations for frontline service providers across sectors that frequently support women survivors of IPV-BI, none focus on employment. To minimize duplication and highlight this new area, I will again focus on recommendations for supporting women in their efforts to maintain and/or obtain employment post IPV-BI. Many of the following suggestions come directly from the stakeholders:

1. Until research has clearly established reliable prevalence rates, appropriate screening tools, and trauma-sensitive identification protocols, all women who have been exposed to physical forms of IPV should be suspected of a possible BI and supported accordingly. Follow-up with a medical professional as soon as it is safe to do so is strongly recommended.
2. It is also recommended that anyone working with women exposed to IPV should be made aware of the high risk of a resultant BI. Widespread efforts to raise awareness must be prioritized until the intersection of IPV-BI becomes a recognized and watched-for condition among women exposed to IPV.
3. Targeted educational campaigns among frontline workers, rehabilitation professionals, and employment support providers are critical. Much of this work could, and should, be done during their own training periods. Professional schools in key fields, such as social work, occupational therapy, physiotherapy, medicine, and nursing, among others, should have the intersection of IPV-BI embedded into their curriculum. These campaigns need to focus on how to identify BI in women exposed to IPV and how best to tailor support services to meet their needs. It is pointless to continue offering services to survivors that are fundamentally inaccessible because of (dis)ability-related challenges.
4. Human-resource and management-level personnel need to be trained in IPV-BI accommodation and support. Women survivors of IPV-BI have much to offer the workplace and should have equal access to meaningful, gainful employment. It is imperative that employers be included in raising awareness and receiving education, and that they be provided with effective tools for support.
5. Employers must move toward a proactive approach to identifying and supporting women survivors of IPV-BI among their employees. Policies and procedures to identify and support women exposed to IPV-BI must be drafted—preferably by consulting with survivors themselves—implemented, and made transparent within the workplace. The conversations need

to be normalized, and the pathways for survivors to gain access to care and resources must be clearly laid out and easy to follow.

6. Stronger advocacy is needed to shift the social construction of IPV away from an individually situated problem and move it toward a form of (dis)ability. If women survivors of IPV were afforded (dis)ability status, they might have more access to effective cognitive rehabilitation and return-to-work supports, strengthening their capacity to maintain or obtain employment.
7. More efforts are needed to bring attention to this intersection and associated economic and social impacts in all levels of government. Just as the condition of IPV-BI is complex, so are the solutions, and they will require an interdisciplinary approach across portfolios. This is neither *just* a social issue nor *just* a healthcare problem, and solutions must recognize the need for cross-sector collaboration. Most importantly, all levels of government must produce the funding to support such a broad approach.

Study Strengths and Limitations

The chief limitation of the study was the lack of diversity among the stakeholders. As all but one identified as a woman, and most identified as being of Caucasian or European origin, there was a distinct lack of Indigenous, Black, and racialized representation, groups which have been particularly disadvantaged in the healthcare and social-support sectors. While attempts were made to address this gap via purposive sampling techniques, they were unsuccessful for unknown reasons. It is possible that individual, culturally determined conceptualizations of IPV and (dis)ability prevent women from self-identifying in this way. Perhaps a culturally specific invitation to participate could be offered that takes this issue into consideration by listing characteristics of each condition rather than labelling them. It is also possible that Indigenous, Black, and racialized survivors felt that their experiences would not be adequately understood by

a team of predominantly white settler women researchers. Additionally, this team composition may have limited the ability to recognize challenges and strengths of an intersectional nature. I would recommend that future efforts be made to overcome these obstacles to include a greater participant diversity. Such diversity would provide much-needed nuanced information and raise awareness around intersectionally specific challenges.

Despite this study limitation, there were sample characteristics that provided additional strengths. Many of the survivors who spoke with us were aware of the intersection of IPV-BI itself and of the existence of their own brain injury. Because an overall lack of awareness of IPV-BI has significantly interfered with identification and diagnosis, such an awareness is unusual within the IPV survivor community, as noted earlier. This level of self-awareness among survivors provided deeper insights into the challenges they experienced and their subsequent support needs. Having the opportunity to contrast and compare the comments provided by knowledgeable survivors with those of frontline workers and employers, who had far more limited IPV-BI awareness and experience, highlighted the disparity between the perceived support offerings by providers and employers and the actual experiences of survivors. Additionally, conversations with stakeholders were extensive and rich with observations, examples of experiences, and suggestions for improvements in a variety of contexts.

Another limitation resulted from the COVID-19 pandemic. All stakeholder recruitment and interviews took place between October 2021 and February 2022, and while this timing allowed us to add invaluable conversations about the very early impacts of the pandemic, it also created unique challenges to the research process. Recruitment techniques could have been hampered by the lack of in-person communication opportunities at our various community-based locations, and potential stakeholders may have been reluctant to engage for health or isolation-

related reasons. Extreme stress and increased workloads experienced by frontline workers in IPV-support organizations (Haag, Toccalino et al., 2022) may have caused these workers and executive directors to feel that they lacked the required emotional or physical capacity to participate. The pandemic may have also played a role in our lack of success in recruiting women who identified as Indigenous, Black, or racialized, as many of these groups experienced additional hardship during COVID-19 and may have had fewer resources and capacity to contribute to a research study conducted during this time. Although we offered a phone interview option, all our interviews were held online and required stable internet access, which could have narrowed the range of stakeholders.

The impact of the COVID-19 pandemic on all stakeholders and researchers cannot be understated. In general, the pandemic had a significant effect on individual health and wellbeing and on people's capacity to engage and contribute to an extensive and complex process, such as a project of this nature. Even the question of whether conducting research at this time was appropriate had to be considered (Vindrola-Padros et al., 2020). During this period, interruptions in the research process led to delays that may have resulted in a disconnect between the researchers and the data as they were pulled away from their work. All team meetings, including data analysis and debriefing sessions, were conducted remotely, potentially adding further strain, and contributing to burnout for the research team. Additionally, the increased stress and anxiety brought on by the pandemic might well have left the research team members more vulnerable to vicarious trauma while engaging in the research process (Vindrola-Padros et al., 2020). Considering these risks and allowing for adequate self-care time for the team contributed to a significant delay between the interview process and completion of the data analysis. While it is

impossible to gauge the full impact that was felt, it should nevertheless be noted, and the findings and recommendations should be considered within the context of the COVID-19 pandemic.

Despite this impact, the depth and richness of the co-created data are still evident. While the study findings that are specifically relevant to the context of the pandemic are reported elsewhere (Haag, Toccalino et al., 2022), the experience was fresh in the minds of the stakeholders and frequently shaped what they considered as strengths to be presented and leveraged. The very recent, and, in many cases, immediately present experience of support services and employment opportunities being catastrophically affected by COVID-19, as well as the subsequent shutdowns and resulting challenges to financial independence, safety, community, and care allowed stakeholders to recognize the value of the support they were able to receive and prompted more conversation about how to protect and expand these supports moving forward. While many conversations centred on the value of remote service delivery and what could be done to enhance and encourage it, stakeholders repeatedly highlighted the importance of in-person supports, particularly in the workplace, and offered creative solutions that might otherwise not have been considered.

In addition to the difficulties brought on by the COVID-19 pandemic, there were other strengths and limitations to the methodology. In past studies, I have opted to run group interviews to allow survivors to engage with one another, build community, and offer support, normalization, and validation. As an emancipatory researcher, it is important to me that stakeholders benefit directly from the research process, whenever possible, and the experience of group interviews can mirror the therapeutic benefits of shared experience, validation, and mutual aid found in traditional group therapy (Eckhardt & Anastas, 2007; Haag, 2009; Shah, 2006; Shakespeare, 1996). Unfortunately, all data collection with survivors in this study was done via

individual interviews, thereby excluding them from these potential benefits. Additionally, the condition of brain injury may have interfered with capacity and comfort when providing an interview via an online platform. Previous authors have also noted challenges when conducting interviews with survivors of brain injury, such as difficulty with memory recall, communication, and external stimuli (Paterson & Scott-Findlay, 2002). In the future, I would revert to prioritizing group interviews with survivors over individual ones to potentially provide immediate emancipatory benefits.

A further limitation of the study reflects one of the overall observations: support providers typically lacked awareness and knowledge about the existence of IPV-BI, let alone any experience in knowingly supporting it. While some stakeholders had extensive experience in working with survivors of IPV-BI and could offer deeper insights into their unique needs and challenges, most frontline workers, executive directors, and employers had very limited, or no previously existing, IPV-BI awareness. This actuality required that they consider the barriers and strengths within their organizations rather than reporting on what they knew to be the case through experience. While they were knowledgeable in either IPV or BI and, as such, could extrapolate and consider the intersection from a position of some experience, the literature has raised concerns about the challenges of abled professionals attempting to understand the lived experience of differently abled people (Asch & Rousso, 1985; Hayes, 2002; Richards, 2008). However, despite these challenges, the inclusion of stakeholders from each of the four groups (survivors, executive directors, frontline workers, and employers) added dimensionality, depth, and nuance to the conversations, allowing for a clearer understanding of the existing situation, the strengths to be built upon, and the barriers faced by everyone involved.

Lastly, another potential limitation to the study is that of researcher bias, as I share the experience of brain injury. Because this is an ongoing challenge for me when engaging in research in this field, I am aware of the implications and take steps to ameliorate them: interviews were conducted by myself and another member of the research team who does not have a brain injury; initial data analysis and coding was done by three members of the team, two of which do not have a brain injury; and consultation among team members was ongoing during my later stages of coding and theme development. Additionally, I made use of supervision and self-reflection to reduce the likelihood of applying my own knowledge and understanding of brain injury to the analysis process instead of allowing the stakeholders' contributions to stand alone. I have also done considerable scholarship in this area (Haag, 2009) and am confident that the literature supports the engagement of researchers who share the experience of participants in a study (Neville-Jan, 2004; Richards, 2008; Shah, 2006). I would suggest that my positionality can strengthen the researcher-participant relationship, work towards the equalization of the inherent power differential within that relationship, provide an opportunity for normalization and understanding, and enable me to gain a deeper understanding of their experiences.

Conclusions

The intersection of IPV-BI and employment is more complex than just a simple gap in services. A participant in a previous study captured this eloquently: "Let's stop saying gaps in service, we're dealing with massive chasms. They are swallowing people whole, and we expect them to just kind of be able to step over the gap and keep on their recovery journey." (Toccalino et al., 2022a, p. E26). I propose that a comprehensive, integrated response which combines the medical and social aspects of the intersection, is needed to adequately address this situation. To

succeed, we need to create a structural solution that contains three critical components: 1) bringing together interdisciplinary partners with existing expertise to develop innovative ways to blend IPV and BI supports; 2) simultaneously seeking to end the pervasive culture of shame and silencing attached to IPV and (dis)ability; and 3) providing adequate funding to sustain these components. The subsequent conversation considers the key observations put forward here and how they can serve as a guide to shape this three-tier, structural solution.

My first observation highlighted the complexity of the situation, and it is here where we must start when considering a solution: only by constructing and fostering bridges between traditional silos can an interdisciplinary approach be taken. The level of complexity found in IPV-BI truly goes beyond what most people would expect at first glance. When put together, IPV and BI become so complex, the situation can be nearly overwhelming for survivors, service providers, and employers alike, as raised here by stakeholders. The experience of being exposed to violence and subjected to ongoing physical assault will interfere with expected recovery from a BI. Equally, women living with a BI are at a higher risk of IPV, and the challenges associated with a BI may well interfere with their capacity to leave an unsafe environment. Further complicating the issue, the associated shame and stigma of both conditions lead survivors to try to hide them instead of actively seeking help. The literature discusses these challenges in the IPV arena (Adams et al., 2013; Banyard et al., 2011; Crowne et al., 2011) and in BI (Andelic et al., 2013; Hofgren et al., 2010; Levack et al., 2004; Roberts & Kim, 2005; Temkin et al., 2009). The impact on employment is also noted in the broader (dis)ability studies literature, with particular attention paid to the lack of understanding of these complexities, which is frequently seen in management levels within an organization (Foster & Wass, 2012; Harlan & Robert, 1998), an observation supported here as well.

The limited IPV-BI literature also raises concerns with the challenge of complexity when identifying and addressing IPV-BI in general, noting that the prevalence of co-occurring mental health challenges, ongoing threats to safety, and significant gaps in diagnosis and treatment all combine to create a highly complex condition that requires a flexible, individualized approach to care (Daugherty et al., 2020; Galovski et al., 2022; Haag, Toccalino et al., 2022; Toccalino et al., 2022b; Toccalino et al., 2023; Valera et al., 2019). While there is no existing literature that explores IPV-BI within an employment context, evidence of this complexity surfaced repeatedly in this study. Many stakeholders highlighted the issue in different areas, including knowledge and service gaps, access to care and supports, and mechanisms to foster employment. The complexity of the intersection acts as a defining characteristic, increasing the level of difficulty when attempting to offer effective support, and acting as an overarching barrier to improving outcomes.

To begin to adequately address this issue, people need to understand that BI is a common and significant result of exposure to IPV, and the complexity needs to be teased apart into smaller, more manageable segments. Solutions for these segments need to be informed by current knowledge and developed using a cross-pollination approach, making effective use of the existing expertise that has traditionally remained siloed. These smaller components can then become the building blocks to support the larger, integrated structural solution that I seek. However, to develop these building blocks, we must also address the overwhelming lack of awareness, knowledge, and training. Current literature clearly calls for increased education and awareness across sectors, including healthcare, social supports, legal systems, and direct IPV or BI services (Haag, Jones et al., 2022; Kwako et al., 2011; Monahan & O’Leary, 1999; Roberts &

Kim, 2005; St. Ivany & Schminkey, 2016; Toccalino et al., 2023), a call that also surfaced here as a key element in nearly every theme.

Stakeholders repeatedly discussed the limitations brought on by a lack of awareness, starting with the impediment to seeking knowledge (one does not attempt to learn about something that one is not even aware of), moving on to the challenge of identifying a survivor, and then to knowing what to say or do and when or how to do it. Even when these pieces of knowledge are in place, stakeholders identified challenges to offering effective services, as systems of care do not consider the complex and ongoing needs of survivors nor is there adequate funding to support them. Employers raised the issue of not knowing how to reach out, and feeling uncomfortable with the tension between what information falls within the public domain and what is private. I believe that the findings are suggestive of an immediate need to bring this intersection forward. It no longer can be seen as a social problem only—it is also a serious healthcare crisis and must be approached in a manner that recognizes and responds to this dual nature.

There are inherent drawbacks to this characterization, since (dis)ability is also constructed within a deficit model. Dobusch (2016) identifies (dis)ability as a doubly problematic category of being. First, it is a highly fractured, heterogeneous minority position; second, it is set up as a medicalized problem, unwanted in nature, and needing to be fixed or cured. She notes that it has been set up as an individual, medically based deficit rather than a political issue of human rights, thereby weakening the argument for equality. Being labelled as ‘disabled’ goes with such socially constructed ideas as fixed and unchanging, essential characteristics that are in direct opposition to the cultural ideals of independence, productivity, and ability (Dobusch, 2016; Zanoni & Janssens, 2004). Foster and Wass (2012) point out that

liberal concepts of equality do not recognize difference, and therefore, cannot usefully create mechanisms for inclusion. Nonetheless, having a formal diagnosis of (dis)ability can provide some benefit, and perceived legitimacy, to a survivor: it allows access to publicly funded social supports; it validates and normalizes their experience; it situates the (dis)ability as a combined health and social issue instead of a personal deficiency; and it provides a starting point from which to identify effective rehabilitation interventions to address challenges and improve outcomes. Reframing IPV-BI in such a way has the potential to reduce the associated shame and stigma, put higher emphasis on embedding IPV-BI education within relevant professional training curricula, and increase access to funding for research and supports.

Not only do we need to raise awareness around the intersection itself, we also need to implement widespread training initiatives for all professionals who routinely come into contact with IPV-BI survivors. The need for training, particularly among healthcare professionals, first responders, and social support providers has been well documented in the literature (Ackerman & Banks, 2009; Anderson et al., 2015; Baumann et al., 2018; Farley et al., 2018; Haag, Jones et al., 2022; Haag, Sokoloff et al., 2019; Kwako et al., 2011; Toccalino et al., 2022a; Toccalino et al., 2022b). Stakeholders in this study repeatedly discussed how the lack of training among professional support personnel created multiple layers of obstacles in accessing services. They extended this conversation to consider the workplace, noting that widespread training among employees at the staff and management levels was of high priority, particularly within human resource departments. While no IPV-BI-specific training is known to exist, there are a few options that could be modified. The VEGA Project (www.vegaproject.mcmaster.ca) is an online IPV training program for healthcare professionals and social workers, while the DVatwork (www.dvatwork.ca) is an online IPV training program for employers; however, neither of them

has any known references to brain injury as a concurrent condition. The IPV Educate (www.ipveducate.com) program offers online IPV education and training, and it does include some information about resultant brain injury, but it is specific to orthopaedic surgeons. All these programs could offer valuable information from their individual perspectives, but there remains a critical need for a more nuanced IPV-BI training program, that can train a broad spectrum of support providers and employers on the unique challenges created by the combined experiences.

In this study, one employer spoke at length about the value of the IPV training program they had implemented internally and expressed an interest in expanding that program to include information on BI. An executive director also highlighted the success of their local IPV-BI support program that utilizes an interdisciplinary approach when training their staff in how best to support survivors. Other stakeholders commented on the significance of having someone who had an existing understanding of the intersection of IPV-BI to assist them and offer support across the conditions. Comments from stakeholders about the value of this approach align with earlier findings that highlighted the necessity of addressing this gap (Haag, Sokoloff et al., 2019; Toccalino et al., 2022a; Toccalino et al., 2022b). Clearly, there is much to be gained from a multi-sectoral approach to awareness, education, and training. Building bridges between traditionally siloed service and knowledge groups via cross-pollination would leverage existing expertise, thereby increasing community capacity.

The second critical component to any successful solution will need to work toward a shift in the narrative that surrounds and constructs both IPV and BI. The next three observations speak to this need. Currently, IPV and BI are still conceptualized as individually situated problems to be dealt with by the survivor and their family, assuming that is an option. These narratives perpetuate a culture of shame and blame, which, when combined into IPV-BI, leaves women at

severe risk of underemployment and unemployment. This observation directly supports existing (dis)ability (Goodley, 2013; Goodley et al., 2012; Williams & Mavin, 2012) and IPV literature (Giesbrecht, 2020; Moe & Bell, 2004; Showalter & McCloskey, 2016). What has not yet been explored is the impact of the two together, a combination that appears to increase the risk of interfering with employment, particularly given the challenges of complexity and lack of awareness, as discussed previously.

Intersectionality Theory (Bowleg, 2012; Crenshaw, 1993; Olesky, 2011) provides one mechanism to unpack the situation by considering how these complex identities intersect with each other, and the resulting personal and professional impact on survivors. When considering Intersectionality as a theoretical lens, other scholars emphasize its importance in recognizing the diverse social identities and experiences that shape peoples' lives without oversimplifying, by acknowledging that not all members of a group experience subjectivity in identical ways (Acker, 2006; Bowleg, 2012; McDonald, 2015; Styhre & Eriksson-Zetterquist, 2008). Bowleg (2012) refers to the "intersectionality paradox" (p. 1269): not all members will experience all intersections, and not all intersectional points are disadvantaged. It recognizes subjectivity as a fluid construct that is influenced by time and context, and that moves into, out of, and between places of power and privilege (Crenshaw, 1993). The power of this framework lies in its capacity to facilitate an understanding of how various intricate social identities (traditionally those of marginalized populations such as race, gender, disability, sexual orientation, and socio-economic status) intersect with one another, both on a micro level of individual lived experience, as well as on a macro level of systems of privilege and power (such as racism, sexism, ableism, heterosexism, and classism) (Bowleg, 2012; Olesky, 2011). Styhre and Eriksson-Zetterquist (2008) suggest it "is a useful framework for analysing how diversity is played out in

organizations: that is, how different social and cultural skills and competencies embedded in various regimes of knowledge and power can be mobilized and used in different operations and under different conditions” (p. 576). Interestingly, no one has yet applied this lens of understanding to the intersection of IPV-BI, despite an excellent fit. While, ultimately, I see limitations to this approach, I also believe that it can offer new ways of understanding IPV-BI and the challenges that accompany it, particularly when used in combination with other lenses via the Considered Inclusive Framework outlined in Chapter 3. The following conversation explores these new ways of considering and conceptualizing IPV-BI and the experiences of women survivors, and can add much to our limited body of literature.

The literature exploring the experiences of return-to-work after a BI highlight several challenges faced by survivors that seemingly dovetail into the impacts of exposure to IPV. The conditions overlap such that they become exponentially more problematic than they might have been on their own. For instance, (dis)ability is still constructed through a deficit model, creating feelings of shame and inadequacy in many people who live with it, particularly around the capacity to work, thereby undermining the development of a positive self-identity (Dunn et al., 2008; Killackey, 2010; Riach & Loretto, 2009). With the ability to engage in meaningful work being linked directly to quality of life and a positive sense of self, it is easy to see its role in the overall wellbeing of BI survivors. But what happens when the BI survivor is also subjected to an ongoing campaign of negative messaging, telling her repeatedly that she is not good enough or smart enough to hold a job or that she does not deserve one? Many stakeholders here discussed the tactic of undermining and belittling that is often used by an abusive partner as a method of control. This form of violence is a common mechanism of IPV and is frequently used to prevent women from seeking financial independence through employment (MacGregor et al., 2020; Moe

& Bell, 2004). If a woman is exposed to this messaging, and it is then re-enforced at her workplace and she finds herself unable to maintain employment for reasons that are characterized within a deficit model, she has every reason to believe the messaging and construct herself as a failure.

There are more examples of how the experiences dovetail to work against a survivor. Because BI and IPV are often ‘hidden’ conditions, they create additional challenges that make employment even more unlikely. These challenges are well documented in BI (Franulic et al., 2003; Lefkovits et al., 2021) and IPV literature (Banyard et al., 2011; Giesbrecht, 2020; Moe & Bell, 2004). The hidden qualities of each condition raise barriers to employment in areas such as accommodation, need for flexibility, and disclosure. When experienced within a vacuum of awareness of even the existence of IPV-BI, let alone an understanding of the implications of living with it, the two conditions together increasingly provide evidence to a survivor of her ‘failure’ to achieve socially determined expectations. She is once again left to see herself as inadequate and incapable of successful employment, while having to function in an atmosphere that is inhospitable and determined to put the responsibility for disclosure and accommodation on her. The findings here support this conclusion, as many stakeholders commented on the silencing of survivors and the challenges associated with seeking and providing accommodations, supporting disclosure, and the importance of flexibility within the workplace. The workplace functions as a microcosm of the larger society in which it is housed. As a result, workplace norms and narratives, the use of power and control, and the resulting impacts on the individual are key considerations if we are to shift the dominant discourse and address the second component of the structural solution.

The importance of the workplace environment is well documented in the BI literature (Bould & Callaway, 2021; Graff et al., 2021; Libeson et al., 2020; Shafi & Colantonio, 2021; Stergiou-Kita et al., 2016; Watter et al., 2021), with comments noting a negative impact on the ability to disclose and/or request accommodations (Gotsis & Kortezi, 2015; Spataro, 2005), as well as negative assumptions around individual capacity and contribution (Cavanagh et al., 2017; Jones & Schmidt, 2004; Lengnick-Hall et al., 2008; Shier et al., 2009). While not as extensively considered in the IPV literature, the challenges of an unsupportive organizational culture are also raised, particularly around disclosure (Giesbrecht, 2020; Swanberg et al., 2006; Swanberg et al., 2007). Here again, applying an intersectional lens leads me to consider what happens when you experience both.

Stakeholder comments highlighted experiencing shame and stigma, challenges around accommodation, lack of available supports, and expectations of the ‘ideal worker’ from an individual and an organizational perspective. The literature identifies self-determination, inner strength, and personal motivation as key factors in supporting a successful return-to-work post BI (Lefkovits et al., 2021; Libeson et al., 2020; Watter et al., 2021); however, these qualities are some of the most likely to be undermined by exposure to IPV. Additionally, existing studies comment on the importance of family support during the return-to-work process after a BI, (Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020; Watter et al., 2021) and note that, in cases where it is not available, return-to-work is actively hindered (Libeson et al., 2020). This issue presents another unique barrier for women exposed to IPV-BI: their family may be either unsafe or non-existent, because an abusive partner will often cut women off from their own family as a means of control. Women exposed to IPV-BI are therefore subjected to exacerbated impacts, since factors previously seen as protective are most likely to be actively

undermined or threatened by an abusive partner. This consequence diminishes the prospect of successful employment post-exposure even further.

Stakeholders reported many instances of workplace-related shame and silencing, as well as circumstances where they were unable to carry out their job tasks because of their partner's abusive behaviours. Many identified the difficulty of keeping the experience of home-based violence separate from a professional life, noting that it took considerable effort to be 'normal' at work the next day. I propose that these examples demonstrate a 'disabling' quality to exposure to IPV in that, like (dis)ability, IPV exposure produces shame and stigma, and interferes with productivity in the workplace. It puts survivors at high risk of low self-esteem and low sense of self-worth, because they conceptualize their inability to achieve a normative standard as a personal deficit, rather than recognizing it as a structurally imposed ideal intended to financially benefit the organization. These issues effectively put women survivors of IPV-BI under multiple layers of disablement, in which the condition of BI and the experience of IPV leave them vulnerable to degradation by an ableist workplace.

I find it interesting that no one has yet conceptualized IPV as a form of disablement. As I alluded to earlier, there is a clear comparison, given that the two are remarkably similar in many ways and have an established relationship, as either one is a known risk factor for the other. The fact that I am unable to find any information that considers IPV as a form of disablement leads me to ask: why not? I would suggest that, in part, the answer lies in the dominant narrative of IPV being seen as a personal 'problem', brought on by a woman's lack of character or her inability to make 'good life choices'. At best, a survivor may be assigned some credit if her social context can be considered as either ameliorating or causal, but she is still held accountable for her own 'choices'. Here again, I would suggest that a reconceptualization of the intersection

of IPV-BI from an individual problem to that of a public health crisis might reduce the ‘shame and blame’ response that is currently prevalent and, at least, open a space for the prioritization of timely identification, diagnosis, and effective care. Here again, Intersectionality theory (Bowleg, 2012; Crenshaw, 1993; Olesky, 2011) is useful: it provides a mechanism for considering IPV-BI as a unique identity category that integrates both the social and the medical aspects.

Intersectionality conceptualizes a new identity and demands that we engage with that new identity as a separate and distinct lived experience (Bowleg, 2012; Tolhurst et al., 2012). Using an Intersectionality lens, IPV-BI is not experienced as merely the sum of the two conditions, it must be considered as a distinct identity, and, I would argue, one wherein the qualities and impacts of each condition are exponentially amplified by the co-existence of the other.

While there are potential ways to ameliorate this issue, these too appear to be subject to the challenges of complexity and lack of awareness discussed previously. Findings have noted the difference that a supportive environment made for survivors, one which understood the challenges of IPV-BI and provided flexibility, accommodation, and access to supports. Many stakeholders discussed the need for workplace policies and procedures to be put in place around IPV-BI support, and key roles and contacts to be identified in advance of people actually needing to use them. This need is in direct support of the existing literature that suggests that a proactive approach to supports is key to successful employment (Bould & Callaway, 2021; Cavanagh et al., 2017; Glintborg et al., 2017; Gotsis & Kortezi, 2015; Lengnick-Hall et al., 2008; MacGregor et al., 2017; Swanberg et al., 2007). However, the findings here also revealed the common practice of needing a formal diagnosis to gain access to (dis)ability-related supports. For this group of BI survivors, perhaps more than any other, this requirement acts as a significant barrier. The literature identifies that many IPV survivors are frequently unable or unwilling to identify

themselves as being at risk of BI, and that access to medical care is often used as a method of control (St. Ivany, Bullock et al., 2018; St. Ivany, Kools et al., 2018). This finding was also supported here, raising the question: if women exposed to IPV are not able to seek medical care and are, therefore, barred from receiving a formal diagnosis of BI, how can they get access to appropriate (dis)ability-related employment supports?

Like all complex problems, the issue of identification and formal diagnosis of IPV-BI defies simple solutions. The literature raises the issue of the risks and benefits to diagnosis (Campbell et al., 2018; Haag, Jones et al., 2022; Haag, Sokoloff et al., 2019), particularly given the reality that we have limited services available and those that do exist are troubled with additional barriers to access and uptake for this population. The question must then be asked: is a formal diagnosis attainable and/or desirable for survivors of IPV-BI? If the answer remains unclear, or if appropriate support services remain largely unavailable to them, should we not seek a support model that does not rely on having a diagnosis? It has been suggested that community-based brain injury associations can be a viable support option (Toccalino et al., 2022a, 2022b), for the singular reason that they do not require a diagnosis to access services. There exists an excellent opportunity to use such organizations to expand existing capacity and provide the tailored IPV-BI employment support services identified here as critically needed. To start addressing these challenges, it is crucial to employ innovative, interdisciplinary, and multi-sectoral solutions that decentralize the authority currently held by healthcare professionals in the existing medical model approach for identification and diagnosis. These women are already subjected to an overabundance of mechanisms of power and control; therefore, solutions that seek to reduce these mechanisms and restore power to the survivors themselves are sorely needed.

Particularly relevant in the literature then is the conversation about ableist organizational policies and procedures as a specific mechanism of power and control (Alvesson, 2008; Gotsis & Kortezi, 2015; Harlan & Robert, 1998; Jack & Lorbiecki, 2007; Spataro, 2005). Micro and mezzo power dynamics, such as withholding information, denying requests for accommodation, monitoring work-related activities, and regulating behaviours are used to encourage workers to self-police and control each other (Acker, 2006; Harlan & Robert, 1998; Gotsis & Kortezi, 2015). This approach is unpleasant enough for workers who are differently abled, but it leaves women survivors of IPV-BI open to coercive control at home and in the workplace. These women are now exposed to layers of power and control in two main areas of their lives, and during most of their waking hours. If neither the home nor the workplace is safe, there is little space left to seek refuge.

In part, what underlies the use of power and control tactics in the organization is the current conceptualization and desirability of the ‘ideal’ worker. A capitalist, neo-liberal society such as ours measures ‘success’ through productivity and financial independence. The (dis)ability literature explores the implications for differently abled individuals working within this construct, noting that the mechanisms of internal power and control used by the organization to shape the worker are based on a desired ideal that is capable of peak efficiency and productivity (Alvesson, 2008; Gotsis & Kortezi, 2015; Jack & Lorbiecki, 2007; Spataro, 2005). Differently abled workers are only hired when there is a direct benefit to the organization (Luecking et al., 2006), and, therefore, are forced to adapt to an ableist construction of the workplace to be eligible to participate (Foster, 2007; Harlan & Robert, 1998; Roulstone et al., 2003, as cited in Williams & Mavin, 2012).

Interestingly, the IPV literature does not offer much conversation on this topic. What little there is focuses either on the impact of IPV on the individual, exploring economic concerns (Adams et al., 2013; MacGregor et al., 2017; Moe & Bell, 2004; Swanberg et al., 2007) and career interruption or termination (Banyard et al., 2011; Crowne et al., 2011; Giesbrecht, 2020; MacGregor et al., 2020; Maskin et al., 2019; Wathen et al., 2018) or on the workplace itself, considering issues around workplace safety (Fejedelem, 2008; Giesbrecht, 2020; MacGregor et al., 2017; Moe & Bell, 2004; Swanberg et al., 2006) and economic loss through decreased productivity and increased administrative costs (Fejedelem, 2008; Giesbrecht, 2020; MacGregor et al., 2019; Maskin et al., 2019; Moe & Bell, 2004; Swanberg et al., 2006; Zhang, 2012). The exploration of survivors' experiences of work within the current neo-liberal context and the implementation of power and control to achieve peak productivity are not considered. While this discussion is not yet present in the literature, it is not difficult to extrapolate from what I have already covered and begin to see the magnitude of challenge for women survivors of IPV-BI and the risk of leaving them vulnerable to a repetitive cycle of underemployment and unemployment. Again, I am left to ask the question: why? Why is it that, despite having theoretical frameworks that allow us to (de)construct difference through an intersectional and critical perspective, we continue to conceptualize women exposed to IPV-BI such that they are left at high risk of unsatisfactory employment?

As much as Intersectionality provides a means to identify pieces of the answer, it also has its limitations, as discussed in Chapter 3. The most concerning, and relevant limitation is its lack of potential to bring about actual change (Olesky, 2011). Intersectionality offers ways to explain the situation but not to shift it; consequently, if my goal is to shift the narrative, another lens is needed. By employing the approach laid out in the discussion of the Considered Inclusive

Framework, I can draw from knowledge in other fields to alter the way we conceptualize and approach IPV-BI. I would suggest that at least part of the answer to the question above lies in the expendability of women with disabilities and/or experience of IPV.

In 2006, with *Precarious Life: The Powers of Mourning and Violence*, and in 2010, with *Frames of War: When is Life Grievable?* Judith Butler expands her previous theoretical work, exploring what determines when human life is worth grieving, and introducing the concepts of precariousness and precarity. She proposes that precariousness is found in the bodily vulnerability shared by all human beings; however, precarity is the unequal exposure some bodies experience to this vulnerability, an over-exposure that is usually defined politically or socially. The allocation of precarity is determined by dominant norms that identify “whose life is grievable and worth protecting and whose life is ungrievable, or marginally or episodically grievable and so, in that sense, already lost in part or in whole, and thus less worthy of protection and sustenance” (Butler, 2012, p. 148). She goes on to note that precarity is sustained through “the organization of economic and social relationships, the presence or absence of sustaining infrastructures and social and political institutions” (Butler, 2012, p. 148). Butler builds on Foucault’s work that lays out how a group of individuals are transformed into a population through active management with “comprehensive measures, statistical assessments, and interventions aimed at the entire social body or at groups taken as a whole” (1986, p. 267, as cited in Watson, 2012). She suggests that precarity is “the maintenance and control of bodies and persons, the production and regulation of persons and populations, and the circulation of goods insofar as they maintain and restrict the life of the population” (Butler, 2006, p. 52).

Butler argues that all political attempts to manage groups utilize a thought-out allocation of precarity, actively selecting who is worthy of safety and who is expendable. I propose to

marginally widen this context, suggesting that this approach occurs not only within a political context in society at large but also within the microcosm of society that is the workplace. I suggest that Butler's ideas on precarity and grievability provide another viable path to unpack these norms and narratives and the use of power and control, a path not taken to date. In her 2010 work, Butler discusses the use of frames employed by privileged groups to present other groups in a certain light for the purpose of eradicating them: if you first make them ungrievable, you do not mourn their loss when you remove them.

I propose to stretch this concept one step further: if you make differently abled people something that never belonged, you make it acceptable to exclude them. I suggest that we need to value difference, create spaces in which it can thrive, and then seek it out to achieve equality. How different employment and employability might be for women exposed to IPV-BI if, as suggested by a stakeholder earlier, their experiences and 'deficits' were reframed as valuable skill sets and exceptionalities that can benefit the workplace and the employer. This is the shift that must take place: these women must be seen as valued members of our society who have much to contribute. In short, to use Butler's language, they must be grievable. It is a lofty goal that, like all things in the 'real world', can only be feasible and sustainable, with a financial base to draw on.

The remaining observation laid out in the opening of this chapter is clearly linked to the final critical component of any viable structural solution we design — there must be adequate funding to sustain it. Despite existing literature documenting new and expanding service needs, extensive recommendations for practice improvements, and comprehensive coverage of critical gaps in knowledge to be addressed through future research, very few authors specifically focus on the need for funding to support these advancements. The explicit need for government

investment into knowledge generation and sustainable supports has been identified by some previous studies (Ballan et al., 2014; Haag, Biscardi et al., 2019; Toccalino et al., 2022a), but, in general, it appears to be either an assumed need or an overlooked conversation.

The findings here have covered funding-related challenges repeatedly and from a variety of perspectives, such as service development and delivery, education and training, access to effective rehabilitation programs, supportive employment programming, and the financial implications of a long-term ‘recalibration phase’ necessary for a successful outcome for survivors of IPV-BI. Yet, the IPV literature does not discuss this issue at all with respect to employment needs, and the BI literature briefly notes that services intended to support employment for survivors are limited and difficult to access, despite evidence to suggest their success (Hooson et al., 2013; Lefkovits et al., 2021; Libeson et al., 2020; Richard et al., 2021; Watter et al., 2021). There is no lack of evidence in the literature to support that the need is there, but an accompanying, transparent call to prioritize funding seems to be missing. I wish to take this opportunity to underscore the need to re-envision women exposed to IPV-BI as grievable and as having the human right to equal access to meaningful work. This goal will require the prioritization of financial resources to achieve successful outcomes. Here, then, is a clear call to all levels of government: IPV-BI is both a social and healthcare crisis and desperately requires adequate funding to support knowledge expansion, service design and delivery, and policy development and implementation.

This section has outlined the need for a comprehensive, integrated response that combines both the medical and social aspects. The findings here clearly show that a simple one-size-fits-all approach to supporting employment for women exposed to IPV-BI will not be enough. We need a structural solution that takes an interdisciplinary approach to knowledge

transfer and mobilization, that actively engages in shifting the narrative away from the existing individually situated, deficit driven conceptualization toward a valuing of difference itself, and that is backed up financially. I would like to complete this chapter by considering how social work can contribute to the task of achieving the integrated solution that I seek.

The Role of Social Work

As I am a social worker and this dissertation is submitted within a School of Social Work, it seems logical to conclude by drawing attention to ways in which my profession is uniquely suited to support these women along with a few gaps we must address moving forward. Social work seems, to me, to be best situated to effectively address most, if not all, of the gaps and suggestions listed above. In the following conversation, I present my thoughts on how we can put our collective knowledge and skills to their best use in this arena.

First, I would suggest that good social work is built on relationship and reflexivity. As such, I wish to take a moment to consider my part in this work, particularly as a woman who identifies as having a shared lived experience with the women here. What did my insider knowledge offer to this study and the observations herein? I think it provides a sensitivity to the subtleties and nuances within the experiences shared by the stakeholders. I am intimately acquainted with what it feels like, physically, cognitively, and emotionally, to maintain or obtain employment as a differently abled woman in a world that privileges a normative standard. I am capable of a level of understanding and comprehension around the impact of internalized stigma that may not be available to someone who has never experienced it. My insider status also helps me shape a study and leads me to ask questions that others might not — not because I believe I know what another survivor ‘must’ be experiencing, but rather because, based on my knowledge

and experience, I suspect what they ‘may’ be experiencing and wish to offer the opportunity to explore it further.

My insider status also allows for relationship to occur. Women exposed to IPV-BI experience shame, stigma, and blame from multiple sources. To have the opportunity to share their wisdom and guidance with an insider provides a safe space that honours them and privileges their voice without fear of someone doubting their honesty or disbelieving their experience. I understand on a deeper level and, when used carefully in the relationship, that shared experience can offer validation and support. It also can lead me astray, because I run a higher risk of making assumptions than others might. I might ask fewer questions when trying to understand the experiences described by stakeholders, as I rely on my own experience to fill in any gaps. It can also cause me more distress when engaging in the work than may be felt by others who did not have such a personal connection to the conversations shared by stakeholders. It is not comfortable to lean into the spaces in your life that are unpleasant or painful, no matter how far behind you they might be. Hearing someone else describe similar experiences in detail is not easy and must be considered before engaging in this type of process.

While this consideration of my personal insider status is relevant here, it is also an excellent example of how our profession can contribute to the solution proposed above. Social work is full of people who are drawn to the work because of their own lived experiences. Therefore, we have an opportunity to lead the way forward in redefining difference and lived experience as valuable assets to a helping profession. Advocacy and social justice are core tenets of our practice, allowing us to create a space in which we can contribute with our specialized skills and knowledge base. We can then combine them with the richness and diversity found among us to offer a nuanced approach to care within an interdisciplinary support model.

Second, while we are often seen as a practice-oriented discipline and, therefore, not imagined as ‘researchers’, I would suggest that we can excel in this field of enquiry, an observation also made by others (Mantell et al., 2018). Social work researchers are well versed in community-based, qualitative methods of research that lend themselves well to exploring many of the questions outlined above. We are trained in trauma-informed practice in a variety of contexts, allowing us to ask difficult questions and work alongside survivors in a respectful and careful manner. We are frequently situated in a bio-psycho-social model and, as such, are accustomed to understanding complex human conditions that require different ways of seeking knowledge, as well as being sensitive to the interconnectedness between them. We come to the table well equipped with the understanding and skills needed to work successfully with interdisciplinary teams. As trained relationship builders, we need only to see the research team as a relationship to be fostered and supported. We often use a critical lens to unpack the socially determined embodied experiences of marginalizing identities, and we have strong commitments to social justice and advocacy, with much of our scholarship framed this way. We are uniquely positioned with one foot in practice and one in scholarship, a balance that brings nuance and creativity to both aspects of what we do and would serve as an outstanding framework from which to explore the research questions outlined above.

Third, social work is equally well suited to move the needle forward in terms of practice. Our profession is very well represented among frontline workers supporting women exposed to both IPV and BI. We are frequently located in healthcare settings, community service organizations, rehabilitation centres, counselling agencies, and private practice. A considerable portion of the IPV frontline is populated by employees holding a degree in some type of social service work or social work designation. Clearly, we are already well established in the

appropriate locations. The recommendations for practice listed above encompass many of our foundational tenets: positioning the client at the centre of care; working with a client where they are at; seeking new knowledge and education as a part of our practice; a commitment to social justice and advocacy; a focus on empowerment; and using a strengths-based approach.

Unmistakeably, much of our professional lives are dedicated to the development and delivery of social services designed to support marginalized groups. We frequently work together, across sectors, to strengthen community capacity and build bridges between silos. We are well suited to identifying a ‘problem’ and finding creative solutions; it is, after all, what social workers *do* fundamentally. We need only recognize the intersection and collectively move forward to implement these recommendations. However, while that sounds like a simple solution, there are two key challenges that must be overcome to succeed.

The first obstacle lies in our own education and knowledge gaps. As someone who lives with a brain injury, who has spent the last 15 years in graduate studies in social work, and who is an educator of social workers, I am keenly aware of the level of knowledge that professional social workers hold about brain injury. It is not enough. Despite a significant growth in social work research into brain injury in the last 10–15 years, there are still very few articles worldwide that focus on the condition from the perspective of social work (Mantell et al., 2018). Stakeholders repeatedly noted the lack of IPV-BI training in frontline professionals. We could so easily include this knowledge in our curriculums and see a substantial increase in capacity. It is one of my strongest hopes to see this simple solution put in place immediately.

The second obstacle is that we are not well acquainted with the workplace. There does not seem to be as strong a relationship between business and social work as one might like in this circumstance. Aside from a peripheral role when providing EAP services, we are not as

embedded in places of employment as we are in the human service sector and, as such, advances within this sector will be more difficult and may take longer. However, as noted above, we are relationship builders by trade. We need only see the workplace as the next place to build a relationship. We must reach out to our local employers and offer them support through education and resources. We must prioritize cross-pollination and foster relationships between business, healthcare, rehabilitation, and social work to ensure that an ongoing multi-sectoral response is possible. We must position this solution as a mutually achievable goal and work together to see it through.

In conclusion, I would like to leave the final words to a stakeholder rather than to me. I agree wholeheartedly with this individual, and I am pleased to see their comments finish this work:

I feel like it's the most important thing happening in the world of IPV right now: this recognition of the prevalence of brain injury and hopefully transforming the way we do our work to make brain injury at the very, very forefront of what we talk about with women. (ED-8)

Appendix A

Information on the Larger Study

Supporting employment and mental health in brain injured women survivors of intimate partner violence: Addressing gaps in knowledge and support.

The larger study was funded by the Ontario Neurotrauma Foundation and supported by an interdisciplinary team of researchers led by me. Working with this team enabled me to gather more extensive data, which otherwise would not have been possible. Funding was awarded to my supervisor, Dr. Angela Colantonio, and administered by the University of Toronto as required by the funder.

Goal and Objectives

The overarching goal of the project was to provide in-depth information about the intersection between intimate partner violence (IPV) and brain injury (BI), and its implications for women's mental health and employment to develop and implement stakeholder informed knowledge transfer and/or mobilization materials intended to support employment and mental health among women exposed to IPV-related BI (IPV-BI). As the study was being designed in early 2020 just as the COVID-19 pandemic emerged, the team decided to include a secondary goal of exploring the impact of the pandemic on survivors and their service providers as well as service delivery and uptake. The study sought to improve social and health outcomes for women survivors by identifying and addressing relevant knowledge and service gaps and developing an innovative knowledge translation module to inform improvements in support sectors serving women survivors. It also provided an opportunity for women survivors to amplify their voices and share their lived experiences of employment and/or mental health within the context of their exposure to IPV-BI. The goal was achieved through the following objectives:

- 1) Explore specific employment and mental health related barriers and facilitators, service needs, and priorities for women survivors of IPV-BI;
- 2) Identify the needs, priorities, facilitators, and barriers to service delivery among frontline providers and employers regarding support of women survivors of IPV-BI;
- 3) Develop stakeholder informed, innovative knowledge translation and mobilization materials and implement them through our existing K2P Network and the *Abused & Brain Injured Toolkit*.

Team Members, Roles, and Responsibilities

The research team consisted of four women and me (HH). Four members of the team are white and at least three identify as cisgendered. Two interviewers (DT and HH) were doctoral candidates during the study with training in facilitation and qualitative research methods and one (HH) identifies as living with a BI. Team members came from multi-disciplinary backgrounds including social work (HH and AM), health systems and policy (DT), and occupational therapy (AC and JE) and represented different levels of career stages including masters' level students, doctoral candidates, and a senior scientist.

I was hired as the project coordinator and had complete oversight of the team. I was responsible for all aspects of the research project including drafting and submission of the funding application, study conceptualization and design, ethics submission and revision, stakeholder consultation and recruitment, interviewing and data co-construction, data coding and analysis, member checking, and final reporting and write up, as well as managerial and administrative duties. DT contributed to the interview guide design, ethics submission, interviewing and data co-construction, preliminary coding and data analysis. A research assistant

(AM) contributed to the preliminary coding and data analysis using only transcript material, and a final research assistant (JE) contributed to a separate data analysis process and write up of specific COVID-19 related findings not discussed here using only compiled preliminary themes and supporting quote material. After each stakeholder interview, DT and I met to debrief and discuss immediate reactions to the interviews. We also maintained separate written interview notes. During the initial coding phase DT, AM, and I read the interview transcripts and held multiple meetings to discuss preliminary codes, reach a consensus, and create a master coding document. This team approach provided an excellent opportunity for triangulation during data analysis. The final analysis reported on here was completed independently by me.

Previously Reported Findings

Because the project focused on different aspects of the experience of IPV-BI (employment, mental health, and COVID-19 impacts) the co-constructed data was extensive and rich. As a result, findings are reported across multiple manuscripts. The COVID-19 findings were published first, providing some of the first information on the topic (Haag, Toccalino et al., 2022). A scoping review exploring the intersection of BI and mental health among survivors of IPV was published in 2023 (Toccalino et al., 2023) and two further manuscripts reporting on (1) survivors' of IPV-BI and their service providers' perspectives on mental health supports; and (2) interwoven experiences of IPV-BI and mental health are currently under review.

Knowledge Transfer Products

Knowledge transfer resources were produced as part of the larger project. Two informational short videos, entitled *Mental Health and Brain Injury* is an educational video on

the intersection of mental health and brain injury which specifically considers the implications for women exposed to IPV. The second is entitled *The Snowball Effect* and is a compilation of stakeholders' direct quotes, woven into a narrative describing their experiences. These videos are freely available in the resource library on the *Abused & Brain Injured Toolkit* (<https://www.abitoolkit.ca/resource-library/video-library/>). In addition to these videos, two infographics were developed to disseminate key employment challenges and mental health concerns for survivors of IPV-BI. These infographics are also freely available for download from the resource library (<https://www.abitoolkit.ca/resource-library/downloadable-information-sheets/abi-toolkit-infographics/>).

Appendix B

Interview Guide: Executive Directors / Program Managers, Direct Service Providers, and Front Line Staff

Opening Statement:

The goals of this project are to provide in-depth information about the intersection between traumatic brain injury and intimate partner violence, and its implications for women's employment and mental health/substance use in order to develop and implement stakeholder informed knowledge transfer and/or mobilization materials intended to support employment and mental health/substance use among brain injured women survivors of intimate partner violence. With that context in mind, please answer the following:

1. What do you think are important topics to be covered? What do you feel are the key messages for support workers and/or employers to understand about women survivor's experiences of employment?
Suggestions: 1) Challenges to maintaining a job
 2) Barriers to finding a job
 3) Accommodations and Adaptations
 4) Support services
2. What kinds of employment support services are you aware of for women survivors?
 - 1) Do you think they are helpful
 - 2) Do you think women are able to get access to them
 - 3) Are there changes you would recommend
 - 4) Are there new services that should be developed & offered
3. What do you feel are the key messages for support workers to understand about women survivor's experiences of mental health?
 - 1) Recognition and acknowledgement of mental health/substance use concerns
 - 2) Barriers to seeking or accessing care for mental health/substance use concerns
 - 3) Support services
4. What kinds of mental health/substance use services are you aware of for women survivors?
 - 1) Do you think they are helpful
 - 2) Do you think women are able to get access to them
 - 3) Are there changes you would recommend
 - 4) Are there new services that should be developed & offered
5. In your opinion, what would be a useful way to present this information so support workers, survivors, and employers can make use of it and can refer to it when necessary?

Suggestions: 1) Website
2) Hardcopy
3) Online training (webinar)
4) In-house training (workshops or videos)
5) Case-studies (vignettes, demonstration scenarios, written cases)
6) Brochures with info for client take-away
7) Power point presentation for training sessions
8) Speaking notes for training sessions

6. We are interested in the impact you have seen of the COVID-19 pandemic on both your organization and the women you work with. How has your organization had to change in light of the pandemic? What impacts have you seen of the pandemic on the women you work with?

- 1) Virtual/online resources
- 2) In person services
- 3) Employment status
- 4) Mental health/substance use

7. Is there anything else on this subject that you think is important for us to know?

Interview Guide: Employers and Representatives of Employers and Labour Unions

Opening Statement:

One of the goals of this project is to provide in-depth information about the intersection between traumatic brain injury and intimate partner violence, and its implications for women's employment in order to develop and implement stakeholder informed knowledge transfer and/or mobilization materials intended to support employment among brain injured women survivors of intimate partner violence. With that context in mind, please answer the following:

1. What do you think are important topics to be covered? What do you feel are the key messages for support workers and/or employers to understand about women survivor's experiences of employment?
 - 1) Challenges to maintaining a job
 - 2) Barriers to finding a job
 - 3) Accommodations and Adaptations
 - 4) Support services
2. What kinds of employment support services are you aware of for women survivors?
 - 5) Do you think they are helpful
 - 6) Do you think women are able to get access to them
 - 7) Are there changes you would recommend
 - 8) Are there new services that should be developed & offered
3. What are your organization's policies and procedures around supports available to women survivors of IPV in your organization?
 - 1) What challenges do you see in offering these supports
 - 2) What are the challenges you can see for women accessing them
 - 3) Are there ways changes you would like to see happen
4. What are your organization's policies and procedures around supports available to people with concussion and/or traumatic brain injury?
 - 1) What challenges do you see in offering these supports
 - 2) What are the challenges you can see for women accessing them
 - 3) Are there ways changes you would like to see happen
5. In your opinion, what would be a useful way to present this information so support workers, survivors, and employers can make use of it and can refer to it when necessary?
 - 1) Website
 - 2) Hardcopy
 - 3) Online training (webinar)
 - 4) In-house training (workshops or videos)
 - 5) Case-studies (vignettes, demonstration scenarios, written cases)

- 6) Brochures with info for client take-away
- 7) Power point presentation for training sessions
- 8) Speaking notes for training sessions

6. Is there anything else on this subject that you think is important for us to know?

Interview Guide: Women Survivors

Opening Statement:

We are aware that some women who have experienced intimate partner violence may also have difficulty with cognitive tasks like memory, planning daily activities, multi-tasking, concentration and physical challenges such as headaches, dizziness, and ringing in their ears. They may also feel they have trouble managing their emotions or feel depressed or anxious a lot of the time. We also know that many women experiencing intimate partner violence also face challenges finding and/or maintaining employment. We would like to expand our educational toolkit to help people better understand these challenges and how they can improve their services to help. Keeping that in mind, please answer the following:

1. Please discuss some of the ways in which your experience of employment has been affected by intimate partner violence?
Suggestions: 1) Challenges with maintaining a job
 2) Barriers to finding a job
 3) Positive action taken by employers
 4) Support services that you were able to use that were useful to you
2. How important is it to you to have a job? Why?
3. What do you think are important topics to be included in the educational materials we are developing? What do you think support service providers should know in order to help you better? What do you think employers should know in order to help you better?
Suggestions: 1) Accommodations and Adaptations
 2) Disclosure
 3) Access to supports
4. In a perfect world, what kind of employment support services would you like to see for women survivors of IPV who also experience the added challenges discussed above?
Suggestions: 1) Healthcare related
 2) Legal
 3) Financial
 4) Job shadowing and coaching
5. How have you experienced mental health or substance use in your life?
Suggestions: 1) Personal experiences with mental health or substance use
 2) What does mental health/illness look/feel like to you
 3) What does substance use/misuse look/feel like to you
6. Where do you go for healthcare and/or healing?
Suggestions: 1) Who do you go to for health-related support or guidance
 2) Who do you talk to about healing
 3) What kinds of healing do you go for

7. What has been your experience with healing overall?
Suggestions:
 - 1) What do you feel works well
 - 2) What doesn't work well
 - 3) Are there any gaps, do you have needs that aren't addressed
8. We are interested in the impact you have experienced with COVID-19. How has your daily life changed? How have your support systems been affected?
 - 1) Access to supports/resources
 - 2) Employment status
 - 3) Mental health/substance use
9. Is there anything else on this subject that you think is important for us to know?

Appendix C

Consent Form

Supporting employment and mental health in brain injured women survivors of intimate partner violence: Addressing gaps in knowledge and support.

Statement of Consent:

By signing this form, you consent to participate in Phase 1 of the study. You agree that all your concerns and questions about this study have been addressed and understand that you can contact the research team or the University of Toronto Research Ethics Board if you have any further questions.

Print Name	Signature	Date
------------	-----------	------

Contact Information where you can be safely reached to set up an interview or focus group:

-

Can we leave a message at the above contact?:

- ☐ Yes
- ☐ No

In the event that you appear distressed during the interview or focus group, may we contact you using the information provided above to follow up?

- ☐ Yes
- ☐ No

Witness

Print Name	Signature	Date
------------	-----------	------

Optional Consent for Re-Contact:

It is possible that we may wish to re-contact you after your initial interview/focus group session in order to confirm details, check in with you regarding our analysis, or seek further information or clarification. Also, there are two more phases to this study: a test phase during which organizations will be asked to use the materials and/or recommendations developed for a period of 2-4 months; and an evaluation phase during which feedback and comments will be sought to determine efficacy and viability of the materials and/or

recommendations developed. You may choose to participate in a Phase 1 interview and not provide consent for re-contact if you wish.

May we use the contact information you provided above to re-contact you for these purposes?

☐ Yes

☐ No

Your Initials:

Appendix D

University of Toronto Ethics Approval



UNIVERSITY OF
TORONTO

OFFICE OF THE VICE-PRESIDENT,
RESEARCH AND INNOVATION

RIS Protocol

Number: 39175

Approval Date: 20-Aug-20

PI Name: Dr Angela Colantonio

Division Name:

Dear Dr Angela Colantonio:

Re: Your research protocol application entitled, "Supporting Employment in Brain Injured Women Survivors of Intimate Partner Violence"

The Health Sciences REB has conducted a Full Board review of your application and has granted approval to the attached protocol for the period 2020-08-20 to 2021-08-18.

Please note that this approval only applies to the use of human participants. Other approvals may be needed.

Please be reminded of the following points:

- An **Amendment** must be submitted to the REB for any proposed changes to the approved protocol. The amended protocol must be reviewed and approved by the REB prior to implementation of the changes.
- An annual **Renewal** must be submitted for ongoing research. Renewals should be submitted between 15 and 30 days prior to the current expiry date.
- A **Protocol Deviation Report (PDR)** should be submitted when there is any departure from the REB-approved ethics review application form that has occurred without prior approval from the REB (e.g., changes to the study procedures, consent process, data protection measures). The submission of this form does not necessarily indicate wrong-doing; however follow-up procedures may be required.
- An **Adverse Events Report (AER)** must be submitted when adverse or unanticipated events occur to participants in the course of the research process.
- A **Protocol Completion Report (PCR)** is required when research using the protocol has been completed. For ongoing research, a PCR on the protocol will be required after 7 years, (Original and 6 Renewals). A continuation of work beyond 7 years will require the creation of a new protocol.
- If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Status: Approved by Full Com		Version: 0003	Protocol #: 20376	Sub Version: 0000	Approved On: 20-Aug-20	Expires On: 18-Aug-21	Page 15 of 15
OFFICE OF RESEARCH ETHICS McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada Tel: +1 416 946-3273 ● Fax: +1 416 946-5763 ● ethics.review@utoronto.ca ● http://www.research.utoronto.ca/for-researchers-administrators/ethics							

Wilfrid Laurier University Ethics Approval

ROMEO - Researcher Portal

Project Info.

File No: 6611

Project Title: Supporting Employment in Brain Injured Women Survivors of Intimate Partner Violence

Principal Investigator: Dr. Nancy Freymond (Faculty of Social Work)

Start Date: 2020/09/24

End Date: 2023/09/30

Keywords:

Project Team Info.

Principal Investigator

Prefix: Dr.

Last Name: Freymond

First Name: Nancy

Affiliation: Faculty of Social Work

Position: Associate Professor

Email: nfreymond@wlu.ca

Phone1:

Phone2:

Fax:

Primary Address:

Institution: Wilfrid Laurier University

Country: Canada

Comments:

Other Project Team Members

Prefix	Last Name	First Name	Affiliation	Role In Project	Email
Ms.	Haag	Halina	Faculty of Social Work	Co-Investigator	hhaag@wlu.ca
	Colantonio	Angela	External	Co-Investigator	angela.colantonio@utoronto.ca

References

- Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender & Society*, 4, 139-158.
- Acker, J. (2006). Inequality regimes: Gender, class, and race in organizations. *Gender & Society*, 20(4), 441-464.
- Ackerman, R.J. & Banks, M.E. (2009). Traumatic brain injury and disability as a consequence of assault: Focus on intimate partner violence. In C.A. Marshall, E. Kendall, M.E. Banks & R.M.S. Gover (Eds.) *Disabilities Insights From Across Fields and Around the World*. Connecticut, London, Praeger Perspectives.
- Adams, A.E., Tolman, R.M., Bybee, D., Sullivan, C.M. & Kennedy, A.C. (2013). The impact of intimate partner violence on low-income women's economic well-being: The mediating role of job stability. *Violence Against Women*, 18(12), 1345-1367.
- Åhman, S., Saveman, B. I., Styrke, J., Björnstig, U., & Stålnacke, B. M. (2013). Long-term follow-up of patients with mild traumatic brain injury: a mixed-method study. *Journal of rehabilitation medicine*, 45(8), 758–764. <https://doi.org/10.2340/16501977-1182>
- Alves, D. E., Nilsen, W., Fure, S. C. R., Enehaug, H., Howe, E. I., Løvstad, M., Fink, L., Andelic, N., & Spjelkavik, Ø. (2020). What characterises work and workplaces that retain their employees following acquired brain injury? Systematic review. *Occupational and environmental medicine*, 77(2), 122–130. <https://doi.org/10.1136/oemed-2019-106102>
- Alvesson, M. (2008). The future of critical management studies. In D. Barry & H.

- Hansen (Eds.) *The Sage Handbook of New Approaches in Management and Organization*. London, Sage Publications Ltd.
- Amoroso, T. & Iverson, K.M. (2017). Acknowledging the Risk for Traumatic Brain Injury in Women Veterans. *The Journal of Nervous and Mental Disease*, 205(4), 318-323.
- Andelic, N., Arango-Lasprilla, J.C. & Roe, C. (2013). The complexity of traumatic brain injury. *Journal of Rehabilitation Medicine*, 45, 708-709.
- Anderson, J.C., Stockman, J.K., Sabri, B., Campbell, D.W. & Campbell, J.C. (2015). Injury outcomes in African American and African Caribbean women: The role of intimate partner violence. *Journal of Emergency Nursing*, 41(1), 36-42.
- Asch, A. & Rousso, H. (1985). Therapists with disabilities: Theoretical and clinical issues. *Psychiatry*, 48, 1-12.
- Ballan, M.S., Freyer, M.B., Marti, C.N., Perkel, J., Webb, K.A., & Romanelli, M. (2014). Looking beyond prevalence: A demographic profile of survivors of intimate partner violence with disabilities. *Journal of Interpersonal Violence*, 29(17), 3167-3179.
- Banks, M.E. (2007). Overlooked but critical: Traumatic brain injury as a consequence of interpersonal violence. *Trauma, Violence, Abuse*, 8(3), 290-298.
- Banyard, V., Potter, S. & Turner, H. (2011). The impact of interpersonal violence in adulthood on women's job satisfaction and productivity: The mediating roles of mental and physical health. *Psychology of Violence*, 1(1), 16-28.
- Barlow, J., Wright, C. & Wright, S. (2003). Development of job-seeking ability in

- people with arthritis: evaluation of a pilot program. *International Journal of Rehabilitation Research*, 26(4), 329-333.
- Barnartt, S.N. & Altman, B.M. (2001). Introduction: Exploring theories and expanding methodologies: Where we are and where we need to go. *Research In Social Science and Disability*, 2, 1-7.
- Barnes, C. (2000). A working social model? Disability, work and disability politics in the 21st century. *Critical Social Policy*, 20, 441-457.
- Barnes, C. (2003). What a difference a decade makes: reflections on doing 'emancipatory' research. *Disability & Society*, 18(1), 3-17.
- Barton, L. (2005). Emancipatory research and disabled people: Some observations and questions. *Educational Review*, 57(3), 317-327.
- Baumann, R.M., Hamilton-Wright, S., Riley D. L., Brown, K., Hunt, C., Michalak, A., & Matheson, F.I. (2018). Experiences of Violence and Head Injury Among Women and Transgender Women Sex Workers. *Sexuality Research and Social Policy: A Journal of the NSRC* doi.org.10.1007/s13178-018-0334-0.
- Bazarian, J.J., McClung, J., Shah, M.N., Cheng, Y.T., Flesher, W. & Kraus J. (2005). Mild traumatic brain injury in the United States, 1998--2000. *Brain Injury*, 19(2), 85-91.
- Bendl, R., Fleischmann, A. & Walenta, C. (2008). Diversity management discourse meets queer theory. *Gender in management: An International Journal*, 23(6), 382-394.
- Bould, E., & Callaway, L. (2021). A co-design approach to examine and develop pathways to open employment for people with acquired brain injury. *Brain*

- Impairment*, 22(1), 50-66. <https://doi.org/10.1017/BrImp.2020.9>
- Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267-1273.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Brown, K., Hamner, D., Foley, S. & Woodring, J. (2009). Doing disability: Disability formations in the search for work. *Sociological Inquiry*, 79(1), 3-24.
- Bryant, R.A. (2001). Posttraumatic stress disorder and traumatic brain injury: Can they co-exist? *Clinical Psychology Review*, 21, 931-948.
- Bukowski, L.A., Hampton, M.C., Escobar-Viera, C.G., et al. (2019). Intimate partner violence and depression among black transgender women in the USA: The potential suppressive effect of perceived social support. *Journal of Urban Health*.
- Burrell, G. & Morgan, G. (1979). Sociological paradigms and organisational analysis: Elements of the sociology of corporate life (London, Heinemann).
- Butler, J. (2006). *Precarious life: The Powers of Mourning and Violence*. Second edition. London, Verso.
- Butler, J. (2010). *Frames of War: When is Life Grievable?* Second edition. London, Verso.
- Butler, J. (2012). Precarious life, vulnerability, and the ethics of cohabitation. *Journal of Speculative Philosophy*, 26(2), 134-151.
- Camilleri, P. (1999). Social work and its search for meaning: Theories, narratives and practices. In B. Pease and J. Fook (Eds.), *Transforming Social Work Practice*,

- Postmodern Critical Perspectives*. (pp.25-39). London, New York: Routledge.
- Campbell, F. (2009). *Contours of Ableism. The Production of Disability and Abledness*. Basingstoke, Palgrave Macmillan.
- Campbell, J.C., Anderson, J.C., McFadgion, A., Gill, J., Zink, E., Patch, M., & Campbell, D. (2018). The effects of intimate partner violence and probable traumatic brain injury on central nervous system symptoms. *Journal of Women's Health*, 27(6), 761-767.
- Cancelliere, C., Donovan, J., & Cassidy, J. D. (2016). Is sex an indicator of prognosis after mild traumatic brain injury: A systematic analysis of the findings of the World Health Organization Collaborating Centre Task Force on Mild Traumatic Brain Injury and the International Collaboration on Mild Traumatic Brain Injury Prognosis. *Archives of physical medicine and rehabilitation*, 97, S5–18.
<https://doi.org/10.1016/j.apmr.2014.11.028>
- Cavanagh, J., Bartram, T., Meacham, H., Bigby, C., Oakman, J. & Fossey, E. (2017). Supporting workers with disabilities: A scoping review of the role of human resource management in contemporary organisations. *Asia Pacific Journal of Human Resources*, 55, 6-43.
- Centre for Evidence-Based Orthopaedics, McMaster University. Retrieved September 24, 2023 from <https://www.ipveducate.com/>
- Centre for Research & Education of Violence Against Women & Children. Retrieved September 24, 2023 from <http://www.dvatwork.ca/>
- Chan, F., Strauser, D., Maher, P., Lee, E., Jones, R. & Johnson, E. (2010). Demand-side factors related to employment of people with disabilities: A survey of employers in the midwest region of the United States. *Journal of*

- Occupational Rehabilitation*, 20(4), 412-419.
- Charmaz, K. (2010). Disclosing illness and disability in the workplace. *Journal of International Education in Business*, 3(1/2), 6-19.
- Colantonio, A. (2016). Sex, gender, and traumatic brain injury: A commentary. *Archives of Physical Medicine*, 97(2), 51-54.
- Colantonio, A., Mar, W., Escobar, M., Yoshida, K., Velikonja, D., Rizoli, S., Cusimano, M. & Cullen, N. (2010). Women's health outcomes after traumatic brain injury. *Journal of Women's Health*, 19(6), 1109-1116.
- Corrigan, J.D., Wolfe, M., Mysiw, J., Jackson, R.D. & Bogner, J.A. (2003). Early identification of mild traumatic brain injury in female victims of domestic violence. *American Journal of Obstetrics & Gynecology*, 188(5), S71-S76.
- Corrigan, J., Lineberry, L., Komaroff, E., Langlois, J., Selassie, A. & Wood, K. (2007). Employment after traumatic brain injury: differences between men and women. *Archives of Physical Medicine and Rehabilitation*, 88(11), 1400-1409.
- Crenshaw, K. (1993). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review*, 43(6), 1241-1299.
- Crowne, S.S., Juon, H., Ensminger, M., Burrell, L., McFarlane, E. & Duggan, A. (2011). Concurrent and long-term impact of intimate partner violence on employment stability. *Interpersonal Violence*, 26(6), 1282-1304.
- Cullen N.K., & Weisz K. (2011). Cognitive correlates with functional outcomes after anoxic brain injury: a case-controlled comparison with traumatic brain injury. *Brain Injury*, 25, 35-43. doi: 10.3109/02699052.2010.531691
- Danforth, S. (2006). From epistemology to democracy: Pragmatism and the

- reorientation of disability research. *Remedial and Special Education*, 27(6), 337-345.
- Danieli, A. & Woodhams, C. (2005). Emancipatory research methodology and disability: a critique. *International Journal of Social Research Methodology*, 8(4), 281-296.
- Daugherty, J.C., Verdejo-Román, J., Pérez-García, M., & Hidalgo-Ruzzante, N. (2020). Structural brain alterations in female survivors of intimate partner violence. *Journal of Interpersonal Violence*, 1-34. DOI: 10.1177/0886260520959621
- Davis, A. (2014). Violence-related mild traumatic brain injury in women: Identifying a triad of postinjury disorders. *Journal of Trauma Nursing*, 21(6), 300-308.
- Deetz, S. (1996). Describing Differences in Approaches to Organization Science: Rethinking Burrell and Morgan and Their Legacy. *Organization Science*, 7(2), 191-207. <https://doi.org/10.1287/orsc.7.2.191>
- Denzin, N.K., & Lincoln, Y.S. (1998) *Collecting and interpreting qualitative materials.*: Sage.
- Denzin, N.K., & Lincoln, Y.S. (2000) *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Dobusch, L., (2016). Gender, dis-/ability and diversity management: Unequal dynamics of inclusion? *Gender, Work & Organization*, 1-19.
- Donnelly, M. & Given, F. (2010). Employment programs and professionals with a disability. *Work*, 36(2), 217-225.
- Donker-Cools, B. H., Daams, J. G., Wind, H., & Frings-Dresen, M. H. (2016). Effective return-to-work interventions after acquired brain injury: A systematic review. *Brain injury*, 30(2), 113–131. <https://doi.org/10.3109/02699052.2015.1090014>

- Dunn, E., Wewiorski, N. & Rogers, E. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59-62.
- Eckhardt, E., & Anastas, J. (2007). Research methods with disabled populations. *Journal of Social Work in Disability & Rehabilitation*, 6(1/2), 233-249.
- Ely, R. & Thomas, C. (2001). Cultural diversity at work: The effects of diversity perspectives on work group processes and outcomes. *Administrative Science Quarterly*, 46(2), 229-273.
- Farley, M., Banks, M.E., Ackerman, R.J. & Golding, J.M. (2018). Screening for traumatic brain injury in prostituted women. *Dignity: A Journal on Sexual Exploitation and Violence*, 3(2), 1-21.
- Faul M., Xu, L., Wald., M.M., & Coronado, V.G. (2010). Traumatic brain injury in the United States: Emergency department visits, hospitalizations and deaths 2006-2010. Atlanta: Centers for Disease Control and Prevention. National Center for Injury Prevention and Control.
- Fejedel, K. (2008). "Private" problem in a public place: a feminist criminological examination of union responses to workplace domestic violence. *UMI Dissertations Publishing*.
- Fleming, J., Tooth, L., Hassell, M., & Chan, W. (1999). Prediction of community integration and vocational outcome 2-5 years after traumatic brain injury rehabilitation in Australia. *Brain injury*, 13(6), 417-431.
<https://doi.org/10.1080/026990599121476>
- Folzer, S.M. (2001). Psychotherapy with "mild" brain-injured patients. *American Journal*

- of Orthopsychiatry*, 71(2), 245-251.
- Foster, D. (2007). Legal obligation or personal lottery? Employee experiences of disability and the negotiation of adjustments in the public sector workplace. *Work, Employment & Society*, 21, 67-84.
- Foster, D. & Wass, V. (2012). Disability in the labour market: An exploration of concepts of the ideal worker and organizational fit that disadvantage employees with impairments. *Sociology*, 47(4), 705-721.
- Franulic, A., Carbonell, C. G., Pinto, P., & Sepulveda, I. (2003). Psychosocial adjustment and employment outcome 2, 5 and 10 years after TBI. *Brain Injury*, 18(2), 1-11.
<https://doi.org/10.1080/0269905031000149515>
- Friedland, D. & Price, R. (2003). Underemployment: Consequences for the health and well-being of workers. *American Journal of Community Psychology*, 32(1-2), 33-45.
- Galovski T., Werner K., Weaver T., Morris K., Dondanville K., Nanney J., Wamser-Nanney, R., McGlinchey, G., Fortier, C.B., & Iverson, K.M. (2022). Massed cognitive processing therapy for posttraumatic stress disorder in women survivors of intimate partner violence. *Psychological Trauma: Theory, Research, Practice, and Policy*, 14(5), 769–779. doi: 10.1037/tra0001100
- Garthe, R.C., Hidalgo, M.A., Hereth, J., Garofalo, R., Reisner, S.L., Mimiaga, M.J., & Kuhns, L. (2018). Prevalence and risk correlates of intimate partner violence among a multisite cohort of young transgender women. *LGBT Health*, 5(6), 333-340.
- Giesbrecht, C. J. (2020). Toward an Effective Workplace Response to Intimate Partner

- Violence. *Journal of Interpersonal Violence*, 37(3–4), 1158–1178.
<https://doi.org/10.1177/0886260520921865>
- Gioia, D. A., & Pitre, E. (1990). Multiparadigm perspectives on theory building. *Academy of Management Review*, 15(4), 584-602.
doi.org/10.5465/amr.1990.4310758
- Glintborg, C., Thomsen, A.S., & Hansen, T.G. (2017). Beyond Broken Bodies and Brains: A Mixed Methods Study of Mental Health and Life Transitions After Brain Injury. *Brain Impairment*, 19, 215 - 227.
- Goldin Y., Haag H.L. & Trott C.T. (2016). Screening for history of traumatic brain injury among women exposed to intimate partner violence. *PM&R*, 8(11), 1104-1110.
- Golub, D. (2006). A model of successful work experience for employees who are visually impaired: The results of a study. *Journal of Visual Impairment & Blindness*, 100(12), 715-725.
- Goodley, D. (2001). ‘Learning difficulties’, the social model of disability and impairment: challenging epistemologies. *Disability & Society*, 16(2), 207-321.
- Goodley, D. (2013). Dis/entangling critical disability studies. *Disability & Society*, 28(5), 631-644.
- Goodley, D., Hughes, B., & Davis, L. (2012). Introducing disability and social theory. In Goodley, D., Hughes, B., & Davis., L. (eds) *Disability and Social Theory: New Developments and Directions*. New York: Palgrave Macmillan.
- Gotsis, G. & Kortezi, Z. (2015). *Critical Studies in Diversity Management Literature: A Review and Synthesis*, London, Springer Publications.

- Goodley, D. & Lawthom, R. (2005). Epistemological journeys in participatory action research: alliances between community psychology and disability studies. *Disability & Society*, 20(2), 135-151.
- Graff, H. J., Deleu, N. W., Christiansen, P., & Rytter, H. M. (2021). Facilitators of and barriers to return to work after mild traumatic brain injury: A thematic analysis. *Neuropsychological rehabilitation*, 31(9), 1349–1373.
<https://doi.org/10.1080/09602011.2020.1778489>
- Graffam, J., Shinkfield, A., Smith, K. & Polzin, U. (2002). Factors that influence employer decisions in hiring and retaining an employee with a disability. *Journal of Vocational Rehabilitation*, 17(3), 175-181.
- Guba, E. G., Lincoln, Y. S. (1986). But Is It Rigorous? Trustworthiness and Authenticity in Naturalistic Evaluation. *New Directions for Evaluation* 30, 73-84.
DOI:10.1002/ev.1427
- Gutman S.A., Diamond H., Holness-Parchment S.E., Brandofino, D.N., Pacheco, D.G., Jolly-Edouard, M. & Jean-Charles, S. (2004). Enhancing independence in women experiencing domestic violence and possible brain injury. *Occupational Therapy in Mental Health*, 20(1), 49-79.
- Haag, H.L., Biscardi, M., Smith, N., MacGregor, N., & Colantonio, A. (2019). Traumatic brain injury and intimate partner violence: Addressing knowledge and service gaps among indigenous populations in Canada. *Brain Impairment*, 20(2), 197-210. doi:10.1017/BrImp.2019.16
- Haag H.L., Caringal M, Sokoloff S, Kontos P, Yoshida K, Colantonio A. (2016). Being a woman with acquired brain injury: Challenges and implications for practice.

- Arch Phys Med Rehabil.* 97(2), 64-70.
- Haag, H.L., Jones, D., Joseph, T., Colantonio, A. (2022). Battered & brain injured: A scoping review of the prevalence and outcomes of brain injury among women survivors of intimate partner violence. *Trauma, Violence, & Abuse*, 23(4), 1270-1287. doi.org/10.1177/1524838019850623
- Haag, H. L., Toccacino, D., Estrella, M. J., Moore, A., & Colantonio, A. (2022). The Shadow Pandemic: A Qualitative Exploration of the Impacts of COVID-19 on Service Providers and Women Survivors of Intimate Partner Violence and Brain Injury. *The Journal of head trauma rehabilitation*, 37(1), 43–52. <https://doi.org/10.1097/HTR.0000000000000751>
- Haag, H.L., Sokoloff, S., MacGregor, N., Broekstra, S., Cullen, N. & Colantonio, A. (2019). Battered and brain injured: Assessing knowledge of traumatic brain injury among intimate partner violence service providers. *Journal of Women's Health (Larchmt)*, 28(7), 990-996.
- Harlan, S. & Robert, P. (1998). The social construction of disability in organizations: Why employers resist reasonable accommodation. *Work and Occupations*, 25(4), 397-435.
- Harrison, A., Larochette, A. & Nichols, E. (2007). Students with learning disabilities in Postsecondary education: selected initial characteristics. *Exceptionality Education Canada*, 17(2), 135-154.
- Hart, T., Dijkers, M., Fraser, R., Cicerone, K., Bogner, J. A., Whyte, J., Malec, J., & Waldron, B. (2006). Vocational services for traumatic brain injury: treatment definition and diversity within model systems of care. *The Journal of head*

trauma rehabilitation, 21(6), 467–482.

<https://doi.org/10.1097/00001199-200611000-00002>

- Hartnett, H., Stuart, H., Thurman, H., Loy, B. & Batiste, L. (2011). Employers' perceptions of the benefits of workplace accommodations: Reasons to hire, retain and promote people with disabilities. *Journal of Vocational Rehabilitation*, 34(1), 17-23.
- Hayes, J.A. (2002). Playing with fire: Countertransference and clinical epistemology. *Journal of Contemporary Psychotherapy*, 32(1), 93-100.
- Hofgren, C., Esbjornsson, E. & Sunnerhagen, K.S. (2010). Return to work after acquired brain injury: Facilitators and hindrances observed in a sub-acute rehabilitation setting. *Work*, 36, 431-439.
- Hooson, J. M., Coetzer, R., Stew, G., & Moore, A. (2013). Patients' experience of return to work rehabilitation following traumatic brain injury: A phenomenological study. *Neuropsychological rehabilitation*, 23(1), 19–44.
- <https://doi.org/10.1080/09602011.2012.713314>
- Hough, G. (1999). The organisation of social work in the customer culture. In B. Pease and J. Fook (Eds.), *Transforming Social Work Practice, Postmodern Critical Perspectives*. (pp. 40-54). London, New York: Routledge.
- Hunnicut, G., Lundgren, K., Murray, C. & Olson, L. (2017). The Intersection of Intimate Partner Violence and Traumatic Brain Injury: A Call for Interdisciplinary Research. *Journal of Family Violence*, 32, 471-480.
- Hux, K., Schneider, T., & Bennett, K. (2009). Screening for Traumatic Brain Injury. *Brain Injury*, 23(1), 8-14.

- Iverson K.M., & Pogoda T.K. (2015). Traumatic brain injury among women veterans: an invisible wound of intimate partner violence. *Medical Care*, 53(4 Suppl 1), S112-119.
- Iverson K.M., Dardis C.M., & Pogoda T.K. (2017). Traumatic brain injury and PTSD symptoms as a consequence of intimate partner violence. *Comprehensive Psychiatry*, 74, 80-87.
- Jack, G. & Lorbiecki, A. (2007). National identity, globalization and the discursive construction of organizational identity. *British Journal of Management*, 18(Suppl 1), 79-94.
- Jackson, H., Philp, E., Nuttall, R.L. & Diller, L. (2002). Traumatic brain injury a hidden consequence for battered women. *Professional Psychology Research & Practice*, 33(1), 39-45.
- Jacob, B., Cullen, N., Haag, H.L., Chan, V., Stock, D., & Colantonio, A. (2020). Assault by strangulation: Sex differences in patient profile and subsequent readmissions. *Canadian Journal of Public Health*, 111, 492-501.
- Janssens, M. & Zanoni, P. (2005). Many diversities for many services. Theorizing diversity (management) in service companies. *Human Relations*, 58(3), 311-340.
- Jones, P. & Schmidt, R. (2004). Retail employment and disability. *International Journal of Retail & Distribution Management*, 32(8), 426-429.
- Jones, M., & Wass, V. (2013). Understanding changing disability-related employment gaps in Britain 1998–2011. *Work, Employment and Society*, 27(6), 982-1003.
<https://doi.org/10.1177/0950017013475372>

- Killackey, E. (2010). All in a day's work: Opportunities and challenges for vocational interventions in early intervention settings. *Early Intervention in Psychiatry*, 4, 267-269.
- Kim, H., Colantonio, A., Dawson, D.R., & Bayley, M.T. (2013). Community integration outcomes after traumatic brain injury due to physical assault. *Canadian Journal of Occupational Therapy*, 80(1), 49-58.
- Kitchen, R. (2000). The researched opinions on research: disabled people and disability research. *Disability & Society*, 15(1), 25-47.
- Klinger, L. (2005). Occupational Adaptation: Perspectives of People with Traumatic Brain Injury. *Journal of Occupational Science*, 12(1), 9-16, DOI: 10.1080/14427591.2005.9686543
- Kuhn, T. (1965) *The structure of scientific revolutions* (reprinted 1996) (London, Routledge).
- Kulkarni, M. & Kote, J. (2012). Increasing employment of people with disabilities: The role and views of disability training and placement agencies. *Employee Responsibilities and Rights Journal*, 26(3), 177-193.
- Kulkarni, M. & Valk, R. (2010). Don't ask, don't tell: Two views on human resource practices for people with disabilities. *IIMG Management Review*, 22(1), 137-146.
- Kwako, L.E., Glass, N., Campbell, J., Melvin, K.C., Barr, T. & Gill, J.M. (2011). Traumatic brain injury in IPV: a critical review of outcomes and mechanisms. *Trauma, Violence, and Abuse*, 12(3), 115-126.
- Laforce, R., Jr. & Martin-MacLeod, L. (2001). Symptom cluster associated with mild traumatic brain injury in university students. *Perceptual and Motor*

- Skills*, 93(1), 281-288.
- Lefkovits, A. M., Hicks, A. J., Downing, M., & Ponsford, J. (2021). Surviving the “silent epidemic”: A qualitative exploration of the long-term journey after traumatic brain injury. *Neuropsychological Rehabilitation*, 31(10), 1582–1606.
<https://doi.org/10.1080/09602011.2020.1787849>
- Lengnick-Hall, M., Gaunt, P. & Kulkarni, M. (2008). Overlooked and underutilised: People with disabilities are an untapped human resource. *Human Resource Management Review*, 47(2), 255-273.
- Lerner, D., Adler, D., Chang, H., Lapitsky, L., Hood, M., Perissinotto, C., Reed, J., McLaughlin, T., Berndt, E. & Rogers, W. (2004). Unemployment, job retention, And productivity loss among employees with depression. *Psychiatric Services*, 55(12), 1371-1378.
- Levack, W. M., Kayes, N. M., & Fadyl, J. K. (2010). Experience of recovery and outcome following traumatic brain injury: A metasynthesis of qualitative research. *Disability and rehabilitation*, 32(12), 986–999.
<https://doi.org/10.3109/09638281003775394>
- Levack, W., McPherson, K. & McNaughton, H. (2004). Success in the workplace following traumatic brain injury: Are we evaluating what is most important? *Disability and Rehabilitation*, 26(5), 290-298.
- Levin, M. & Greenwood, D. (2001). Pragmatic action research and the struggle to transform universities into learning communities. In P. Reason & H. Bradbury (Eds.), *Handbook of action research: Participative inquiry and practice* (103-113). London, California, New Delhi: Sage Publications Ltd.

- Libeson, L., Downing, M., Ross, P., & Ponsford, J. (2020). The experience of return to work in individuals with traumatic brain injury (TBI): A qualitative study. *Neuropsychological rehabilitation, 30*(3), 412–429.
<https://doi.org/10.1080/09602011.2018.1470987>
- Lincoln, Y.S. (2001). Engaging sympathies: Relationships between action research and social constructivism. In P. Reason & H. Bradbury (Eds.), *Handbook of action research: Participative inquiry and practice* (124-132). London, California, New Delhi: Sage Publications Ltd.
- Lincoln, Y.S. & Guba, E.G. (1990). Judging the quality of case study reports. *International Journal of Qualitative Studies in Education, 3*(1), 53-59.
- Linton, K.F. & Kim, B.J. (2014). Traumatic Brain Injury as a result of violence in Native American and Black communities spanning from childhood to older adulthood. *Brain Injury, 28*(8), 1076-1081.
- Linton, K.F. & Perrin, P.B. (2017). The Differential Impact of Alcohol and Interpersonal Violence on the Severity of Violent Traumatic Brain Injuries among American Indians. *Social Work in Public Health, 32*(3), 202-209.
- Lubet, A. (2009). Disability, music education and the epistemology of interdisciplinarity. *International Journal of Qualitative Studies in Education, 22*(1), 119-132.
- Luecking, R., Cuozzo, L. & Buchanan, L. (2006). Demand-side workforce needs and the potential for job customization. *Journal of Applied Rehabilitation Counseling, 37*(4), 5-13.
- MacGregor, J. C. D., Naeemzadah, N., Oliver, C. L., Javan, T., MacQuarrie, B. J., &

- Wathen, C. N. (2020). Women's Experiences of the Intersections of Work and Intimate Partner Violence: A Review of Qualitative Research. *Trauma, Violence & Abuse*, 1-17. <https://doi.org/10.1177/1524838020933861>
- MacGregor, J. C. D., Oliver, C. L., MacQuarrie, B. J., & Wathen, C. N. (2019). Intimate Partner Violence and Work: A Scoping Review of Published Research. *Trauma, Violence & Abuse*, 1(11). <https://doi.org/10.1177/1524838019881746>
- MacGregor, J. C. D., Wathen, C. N., & MacQuarrie, B. J. (2017). Resources for domestic violence in the Canadian workplace: Results of a pan-Canadian survey. *Journal of Workplace Behavioral Health*, 32(3), 190–205. <https://doi.org/10.1080/15555240.2017.1349612>
- Malacrida, C. (2009). Performing motherhood in a disablist world: Dilemmas of motherhood, femininity and disability. *International Journal of Qualitative Studies in Education*, 22(1), 99-117.
- Mantell, A., Simpson, G.K., Vungkhanching, M., Jones, F.K., Strandberg, T., & Simonson, P. (2018). Social work-generated evidence in traumatic brain injury from 1975-2014: A systematic scoping review. *Health Social Care Community*, 26, 433-448.
- Marschark, M., Richtsmeier, L.M., Richardson, J.T.E., Crovitz, H.F., & Henry, J. (2000). Intellectual and emotional functioning in college students following mild traumatic brain injury in childhood and adolescence. *Journal of Head Trauma Rehabilitation*, 15(6), 1227-1245.
- Maskin, R. M., Iverson, K. M., Vogt, D., & Smith, B. N. (2019). Associations between intimate partner violence victimization and employment outcomes among male

- and female post-9/11 veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, 11(4), 406–414. <https://doi.org/10.1037/tra0000368>
- Mateo, M.A., & Glod, C.A. (2003). Mild traumatic brain injury and psychiatric disorders. *Journal of the American Psychiatric Nurses Association*, 9(4), 129-133.
- Matjasko, J. L., Niolon, P. H., & Valle, L. A. (2013). The role of economic factors and economic support in preventing and escaping from intimate partner violence. *Journal of Policy Analysis and Management*, 32(1), 122–141. <https://doi.org/10.1002/pam.21666>
- McDonald, J. (2015). Organizational communication meets queer theory: Theorizing relations of “difference” differently. *Communication Theory*, 25, 310-329.
- McMaster University (2020). Retrieved September 24, 2023 from <https://vegaproject.mcmaster.ca/home/>
- Menon D.K., Schwab K., Wright D.W., & Mass, A.I. (2010). Position statement: definition of traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*, 91(11), 1637-1640.
- Mighty, E. J., & Leach, L. E. (1998). Bumps Along the Road: Survivors of Domestic Violence Share their Workplace Experiences. *Canadian Woman Studies*, 18(1), 92-96.
- Mikkonen, J., & Dennis, R., (2010). *Social determinants of health: The Canadian facts*. York University School of Health Policy and Management; Toronto, ON.
- Mikkonen, J. & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. York University School of Health Policy and Management; Toronto, ON.

- Moe, A. M., & Bell, M. P. (2004). Abject Economics: The Effects of Battering and Violence on Women's Work and Employability. *Violence Against Women*, 10(1), 29–55. <https://doi.org/10.1177/1077801203256016>
- Monahan, K. (2018). Intimate partner violence, traumatic brain injury, and social work: Moving forward. *Social Work*, 63, 179-181.
- Monahan, K., Bannon, S., & Dams-O'Connor, K. (2020). Nonfatal strangulation (NFS) and intimate partner violence: A brief overview. *Journal of Family Violence*. <https://doi.org/10.1007/s10896-020-00208-7>
- Monahan, K. & O'Leary, K.D. (1999). Head injury and battered women: An initial inquiry. *Health and Social Work*, 24(4), 269-278.
- Moosa-Mitha, M. (2005). A difference-centred alternative to theorization of children's citizenship rights. *Citizenship Studies*, 9(4), 369-388, DOI:10.1080/13621020500211354
- Morris, J. (1992). Personal and political: a feminist perspective on researching physical disability. *Disability, Handicap & Society*, 7(2), 157-166.
- Mukherjee, D., Panko Reis, J. & Heller, W. (2003). "Men's" illness overlooked in women and "women's" illness misdiagnosed or dismissed. Women living with traumatic brain injury: social isolation, emotional functioning and implications for psychotherapy. *Women & Therapy*, 26(1/2), 3-26.
- Murray S., & Powell A. (2007). Family violence prevention using workplaces as sites of intervention. *Research and Practice in Human Resource Management*, 15, 62–74.
- Nalder, E., Fleming, J., Cornwell, P., Foster, M., Skidmore, E., Bottari, C., & Dawson, D. R. (2016). Sentinel events during the transition from hospital to home: A

- longitudinal study of women with traumatic brain injury. *Archives of physical Medicine and Rehabilitation*, 97(2 Suppl), S46–S53.
- <https://doi.org/10.1016/j.apmr.2014.07.428>
- Nemeth, J.M., Mengo, C., Kulow, E., Brown, A. & Ramirez, R. (2019). Provider perceptions and domestic violence (DV) survivor experiences of traumatic and anoxic-hypoxic brain injury: Implications for DV advocacy service provision. *Journal of Aggression, Maltreatment, and Trauma*, 28(6), 744-763.
- Neville-Jan, A. (2004). Selling your soul to the devil: An autoethnography of pain, Pleasure and the quest for a child. *Disability & society*, 19(2), 113-127.
- Nicol, B., van Donkelaar, P., Mason, K., & Gainforth, H. (2021). Using behaviour change theory to understand how to support screening for traumatic brain injuries among women who have experienced intimate partner violence. *Women's Health Reports*, 2(1). DOI: 10.1089/whr.2020.0097
- Olesky, E.H. (2011). Intersectionality at the cross-roads. *Women's Studies International Forum*, 34, 263-270.
- Oliver, M. (1992). Changing the social relations of research production? *Disability, Handicap & Society*, 7(2), 101-114.
- Oliver, M. (1986). A sociology of disability or a disablist sociology? In L. Barton (Ed.) *Disability & Society: Emerging Issues and Insights*, 18-42. London and New York, Longman Publishing.
- O'Reilly, K., Wilson, N. J., Kwok, C., & Peters, K. (2021). Women's tenacity following traumatic brain injury: Qualitative insights. *Journal of Advanced Nursing*, 77(4), 1934–1944. <https://doi.org/10.1111/jan.14749>

- O'Reilly, K., Wilson, N., & Peters, K. (2018). Narrative literature review: Health, activity and participation issues for women following traumatic brain injury. *Disability and Rehabilitation*, 40(19), 2331–2342.
<https://doi.org/10.1080/09638288.2017.1334838>
- Owensworth, T., & McKenna, K. (2004). Investigation of factors related to employment outcome following traumatic brain injury: A critical review and conceptual model. *Disability and Rehabilitation*, 26, 765-783.
<http://dx.doi.org/10.1080/09638280410001696700>
- Paterson, B., & Scott-Findlay, S. (2002). Critical issues in interviewing people with traumatic brain injury. *Qualitative Health Research*, 12(3), 399-409.
- Patten, S., Mitton, C. & Donaldson, C. (2006). Using participatory action research to build a priority setting process in a Canadian regional health authority. *Social Science & Medicine*, 63(5), 1121-1134.
- Payne, M. (1997). *Modern Social Work Theory*, 2nd Edition. Chicago: Lyceum Press.
- Permenter, C.M., Fernández-de Thomas, R.J., & Sherman, A.I. (2022). Postconcussive Syndrome. *National Institutes of Health National Library of Medicine*. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK534786/> September 8, 2023.
- Prigatano, G. P., & Schacter, D. L. (1991). *Awareness of Deficit After Brain Injury: Clinical and Theoretical Issues*. Oxford University Press.
- Riach, K. & Loretto, W. (2009). Identity work and the ‘unemployed’ worker: Age, disability and the lived experience of the older unemployed. *Work, Employment and Society*, 23(1), 102-119.
- Richard, P., Patel, N., Gedeon, D., Hyppolite, R., & Younis, M. (2021). Common

- symptoms of mild traumatic brain injury and work functioning of active-duty service members with a history of deployment. *International Journal of Environmental Research and Public Health*, 18(15), 8079.
<https://doi.org/10.3390/ijerph18158079>
- Richards, R. (2008). Writing the othered self: Autoethnography and the problem of objectification in writing about illness and disability. *Qualitative Health Research*, 18(12), 1717-1728.
- Roberts, A.R. & Kim, J.H. (2005). Exploring the effects of head injuries among battered women: A qualitative study of chronic and severe women battering. *Journal of Social Service Research*, 32(1), 33-47.
- Rosenau, P.M. (1992). *Post-Modernism And The Social Sciences. Insights, Inroads, and Intrusions*. Princeton, New Jersey: Princeton University Press.
- Roulstone, A. (1998). Researching a disabling society: the case of employment and new technology. In Shakespeare, T. (Ed.), *The Disability Reader. Social Science Perspectives*, London: Cassell.
- Roulstone, A, Gradwell, L., Price, J., & Child, L. (2003). *Thriving and Surviving at Work. Disabled People's Employment Strategies*. Bristol: The Policy Press.
- Saverino, C., Swaine, B., Jaglal, S., Lewko, J., Vernich, L., Calzavara, & Colantonio, A. (2015). Rehospitalization after traumatic brain injury: A population based study. *Archives of Physical Medicine*, 96(2), e24-e24.
- Scheid, T. (2005). Stigma as a barrier to employment: Mental disability and the Americans with Disabilities Act. *International Journal of Law and Psychiatry*, 28(6), 670-690.

- Schultz, M., & Hatch, M. J. (1996). Living with Multiple Paradigms: The Case of Paradigm Interplay in Organization Culture Studies. *Academy of Management Review*, 21(2), 529-557. <https://doi.org/10.5465/AMR.1996.9605060221>
- Schulze, B. & Angermeyer, C. (2003). Subjective experiences of stigma: A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science & Medicine*, 56, 299-312.
- Schur, L., Kruse, D. & Blanck, P. (2005). Corporate culture and the employment of persons with disabilities. *Behavioural Sciences & the Law*, 23(1), 3-20.
- Schur, L., Kruse, D., Blasi, J. & Blanck, P. (2009). Is disability disabling in all workplaces? Workplace disparities and corporate culture. *Industrial Relations*, 48(3), 381-410.
- Shafi, R., & Colantonio, A. (2021). Assessing the effectiveness of workplace accommodations in facilitating return to work after traumatic brain injury: a systematic review protocol. *BMJ open*, 11(5), e041581. <https://doi.org/10.1136/bmjopen-2020-041581>
- Shah, S. (2006). Sharing the world: the researcher and the researched. *Qualitative Research*, 6(2), 207-220.
- Shakespeare, T. (1996). Rules of engagement: doing disability research. *Disability & Society*, 11(1), 115-119.
- Shakespeare, T. (2006). *Disability Rights and Wrongs*. London: Routledge.
- Shepherd, C.E., & Challenger, R. (2013). Revisiting paradigm(s) in management research: A rhetorical analysis of the paradigm wars. *International Journal of Management Reviews*, 15, 225-244.

- Sheridan, D.J. & Nash, K.R. (2007). Acute injury patterns of intimate partner violence victims. *Trauma, Violence, and Abuse*, 8(3), 281-289.
- Shier, M., Graham, J. & Jones, M. (2009). Barriers to employments as experienced by disabled people: A qualitative analysis in Calgary and Regina, Canada. *Disability & Society*, 24(1), 63-75.
- Showalter, K. (2016). Women's employment and domestic violence: A review of the literature. *Aggression and Violent Behavior*, 31, 37–47.
<https://doi.org/10.1016/j.avb.2016.06.017>
- Showalter, K., & McCloskey, R. J. (2021). A Qualitative Study of Intimate Partner Violence and Employment Instability. *Journal of Interpersonal Violence*, 36, 23-24. <https://doi.org/10.1177/0886260520903140>
- Simpson, G., Simons, M., & McFadyen M. (2002). The challenges of a hidden disability: social work practice in the field of traumatic brain injury. *Australian Social Work*, 55(1), 24-37.
- Sinha M. (2013). *Family violence in Canada: A statistical profile, 2011*. Ottawa: Statistics Canada.
- Skirbekk, G. & Gilje, N. (2001). *A History of Western Thought From ancient Greece to the twentieth century*. New York, USA: Routledge.
- Spataro, S. (2005). Diversity in context: How organizational culture shapes reactions to workers with disabilities and others who are demographically different. *Behavioural Sciences and the Law*, 23, 21-38.
- Statistics Canada. (2011). Family violence in Canada: A statistical profile. Available at <http://www.statcan.gc.ca/pub/85-224-x/85-224-x2010000-eng.pdf>

(Accessed Jan 15 2016)

Statistics Canada (2015). *Family violence in Canada: A statistical profile, 2013*. Ottawa:

Statistics Canada, 2015.

Stergiou-Kita, M., Mansfield, E., Sokoloff, S., & Colantonio, A. (2016). Gender

influences on return to work after mild traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*, 97, 40–45.

<https://doi.org/10.1016/j.apmr.2015.04.008>

Stevenson, M. (2010). Flexible and responsive research: Developing rights-based

emancipatory disability research methodology in collaboration with young adults with down syndrome. *Australian Social Work*, 63(1), 35-50.

St. Ivany, A., & Schminkey, D. (2016). Intimate partner violence and traumatic brain

injury: State of the science and next steps. *Family & Community Health*, 39, 129-147.

St. Ivany, A., Bullock, L., Schminkey, D., Wells, K., Sharps, P. & Kools, S. (2018).

Living in fear and prioritizing safety: Exploring women's lives after traumatic brain injury from intimate partner violence. *Qualitative Health Research*, 1-11.

St. Ivany, A., Kools, S., Sharps, P. & Bullock, L. (2018). Extreme control and

instability: Insight into head injury from intimate partner violence. *Journal of Forensic Nursing*, 14(4), 198-205.

Stone, E. & Priestly, M. (1996). Parasites, pawns and partners: Disability research

and the role of non-disabled researchers. *British Journal of Sociology*, 47(4), 699-716.

Stone-Romero, E., Stone, D. & Lukaszewski, K. (2006). The influence of disability on

- role-taking in organizations. In Konrad, A., Prasad P. & Pringle, J. (Eds.) *Handbook of Workplace diversity*. London, Sage Publications Ltd.
- Styhre, A. & Eriksson-Zetterquist, U. (2008). Thinking the multiple in gender and diversity studies: examining the concept of intersectionality. *Gender and Diversity Studies*, 23(8), 567-582.
- Styrke J., Sojka, P., Bjornstig, U., Bylund, P.-O. & Stalnacke, B.-M. (2013). Sex differences in symptoms, disability and life satisfaction three years after mild traumatic brain injury: A population-based cohort study. *Journal of Rehabilitation Medicine*, 45, 749-757.
- Swain, J., Griffiths, C. & Heyman, B. (2003). Towards a social model approach to Counselling disabled clients. *British Journal of Guidance & Counselling*, 31(1), 137-152.
- Swanberg, J. E., Macke, C., & Logan, T. K. (2006). Intimate partner violence, women, and work: Coping on the job. *Violence and Victims*, 21(5), 561–578.
<https://doi.org/10.1891/vivi.21.5.561>
- Swanberg, J., Macke, C., & Logan, T. K. (2007). Working women making it work: Intimate partner violence, employment, and workplace support. *Journal of Interpersonal Violence*, 22(3), 292–311.
<https://doi.org/10.1177/0886260506295387>
- Temkin, N.R., Corrigan, J.D., Dikmen, S.S., & Machamer, J. (2009). Social functioning after traumatic brain injury. *Journal of Head Trauma Rehabilitation*, 24(6), 460-467.
- Toccalino, D., Haag, H. L., Estrella, M. J., Cowle, S., Fuselli, P., Ellis, M. J., Gargaro, J.,

- Colantonio, A., & the COVID TBI-IPV Consortium. (2022a). The intersection of intimate partner violence and traumatic brain injury: Findings from an emergency summit addressing system-level changes to better support women survivors. *The Journal of Head Trauma Rehabilitation*, 37(1), e20–e29.
<https://doi.org/10.1097/HTR.0000000000000743>
- Toccalino D, Haag HL, Estrella MJ, Cowle S, Fuselli P, Ellis MJ, Gargaro J, Colantonio A., & the COVID TBI-IPV Consortium. (2022b). Addressing the shadow pandemic: COVID-19 related impacts, barriers, needs, and priorities to health care and support for women survivors of intimate partner violence and brain injury. *Archives of Physical and Medical Rehabilitation*, 103(7), 1466-1476.
[doi:10.1016/j.apmr.2021.12.012](https://doi.org/10.1016/j.apmr.2021.12.012)
- Toccalino, D., Moore, A., Cripps, E., Gutierrez, S. C., Colantonio, A., Wickens, C. M., Chan, V., Nalder, E., & Haag, H. L. (2023). Exploring the intersection of brain injury and mental health in survivors of intimate partner violence: A scoping review. *Frontiers in Public Health*. doi: 10.3389/fpubh.2023.1100549
- Tolhurst, R., Leach, B., Price, J., Robinson, J., Ettorre, E., Scott-Samuel, A., Kilonzo, N., Sabuni, L.P., Robertson, S., Kapilashrami, A., Bristow, K., Lang, R., Romao, F., & Theobald, S. (2012). Intersectionality and gender mainstreaming in international health: Using a feminist participatory action research process to analyse voices and debates from the global south and north. *Social Science & Medicine*, 74(11), 1825-1832.
- Valera E., & Berenbaum H. (2003). Brain injury in battered women. *Journal of Consulting and Clinical Psychology*, 71(4), 797-804.

- Valera, E. & Kucyi A. (2017). Brain injury in women experiencing intimate partner violence: Neural mechanistic evidence of an “invisible” trauma. *Brain Imaging and Behaviour*, 11(6). DOI 10.1007/s11682-016-9643-1.
- Valera, E.M., Campbell, J., Gill, J., & Iverson, K.M. (2019). Correlates of brain injuries in women subjected to intimate partner violence: Identifying the dangers and raising awareness. *Journal of Aggression, Maltreatment & Trauma*. 695-713.
<https://doi.org/10.1080/10926771.2019.1581864>
- Valera, E.M., Cao, A., Pasternak, O., Shenton, M.E., Kubicki, M., Makris, N. & Adra, N. (2018). White matter correlates of mild traumatic brain injuries in women subjected to intimate partner violence: A preliminary study. *Journal of Neurotrauma*, 36, 661-668.
- van der Vlegel, M., Polinder, S., Mikolic, A., Kaplan, R., von Steinbuechel, N., Plass, A. M., Zeldovich, M., van Praag, D., Bockhop, F., Cunitz, K., Mueller, I., Haagsma, J. A., & The Center-Tbi Participants And Investigators (2021). The association of post-concussion and post-traumatic stress disorder symptoms with health-related quality of life, health care use and return-to-work after mild traumatic brain injury. *Journal of Clinical Medicine*, 10(11), 2473.
<https://doi.org/10.3390/jcm10112473>
- Vindrola-Padros, C., Chisnall, G., Cooper, S., Dowrick, A., Djellouli, N., Mulcahy Symmons, S., Martin, S., Singleton, G., Vanderslott, S., Vera, N., & Johnson, G.A. (2020). Carrying out rapid qualitative research during a pandemic: Emerging Lessons from COVID-19. *Qualitative Health Research*, 30(14), 2192-2204.
- Wathen, C. N., MacGregor, J. C. D., & MacQuarrie, B. J. (2018). Relationships Among

- Intimate Partner Violence, Work, and Health. *Journal of interpersonal violence*, 33(14), 2268–2290. <https://doi.org/10.1177/0886260515624236>
- Watson, J. (2012). Butler’s biopolitics: Precarious communities. *Theory & Event*, 15(2), Johns Hopkins University Press. Retrieved April 19, 2017, from Project Muse database.
- Watter, K., Kennedy A., McLennan V., Vogler J., Jeffery S., Murray A., & Ehlers S., Nielsen M., (2021). Consumer perspectives of vocational rehabilitation and return to work following acquired brain injury. *Brain Impairment*, 2, 1-21. 10.1017/BrImp.2021.4.
- Wehman, P., Targett, P., West, M., & Kregel, J. (2005). Productive work and employment for persons with traumatic brain injury: What have we learned after 20 years? *Journal of Head Trauma Rehabilitation*, 20(2), 115–127. <https://doi.org/10.1097/00001199-200503000-00001>
- Westhues, A., Ochocka, J., Jacobson, N., Simich, L., Maiter, S., Janzen, R. & Fleras, A. (2008). Developing theory from complexity: Reflections on a collaborative mixed method participatory action research study. *Qualitative Health Research*, 18(5), 701-717.
- Whalley Hammell, K. (2007). Reflections on...a disability methodology for the client-centred practice of occupational therapy research. *Canadian Journal of Occupational Therapy*, 74(5), 365-369.
- Williams, J. & Mavin, S. (2012). Disability as constructed difference: A literature review and research agenda for management and organization studies. *International Journal of Management Reviews*, 14, 159-179.

- World Health Organization (2021). *Violence Against Women*. Geneva, Switzerland: World Health Organization.
- Yang, Y. & Konrad, A. (2011). Understanding diversity management practices: Implications of institutional theory and resource-based theory. *Group & Organization Management*, 36(1), 6-38.
- Zanoni, P. & Janssens, M. (2004). Deconstructing difference: The rhetoric of human resource managers; diversity discourses. *Organization Studies*, 25(1), 55-74.
- Zanoni, P. & Janssens, M. (2007). Minority employees engaging with (diversity) management: An analysis of control, agency, and micro-emancipation. *Journal of Management Studies*, 44(8), 1372-1397.
- Zarb, G. (1992). On the road to Damascus: first steps towards changing the relations of disability research production. *Disability, Handicap & Society*, 7(2), 125-138.
- Zhang T., Hoddenbagh J., McDonald S., & Scrim K. (2012). An estimation of the economic impact of spousal violence in Canada, 2009. Department of Justice Canada, Research and Statistics Division.
- Zieman, G., Bridwell, A. & Cardenas, J.F. (2016). Traumatic brain injury in domestic violence victims: A retrospective study at the Barrow Neurological Institute. *Journal of Neurotrauma*, 33, 1-5.
- Zorn K. G. (2017). *The impact of intimate partner stalking on women targets: A narrative inquiry analysis* [Doctoral dissertation]. University of Regina.