

Experiences of support and help-seeking: A secondary analysis of
interviews with women with disabilities who have experienced intimate
partner violence

by

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Abstract

While previous research has explored women's experiences of intimate partner violence (IPV), their help-seeking experiences and the barriers they encounter when seeking support, little research has explored the perspectives of women with disabilities regarding helpful IPV prevention, intervention, and healing strategies. My qualitative research project sought to address two research questions: what have women with disabilities experienced when accessing support (from family, friends, and services) for IPV; and what do women with disabilities say would be helpful in the prevention or intervention of intimate partner violence. I undertook a secondary analysis of six interviews of women with disabilities who had been interviewed as part of a larger research study. My thematic analysis revealed many themes including experiences with sources of support—such as family, friends, counselling, and shelters—and strategies for prevention, including education and awareness; support system; affordable childcare and transportation; and self-care, spirituality, community, and social change. Barriers to support I identified include lack of education and awareness, lack of resources, lack of services, community size and dynamics, and potentially exclusive admission criteria. My intersectional analysis revealed the ways in which women's social locations—such as their gender, cultural background, socioeconomic situation, religion, disability, and relationship status— influenced and shaped their help-seeking behaviours and their access to support systems. Several recommendations to address gaps in service provision are provided.

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Chapter 1: Intimate Partner Violence and Women's Help-Seeking

Experiences

Intimate Partner Violence (IPV) is a serious and complex social issue. Defined as: “the physical, emotional, psychological, and sexual abuse that takes place between intimate partners” (Hattery, 2009, p. 11), IPV can occur among partners who reside together or separately, during the relationship and / or following the ending of a relationship, and regardless of the type of relationship between partners i.e., legally married spouses, common-law partners, girlfriend(s) / boyfriend(s), etc. (Hattery, 2009). Although IPV can affect any woman irrespective of age, class, income level, ethnicity, culture, dis/ability, sexual identity, immigration status, housing situation, family status, and a variety of other factors, the experiences of IPV and help-seeking are not the same for all women. Women with disabilities, women experiencing violence in same-sex relationships, immigrant women, and women of color may all face abuse and barriers to support that are specific to their social location and / or multiple identities (Bograd, 2005; Lightfoot & Williams, 2009b; Olkin, 2003; Raj & Silverman, 2002; Ristock, 2002; Womendez & Schneiderman, 1991). It is the experiences of support, help-seeking, and intervention/prevention among women with disabilities that I explored in my research. My two central research questions were:

- What have women with disabilities experienced when accessing support (from family, friends, and services) for IPV?
- What do women with disabilities say would be helpful in the prevention or intervention of intimate partner violence?

Review of the Help-Seeking Literature

Several studies have explored the experiences of support and / or help-seeking among women who have experienced violence in their intimate relationships. While not all of the studies to which I will refer in my review of the literature have focused specifically on women with disabilities, or in some cases even made any mention of disability at all, much can be learned from the existing body of research related to the help-seeking behaviours and experiences of women who have experienced IPV.

Attitudes and responses to IPV have changed significantly over the past 40 years. Stark and Buzawa (2009) briefly highlight the changes that occurred during the course of the “domestic violence revolution” (p. viii). They explain how shelters came into being to address the failure of law enforcement and health care services to adequately respond to incidents of IPV (Stark & Buzawa, 2009). Since that time, awareness surrounding IPV and rights has increased, and legal, judicial, and health-based system responses have improved while more programmes and services have been created to address the needs of women who have experienced IPV (Stark & Buzawa, 2009). Despite the remarkable developments, questions and concerns continue to be raised regarding our understanding of IPV, and how various factors influence women’s experiences of IPV (Stark & Buzawa, 2009). Barriers to support exist for many women including women who may be marginalized as a result of social dimensions such as cultural background, socioeconomic situation, sexual orientation, immigration status, and disability.

Many parallels can be drawn between the experiences of various marginalized populations. For example, several parallels can be drawn between the experiences of women with disabilities and women involved in same-sex

relationships, not to say that having a disability precludes a woman from being a lesbian or having an intimate relationship with another woman. According to Hunt, Matthews, Milsom, and Lammel (2006) and Sherry (2004), commonalities between the two communities include members of both groups having often experienced violence, both historically and current-day; both regularly face prejudice, misunderstanding, and lack of awareness about their experiences and realities; and both face assumptions of either able-bodiedness and / or heterosexuality and must negotiate if, how and when “passing, disclosure and coming out of the closet” (Sherry, 2004, p. 773) are safe, comfortable, or appropriate. Other commonalities include the likelihood that they “may be the only members of their family with that identity” (Sherry, 2004, p. 771), or “that the awareness of being a member of a minority group often occurs later in life” (Hunt et al., 2006, p. 164) especially in the case of acquired disability, and as a result both may lack appropriate role models (Hunt et al., 2006; Sherry, 2004). Exploring the experiences of populations with whom parallels can be drawn or the communities with which women with disabilities might also identify can therefore be valuable for understanding the barriers to support and IPV intervention services that women with disabilities may experience. This may be especially relevant when one considers that divisions between various systems of oppression “are permeable” (Meekosha, 2006, p. 172) and disability status and identity are rarely static.

In this chapter, I review literature related to women’s experiences with help-seeking and support. I address factors affecting women’s decision whether to leave an abusive partner, experiences of support from friends and family, counselling experiences, experiences with police and the legal system, experiences with shelters, women’s agency and resistance, and collaboration between organizations.

Deciding whether to leave.

Women's efforts to seek help for IPV may take place during the course of the relationship, while attempting to leave the relationship, and /or following physical separation from an abusive partner (Moe, 2007). Leaving a partner can be a complicated undertaking and many women have returned to abusive partners for a variety of reasons including a lack of money or support, pressure to reconcile, guilt, and loneliness (Moe, 2007). Although leaving an abusive partner may require much thought and planning for any woman, for women with physical disabilities there are often additional factors to consider. Olkin (2003) identifies four categories of barriers that women with physical disabilities might confront when debating whether to leave an abusive relationship. These barriers include: "(a) physical needs; (b) financial needs; (c) custody concerns; and (d) relationship issues" (Olkin, 2003, p. 238). For women who require assistance with activities of daily living, securing essential assistance can be a concern; a woman may fear losing attendant care if her abusive partner was the one providing much of the assistance she required and she is unable to afford to pay someone else to assist her (Olkin, 2003). In addition, not all shelters are equipped for or allow attendant care providers (Chang et al., 2003; Lightfoot & Williams, 2009b). Financial needs include the fear that losing her partner's income may make purchasing, maintaining, and repairing necessary assistive devices challenging (Olkin, 2003). The cost of moving and adapting new accommodations may be a concern, or in the case of joint home ownership, buying out the abusive partner's share of the house so she can remain in place may be financially overwhelming (Olkin, 2003). Olkin (2003) adds that the loss of the partner's health insurance coverage may also be worrisome for women contemplating leaving their partners. Custody concerns entail the fear of court bias

resulting in losing custody of children to a non-disabled partner, or for non-biological mothers of children in same-sex relationships, the lack of adoptive rights—at least in the United States—may result in fear of losing contact with the children (Olkin, 2003). Finally Olkin (2003) identifies relationship issues such as fear of being alone, of not finding another partner, or of negotiating sensitive issues such as sex with a new partner as potential barriers or cause for concern when contemplating leaving an abusive partner. Olkin acknowledges that there may be added complexities for women from ethnically marginalized communities, but she does not discuss them. While Olkin outlines some important points regarding the potential barriers that may complicate or prevent women with physical disabilities from leaving abusive intimate relationships, her closing words are problematic and disturbing. She suggests that:

It is possible that dyadic romantic relationships are not the best arrangements for women with disabilities. Their freedom to leave is compromised, and the high dissolution rate of relationships makes women with physical disabilities especially vulnerable to isolation. A safeguard is for women with disabilities to be part of a larger interdependent community, within which they might or might not be with partners. Women with disabilities might not ever enjoy the physical and economic means necessary for independence, and marriage and partnerships might be no more than temporary masks of this basic disempowered status. (Olkin, 2003, pp. 243 - 244)

Olkin (2003) paints a rather bleak picture for women with physical disabilities interested in pursuing romantic relationships; she suggests that relationships rarely last, that women with disabilities may have trouble leaving a relationship should it become abusive, and that as a result of systems of power and oppression, women

with disabilities are unlikely to be physically and financially independent. Rather than advocating for social change in the form of greater awareness of disability and of abuse and the elimination of attitudinal and structural barriers, Olkin (2003) advises women with physical disabilities to refrain from entering into intimate relationships. She places the onus of women with physical disabilities to avoid IPV rather than addressing the systems and contexts that support it. Just because women with disabilities may face unique or additional barriers to leaving a relationship should it prove abusive, it does not mean they should refrain from ever engaging in intimate relationships.

Friends and family.

Informal supports such as friends and family are often the first place women experiencing IPV turn for support (Moe, 2007) and are the most utilized of various sources of support (Fugate et al., 2005; Moe, 2007; Ristock, 2002). Although women are more likely to turn to friends or family during experiences of intimate partner violence than any other type of support, the responses they receive are often mixed; some women report that reaching out to friends and family proved quite helpful while others' experiences of informal support were quite disheartening (Moe, 2007; Ristock, 2002). In addition, Moe found that "help sometimes came with an ultimatum" (p. 685), citing as an example the words of an interviewee whose father not only helped her on the condition she leave her partner but threatened to disown her if she ever returned to him, which she later did. Unfortunately, negative and / or conflicting responses from informal supports can be detrimental to abused women's mental health and wellbeing. Kocot and Goodman (2003) found that "among low-income, urban, and predominantly African American women" (p. 340) in court due to

their male partner's arrest for assaulting them, receiving conflicting advice from friends and family or being urged to stay with their partners was associated with more depressive symptoms, while lack of tangible support was associated with greater post traumatic stress disorder (PTSD) symptoms. In another study, Goodkind, Gillum, Bybee, and Sullivan (2003) revealed that negative reactions from family and friends have a negative impact on women's perceived quality of life, while lack of tangible support in the form of offering abused women a place to stay, have a greater negative impact on women's depression. In addition, Goodkind et al.'s (2003) data suggests that the type of response a woman receives from family and friends may depend on whether or not she is married to her abusive partner, whether there are children involved, the number of times she has separated from her partner, and whether or not the family members or friends in question have been threatened by her partner.

Although many women choose to reveal their abusive relationships to those close to them, some do not. There are a variety of reasons women may choose not to reach out to family and friends. Isolation and shame appear to prevent many women from speaking about their experiences with friends or family (Fugate et al., 2005; Ristock, 2002). Other reasons may include not having someone with whom to speak, discomfort or embarrassment in discussing something of such a personal nature, a belief that talking about the violence is not necessary or will be useless, and fear that "family members would seek revenge if told about the incident" (Fugate et al., 2005, p. 301). For women who have experienced violence in their intimate relationships with another woman, additional barriers to discussing their experiences with friends and family included "fear of homophobic responses, closetedness, and fear of retaliation from an abusive partner" (Ristock, 2002, p. 94). Alternatively,

assumptions of heterosexuality and / or able-bodiedness and heterosexist, homophobic, and ableist attitudes may prompt lesbians with physical disabilities to turn to “friends and social networks” (Hunt et al., 2006, p. 164) over more formal supports and services. Additional information regarding experiences with informal support among women with disabilities is lacking in the literature.

Counsellors.

In Ristock’s (2002) study, more than half of her interviewees had sought counselling, with mixed results: some found the experience beneficial, while others encountered homophobic responses, and felt their experiences were trivialized or misunderstood. Barriers to seeking counselling include the prohibitive cost of private counselling and long waiting-lists for free counselling (Ristock, 2002), a lack of insurance or time, or being prevented by a partner from attending (Fugate et al., 2005). Additional reasons for not seeking counselling are lack of awareness of available services, a belief that a woman must leave her partner before she can receive any counselling, confidentiality concerns, fear of children being removed, or a belief that counselling will not be helpful (Fugate et al., 2005). Aside from an exploratory study of lesbian women with physical disabilities conducted by Hunt et al. (2006), there does not appear to be much literature addressing experiences of counselling among women with disabilities. Similar to Ristock’s (2002) findings, Hunt et al. (2006) found that participants reported a mix of positive and negative counselling experiences: some women had very positive experiences and found their counsellors to be great advocates while some experienced unprofessionalism, outdated thinking, and a lack of understanding about their sexual orientation, their disabilities, or both. Some women also experienced problems with physical access to the counsellor’s office:

after explaining her needs, one woman showed up for her first appointment to find the waiting room was located on an inaccessible 2nd floor, while another frequently showed up to appointments to find that the door at the top of the ramp was locked, barring her access (Hunt et al., 2006). One participant related examples of counsellors' inability to accommodate her vision impairment (Hunt et al., 2006). For example, when attending couple's counselling, her partner had to fill in her answers to the paperwork they were meant to be completing individually causing her to answer differently than if she had been able to complete the paperwork independently (Hunt et al., 2006). Although Hunt et al.'s (2006) study is not specific to women seeking counselling in response to their experiences of IPV, it does highlight some of the barriers lesbians with physical disabilities encounter when seeking or receiving counselling services.

Police and / or the legal system.

Although some women may contact the police for assistance with violence in their relationships, many are hesitant or unwilling to do so. Fugate et al. (2005) report that women may not contact police because they do not feel the situation is serious enough to merit police intervention. For women with disabilities, many of their reasons for not calling the police are the same as non-disabled women: "fear, dependency, shame, and a belief that marriage is an unbreakable covenant or that the abuse is their fault" (Masuda, 1990, p. 31). The fear that prevents women from calling the police can include fear of getting her partner in trouble, of retribution, of loss of support, or of having children removed (Fugate et al., 2005; Masuda, 1990). For women in abusive lesbian relationships, reluctance to contact authorities may stem in part from a history of police mistreatment and homophobia (Ristock, 2002).

In addition, calling the police is not always without problems: it can prove dangerous if it further incites a partner's rage, be ineffective if police are slow to respond or take no action when they do, or have negative legal repercussions for the woman herself if she has a criminal record and outstanding warrants (Moe, 2007).

Shelters.

The inaccessibility of shelters is but one of many barriers for women with disabilities wishing to flee abuse (Lightfoot & Williams, 2009b; Masuda, 1990; Smith, 2008; Swedlund & Nosek, 2000; Womendez & Schneiderman, 1991). Inadequate funding, lack of awareness, and structural barriers may account for lack of shelter accessibility (Chang et al., 2003; Masuda, 1990; Smith, 2008). For example, many shelters simply lack the funds necessary to make their facilities accessible (Chang et al., 2003; Masuda, 1990; Smith, 2008; Swedlund & Nosek, 2000) while others may find that the age of their building makes structural changes either impossible or cost prohibitive (Masuda, 1990; Smith, 2008). Lack of awareness regarding accessibility is also an issue:

...for many shelters, 'accessible' is equated with wheelchair accessibility.

However, the larger job needed is to educate shelters on the complexity of disability and chronic illness and how women can be accommodated by the addition of more than just a ramp and accessible bathroom." (Smith, 2008, p.35)

Although attitudinal barriers may still hamper shelter accessibility, this appears to be less of an overt problem among Canadian shelters now than it was 20 years ago. In 2008, Jewelles Smith surveyed shelters across Canada regarding accessibility. Survey responses indicate that some ignorance and lack of awareness regarding

disability and accessibility, and resistance or refusal to provide service to women with certain disabilities – generally psychiatric disabilities and chronic illnesses – still exist. Obvious ableist attitudes, however, are not as evident among respondents of the 2008 survey as they were among respondents to Masuda's 1989 survey of Canadian women's shelters. For example, in 2008, one shelter reported accessibility was not required given they never had any requests for it. In contrast, in 1989, one shelter returned the uncompleted survey with a note stating: "clientele is specifically female victims of conjugal violence, thus do not serve disabled people..." (Masuda, 1990, p. 45). In addition, Masuda (1990) reported that several survey respondents referred to women with disabilities as *disabilities* or as *people with disabilities* totally negating their humanity and / or gender, not to mention their sexuality. Masuda also reported that some shelters that had once been accessible were accessible no longer after shelters had been renovated: one shelter's accessible bedroom was converted to a playroom while another shelter, built and named for a wheelchair user, became inaccessible when its exterior ramp was removed during renovations to the sundeck. While physical and attitudinal access continue to present barriers for women with disabilities seeking shelter services and more change is needed, there has been at least been some improvement over the past 20 years.

Communication access may also be a problem for women wishing to contact a shelter via TTY (teletypewriter -an accessible telecommunication device, used predominantly by people who are deaf or have speech difficulties), as not all shelters have TTYs and those that do often do not know how to use them (Masuda, 1990; Smith, 2008; Swedlund & Nosek, 2000; Womendez & Schneiderman, 1991). Sadly, although Masuda's, and Womendez and Schneiderman's research is 20 years old,

many of the barriers to seeking safety they outline still exist to this day. Smith (2008) reports that of the 58% of shelters who reported having provided shelter to women who were deaf or hard-of-hearing over the previous four years, “only 34.1% have TTY on their crisis line, [and] 38.9% have TTY available for women staying in their shelters” (p. 30). In my experience of updating a TTY directory and facilitating TTY repairs while working for a Deaf organization in Winnipeg, and from my unpublished research (2007) into the accessibility of, and the presence or absence of disability in, pamphlets about abuse and abuse services found at four women’s centres in Winnipeg, I have experienced first-hand many organizations’ ignorance surrounding TTYs. Of the few women-centered organizations who have TTYs, fewer still know how to use them. Some organizations may believe they are accessible to Deaf women and other women who rely on a TTY as a means of communication access if they have a TTY and publish the TTY phone number, however then fail to realize that no one in their organization knows how to use the device. I interviewed a staff person from a women’s centre in Winnipeg who confidently told me that although her organization possessed a TTY, no one ever called them on it anymore. From having tried to reach them countless times via TTY and finally calling on the regular telephone voicemail, I knew that they no longer received any calls via TTY because staff did not know how to use it (Keys, unpublished, 2007).

Agency and resistance.

In addition to seeking help from informal and formal sources of support, women also rely on their own strength and ingenuity to cope with experiences of IPV. Ristock (2002) uses the word *agency* to describe women’s negotiations of, and their resistance to, the violence within their relationships. Acts of resistance may at times

be subtle and, to the outsider, seemingly inconsequential, as is illustrated by one of Ristock (2002)'s interviewees who would intentionally wear an article of clothing her partner detested in the hopes her partner would tire of her and end the relationship. Alternatively, acts of resistance and agency may be much more involved: Ristock (2002) recounts an interviewee's decision to embark on a six-month trip to Australia as a means of extricating herself from her violent relationship. Both Ristock (2002) and Moe (2007) emphasize that the manner of resistance and agency that women in violent relationships exhibit is influenced by the reality of their situations and their social positioning. In other words, the extent of a women's marginalization may determine the extent of her resistance, however most women experiencing IPV do find creative ways of coping with and negotiating their situations.

Collaboration between organizations.

A common theme that emerged from the literature review was the potential to improve service delivery and reduce barriers through organizational collaboration. Several authors point to collaboration between organizations as an effective way to raise awareness about important issues, make effective use of resources, and better meet the needs of the women the organizations serve (Chang et al., 2003; Lightfoot & Williams, 2009b; Raj & Silverman, 2002; Ristock, 2005; Swedlund & Nosek, 2000). Lightfoot and Williams' (2009b) study revealed that people of colour who are Deaf or have physical or sensory disabilities are more likely to turn to a Deaf or disability organization for support over an abuse service organization for reasons of accessibility and familiarity. However given that "agency staff tends to be most knowledgeable about their own type of service provision. ...[and] agency rules and regulations create barriers that prevent service providers from providing help outside

of their main knowledge base” (Lightfoot & Williams, 2009b, p. 143) collaboration between different types of organizations makes sense. For example, cross-referral can ensure that when an organization needs to refer a client elsewhere, staff have a better understanding of what organizations will be able to meet the client’s needs and how the client can access the other services (Chang et al., 2003; Ristock, 2005; Swedlund & Nosek, 2000). Cross-training can be used to improve awareness about disability and accessibility among abuse service providers and increase disability organizations’ knowledge about IPV (Chang et al., 2003; Swedlund & Nosek, 2000). Similarly, collaboration between abuse services and cultural or ethnic organizations and communities and / or LGBTQ organizations can lead to more culturally appropriate service provision (Lightfoot & Williams, 2009b; Raj & Silverman, 2002; Ristock, 2005). In addition to increasing awareness about accessibility, Swedlund and Nosek (2000) found that as a result of collaboration between Independent Living Resource Centres (ILRCs) and shelters in the U.S., the ILRCs were able to recommend potential sources of funding to enable shelters to undergo renovations to increase accessibility. Collaboration between organizations can also lead to better outreach services (Raj & Silverman, 2002; Swedlund & Nosek, 2000). Although Lightfoot and Williams (2009a & b) do suggest collaboration between organizations as a means of improving service and increasing awareness and sensitivity regarding different social locations, they (Lightfoot & Williams 2009a) suggest the needs of people of colour who are Deaf or have disabilities and have experienced IPV might best be served by separate specialized services. In contrast however, Swedlund and Nosek (2000) found that collaboration with abuse services “proved to be a more effective means of improving services to women with disabilities than establishing a separate, ILC-based intervention program” (p. 62).

Clearly, regardless of one's preference for separate abuse services for clientele with disabilities or more accessible general community abuse services, collaboration between different types of organizations can lead to more successful, accessible, and sensitive service provision for women with disabilities.

In summary, women with disabilities may have additional potential barriers with which to contend when deciding whether to leave an abusive relationship. Although the social location of women will determine the degree of resistance and agency they can exhibit in their abusive relationships, women experiencing IPV tend to find creative ways to negotiate their situations. When reaching out for support, marginalized women will often reach out to friends and family with mixed results. Women may also seek counselling services, police or legal intervention, and / or assistance from shelters, again with varying results. Physical, communication, and attitudinal barriers hamper the help-seeking efforts of women with disabilities. One way to improve service delivery to women with disabilities and to reduce barriers is for different types of organizations, such as abuse service providers and disability organizations, to work together; cross-training, cross-referral, and joint outreach efforts can result in more effective all-around service provision.

Although the literature does provide valuable information regarding the help-seeking efforts of marginalized women and their experiences with support, more research on the specific experiences and efforts of women with disabilities is needed. Much of the literature that does examine the experiences of women with disabilities is focused on physical disability. Research regarding experiences of support and help-seeking among women with other types of disabilities—such as mental health conditions, chronic illnesses, and sensory disabilities—is long overdue. In addition to research examining the help-seeking efforts of women with

disabilities, it would be worth building on Fugate et al.'s work to explore why women with disabilities in particular do not pursue specific types of support in response to IPV. Also important would be an exploration of what women feel could help in the prevention, intervention of, and recovery from IPV. Aside from a study examining the types of responses women want when disclosing IPV to health care providers (Dienemann, Glass, & Hyman, 2005), I uncovered very little research examining prevention from the perspective of women who have experienced violence.

My research addresses some of the current gaps in the literature. Using an intersectional lens, I examine the help-seeking efforts and experiences of support in response to IPV among women with disabilities. I also explore the prevention and intervention strategies women with disabilities feel would better address their needs.

Chapter 2: Methodology and Methods

I undertook a secondary analysis of six qualitative interviews conducted with women with disabilities as part of a larger research project. In this chapter, I describe my theoretical framework, briefly introduce the larger study from which my data are drawn, and outline methods of data collection, sample selection, and data analysis. I also discuss the credibility of my research and my social location.

Theoretical Framework

A framework of intersectionality has informed my work. Ristock (2005) defines intersectionality as:

an analytical framework used to understand the way multiple identities (for example, gender, race, class, sexuality) shape people's experiences of oppression and privilege. The analysis exposes the different types of discrimination and disadvantage that occur as a consequence of multiple identities. (p. 19)

Several authors underscore the value of using intersectional analyses in the study of women's experiences of IPV (Bograd, 2005; Hiebert-Murphy, Ristock, & Brownridge, 2011; Josephson, 2005; Ristock, 2005). Josephson (2005) states that intersectional "analyses highlight the ways in which the particular social locations of women based on race, ethnicity, class, immigrant status, and familiar relationships, shape their experiences of domestic violence and demarcate the available options for dealing with their situations" (p. 86). In other words, intersectionality reveals the ways in which social location can impact a woman's access to relevant services, her treatment by potential sources of support, and influence her help-seeking decisions

and behaviours (Bograd, 2005; Hiebert-Murphy et al., 2011; Josephson, 2005). Intersectionality helps further understanding of IPV and IPV-related help-seeking by “go[ing] beyond single-factor descriptions of domestic violence, such as gender inequality” (Bograd, 2005, p. 33) and “factors that can be defined and measured at the level of the individual” (Hiebert-Murphy et al., 2011, p. 42).

My intersectional analysis adds an awareness of disability as a potential source of oppression—one that can put women at risk for violence and / or affect their access to support and intervention services. I examined how the intersections of disability and other social dimensions such as gender, class, and ethnicity shape women’s experiences of IPV and support. All too often disability is left out of intersectional analyses or simply given token mention which does little to further our understanding of how disability and other systems of oppression intersect to marginalize women. As Carol Thomas (2006) cautions:

... disabled feminists must be aware of the danger of tokenism here, and of the possibility of a second type of exclusion - what we might call exclusion by nominal inclusion. Simply including disability in a list of discursively constructed differences will sell disabled women very short indeed, because much more sustained analyses of the social and gendered character of disability and impairment - both culturally and materially - is required. (p. 183)

Mays (2006) advocates an integrated analysis of IPV drawing on elements of material feminist theory and of disability theory as informed by the social model of disability. Citing Hamilton (1979), Mays (2006) explains that:

The feminist material standpoint draws connections between historical, social and economic antecedents, which support and institutionalise a patriarchal society that privileges male power over women. From this stance, women’s

oppression is linked to the way society is organised around capitalism and unequal social arrangements. (p. 150)

The social model of disability grew out of the work of British disability activists, particularly the Union of the Physically Impaired Against Segregation (UPIAS), in the 1970s (Barnes & Mercer, 2004; Oliver, 2004). In contrast to the medical or individual model in which disability is viewed as a problem inherent to the individual in need of fixing, the social model views disability as arising from the interactions between individuals with impairments and societal, cultural, and environmental barriers resulting in “externally imposed restriction” (Oliver, 2004, p. 19). While the social model, in its various forms, has been highly praised by some and criticized by others, “... the social model provides a basis for understanding disability as a social construct, rather than an individual problem” (Mays, 2006, p. 149). Mays (2006) argues that neither theoretical approach on its own adequately addresses the structures of oppression operating in the lives of women with disabilities who have experienced IPV: traditionally, the social model has ignored gender while feminist material theory has ignored disability. While Mays (2006) does not specifically mention class, ethnicity, or dimensions other than gender and disability as potential sources of oppression worthy of consideration, she does highlight how the intersections of gender-based and disability-based oppression can result in poverty and decreased employment opportunities for women with disabilities further shaping their experiences of intimate partner violence.

Other authors take this intersection of different social locations even further. As noted above, Bograd (2005) explains how various social positionings, particularly gender, race, class, and sexual orientation intersect to vary the experience of violence, help-seeking, and support in the lives of women. While she makes a

strong argument for applying an intersectional lens to the examination of IPV in the lives of women, disability is noticeably absent—apart from a token mention in her concluding comments—from her discussion of the social locations that may come into play.

Meekosha (2006) clearly illustrates how various social dimensions including gender, ethnicity, race, and disability intersect in different ways for different people complicating the meanings of these social dimensions and contextualizing the experiences of marginalization and exclusion. Using Australia's colonial roots and history, she explains how various social dimensions such as race and ethnicity that often result in oppression and exclusion have evolved and changed over time and are interpreted differently by different segments of society. She describes how ableist language was historically applied to marginalize populations, such as the Aborigines, and to reinforce their supposed inferiority. She discusses the disabling process and legacy of colonization: ill health, impairment, lower life-expectancy, lack of opportunities, reduced self-worth, and the social ills prejudice and marginalization can breed. While still drawing on social history to provide context, Meekosha (2006) explores how various different social dimensions intersect to marginalize people in current-day Australia. For example, she highlights how gender and disability intersect to produce different social realities for men and women, then takes that further to explore how a disabled woman of colour might be socially located. In addition to offering thorough analyses of the intersections of various social contexts, Meekosha (2006) warns that "No one dimension takes precedence in this array - rather the interwoven social relationships that people experience and manage are held by multiple dualities - enabled/disabled; male/female; age privileged/ age oppressed; culturally powerful/culturally powerless; visibly majority/ visibly minority."

(p. 171). She also points out that “the boundaries between gender, race, ethnicity, class and disability are permeable” (p. 172). While not the focus of her analysis, Meekosha comments on the value of using an intercategory analysis in the examination of a wide variety of social concerns, including violence. I sought to emulate Meekosha’s robust, thorough, and encompassing style of analysis. For example, I have attempted to illustrate how the intersections of women’s multiple social locations and identities have impacted their experiences of violence and help-seeking. I examined how various categories can at times be useful, for example in defining the parameters of study, but are rarely as straightforward and as uncomplicated as they might appear. Not only are the boundaries between categories permeable as Meekosha (2006) points out, but identity, social positioning, and dimensions such as disability are rarely static. With this in mind, I trouble off-assumed dualities while trying to stay reflective and acknowledging that “the imagining of others’ positions is not a fluid and unproblematic path” (Meekosha, 2006, p. 172).

Methods

Background: the study from which my sample is drawn.

For my thesis research, I conducted a secondary analysis of six transcripts of qualitative interviews that I conducted with women with disabilities in 2007 while working as a research assistant for a relationship violence study at the University of Manitoba. The study, “Understanding women’s perceptions of risk for intimate partner violence: A focus on women with disabilities, women experiencing a separation, and women in lesbian relationships”, was funded by the Social Sciences

and Humanities Research Council (SSHRC) and was approved by the Joint-Faculty Research Ethics Board at the University of Manitoba. The research team consisted of Drs. Douglas Brownridge, Diane Hiebert-Murphy and Janice Ristock.

The Perceptions of Risk project contains both qualitative and quantitative components. I became involved with the qualitative component of the project during the recruitment planning phase in the spring of 2007. I assisted with the recruitment planning, carried out the initial recruitment and screening, and conducted the first round of 40 interviews. Another research assistant conducted fifteen subsequent interviews in 2009 to further diversify the sample. In total, 55 interviews were conducted, 35 of those with women who disclosed disabilities. All interviews were audio recorded using an iPod touch then transferred to CD for professional transcription. Once transcription was complete, the research assistant who had conducted the interview checked the transcript for accuracy. Using QSR International's NVivo 8 software, I then coded the verified transcripts, drawing on common themes that had emerged during transcript verification and field notes review, and during the coding process itself.

Although a couple of minor changes were made to the interview guide after I began work on the project, the interview questions were devised before I was hired. As its title implies, the main focus of the study was women's perceptions of risk for intimate partner violence. Only one question in the interview guide specifically addressed the prevention of intimate partner violence (see Appendix A for the project's Interview Guide), although the interview style was such that I was able to ask interviewees to expand upon their comments and to probe topics that arose during the interview. Several women spoke about their experiences with support and offered valuable input regarding helpful IPV intervention and / or prevention

strategies. As a result, I was able to select six interviews for analysis that were rich in content relevant to my research focus on women's experiences of accessing support for IPV and their views regarding what would be helpful in the prevention or intervention of IPV.

Recruitment, screening, and interview process.

Recruitment planning for the first round of interviews began in late spring of 2007. Distribution of recruitment materials began in late May and continued until early July, with materials being delivered to one additional location in mid-September. Recruitment materials included posters with tear-off strips containing the project's confidential email address and voicemail number, small handouts (half of an 8.5" x 11" page) that women could take with them, and a plain text version of the handout in electronic format for email distribution. Posters and handouts were distributed to a variety of organizations in Winnipeg including counselling centres, women's centres, shelters and second stage housing organizations, disability organizations, the Rainbow Resource Centre, and family and / or community focused organizations. Organizations known to have electronic distribution lists were asked to distribute the plain text electronic recruitment notice in addition to posting posters and / or accepting handouts. There was occasional contact with some of the organizations that had agreed to post and / or distribute recruitment materials to confirm we were still recruiting and to ask that recruitment materials be left up, or later when recruitment was winding down, to ask that organizations stop advertising the study.

The study's criteria were clearly outlined in all recruitment material. Criteria required participants be at least 18 years of age and not currently involved in an abusive intimate relationship. Women who had previously experienced IPV and had

a disability and / or had experienced violence while separated and / or experienced violence in a same-sex relationship were eligible to participate. Women inquiring about the study—most of whom did so by phone as opposed to email—were given additional information, and, if they expressed an interest in being interviewed, were screened to ensure they met the criteria. Women selected for an interview were asked about their availability and asked to choose from among several interview locations. A tentative date, time, and location were agreed upon with the interviewee. After ascertaining the desired location was available at the agreed-upon time, I reserved the space and confirmed interview particulars with the interviewee. In some cases, if the interview were some time away or if I suspected the interviewee might forget about our arrangements, I would make contact to again confirm and remind the interviewee we were meeting.

Interviews began in June 2007, with the bulk of the interviews taking place between July and October of 2007. Two additional interviews took place late in 2007, one in November and one in December. The majority of interviews (14) were conducted at the Millennium Library, which is centrally located, easily accessible by bus and wheelchair accessible. Eleven interviews were conducted at the North End Women's Centre, six at the former Elizabeth Hill Counselling Centre, five at an accessible location near Confusion Corner, and two at the University of Manitoba's Fort Garry campus. Two other interviews were held at locations more convenient to, and specifically requested by the two interviewees.

The length of individual interviews varied greatly, with some lasting beyond the 90 minutes allotted and others lasting far less time. Interviewees were met and shown to the room in which the interview would take place. They were asked to read and sign a consent form and were given an unsigned copy of the consent form

for their records. On a page attached to the consent form, interviewees could provide their mailing addresses if they wished to receive a copy of their transcripts and / or have a summary of the study's findings sent to them. All interviewees were offered a bottle of water and Kleenex was on hand in the event that it was required during the interview. Interviewees were asked if they were ready before the recording was started. At the end of the formal part of the interview, interviewees were asked if they had anything else to add before the recording was stopped. Interviewees were given a \$50 cash honorarium inside a thank you card. They were then asked to verify the amount of the honorarium and, for grant accounting purposes, to sign a receipt to confirm they had received the correct amount. Women were assured that the people processing the receipts would have no knowledge of their contact information or any other details about their participation in the project.

Selection of transcripts for analysis.

I selected the six interviews for my thesis analysis from among the 28 interviews that I conducted with women with disabilities, as I am far more familiar with the interviews I conducted than those conducted by the other research assistant. I read and worked with each transcript multiple times while carrying out my duties as a research assistant for the study. The sample of 28 interviews I conducted with women with disabilities comprised women who disclosed the following categories of disabilities: mental health (22 women), medical (12 women), physical / mobility (7 women), and hearing loss (2 women). Twenty-one women disclosed more than one disability, therefore the previous numbers do not add up to 28. Although seven women reported disabilities that were physical in nature and / or impacted their mobility, most of these conditions were not visibly obvious, meaning most of the 28 women in

the sample had invisible disabilities. Twelve women were Aboriginal; eight were white; seven were of mixed Aboriginal and white heritage, including a mix of women who identify as Métis, sometimes identify as Métis, and who do not identify as Métis; and one woman was of mixed Caribbean, South American and Canadian heritage. All women were born in Canada. Two women identified as lesbian, three women as bisexual, 22 as heterosexual, and one woman chose not to label her sexual identity. The women ranged in age from 23 years to 57.5 years with an average age of 40.7 years. Two women were working full-time at the time of the interview, two women were working part-time, two women worked on a casual basis, three were students, including one woman who also worked part-time, and the remaining 20 women were not employed. Education levels ranged from Grade 6 (one woman) to undergraduate degree (two women). Ten women had some high school, five women had completed Grade 12 including three women who were enrolled in post-secondary education programmes at the time of the interview—one in a university programme, one in a college programme, and the other's programme was unknown—one woman reported some college education, five women had college certificates, and three women had some undergraduate university. One woman's education level is unknown.

In selecting interviews for my secondary analysis, I re-examined the transcripts for content relevant to my research focus. I sought transcripts in which women:

- discussed their experiences with informal and / or formal supports, regardless of whether these experiences were positive, negative, or a combination thereof;

- provided significant information regarding several different types prevention/intervention strategies without significant prompting;
- revealed the context of their experiences, either directly or indirectly;
- spoke, to some degree, about their disabilities beyond their initial disclosure when asked during the interview whether they had any disabilities and / or long-term illnesses.

I was not looking for consistency of opinion regarding whether their disabilities made them more vulnerable to abuse or whether disability played into the dynamics of abuse or impacted their help-seeking, I simply wished to be able to give some context to their experiences and discuss how disability may have affected their social positioning and experiences of seeking help.

In addition to reassessing the transcripts, I also reviewed my field notes and the risk and intersectionality summary sheets I had completed for each interview. The risk and intersectionality summary sheet template was devised by my advisor, Janice Ristock, for use in the analysis of the perception of risk portion of the larger study. I created my own summary sheet (see Appendix B)—based on the one devised by Janice Ristock—to assist me in selecting the most appropriate interviews for my research focus and to aid me in my analysis. I used the prevention, intervention, and support summary sheets to record each interviewee's experiences with support, her recommended prevention and intervention strategies, and any content relevant to an intersectional analysis including, but not limited to, barriers to assistance, social perception of disability, other identities or structures at play, and problems with categories or language. I also used the summary sheets to compile basic demographic information, details about relationship dynamics and anything

else that stood out about the interview or the interviewee's experiences. The summary sheet was a valuable tool: it enabled me to pull relevant data out of each transcript to save in a single, organized file; provided a good indication of the quality and quantity of the content relevant to my research focus found in each interview; facilitated a fairly quick review of pertinent data during the selection process; and provided a good place to start my analysis.

After reviewing each interview and completing the prevention, intervention, and support summary sheet, I indicated in the interview selection table I had devised how well the interview met my selection criteria (described above) and noted any additional details worthy of consideration during the selection process. For example, I made note of potential drawbacks to particular interviews such as cases where interviewees did not elaborate on their ideas or experiences, required significant prompting to elicit relevant responses, and / or mentioned things which prevented further abuse in their situations, but which would not be generally advisable as a prevention or intervention strategies. After I had reviewed all 28 interviews, I examined my interview selection table and revisited the summary sheets for the interviews I was considering including in my analysis to ensure I had been consistent in the application of my methods and criteria.

The result of this process was the selection of six interviews in which women had the most to say overall about their experiences with support, their ideas for prevention and intervention strategies, the larger context in which their experiences took place, and how disability was part of their social positioning. Although I recognize that there is value in examining what goes unsaid in women's experiences of IPV, for the purposes of my thesis analysis, I chose to select the interviews during which women had the most to say regarding my area of focus so I would have a rich

variety of material with which to conduct my analysis. I was reluctant to select only interviews in which there were many silences and little relevant data for several reasons: such interviews would limit the breadth of my analysis; I would have to make greater stretches and assumptions, likely with less accurate results, but with no way of knowing for certain whether my assumptions and interpretations were correct; and determining a criteria upon which to select such interviews would have proven quite challenging. Despite having chosen interviews with the most relevant material, there was at least one instance in which a woman in my sample of six identified a particular issue but seemed reluctant to discuss the issue in much detail. I noted any such occurrences that pertained to my research focus in my prevention, intervention, and support summary sheets and explored the issue in the discussion section of my thesis. Therefore, although I did not base my sample selection on silences or what was left unsaid, I remained conscious of any silences that arose and explored them in my analysis.

Data analysis.

I employed two types of analysis in my research: thematic analysis and intersectional analysis. I found myself in a rather unique position as a researcher in that I was already well acquainted with the data prior to selecting my sample and commencing my secondary analysis. As a result of both my familiarity with the data and my review of the literature I had tentative themes in mind when creating my prevention, intervention, and support summary sheet template, a tool upon which I relied during sample selection and when starting each level of analysis. It may seem risky to commence an analysis with preliminary themes or codes in mind; indeed Esterberg (2002) cautions against “develop[ing] codes in advance [of open coding],

[as] you will impose your own sense of what *ought* to be there in the data and may very well miss what *is* there” (p. 158). Having previously coded all 28 interviews I had conducted with women with disabilities for the larger study however, I had worked through various stages of theme development including familiarizing myself with the data, recording noteworthy aspects of women’s experiences and applicable emerging common themes in the field notes for each interview following transcript verification, and carrying out open and focused coding using QSR International’s NVivo software. Although the main focus of the study from which my data are drawn is women’s perception of risk, I coded all transcripts for themes related to risk, prevention, and intersectionality. As a result I was aware of the prevention and support-related themes that emerged from the larger study and was able to build on and refine those themes for my own research after selecting my sample. Nevertheless, I “remain[ed] open to whatever [I] saw in the data” (Esterberg, 2002, p. 158) while undertaking my secondary analysis.

Once my sample selection was complete, I copied the sections pertaining to experiences with support and ideas for prevention from each of my sample’s summary sheets into a separate document so that all that data were in a single file. I ensured that the appropriate interview number was listed in brackets next to each item in the document so that I could keep track of who had said and experienced what. This is especially important in an intersectional analysis given that the context of women’s lived experiences and social locations shape their experiences of IPV and help-seeking and influence what they think is needed in terms of intervention and prevention.

I organized the support and prevention material into themes based on the preliminary themes that arose from the coding I had done for the larger study, my

review of the literature, and my completion of the summary sheets. I refined the themes as I reviewed the data, expanding some themes and collapsing or eliminating others to suit my sample. My thematic analysis of women's experiences of support yielded the following themes: experiences with informal supports—including subthemes of family, and friends or other informal supports—; counselling experiences; shelters and second stage housing experiences; legal system experiences; Child and Family Services experiences; encounters with medical professionals; and crisis centre support. Themes related to prevention, intervention, and healing included: education / awareness—with subthemes of abuse awareness and education, mental health / disability awareness and education, general education and awareness, and role models and mentorships—; support system; counselling for prevention, intervention, and healing; diagnosis and appropriate and effective treatment; addictions treatment services, recovery and abuse services—with a subtheme of provide childcare and funding to train teens to provide childcare—; shelters and / or second stage housing services; culturally based services; legal mechanisms: restraining orders, better enforcement, and stiffer penalties; safety precautions and escape plans; and self-care, spirituality, and community—with subthemes of heal, take care of self, and improve self-esteem; spirituality; community; social change; and protected her from further abuse.

For my intersectionality analysis, I made use of the analysis section of my sample's summary sheets, which detailed how each interviewee's social location, personal history, and the context in which violence took place affected her experiences of IPV and help-seeking. My exploration of the barriers to support that women in my sample experienced resulted in the following barrier themes: a lack of education and awareness, lack of resources, lack of services, community size and

dynamics, and potentially exclusive admission criteria including an examination of the relationship between abuse and disability. Next, by interrogating the context of women's experiences and their social locations, I found that the following social dimensions helped shape the experiences of women in my sample: gender, cultural background, socioeconomic situation, religion, disability, and separation and relationship status. I paid special attention to the potential problems with language and categories, incorporating these into my discussion of these social dimensions.

During each level of analysis, I referred back to the transcripts as required for clarification, for additional information, and to gather additional quotations. I also revisited other documents such as field notes and summary sheets as required and revisited my questions and musings notes for each theme as I went, updating them as I went. This enabled me to strengthen my overall analysis and be confident in the themes that emerged from all levels of analysis.

Credibility of the research.

Tracy (2010) offers eight criteria for producing high calibre qualitative research. She writes: "high quality qualitative methodological research is marked by (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence" (p. 839). She describes and gives examples of her eight proposed criteria, concluding that even the best researchers will be unable to achieve the ideal of the eight criteria in each and every project:

While rules and guidelines are helpful, if it were really as straightforward as "eight simple criteria," there would be no magic, no surprises, and therefore no genius.

Furthermore, although best practices serve as goals to strive for, researchers can and will fall short, deviate, and improvise. . . . Indeed, our human instrument will show its innate humanness by not being able to achieve everything all of the time. The key is to be truthful with ourselves and our readers. (Tracy, 2010, p. 849)

In the following paragraphs, I will use Tracy's criteria as a basis for discussing the quality and trustworthiness of my research.

Worthy topic.

Tracy (2010) says: "good qualitative research is relevant, timely, significant, interesting, or evocative." (p. 840). Both my research and the study from which my data are drawn are relevant, significant, and interesting. IPV is a serious social issue that merits further study. Exploring what women who have experienced IPV have to say is not only interesting, but is also revealing; Women who have sought help for the IPV they have experienced offer unique perspectives regarding the effectiveness of abuse-related services, the barriers to accessing support, factors that put them and / or their partners at risk for becoming involved in abusive relationship(s), and what could help to prevent IPV. The narratives of the women in both my sample and the larger study reveal discrepancies between service organizations' policies and practice, point to gaps in service provision, and highlight the need for additional supports. Their stories have much to tell us. Tracy (2010) says: "worthy studies are interesting and point out surprises—issues that shake readers from their common-sense assumptions and practices" (p. 841). My research does this.

Rich rigour.

According to Tracy (2010), rich rigour is achieved when “the study uses sufficient, abundant, appropriate, and complex theoretical constructs[,] data and time in the field[,] sample(s)[,] context(s)[, and] data collection and analysis processes” (p. 840). Great care has been taken during all steps in the research process. For the larger study, attempts were made to get a diverse sample in terms of socioeconomic class and disability type; the interview style resulted in rich interviews; thorough field notes were recorded immediately following each interview; one of the researchers designed a project-specific tool to facilitate the analysis; and the initial stages of analysis were carried out by three to four people to ensure that everyone reached similar results while bringing their unique perspectives to the analysis. Given that my research is being done to fulfill the requirements of a Master’s degree, my small sample size and the scope of my of research is appropriate for my research goals.

Sincerity.

Tracy (2010) focuses predominantly on self-reflexivity and transparency as a means of demonstrating sincerity. Field notes were part of the methodology for this study. I include a reflexivity section (below) where I discuss my social location, self-reflexivity, and transparency.

Credibility.

“*Credibility* refers to the trustworthiness, verisimilitude, and plausibility of the research findings” (Tracy, 2010, p. 842). Part of the credibility of my findings can be attributed to the quality of the data and the quality of the study from which my data are drawn. My data were derived from a well-established research project, devised

and run by well-respected researchers, funded by a reputable body and approved by university ethics board. At the time of the interview, participants were asked to indicate whether they would like a copy of their interview transcripts. After the transcripts had been verified, transcripts were mailed to those who had requested them, and interviewees were given one month to respond with any changes or corrections. No one did.

Another means of ensuring the trustworthiness of my findings is through the use of thick description.

One of the most important means for achieving credibility in qualitative research is thick description. By this, I mean in-depth illustration that explicates culturally situated meanings (Geertz, 1973) and abundant concrete detail (Bochner, 2000). Because any single behavior or interaction, when divorced from its context, could mean any number of things, thick description requires that the researcher account for the complex specificity and circumstantiality of their data (Geertz, 1973). (Tracy, 2010, p. 843)

Thick description appears to be well matched to an intersectionality framework as both rely on providing rich amounts of detail, context, and examples to explain results. I have often used the interviewee's own words to illustrate, enrich, and contextualize my research findings. Although I sometimes worried that I was providing excessive amounts of detail, I was reassured to read that: "In qualitative research, 'things get bigger, not smaller and tighter, as we understand them' " (Tracy, 2010, p. 843 quoting Gonzalez, 2000, p. 629). Fortunately, as this is a Master's thesis—as opposed to an abbreviated report of the research—there is space to provide ample context and detail.

Resonance.

I hope that the presentation of my research will resonate with readers. By sharing women's stories, using their words, and contextualizing their experiences, I hope that my research causes people to "feel, think, interpret, react, or change" (Tracy, 2010, p. 845 citing Richardson, 2000a).

Significant contribution.

Tracy (2010) identifies four types of significance: theoretical significance, heuristic significance, practical significance, and methodological significance. My research is theoretically significant in that it will add to the extremely limited body of literature exploring disabled women's help-seeking and experiences with support in relation to IPV. It will also expand the literature regarding intersectional analyses of IPV and intersectional analyses including disability.

In addition to being theoretically significant, I hope that my research will prove to be heuristically and practically significant. In the conclusion section of my thesis, I have outlined areas for further research including a broader exploration of my thesis topic using a larger sample. I hope my work and my suggestions for further research inspire others to explore related topics. It would also please me if my research were to result in greater awareness and remedy of the discrepancies between policy and practice among service providers; increased access to services and supports for women with disabilities—including those with low incomes—who have experienced IPV; the implementation of new and / or improved services; and a realization among readers that they *can* do something to help women experiencing IPV: they can be a support. Furthermore, I hope to cause others to view disability in a different light and to approach research with participants who have disabilities from more of a social

model and / or intersectional perspective, as opposed to the medical model perspective that seems to inform many studies.

Ethics.

Procedurally, the study was conducted in an ethical manner. Ethics approval from the Joint-Faculty Research Ethics Board was obtained prior to commencing recruitment of participants. The nature of the study was made clear to participants during recruitment, screening, and the interviews. Women were advised that they could stop the interview at any time if they no longer wished to continue and that they did not need to answer anything they did not want to. Data, such as interview transcripts and audio files, field notes, and signed consent forms were kept in secure locations: paper copies and cds containing back-ups of digital files of confidential materials were secured in a locked filing cabinet in a locked office; digital working copies were kept on a password protected computer. Interviews were assigned case numbers to protect the identity of the interviewees. In my thesis research, I assigned pseudonyms to the interviewees in my sample to further protect their identities and to personalize the recounting of experiences. As I worked solely with data collected with the approval of a university ethics board and did not collect any additional data from human participants, further ethics approval was not required for my thesis research.

Situational, relational, and exiting ethics were taken into account during the study. According to Tracy (2010), “a situational ethic assumes that each circumstance is different and that researchers must repeatedly reflect on, critique, and question their ethical decisions” (p. 847). Situations arising during the research process—such as questions regarding prospective participants’ eligibility to

participate in the study and whether to contact the authorities regarding a potential case of child abuse that had previously been reported to the appropriate authorities—were treated on an individual basis in consultation with the research team. In terms of what Tracy (2010) calls relational ethics, participants and those potential participants who did not meet the study's criteria were treated with respect and thanked for their interest and / or participation. As the initial contact and the interviewer, my position vis-à-vis, and rapport with, the participants were also things to which I gave a lot of thought.

Exiting ethics, which Tracy (2010) says relate to the presentation or dissemination of findings, have and will continue to be undertaken with great care. In writing my thesis, I have tried very hard to find the balance between providing adequate context and maintaining participant anonymity and confidentiality. In any dissemination of my findings beyond my completed thesis, I will tailor my language and presentation style to the intended audience: I will continue to use academic terminology and language in writings intended for academic publication while I will use more plain language for any community dissemination of findings.

Meaningful coherence.

According to Tracy (2010):

Meaningfully coherent studies (a) achieve their stated purpose; (b) accomplish what they espouse to be about; (c) use methods and representation practices that partner well with espoused theories and paradigms; and (d) attentively interconnect literature reviewed with research foci, methods, and findings.

In my thesis research, my findings answer my research questions; my framework and methods are well matched; and I have tried to integrate all components of my research into a well-written report. Tracy (2010) points out that meaningful coherence does “not mean that a study cannot or should not be messy, disturbing, unexpected, or jarring” (p. 848). Therefore my discussion of the sometimes non-static nature of identity, impairment, and social constructs and the problems with demographic categories does not negate the meaningful coherence of my study.

Social Location and Reflexivity

Several authors (Kirby, Greaves, & Reid, 2006; Ristock, 2002; Ristock & Pennell, 1996; Tracy, 2010) advocate the use of reflexivity in qualitative social research.

They highlight the importance of examining one’s social location in relation to one’s research including examining one’s own biases and assumptions and how one’s social location influences various aspects of the research process. In this light, I will describe my own positioning and how I feel it impacts the research.

I am a white, middle-class woman, born and raised in southern Ontario. At the time I started conducting interviews for the Perceptions of Risk project, I had resided in Manitoba for just under a year and a half and was therefore not as familiar with the city and province and the services offered therein as someone who had lived here much longer. I mention this because there were a few times during interviews when a woman would mention something with which I was not immediately familiar, which in most cases was likely due to my having resided in the city for a relatively short time. Although I have experienced harassment while travelling abroad, and may not always have been as assertive as was healthy in past

relationships, I have not experienced violence in my own intimate relationships.

There were times that my lack of first-hand experience of IPV may have affected the dynamics of an interview, though not necessarily for the worse. I recall a time in one interview when a woman said that she felt it was best to have abuse services providers who had actually experienced IPV versus someone who had learned about abuse through books. We both had a laugh when I responded “like me?”.

I have never been comfortable identifying as either able-bodied—or temporarily able-bodied as some people like to say—or disabled. Although, in the past I would have been irritated at seeing or hearing the words *struggled* or *suffered* used in relation to discussions of disability, my views have since changed. Although I feel these words are often inappropriately added to descriptions and / or discussions of disability, I now feel there are times when comments about struggle, discomfort, or the like are reflective of some people’s realities. That said, I struggled with depression during the thesis proposal process. I took long breaks from my thesis because I had developed such an aversion to it or because I became so overwhelmed I needed time away. Although I never disclosed my depression to any of the interviewees, and my experiences of poor mental health have differed from theirs in some respects, I felt able to relate to some interviewees’ discussions of their experiences with their own mental health and how it played into the dynamics of their relationships. Interviewing women who spoke about their own mental health struggles or those of a partner caused me to reflect on my own situation and experiences.

My experience with depression was not my introduction to disability: I have lived and worked with people with disabilities for many years. I have long had a

passion for accessibility and advocacy. My interest in accessibility and inclusivity as well as my various experiences—both first-hand and through my interactions with or support of others—has definitely shaped my interpretations and analyses during the research process.

Throughout the research process, I have reflected on my interactions with the interviewees and my interpretations of their experiences and ideas. Following each interview I recorded detailed field notes, often including reflections regarding my relation to, or rapport with, an interviewee; the tone of the interview; my feelings or mood at the time if I thought them relevant; any difficulty the interviewee and I had in understanding each other; and what I might have done differently. I have often looked back on my field notes when coding and analyzing the interview transcripts and when writing about the research in order to remind myself of the tone of the interview, how my position or personality might have shaped the interview, and to reflect on how I interpreted the data. While writing about my findings, I was especially conscious of the responsibilities and risks associated with the retelling and reframing of others' stories and experiences. Although I hope my work effects positive change—in attitude, perception, practice—I am acutely aware of the danger my work may be misinterpreted and / or may negatively impact how readers view the women in my sample. As Tracy (2010) points out:

Certainly, researchers never have full control over how their work will read, be understood, and used. However, they can consider how best to present the research so as to avoid unjust or unintended consequences. . . . Stories about people who are poor, stigmatized, abused, or otherwise marginalized can serve to further negatively portray such people—even if that is not the intent of the author.” (p. 847).

As a result, I exercised great care in introducing the women in my thesis sample. I debated about whether to include information such as that a woman's children were in foster care for fear that readers would judge the woman's ability to parent and / or otherwise judge her character. In my attempt to highlight similar demographic and contextual information for all interviewees, I may have given more weight or implied significance to some things than was perhaps necessary. For example, I sometimes wrote something in an interviewee's introduction that she mentioned only briefly before, during, or after the recorded portion of the interview, therefore attributing greater prominence than might have been called for. I felt a real responsibility to the interviewees, to present them in a way that they would find fair, to treat both them and their stories with the utmost respect, to provide enough detail that their experiences can be understood in context without revealing identifying information, and to be open and honest in my interpretations of their experiences. Meekosha (2006) cautions that "care needs to be taken that we note the imagining of others' positions is not a fluid and unproblematic path, though empathetic understanding can offer a way forward once the complexity of the parameters framing peoples' lives are recognized" (p. 172-173). I hope that I have done the women and their stories justice.

Chapter three: Stories of Support, Strategies for Prevention: Findings from the Qualitative Interviews

The Participants

My sample was comprised of six women, five of whom disclosed multiple disabilities including at least one mental health condition. Three of the five women who disclosed multiple disabilities disclosed medical conditions in addition to mental health conditions while another disclosed medical and physical disabilities in addition to mental health conditions. The woman who disclosed a single disability reported having a medical condition. The women, all of whom were born in Canada, were Aboriginal (two women), of mixed Aboriginal / white heritage (one woman), of mixed Caribbean, South American and Canadian heritage (one woman), and white (two women). All women self-identified as heterosexual. They ranged in age from 28 to 46 years, with an average age of 35.33 years. Two women were students at the time of the interview, including one woman who was also working part-time, the other four were not working. The women's highest level of education completed ranged from grade 9 to university in progress. Two women had some high school, two women had completed grade 12 and were pursuing post-secondary studies at time of interview, and two women had college certificates. Five women had children; two women's children were in care.

Most women in my sample had experienced violence in more than one intimate relationship: four women reported having experienced IPV in three relationships, one woman experienced IPV in two relationships, while one woman experienced one abusive intimate relationship. The length of the most recent

abusive relationship or the relationship that was the focus of the demographic section of the interview ranged from 2 years to 21 years with an average relationship length of 9.58 years. The length of time the relationship in question had been abusive ranged from 1.5 years to 21 years with an average duration of abuse of 9.25 years, during which women experienced the following types of violence: financial / economic (five women); psychological / emotional (all six women); physical (all six women); sexual (five women); verbal (five women); threats to disclose her disability(ies) (three women); and threats to withdraw essential disability-related supports (two women). Several women also reported disability-targeted abuse such as the withholding of medication, disposal of medication and medical devices, interfering with prescribed treatment, providing inappropriate food, and withholding healthy food. Two of the women who experienced sexual abuse said their second child was conceived as a result of being raped by their husbands; one of these women was separated from her husband at the time of the rape. All women resided with their partners during the abusive relationship that was the main focus of the interview; three were married to their abusive partner and three were living common-law.

In the paragraphs that follow, I will briefly introduce each participant before moving on to present my findings. I have given each woman a pseudonym in order to protect her identity. I have made a conscious effort to reveal enough about each interviewee to provide context while omitting any details that may serve to identify any of the interviewees.

At the time of the interview, Zoë, 28, who is of mixed Caribbean, South American, and Canadian heritage, was pursuing a degree in education. She hopes “to develop

a life skills curriculum for grades 5 to 7” as she feels many children and parents of young children, especially in the inner city, lack the essential skills and knowledge to become healthy adults and engage in healthy relationships and behaviours. She experienced violence in three intimate relationships, the first of which she described as the “worst” and was the focus of the demographic section of the interview as she experienced violence while separated from that partner. Apart from her crack addiction, she was not aware of her disabilities — anxiety, depression, PTSD, and borderline personality disorder —during her abusive relationship, though looking back, she can see how they may have factored into her experiences. She was transient when she met her first abusive partner and later wound up being “pimped” by him, though she feels her crack addiction might have led her to the sex trade eventually had he not expedited her involvement. She has 3 children, at least two of whom are in care.

Audrey, 39, who is white, is a former bar manager and waitress who has experienced three abusive relationships. Although she has also been diagnosed with borderline personality disorder, sinusitis, and skin cancer, her bipolar disorder and anxiety appear have the greatest impact on her day-to-day life. She offers valuable insight into the relationship between mental health conditions and IPV. Growing up, her mother was often ill and was not always available for her. Similarly, she feels she might not have been as available to or supportive of her children as she would have liked due to her struggles with IPV and poor mental health. In addition, a lack of services for children at the time meant she was unable to secure counselling services for her children after they witnessed her being abused. She is worried that her two daughters are following in her footsteps; the eldest, whom she

suspects has anxiety, was recently abused by her boyfriend and the youngest is a new teenage mom whose partner is “a good guy but I see the control aspect”. She is trying to support her daughters and to secure the professional assistance they require, especially now that she is much healthier than in the past.

Henrietta, 36, was working part-time as a health care aide and training moms for Child and Family Services (CFS) in addition to pursuing further schooling when we met. She had given up her Licenced Practical Nurse (LPN) license, as she did not want the responsibility of working as a nurse while she recovered from a 17-year long abusive relationship. Both she and her ex-husband, from whom she is legally separated, are Aboriginal and grew up in foster care. She and her children moved to Manitoba after her ex-husband kidnapped their daughter. She is extremely safety conscious, has developed a strong network of support, and has implemented numerous protective measures to safeguard herself and her children as her ex-husband continues to harass her from afar. She has Type II Diabetes.

Patricia, 30, is of mixed Aboriginal and white heritage. She has a grade 9 formal education, though she has educated herself further by researching, reading, and engaging with the information she collects. She appears to have grown up surrounded by violence: she was removed from her birth family at a very young age, was sexually abused by her adoptive brother, and was then kicked out of the (adoptive) family for speaking out about it. In addition, she was exposed to violence in her community when living on reserve as a child. She also reported being abused in three intimate relationships. She has a “psychiatric background”—a history of depression and PTSD, past suicide attempts, and self-harming behaviour—which

her husband used to his advantage. She also has chronic pain, hip problems, and Hepatitis C, which were exacerbated during her abusive relationships. The authorities have discounted her concerns that her two young daughters are being abused in care. In addition to many IPV prevention and intervention ideas, her experiences with formal supports and services are quite revealing.

Wendy, 33, is a single mom to four children. She receives little support for her children, financially or emotionally. Her anxiety developed during her second of three abusive relationships. She also experiences bad headaches, which cause blurred vision. She is Aboriginal and has a grade 10 education. She was raised by her grandparents and does not have a close relationship with her birth mother. She had a lot of insight into the challenges of accessing support as a single mother on a limited income.

Oonagh, 46, is white, and has a college education. She grew up in an abusive home and has experienced IPV in two relationships, the longest of which lasted 21 years. She does not have children—she lost 5 through miscarriage and tubal pregnancies—but hopes to foster children one day. She believes her depression started during her sixth year of marriage. She has also been diagnosed with bipolar disorder, pre-menstrual dysphoric disorder, and high blood pressure. She experienced panic attacks and a variety of other ailments during her marriage as a result of the abuse she experienced. She is thankful for the support and services she has been able to access and has a strong desire to give back to the community and has done so.

Findings: Experiences of Support

All women in my sample spoke of experiences with potential sources of support that took place during and after their abusive relationships. Women recounted stories of their interactions with, and the responses they received from, various sources including informal supports—family, friends, and acquaintances—and more formal supports such as counselling services; shelters and second stage housing services; the legal system, including police and the courts; Child and Family Services; medical professionals; and a crisis centre. In this section, I explore their experiences of support, thereby addressing my first research question: What have women with disabilities experienced when accessing support for IPV?

Informal supports.

Family.

All six interviewees reported experiences with informal support. Three women gave examples of positive experiences of family support. While two women gave examples of positive support that took place during or following the abusive relationship, the third woman's experience appears more general and it is unclear whether it pertained to her experiences of IPV.

Oonagh spoke about the support she received from her mother when she decided to seek a divorce. While staying in a psychiatric hospital following a suicide attempt—her only perceived way out of the relationship at the time—her mother helped her retrieve her belongings from the house she had shared with her husband and offered her a place to stay, though Oonagh did not accept for fear that her

husband would harm her or her mother. During her marriage, Oonagh found support in her mother-in-law:

his mom said, like to look after him the best you can, make sure he's fed on time, make sure he goes to bed on time, like look after him really well and maybe he won't get so angry. But you can do anything and everything and those are the words of an abused woman too. (Oonagh)

Although her mother-in-law's words may not sound particularly supportive, coming from a woman who had been abused most of her life they were likely reassuring. Her mother-in-law's support clearly meant a lot to Oonagh at the time: "I always thought I had to be like his mom. I thought she was such a great mom, because my mom was so controlling and so overbearing, and I just, I was so close to his mom".

Zoë acknowledges the support family—particularly a cousin—provided to her during her first abusive relationship:

Zoë: And I think having a relationship with my family, my cousin was involved, I think that was huge. I think it could have been a lot worse had I been completely alone, you know. But he always knew that there was a limit. He always knew, you know, like I was never hospitalized, stuff like that and I think the reason for that is because my family was always there. They were always, you know, they would come and bring us food. They would, you know, take me away from him time and time again whenever I got ready to leave and I always ended up going back, you know, but they were there.

Int.: So you felt you had a real support system then? Or some degree of support system?

Zoë: Well looking back now, I realize that they were there when I was ready to make a change, you know what I mean? But at the time I didn't feel supported. . . . but I think that had I not had that familial support that he would have been [able] to take things to a lot greater extremes than they had been taken to, you know. Yeah it could have just been a lot worse, because I was able to, you know be open and honest with my family and say this, well one member of my family. This is what's happening. This is what's going on, and this is what this looks like. And the first time I left him I went with the baby to stay with, somewhere.

Wendy reported that her grandmother, who is now deceased, was her confidante, "the one person I always talked to and listened to and went to for advice". Although unclear, given that Wendy's comments about her grandmother being her confidante were made when she suggested that abused women speak with an Elder, it is likely that if her grandmother were alive during her experiences with IPV Wendy would have gone to her for support.

All six women disclosed negative encounters with family, lack of family support and / or distrust of family, however the experiences recounted by four women were general, took place during childhood or were unclear as to how they related to the women's experiences of IPV. Examples that are unclear or that took place during childhood include a perceived lack of parental support and availability, lack of discipline and / or healthy boundaries, being thrown out of the family for disclosing abuse, and not having a good relationship with a birth parent. At least three women experienced sexual abuse during childhood, in one case at the hands of a sibling, in another by a foster father. Another woman reported being raped when she was 16 or 17 years old however she did not specify who perpetrated the

crime. Yet another woman mentioned that her brother was abusive, however she did not elaborate and I did not probe further. She also said that having experienced sexual abuse may increase women's risk of experiencing IPV.

I think something else that may have contributed, I'm sorry, to my being vulnerable and to other women being vulnerable to abuse would be sexual abuse, you know, because you're not, you don't value your body, you know. You don't, it's just something that's there, kind of dissociating. Two separate identities. There's me and there's my vagina, you know, and they don't have anything to do with each other. (*Both laugh*). (Zoë)

Again, the circumstances surrounding the sexual abuse to which Zoë refers are not known – was she referring to having been sexually exploited by her partner or was she sexually abused prior to her first abusive relationship? Zoë is not the only interviewee to speak about dissociating: Oonagh speaks of being able to “leave my body” as a result of having been raped when she was younger – something she did time and time again during her abusive marriage. Although the context of the interviewees' previous sexual abuse are not always clear, what is clear is that sexual violence, experienced during childhood or otherwise, has a lasting impact and likely, in some way, helped shape how women later experienced IPV. Given the perceived lack of family support and availability and the cases of childhood abuse, one may infer—perhaps incorrectly—that most women did not receive overwhelming family support during or following their abusive relationships.

Two women reported negative experiences with family members related to IPV. Henrietta distrusts her ex-husband's family and will not allow her children to go anywhere with them for fear her children will be kidnapped again. She is also

cautious around her own family as her children are nervous around men and around alcohol and pick-up on “bad vibes”:

We can't even go to our own family when they're drinking. We can't even be around people. I can see my children pacing. I can see my children, my kids just latch on to me. Mom, let's go. Okay, let's go. We cannot even go in public places where they see that because we're still dealing with that violence. (Henrietta)

Henrietta's family also laughed at her when she told them her husband had raped her.

For Oonagh, leaving her husband had unintended and upsetting consequences: the loss of her sister, niece, and nephew.

I've lost my sister and my niece and nephew over this because her husband is best friends with my ex, so I've lost them, but my mom, I've told my mom now things, I kept everything a secret, but I've told my mom things and so my mom is telling my sister. So my sister will tell my mom things but she won't tell me anything, so I hear things what's going on with his life. (Oonagh)

Although her sister will not communicate directly with her, Oonagh's sister provides indirect updates via their mother about her ex and his relationship with his new girlfriend whom he is abusing. During their marriage, when Oonagh's husband was away, he would have her brother-in-law—her sister's husband—watch her.

Friends or other informal support.

Women also recounted experiences with friends, acquaintances, and other non-family informal supports during their interviews. Four women reported positive experiences of non-family informal support. For Henrietta, her friends are a source

of support: they check in with her regularly to ensure she is safe, help her remain healthy, and hold supportive gatherings. Her friends are aware she has diabetes, know what to do if she gets sick, and know what she needs to do to stay healthy: “the people in my life that support me on my, that help me. Make sure I’m okay. Make sure that I’m eating right. Make sure I’m exercising.” In addition, she and a circle of friends who have or are currently experiencing IPV get together to support each other: “We have our little women evenings. It could be at one home or another home. We’ll sit there, have coffee, and if they’re not comfortable speaking out loud, they can have a piece of paper or ...” (Henrietta). Audrey, on the other hand reported that it was her abusive partner’s friends who stuck up for her: “His friends really hated it. His friends always tried to stick up for me a lot of the time. Later on in the relationship, they started to, that’s enough already. Leave the poor girl alone.” Her ex’s friends did not approve of his constant cheating or his controlling and abusive behaviour. It was the support of one of her teachers, however, that was instrumental in enabling Audrey to regain control of her life.

Audrey: I had taken control of myself after that. I started going to school.

Before we had broken up, I went to school, so I just went back to school. That’s when I got my certificate at *[name of school]*, and going back to school and being in the public again, and my teacher and I hit it off really, really well at the time. He gave me a lot of attention. He was very supportive in a good way, in a healthy way and I started taking some control back of myself, and was able, after I finished school and I went to work. I was working full time, and yeah, to hell with this. I took back my life.

Int.: Okay. So you feel that by doing all those things and having support, it improved your self-confidence and helped you?

Audrey: If I hadn't had that teacher that I had at *[name of school]*, I don't think I would have made it through that full course.

Int.: Okay. So you found a support system that made the difference.

Audrey: Yeah, and he knew about all the stuff that was going at home, so he was even more supportive, like you know. Like in a way, like he would send food home with me every Friday, you know a couple of boxes of food and he would drive me home with the food so he knew that the kids had food, because he knew about him spending all the money and never having food and stuff, so. So that kind of support, like he helped me to take control of my life. He taught me how to take control back of my life. The first steps at least.

During her relationship, Audrey valued the support of her teacher. After ending the abusive relationship, Audrey was able to turn to her neighbour for support; she and her children were able to stay with the neighbour for a week, until her ex had been notified that she had a restraining order against him, and later she called upon her neighbour to come over when she found out her ex was on his way to her house.

Some women found acquaintances supportive. Patricia found support among other women at shelters: "I met lots of other women in shelters who helped each other rather than relying on the staff". For Oonagh, knowing that lots of people were praying for her gave her comfort after her abusive marriage.

Unfortunately, women also experienced negative reactions from friends and acquaintances when disclosing abuse. Neither Henrietta nor Patricia received much support from friends or community members when they told people that their

husbands had raped them. Both feel that society condones sexual abuse committed by a spouse. Patricia recounts how members of her church would tell her husband his ill treatment and abuse of her was inappropriate yet tell her his sexual abuse was permissible:

I honestly believe that that was all he knew. Although he knew it was wrong because he was told so by members of our church and friends of ours. They said, you know it's not right to treat your wife that way. But there was still way too much acceptance of it, like *oh she must have brought it on myself*, or if I complained about being raped and choked, they said well he can do that. He's allowed. He's your husband. Still today, in this day and age, they're still saying that. (Patricia)

Henrietta found that while professionals would acknowledge the inexcusability of her husband's rapes and explained to her that his actions were criminal, her family, friends, and society in general found it acceptable.

Henrietta: Because I know when I said it and everything like that, people laughed at me. Even my own friends, even my own family, even my own people, but more the professional people I tell, they didn't laugh. It was more the generalization society and that. When I would tell like a friend who's a different culture, from *East Indian* to Chinese or whatever, I tell them and they said, you did what? You're not supposed to do that. He is your husband.

Int.: So culturally, you were saying that you

Henrietta: Like I had friends of different ethnic backgrounds, and when I was telling them about that, to them that was normal. To them, they

said, you're not supposed to do that. He's your husband. You need to support him.

In addition to having people condone the abuse they experienced, both Henrietta and Patricia found they were not always believed when disclosing abuse. Henrietta explains that she initially had trouble admitting to herself that she was an abused woman, in part because of her socioeconomic status. When she tells others of her experiences, they too find it hard to believe that a woman who had, among other things, a decent job, a house, and car could be abused:

And being a positive role model where I'm addiction free now and I tell them, and that wasn't easy. I always show them my scars. I always show them and everything what was happening. And they say, well how do you know what it's like, they always tell me. You had a house. You had a car. Don't let that fool you. Do not let . . . the fact that I had money, that I had all that tangible, materialistic stuff that violence was not occurring in my home. (Henrietta)

Although Patricia's accounts of not being believed do not pertain directly to disclosures of IPV, they do highlight the difficulties some women and children face in getting help for abuse. Patricia recounts that growing up on a reserve, she was not initially believed when she disclosed that her brother was abusing her:

There was a lot of sexual exploitation going on. It didn't really have to be either race, it was both races, but it was just a nightmare because there was nobody to tell. I mean even as a child, you tell somebody and you're not believed. (Patricia)

Patricia told her church pastor that she was being abused, though it is not clear whether it was her pastor who finally believed her enabling her to get treatment. Years later, Patricia's suspicions that her children were being abused in care were

discounted. Although Patricia did not mention whether she was believed when disclosing having experienced IPV, she was not believed when reporting other experiences with abuse.

Some women in my sample spoke of receiving support from friends and others spoke of friends who condoned their abuse, however it is hard to gauge Wendy's experiences with friends. Wendy spoke about her friends turning to her for support and information, however it is unclear whether they are as supportive of her: "I have few friends that were in abusive relationships that, like they talk to me about it. I'm like, well why are you asking me about all that? Well you seem to know where to go and what not." Wendy is resourceful and will sometimes call around to find out about existing programmes that may be of interest to her and / or her friends. She recently found an 8-week programme for abused women that she and a friend will take together. She also offered to tell her friends about the study (for which she was interviewed). Although she appears comfortable sharing information and attending healing activities with friends, she also says that "sometimes it's better not to talk to friends, if there's somebody else who is more knowledgeable" (Wendy). Wendy's friends appear to be good company when attending IPV services, but are not likely her ideal confidants.

In addition to their experiences with informal supports, women also spoke of their experiences with the following formal support services: counselling services, shelters and second stage housing services, the legal system, Child and Family Services, medical professionals, and a crisis centre.

Counselling experiences.

Four women in my sample mentioned having sought counselling, however the experiences of one of those women are unclear. Wendy prefers to seek counselling services to going to a shelter, however she did not elaborate about her experiences with counselling or counsellors. Audrey reported having had mixed experiences with counselling: "Yeah, I've been for a lot of different things. So yeah, I found some of it to be really good and some of it being not so great." She reported that yoga has done more for her than counselling. She stopped attending a group for people with bipolar disorder she went to years ago as she found that the people there just "bitched". Audrey also mentioned having attended counselling with her mother at one stage in her youth, though it is unclear whether it was helpful. Audrey sought counselling for her children when they were young after they witnessed her being abused, however she was unable to find anything; she now fears one daughter is at risk for IPV, while the other daughter has already been assaulted by her partner.

Oonagh reported having trouble accessing long-term counselling services. She was able to access temporary counselling through a shelter to tide her over until she was able to get counselling elsewhere. Most organizations however, had waiting lists. One organization's waiting list was so long they would not add Oonagh to their list and instead referred her to another organization whose waiting list was much shorter. She was able to put her name on the other organization's waiting list and to sign-up for a fall support group focused on self-esteem. Oonagh also mentioned having received temporary psychotherapy through her regional health authority upon the recommendation of a hospital with a psychiatry department, as the hospital could not accommodate her request for therapy. While Oonagh was

able to access counselling services, all appeared to be temporary services she strung together while she waited for more long-term therapy.

Henrietta's experience with therapy was quite positive. She started seeing a psychiatrist during her marriage. It was through her psychiatrist that she learned that many of the things she had experienced constitute abuse and became aware of her rights. Her psychiatrist helped her develop and institute safety and escape plans in preparation of leaving her husband. She says: "I'm so glad I had the knowledge of what that psychiatrist told me" (Henrietta). Although Henrietta has moved out of province, she was still receiving therapy at the time of the interview and her children were seeing a child psychiatrist to help them heal from their experiences.

For most women in my sample, access to quality and effective affordable counselling services appears to have been a concern.

Shelters and second stage housing experiences.

All six women mentioned shelter and / or second stage housing services during the course of the interview. Five women spoke about having accessed shelter and second stage housing services, however it is unclear whether the sixth woman ever sought and /or accessed such services. Three women had positive experiences—two of whom spoke highly of the assistance they received from shelters and / or second stage housing—and two women reported negative shelter experiences.

Both Henrietta and Oonagh had positive things to say about their experiences with shelters. Henrietta spoke about the assistance shelter staff provided in helping her apply for housing:

Went to a shelter and everything like that, and that's where our life began. . . .

I'm glad that the lady at the shelter told me what to do, showed me how to fill

an application. Now I'm an educated woman, but sometimes you don't know what. I didn't even know how to apply for a home, cause I had a mortgage.

So I didn't know what a landlord wanted of a person. (Henrietta)

Oonagh credits shelters and second stage housing services for her still being alive: "they really help you, so I know if there wasn't, I probably would have went back to him and I probably would be dead". She later adds: "I know I'd be dead if it there wasn't these places. They've given me a second chance on life and now I want to live and I want to give back." (Oonagh). Oonagh also talks about learning she was abused during shelter counselling – up until that point she thought emotional abuse was normal as that was all she had ever known growing up. Second stage housing also helped her apply for disability assistance—though she was initially embarrassed about doing so—and to get her own apartment. A shelter provided her with the name of lawyer so she could start the divorce process.

Audrey felt that she had learned valuable skills during her stay in a shelter, however she was not "taught to keep my mouth shut at home". The abuse was worse after her stay in the shelter as when her partner returned, she told him what she'd learned "and he beat those down, like right down quick, you know, he learned how to get around the tools that I had learned" (Audrey). Although her shelter experience appears to have been a positive one, the tools she learned while there failed to keep her safe when her partner returned.

Wendy found the shelter environment disruptive: "I found it so hard on the kids and just having to be around in an unfamiliar place kind of thing and having to abide by all these rules and stuff, which is okay". She points out that while some women must leave home for safety reasons, others such as herself prefer to stay at

home and seek non-residential counselling services after ending their abusive relationships.

Patricia's experiences with shelters were far from positive. She appears to have accessed the services of at least five shelters and / or second stage housing organizations and had negative experiences at all of them. One shelter failed to provide her with essential information with upsetting repercussions:

[name of shelter], ohhhh (said with emphasis) it was a horrible experience.

This was when they were short staffed and everything else. They were short staffed to begin with for years anyway, but we weren't treated there very well, or informed of anything that could happen, or you know, like we weren't told our rights. Nothing. I wasn't told I should get a lawyer, and so when CFS shows up and takes my kid, I am left going. . . I thought I was gonna go crazy. I was so sad. (Patricia)

Patricia's mental health conditions also affected the treatment she received: "I was treated badly because I couldn't keep hold of my emotions. And shamed for it too."

She says that the shelters from which she sought help: "were actually very, well if we can avoid taking in somebody who's disabled, we will" (Patricia). She later adds that organizations offering long-term housing for women who have been abused "won't help people who are mentally ill. To tell you the truth, I was asked to leave from 3 places because I cried too much." (Patricia). In addition such organizations appear ill equipped to offer appropriate support to women with mental illnesses, even though mental illness may be a result of having experienced IPV:

I wish I'd been more understood when I went to the shelter. They didn't understand. They really don't have the level of understanding they need to work with women who have been abused by their spouse or partners. I felt

that they were scared of my emotions. They were scared of, you know, my background, which I've had some suicide attempts. They didn't understand that comes from being abused, not necessarily, there's a difference between psychological and psychiatric problems, and they didn't understand that.

They didn't really, I don't know, they didn't even understand my post traumatic stress disorder very well. (Patricia)

Cultural heritage also appears to influence women's experiences at shelters:

I noticed in the shelters that women who were Native weren't treated as well as some of the *lighter*. And they were very much split off. . . the Native sat at one table and the white people sat at the other. And I'd be like going back and forth to each table to show them like I'm not gonna play your little game, right. And they turned around and called me white trash. I said, well excuse me, but I'm not white trash. You're calling yourself that if you're gonna call me that because I'm mixed, very mixed. (Patricia)

Taken together, my sample reported mixed experiences with shelters: two women received valuable support; one appears to have had a positive experience in the shelter, but discovered upon her return home that her new-found knowledge was ineffective in the face of her partner's abuse; one found being in a shelter disruptive; and another had overly negative experiences at multiple shelters and second stage housing programmes.

Legal system experiences.

Three women expressed frustration with the legal system. Two women, both of whom were separated from their husbands at the time of the interview, commented

on the challenges of divorcing an abusive spouse. Oonagh is angry that she has been told not to mention the abuse in order to expedite her divorce proceedings:

So he has not acknowledged that there was any abuse or anything, and that's what I'm mad about. You know, all the men, like my psychiatrist, my lawyer, his lawyer, the judge, I'm not allowed to say one word about any of the abuse because the court will go quicker if I don't mention it. (Oonagh)

In addition to being angry, Oonagh is also confused and overwhelmed: she does not understand why her lawyer does not use some of the information she has provided, is uncertain about what to do about spousal support, and is annoyed that her ex can make ridiculous lists of reasons she owes him money when she is told not to mention the abuse he put her through. Although refraining from mentioning the violence she experienced during her marriage is supposed to speed up the legal proceedings, Oonagh says: "It takes forever to get a divorce. . . . With these guys yeah, it's not a simple thing." Patricia also comments on the seeming gender inequity within the system: "[I'm] scared to divorce him because he was, things are not on the woman's side when you divorced, you know. It's on the men's side."

In addition to concerns about judicial proceedings, two women expressed anger with police reaction time, lack of enforcement of zero-tolerance policies, and the inability of restraining orders to keep them safe. Both women recounted incidents for which they called police, however were unsatisfied with the responses they received and both expressed displeasure with the application—or lack thereof—of the zero tolerance policy. In addition, one woman told of several cases in which police response time was unsatisfactory and her restraining order against her ex failed to protect her. In one account, in which Audrey's daughter had been abused by her boyfriend and physically thrown out of their apartment, police took 4 hours to

respond. In another case, it took police 45 minutes to respond when Audrey's ex tried to kill her: she was on the phone with 911 operators when her ex burst in "grabbed me by the throat and he got on the phone, and said, you'd better bring a body bag cause I'm gonna kill the fucking bitch". She says:

Having a restraint against somebody is absolutely the most useless piece of paper in the entire world. I had a restraint against him the night he tried to kill me. It still took them 45 minutes to show up at my door. Yeah, so that's what I mean about some of the Winnipeg services that you were talking about, that are not so spectacular (*laughing*). Yeah, 45 minutes it took them. (Audrey)

Patricia related the response she received when police showed up after she called them to report being punched in the face by her friend's boyfriend while trying to get him to stop abusing her friend:

I walked out of there and called the police and the police came down. Oh, well we didn't see it. I said, what about zero tolerance? Well if he does it again, we'll give him a cautionary warning. If he does it again, then we'll do something about it. So what, you know, if sticks a knife in my back the next time, then they'll do something about it. So yeah, I was very disgusted with the police and the way the things went in some area. (Patricia)

Audrey's, Oonagh's, and Patricia's experiences suggest that judicatory and law enforcement responses to IPV are far from ideal. Even more upsetting to Patricia, however, is her feeling that the police completely discounted her concerns that her children are being abused in care.

Child and Family Services experiences.

Two women spoke of their experiences with CFS. Zoë spoke of the support she received from CFS during her first abusive relationship:

From the time I was 7 months pregnant, they were involved. And I actually left him for the first time, when my son was, I think, around a month or two months old because he had thrown a glass coffee table at me when I was changing the baby's diaper, cause I burned the bacon. And there was all glass on the diaper and stuff and then he went to work, and from there I called CFS and said this is what happened and I'm scared for the baby and I need to leave. And they came right away and they got me out. (Zoë)

Although her ex would threaten to tell CFS about her addictions during their relationship and threaten to take their baby away from her, Zoë contacted CFS when she felt her baby's safety was at risk. While Zoë recounted a situation in which CFS appears to have acted quickly to protect her and her new baby, Patricia feels that CFS is slow to act. Patricia says:

they claim to give a lot of help but they don't, CFS. Like they won't give a psychological assessment if needed, right away. They'll wait until it gets really bad before they, and I've seen it again and again. You cannot tell me that CFS gets help for people right away, cause they don't. They wait till it gets really bad to the point where, if they had caught it earlier, noticed it earlier, it wouldn't seem so...

In addition to feeling CFS is slow to act, Patricia also feels that neither CFS nor the police will take her concerns about her children being abused in foster care seriously:

Pat.: Now I suspect my daughter is being abused in care, but I don't know for sure and it's driving me nuts. It's just heartbreaking because she's showing up with bruises and stuff. She says she fell off the couch or something. You don't get bruises like that falling off the couch. So I went to the workers. I went to the top director. I phoned the police, everything, and she told me that they were taking pictures of her while she was naked and my little baby. She said, they're doing it to baby *[youngest daughter's name]* too mommy. Oh shit. I said, Thank you for telling mommy, but you know what? You've got to tell your worker. You've got to tell them these things. They didn't believe me and they sent her right back to the home, even though she told me. Now of course it's gonna make sense that she's gonna go to one person that's been there all her life consistently, her mom. She's 6 years old. And what? They give her shit for that?

Int.: For talking to you, you mean?

Pat.: Yeah. And then they acted as if they did not believe me. They got angry at me for phoning the police and double checking on them to make sure that they were really investigating. Just creepy. Like who's side are you on anyway? So my daughter showed up with bruises about 3 times now, and. . . . They haven't done anything. She also asked for – she's in foster care. She also asked me to put her to sleep with something. I said, sweetie, what do you mean? Well mommy, when I'm at the foster home, they give me this cherry stuff to make me sleep. I said, when you're sick? She said yeah, and even when I'm not sick. They're an older couple and they're drugging my kids instead of

giving her what she needs (*crying*), and nobody will believe me, cause they think I just have a vengeance against CFS. Seriously. The cops told me that. They're like, oh you just something against CFS. You just want to make things bad for them.

Int.: Oh. That's heartbreaking. It sounds like there's...

Pat.: I don't feel like I'm being taken seriously at all.

While neither mother appears to want her children in care, each woman's perceptions of and experiences with CFS vary markedly. Late in her pregnancy and later as a new mother, CFS offered Zoë and her baby protection and removed her from a dangerous situation. Patricia however, feels betrayed by various sectors of the formal support system: her daughter was taken from her during her stay in a shelter; her second daughter was conceived as a result of being raped by her husband—from whom she was separated—following a shared, unsupervised visit with her first daughter arranged by CFS; and her suspicions and concerns about her daughters being abused in care have been discounted. Her fears about losing custody of her daughter if she left her abusive husband were realized:

If I stop it, then I'm gonna take the kid and go away, and then he'll just take my kid away. That's exactly what happened. I sacrificed a kid for my own personal safety. It's so unfair. I should have been able to keep her. They shouldn't believe an abusive man when he says this or that against the mother because obviously he has a vested interest in getting the kid too.

Cause then you try to attach to the mom again and get back into her life. He ended up raping me and we ended up having another baby. (Patricia)

In addition to feeling betrayed, Patricia feels like she is being punished for having experienced IPV:

the most horrible experience in my whole entire life was both times when they took my babies. It was like they were punishing me for getting abused and *blaming me (said with emphasis)* for not being able to protect my children. Meanwhile, I already took them *out of there (said with emphasis)* before anything could happen.

While Zoë was able to count on CFS for assistance—at least early in the life of her first child—, Patricia feels CFS has failed her and her children and is punishing her for having been abused.

Encounters with medical professionals.

Two women spoke of encounters with medical professionals related to IPV. Oonagh has had mixed experiences with medical care. She relates two examples in which she received assistance and / or support for her IPV from medical practitioners and two cases in which, following her relationship, she was unable to get the medical attention she required in a timely and compassionate fashion. Helpful experiences include being sent immediately to a women's shelter by her doctor after her husband caught her trying to leave and prevented her from doing so but did allow her to attend her doctor's appointment. She also credits her psychiatrist at the mental health centre in which she was staying following a suicide attempt with making her realize divorce was an option—until then, she'd thought suicide was her only way out—and with providing her the security she required to safely tell her husband she was leaving him. To prevent her from being harmed, her psychiatrist and several security guards stood by while she told her husband the relationship was over:

Then I sat there and the security were around and I told him that I was, he's a big guy too and has lots of guns and everything and he threatened me with

them and I told him I was leaving. And he was quite upset and he got kind of mean, but he knew he couldn't do anything there so he just stomped off, but, and then I never went back after that. (Oonagh)

Although Oonagh has had some very helpful medical practitioners, she has also had negative experiences. For example, although she was able to find a new doctor and a new psychiatrist after both of hers "quit on me", the new psychiatrist made her feel worse than she was already feeling. She only saw him twice, but both times, "I went in there feeling good and I came out bawling my head off. And I heard him screaming at other patients before too and everything. It's scary, he's very scary" (Oonagh). Fortunately, her psychiatrist of 11 years came back from medical leave so she was able to return to him. Although hospital staff encouraged her to report the demeaning psychiatrist to the College of Physicians and Surgeons, Oonagh points out that it is very hard to bring yourself to do so when you are not well. Oonagh has also had trouble accessing emergency medical assistance. As a result of a shortage of medical personnel and hospital beds, she has been turned away from the hospital emergency ward.

I know now on my own to go to the hospital when I, my signal is when I stop sleeping, that's the biggest signal for me even on sleeping pills to, that I, going down and getting depressed, and now I know to go in hospital. But I've gone to the hospital here now in the city and every bed is full. They're turning us away and that, and a lot of it's coming, they say 1 in 4 women suffer from depression, and a lot of it comes from, like the guy's an alcoholic, there's some form of abuse or we grew up in abuse, and they're prescribing anti-depressants like they're candies. Almost everybody I know is on some kind of anti-depressant so, we're saying, like we need another mental health

hospital in the city and then you would get rid of a lot of, cause we all go like to St. Boniface Hospital or Health Sciences Centre, and the Emergency and we have to wait like 2 days, and then they send us like home because there's just not one bed available. (Oonagh)

Patricia had a negative experience with emergency medical personnel when she went to the hospital emergency at one point during her marriage. She recounted an incident in which her husband burst through the door behind which she had locked herself, just as she was about to open it. The door "slammed into my face cause I was on the other side of it, and split my eyebrow open". Hospital staff "couldn't believe it when I told them I ran into a door" and asked "which one of you threw the first punch" (Patricia). She felt that hospital staff misunderstood the situation and didn't believe it wasn't intentional. Her recounting of the incident however suggested to me a lack of sensitivity and concern on behalf of medical personnel who treated her. The question about who threw the first punch seems to trivialize what staff knew was an incident of IPV.

Crisis centre support.

One woman reported an exchange with a crisis centre that I interpreted as positive. Oonagh complained that for two weeks she asked her husband to take her to the hospital because she wanted to kill herself. He refused, told her she didn't need to go to the hospital as she knew what "to do to get yourself well" and told her "not to phone the crisis line, it's too embarrassing". When she finally did call for help, her husband was furious she had done so and was angry they were going to miss their evening out: "the Crisis Centre said that they would come get me if he wouldn't drive

me, so it's like he had to bring me and he was mad that I had phoned them and stuff" (Oonagh).

Although I believe Oonagh's intention in relaying the incident was to highlight her husband's resistance to her getting the medical attention she required when she was suicidal, to me to the incident also demonstrates that the crisis centre was willing to do what was necessary to ensure she received help before she made an attempt on her life. When she desperately needed it, there was an organization willing to step in to help.

Findings: Prevention, Intervention and Healing

All the women in my sample had more to say about prevention, intervention, and post-IPV healing strategies than their experiences with support. This is likely due, at least in part, to the fact that women were asked what they thought could prevent the abuse of women with disabilities while they were not specifically asked about their experiences of support. In this section, I address my second research question: What do women with disabilities say would be helpful in the prevention or intervention of intimate partner violence? The themes I explore include: education and awareness; support systems; counselling for prevention, intervention, and healing; diagnosis and appropriate and effective treatment; addictions treatment services, recovery and abuse services; shelters and / or second stage housing services; culturally based services; legal mechanisms including restraining orders, better enforcement, and stiffer penalties; safety precautions and escape plans; and self-care, spirituality, community, and social change. I also examine measures that protected women from further abuse that may not be generally advisable or were not specifically mentioned as adequate prevention strategies.

Education / awareness.***Abuse awareness and education.***

When asked what could help prevent the abuse of women with disabilities, all women in my sample suggested that some type of education or awareness is vital for the prevention of violence. One interviewee went so far as to say that education was likely the only means of prevention – everything else is just intervention: “Prevention-wise, the only thing I can think of is educating youth so that they don’t get into the position where they need intervention or they have a tool to prevent things themselves and to intervene with their friends” (Zoë). Some women stressed the need for more awareness about particular forms of IPV in addition to general abuse awareness. For example, one woman who spoke about society’s ignorance of the inexcusability and the effects of emotional abuse felt more education was needed to inform people not only that emotional abuse is wrong, but that is often more devastating than physical abuse to the women who experience it. Another woman, who conceived her 2nd child as a result of being raped by her husband and who did not realize at the time that sexual abuse by a spouse was a criminal offence, said that more needs to be done to teach people about sexual abuse and their rights: “So, the more women know that even though you’re in common-law, even though you’re married, even though you’re in a same sex, same- whatever, it’s not right” (Henrietta). As mentioned earlier, Henrietta notes that many women, including women of various cultures and cultural backgrounds, believe that they must submit to their husband’s sexual advances and do not realize they too have rights over their bodies. She herself was shocked to learn from her psychiatrist that she could charge her husband for raping her: “I did not know that rape is not, is a no-no even if

you're man and wife. I was, to this day, I'm still shocked. If I knew that back then I would have had him charged" (Henrietta). Therefore it is quite clear that for women to better protect themselves against IPV and to seek legal recourse following abuse, they must be taught that all forms of abuse are wrong and be informed about their rights.

All women mentioned the need to teach children in school about abuse and their rights. Two women remarked that children are taught about "babies" or given sex education, but are not taught about abuse. Perhaps as a result of the lack of abuse education in schools and / or out of a desire to prevent their children from being abused and / or abusive in their future relationships, three women say they talk to their children about abuse. Wendy commented on the current divide between what is taught in schools—sex education— and what is taught at home, or at least in her home—abuse education:

Maybe they could have something about it in school also, in the schools. I don't think they offer that in schools right now, eh? Like signs of abuse and what is abuse? I know they have sex education, but they don't have something like abuse and that. Like my sons, I actually, they've seen it and what not, so I've actually talk[ed] to them about it and told them it's not right. Like it's more like they learn at home, I guess, and they learn the sex education and that at school. They're too shy to talk about it at home, but the abuse thing and that, I really talk to them about it at home. I asked them if they learned about it in school and they said no. (Wendy)

Henrietta is more specific about how she educates her children about abuse:

I constantly am talking to my children. I'm constantly getting those pamphlets. Constantly showing them about the violence on TV, about how

my own friend died, got killed from an abusive relationship. And he knew this woman. And I told my son, you remember so and so? Yes. Well she died. How? And I said, so and so killed her. No way. My two little children are so young and they've already experienced so much. And now he's gonna be man soon, very soon. And then he's gonna be at the point where he's gonna go to university. He's gonna start his own life. He's gonna start having a wife, and I would not want his wife or him to, even women, women can be abusers too. I would not want him to suffer that. So I'm always aware. I'm always teaching him. I'm always showing them, keeping newspaper clippings things and getting him to do things that are positive. (Henrietta)

Henrietta teaches both her children about abuse, though she appears to be a little more explicit in the information she shares with her son, who is six years older than his sister.

Patricia, whose two young daughters are in foster care, recounts having spoken with her eldest about abuse on at least two occasions. When her daughter disclosed some concerning incidents that took place at her foster home, Patricia thanked her daughter for telling her and encouraged her daughter to speak to her caseworker.

Several women mentioned ages at which they thought children in schools should start to be educated about abuse. Suggested ages ranged from Grades 1 or 2 to Grades 9 or 10 and up. One woman who spoke at great length about the need to educate children from a young age in order to really prevent abuse felt that education should start between grades 5 and 7:

I was looking at grades 5 to 7, just because what I've noticed, like I've done a lot of work with youths that are transitioning from sex trade and getting out of

addiction, what I've noticed is that like from middle years, like grade 8 on, is when you get entrenched in gangs, domestic abuse situations, addictions, you know, so to know how to recognize these situations prior to and to know how to defend yourself against them, to know how to handle your anger during bullying situations, peer pressure situations, you know, things like that is important because it helps you from allowing yourself to become involved with individuals who don't have anything positive to teach you, you know.

(Zoë)

Zoë elaborates by explaining her reason for focusing greater education efforts on children as opposed to adults:

The reason that I personally target children is because education is compulsory. Whereas with adults, how do you make them get it unless they need it, do you know what I mean? How can it be a preventative measure? You can send them stuff in the mail but half the time I don't read the stuff that comes in the mail, you know what I mean? (Zoë)

Other abuse-related education or awareness topics suggested include learning the red flags and opening your eyes; teaching abused women not to share the knowledge they gain through counselling with their abusive partners; teaching children "that 911 is not a . . . cure-all" (Audrey); and posting a website. One woman also spoke about the need to teach women and children to persist in seeking help if they are not believed when they first disclose being abused; to help women learn to accept respect in order to break the cycle of violence; and to encourage abused women to make their own decisions, with guidance if required. The same woman also advocated for more training and assistance coupled with more long-term housing for women fleeing abuse who are acting out what they have learned—acting

inappropriately or abusively towards their children for example—versus kicking them out of shelters and denying them services; she advocates working with such women to break the cycle of violence they have lived all their lives. She also feels it is important to teach women who have been abused why they are the way they are:

If they're educated on why they are the way they are, then they stop hating themselves. Oh it was the abuse that made me this way. Oh, maybe I can move past that. That was what happened to me. I realized that it was a lot of what happened to me that made me the way I was, and that I could break those patterns, but it took time, effort, and a lot of reading and education for myself. (Patricia)

Another woman advised directing attention towards abusers in the media to let them know that abuse will not be tolerated versus focusing solely on the women being abused and putting their lives on display. Wendy suggested increasing publicity of existing abuse-related courses, programmes, and services so women know what is available. Increased publicity of available services along with informing more women that they do not need a man to live fulfilling lives or to survive financially may help prevent women from becoming involved with, staying with, or returning to abusive partners:

The women that don't think there's any help out there for them, all they do is rebound, go to the next man. That's what we're trained to automatically do and a lot of us go back to our husbands or we go to the next one. And like, I was with a man since I was 16 till I was 45, 30 years with men, and this is my first time without a man, and it is very, very hard. Very, very hard, if you've never been without a man and most women think you're complete with a man. You have to have a man, so they rebound to this next man, and as long

as this man's not hitting them, he's got to be better, so we found, all us women were going from abusive relationship to abusive relationship to abusive. But with the support out there, and the second stage housing, and what they're doing for us, we're finding out and you can go back to, a lot of us want to go back to school so we can get a better job and we don't want to be on the system. That's when they, that's help for us with our kids that we can do that. We don't have to go to men. They're trying to teach us there at those programmes you don't need a man to financially look after you and your children, that there's a system that will help you, and you know, there's a lot of free babysitting too and stuff like that, and you can go back to school, and you can go to work. You can do this so that we don't have to keep going with these men. . . . We're starting to heal ourselves and get better and get on with our lives, that we don't have to be dependent on a man. (Oonagh)

Many women in my sample are proof that education and awareness can be effective in preventing further IPV. Henrietta gave examples of how education and awareness efforts helped her to realize she was abused, learn her rights, to seek assistance, and to plan her departure so she and her children could get away safely. For example, she said that attending a presentation about relationship violence at her college was the first step she took in acknowledging to herself that she was being abused. She said:

I had nothing to do. . . . I thought okay, well I had about an hour before my next class and I thought okay, I'll go be nosy. But in my heart I was I was already starting to have, you know, getting tired of it so I thought that's my first step I guess. (Henrietta)

She goes on to say that following the presentation, they were given “a sheet of all resources you could go to in the city and 1-800 number and everything like that” so attendees knew where to seek help. Abuse education for women, and especially for children, is highly recommended by all the interviewees included in my analysis.

Mental health / disability awareness and education.

Three women emphasized the need for mental health and disability awareness education and awareness. At least one woman felt that earlier diagnosis of and greater personal knowledge and awareness about her mental health conditions would have prevented or mitigated her experiences of IPV. Several women also felt that greater awareness of mental health and disability would have resulted in greater access to quality appropriate support for women with disabilities seeking assistance for their experiences of IPV. For example, in addition to suggesting increased mental health awareness for the general public, two women suggested education and awareness should be targeted to specific audiences including professionals and women with bipolar disorder. Patricia advocates more disability and mental health education and training for women’s shelter staff and sensitivity training for others who may come into contact with people who have been abused including police officers and CFS workers. Audrey suggested that women with bipolar disorder should be taught about the parts of their illness that men can attack, how to stay healthy, and how to protect themselves. She also feels that women with bipolar disorder should not bother sharing their coping tools with people who don’t have bipolar disorder: “teach[ing] somebody who doesn’t know is a waste of your time, I feel. Keep it to yourself, cause it’s your own tool. It’s your own thing for yourself. It’s not for anybody else but you” (Audrey).

General education and awareness.

One woman made suggestions for education that were a little more general in nature. One idea put forth by Patricia was more “Roots of Empathy” programmes in schools so children can learn empathy and compassion through their interaction with a baby and its parent – she’s heard that the programme also reduces bullying among school-aged children who have gone through the programme. Patricia also suggested getting an education – it does not need to be a formal education as women can educate themselves by reading and thinking critically about what they’ve read.

Role models and mentorships.

Three women mentioned role models or mentorships as possible IPV prevention strategies. Henrietta models a healthy lifestyle, community involvement and positive choices for her children and hopes she is serving as a role model to the woman in her support circle who have been or remain in abusive relationships. Zoë also thinks the idea of modeling healthy relationships to women who have or are experiencing IPV would quite valuable. Mentors could be:

... someone who is in a positive relationship that can model what a positive relationship is. I think if women know that it’s out there and they can form a vision for it for themselves, you know, the longer I’m with people that have the kinds of relationships that I want, the less likely I am to settle for what I have, right? Because I know what’s out there. I know it’s great and I have this woman or this couple even reinforcing that I deserve it, that there’s nothing wrong with me. That I’m okay. That even though I’m doing drugs, or even

though I have a disability, or even though whatever, that I'm still a valuable human being, and sometimes we don't have that in our life. (Zoë)

In addition to being in a healthy relationship, mentors would ideally have previously experienced IPV so as to better relate to the experiences of the women they are mentoring:

even with the mentorship model that would be a perfect idea, to have somebody who has been involved in abuse, you know, to then, you know, become after 2 years being in relationships, healthy relationships or whatever the case, become a mentor and a model to that individual because they speak the same language, you know. Even more effective than watching a healthy relationship and thinking, I can never have that because I'm not her, because you can have that because she was you. (Zoë)

Zoë also suggested mandatory mentorships for young mothers by a non-family member to instill relevant life and parenting skills in the mothers and serve as role models for the children.

Support system.

All women identified a support system as an important protective and healing mechanism, though as Audrey points out a support system must “be rock solid, cause if it's not, it won't work”. Five women spoke about the importance of informal support, such as friends and family, while a sixth woman—Oonagh—spoke about support groups being an extremely important source of support and information for women with mental illnesses. Given that Oonagh also mentioned some of her (positive) experiences with informal support and her enrollment in a support group

for women who have experienced IPV, it is likely she also values informal as well as formal supports.

Two women identified other potential sources of support: employers (one woman) and teachers and / or teaching assistants (one woman). Henrietta highlighted the need for employers to be more understanding, supportive, and accommodating of women experiencing IPV or having left an abusive partner, by being more flexible regarding women's need for time off or providing an escort to a woman's vehicle after work for example. Patricia spoke about the potential influence teachers and teaching assistants can have on abused children: they can provide extra support, affection, and guidance in addition to serving as positive role models for children who may lack healthy role models:

Teachers definitely have a big role to play. I know I talked to a number of people who were abused, who were being abused at home while they were going to school, who found support and a good example in the teacher.

Teachers who were affectionate, who went the extra mile to mould that child into a person who wanted to be something, you know, or to mould that person into wanting to be a woman because she sees somebody else who's healthy, isn't a drunk, or she's her teacher and knowing so much and such a positive thing for young children to see women, like knowledgeable and teaching and, you know. Not stupid and being told what to do. . . . teacher's assistants can even do that, doing extra stuff, you know. (Patricia).

Given Audrey's experience with a supportive teacher, it appears educators can be a huge source of support and encouragement for students regardless of age, for children and mature students alike.

Counselling for prevention, intervention, and healing.

Four women recommend counselling for women and children who have experienced and / or witnessed abuse. Henrietta, who is still seeing a counsellor, as are her children, recommends counselling “100%. Each day, we cannot move forward.” Wendy intends to seek counselling for her young children who witnessed her being abused; she worries that after witnessing IPV, her children will think it is ok to hit people and end up being abused and / or becoming abusive in their future relationships. Oonagh, who grew up in an abusive household and was raped during her teenage years, says:

I should have got counselling a long time ago, cause the longer you wait with counselling, the worse we get and the more we drain the system. If we got the help sooner, I learned, yeah cause I was raped when I was 16 and 17 and then the, witnessing the abuse, like if there was stuff available, yeah you would get better faster and you wouldn't be on as many disabilities and things like that, I think. (Oonagh)

Diagnosis and appropriate and effective treatment.

Audrey spoke about the impact earlier diagnosis and treatment of her bipolar disorder would have had on her life. She says:

I think I should have been diagnosed when I was a teenager because I went through a lot of ups and downs, ups and downs all the time, like you know, the smallest thing to you would be absolutely devastating to me. (Audrey)

Had she been diagnosed earlier, she “would have learned more coping skills and tools and how to go out in the big bad world and tackle it”. In addition to earlier

diagnosis and coping skill development, she feels that had she been on the right medications years earlier, her experiences of IPV might have been different:

Audrey: if I had been on the right medications 20 years ago, maybe none of this would have happened, or at least not as bad. Or as a long of a period. I may have been stronger, smarter, but when you're trying to figure out who you are every day, all day long, it's very difficult, very difficult. Especially when they're trying to suck your personality into them. So you have a sort of dual personality. You're trying to be yourself but you're trying to be what they want too at the same time.

Int.: So it's a real emotional turmoil...

Audrey: All the time. And when you're bipolar, emotional turmoil like that on top of the emotional turmoil just going on regularly in your brain, you know, you don't even have a chance, ever, at all.

For Audrey, earlier diagnosis and effective treatment may have prevented her from experiencing IPV or at least reduced the duration and severity of her IPV and the resulting exacerbation of her mental health conditions.

Oonagh advocated the creation of another dedicated mental health hospital in Winnipeg to provide better, faster service to people in mental distress and to free up space in general hospital emergency waiting rooms. She's been told that there are: a lot of mental health patients but there's no room for them, and we're taking up a lot of the room in the emergency wards for the doctors to work on the people, like, yeah. They said if they had a mental health centre, you'd get rid of a lot of the waiting in emergency rooms. (Oonagh)

As noted earlier, Oonagh spoke about the relationship between poor mental health and a history of having experienced abuse, and the difficulty in accessing

appropriate emergency and ongoing mental health treatment and support. Her suggestion of additional dedicated mental health care would likely improve access to mental health services for abuse survivors and alleviate some of the strain on hospital emergency departments.

Addictions treatment services, recovery, and abuse services.

Seeking treatment for addictions not only helped Zoë with her addictions, but also helped her learn to respect herself and to recognize that IPV was not ok. She likened having a prolonged period of time away from an abusive partner during which one learns valuable coping skills to being in recovery for addictions:

It's like being in recovery from addiction. I found that when I quit and I went and got help when I went back to using, I couldn't enjoy it anymore. I couldn't pretend that it was okay or that I didn't know what I knew, that I didn't know what was happening to my body, that I didn't know what these people wanted from me, that I didn't know how I could change things and make them better.

(Zoë)

While made in reference to her suggestion of a mandatory separation of 6 months to be spent learning skills in a transition home for any woman who reports IPV, her comments demonstrate that appropriate and effective addictions treatments and / or abuse programmes can help women to heal and make positive changes in their lives. As a result of her experiences with IPV, addictions, and sexual exploitation and her work with others—both adults and youth—transitioning from the sex trade and addictions, Zoë advocates client-based models and tailoring addictions programmes for specific populations, such as women with addictions who have experienced IPV and women with addictions who have been or are sexually

exploited. Zoë points out that some women may be comfortable and successful in co-ed programmes, but others may not. In addition, a general programme may not address all of a woman's particular needs; therefore allowing women to choose from a variety of tailored programmes may be the most effective.

Provide childcare and funding to train teens to provide childcare.

Three women highlighted the need to provide free or affordable childcare to women attending abuse and / or addictions programmes and / or pursuing work and / or educational opportunities. In addition to being free, childcare should be flexible in hours—not just during business hours—and ideally be provided on-site for support group meetings and other programmes; Wendy suggested providing childcare “in the next room maybe, if you could have the kids or something. Something like that”. Wendy also said that programmes are often not worth attending if childcare is not provided:

Like a lot of the programmes I go to, I always make sure there's childcare. If there's no childcare, then I don't bother because it's too much of a stress to have to find babysitters here and there, and there's not always the money for it. (Wendy)

Oonagh and Henrietta also recognize the value of providing free childcare to mothers escaping violence. Oonagh—who does not have children of her own—said that childcare provided by second stage housing services is important as it enables women to return to school or find employment. Henrietta feels that free on-site childcare is so vital that she volunteers to provide it for a group of women attending an addictions programme. She feels good knowing she is giving back and giving someone else a chance to heal. Wendy would like to see more funding to provide

subsidized or free babysitter training and CPR courses for low-income and / or at-risk youth as it is hard to find affordable classes for youth—or adults—and when free classes are offered, “they fill up really fast”. If youth were able to get the necessary training, they could then be hired to provide on-site childcare. That way funding for training and childcare would not only enable women to attend programmes and ensure children are properly cared for, but also provide youth with jobs and a source of income as well as building their self-esteem. Wendy says:

it should be more accessible for people to get this kind of training, even kids.

That way it'll give them a feeling, I guess, that they're earning their money and feeling good about themselves, I guess. Not happen to depend or having to sell drugs for their money, you know.

Wendy planned to enroll her son in CPR and babysitting training when he reached the minimum age requirement and she was able to get him into a class. She adds that once youth have the training, they can also babysit for parents wanting to get out of the house to go to bingo for example; they are not limited to providing childcare at programmes though could fill a need by doing so. Henrietta hopes her son—who has completed babysitter, CPR, and first aid training, and has received his TB shot—will help her provide childcare to women in need.

Shelters and / or second stage housing services.

Two women mentioned the need for more shelters and / or second stage housing. Oonagh offered that in addition to the benefits offered, such as educational and vocational assistance, if there were more second stage housing, there might be a decreased need for Manitoba Housing. Patricia also saw a need for more long-term housing for women who are poor:

quite often they have to retrain them and that's hard so that's where we have the long stage housing, and there's not enough of that either. You wait 2 or 3 years for long stage housing to make sure you don't go back to that situation when you're poor or you're hungry or the children are begging you to go back to the dad. And it's hard to say no to your kids.

In addition, Patricia pointed to the need for more shelters, more programmes and services, and more money to staff shelters as shelters are underfunded and the staff are overworked and underpaid.

Zoë mused about requiring a mandatory six-month separation and stay in a transition house for abused women to provide them with necessary skills and to make them realize there are other options. She said that as a result:

... you're gonna know that this isn't my fault. I don't deserve this. There is better out there. You're gonna try to implement things to make the relationship better, like setting boundaries and stuff, and if that doesn't work, you're gonna see that, you know what, this isn't me, it's him, or there's better and I don't want this, like it's, you know, it's a process. With anything that is healing, it involves a process and I think that just to find a way to get involved in that process, you know, is key to helping them help themselves. (Zoë)

Zoë acknowledged that her idea was not without challenges; mandatory separations and shelter-stays could lead to less reporting of IPV, women may not yet be ready or willing to accept help, and enforcing mandatory separation and shelter-stays would essentially penalize women for having been abused. Although only half of my sample talked in detail about shelters and second stage housing services when specifically asked about IPV prevention, all of the women in my sample acknowledged the importance of the availability of quality shelter and second stage

housing services in the intervention of IPV, even if shelter services were not her preferred means of IPV support.

Culturally based services.

Wendy had a lot to say about the types of services she would find meaningful, including services rooted in Aboriginal culture. She would like to see more Aboriginal sharing circles; she found the sharing circle she attended quite helpful, however it ended, mostly due to a lack of funding, and she has been unable to find another sharing circle to attend.

And I know of a few people actually too, women who were in abusive relationships that aren't in them anymore but still have issues they want to talk about, and them also, they can't also find sharing circles. I find that sharing circles does a lot for people, like where they can go sit and just talk and talk and just let it out kind of things. (Wendy)

In addition to starting more sharing circles, Wendy suggested holding them in areas easily accessible to the people who would like to attend them:

And also having the meeting, like if you were to have a sharing circle, maybe having it closer to like the areas that you figure you want to try and have them in. Like accessible to everyone. Like and maybe, you know, there's a lot of low rental housing units and all these, where there's a bunch of things together, maybe having one a little ways from there or something, like not too far, but also close enough for the people to walk to and get to. (Wendy)

Another service Wendy would like to see is a home visitor programme where an Aboriginal Elder would visit women in their own homes, which is where many women are more comfortable.

Wendy: Or even just having somebody come by, and I never see those things around where a person would come and see you just to sit and chat.

Int.: Okay, so some kind of ...

Wendy: There's friends, but you know, sometimes it's better not to talk to friends, if there's somebody else who is more knowledgeable in those parts I guess, those issues, being able to ...

Int.: Um hum. So when you're talking about somebody coming to talk, so for like some kind of a counsellor doing home visits.

Wendy: Or even an Elder. Like the Aboriginal culture, the Elder are a large part of healing and trying to better yourself, and they're really respected. So like, if I, like my grandmother passed away and that was the one person I always talked to and listened to and went to for advice, but now I don't have her. And I have a birth mother, but I only see her maybe once or twice a year, so it's somebody I would rather not bother with. And I have friends and that too, but it would be good also to speak to an Elder. Like I guess it depends on what cultural, what your culture is, where you come from, but I find like the Aboriginal culture very useful.

Wendy also encouraged changing the format of existing services to better engage women. For example, she suggested conducting meetings outside on nice days, or walking to a park, so women don't have to sit inside listening to someone talk. She would also like to see the creation of more fun but educational programmes and activities to get women out of their homes and improve their self-esteem, among other things; these programmes do not necessarily need to be abuse-based. In addition, Wendy suggested providing bus tickets to low-income women to enable

them to attend abuse programmes outside their neighbourhoods, either because nothing is offered within walking distance or because women are not comfortable attending a programme locally for privacy reasons. For Wendy, the provision of more services and supports rooted in Aboriginal cultural traditions is important, as is greater flexibility in service provision format to better engage a wider variety of women.

Legal mechanisms: restraining orders, better enforcement, and stiffer penalties.

Two women spoke about the ineffectiveness of restraining orders. Although Henrietta acknowledges that restraining orders do not keep women safe or protect them from further abuse, she has an active restraining order against her ex which she renews every year even though they no longer reside in the same province.

In my heart, I thought oh finally he'll leave me alone. But then he goes, he or [his girlfriend] will come and do something where I have to renew my restraining order. The lawyer always laughs, okay, I'll just renew it.

(Henrietta)

Audrey called for better enforcement of restraining orders and stiffer penalties for people who abuse their partners:

Make it serious for them. Make them realize that they're in trouble for what they've done. Not give them a slap on the hand and tell them, here go back to her. Or you know, go back to whatever but the piece of paper is gonna stop you. Half the men out there, a brick wall won't stop them so why would a piece of paper. (Audrey)

She suggested keeping abusive partners in jail until the first court date instead of the current practice of arresting them for abuse only to let them go a few hours later, when they are even angrier:

Yeah, not just arrest them. Keep them in jail at least until the first court appearance, you know, then they're sitting there for 30 days or 2 weeks, you know. Then their life gets stopped. You know, why should they be allowed to go back to their happy little life after doing something like this to another human being, whether it be male or female. (Audrey)

Safety precautions and escape plans.

Henrietta spoke at great length about the safety precautions she has employed to keep both herself and her children safe from her ex-husband and how she extricated herself from the relationship. During her marriage, Henrietta became very diligent about secretly saving money. She would borrow a friend's receipts to make her husband believe she had spent the allowance he granted her, but in reality she put most of the money aside in preparation of leaving him. She also kept an emergency bag and extra clothes for her children at a friend's in anticipation of leaving her husband. She recommends that other women develop safety plans and alter their routines to prevent being stalked by their former partners. She cautions women not to assume their exes "won't take the time and energy [to stalk, harass, or further hurt you]. Don't let that time and energy fool you. That's what I say. Always, if you don't think of yourself, think of your children" (Henrietta). To protect her children from harm or from being used to get at her—as happened when her husband kidnapped their daughter—she has had her children fingerprinted and registered with Child Find, she takes a photographs of her children every three months so she always has

a current picture of them, and she requests references and criminal record checks from anyone with whom she is contemplating leaving her children. Both Henrietta and her eldest child carry cell phones. All of them carry identifying information with them at all times; Henrietta keeps a paper containing her name and identifying information in her sock or shoe in the event that anything ever happens to her, while her children wear jewellery her family will recognize in addition to carrying identifying information. Henrietta has also considered having her name tattooed on her body. Her children know they are not to go anywhere with their father or anyone on his side of the family and she has developed secret code words with her children to guard against them going somewhere with someone she does not trust; her children know to ask a specific question and if the person does not answer with the correct code word, then the person does not have Henrietta's permission to be with her children. Other measures Henrietta both uses and recommends include providing schools (her children's and her own) with a picture of her ex and a copy of the restraining order against him, living in a secure building (one that has a security system or a security guard on duty and security bars on the windows that can be removed in case of fire), and developing a strong network of people with whom to check-in on a regular basis. Henrietta's friends check-in with her at pre-arranged times to ensure she is ok if she has not contacted them, she notifies people of her whereabouts "no matter if I go to the bathroom across the street, somewhere, I tell somebody", and she has taught those with whom she has regular contact about her diabetes in case of medical crisis: "I tell them straight up honestly I'm diabetic. In case I have a diabetic or insulin, like I get sick. They know. I teach everybody about my glucose machine" (Henrietta). Henrietta also has a living will and has made arrangements so that her children will be taken care of financially should anything

happen to her. In addition, Henrietta, Oonagh, and Audrey have all moved and /or changed their phone numbers to avoid their abusive former partners. While Henrietta acknowledges that: “it took a lot of training [and] a lot of lifestyle changes” to implement her family’s extensive safety measures, she feels “it’s pretty much for the better” although it is still scary. She highly recommends other women who have experienced abuse undertake similar measures to protect themselves and their children.

Self-care, spirituality, community, and social change.

Women in my sample spoke about the importance of self-care, spirituality, community, and social change for healing, and preventing and intervening in IPV.

Heal, take care of self, and improve self-esteem.

At least three women spoke of healing, taking care of themselves and working on their self-esteem. For two women in particular, taking care and control of their mental health was empowering. For Audrey, educating herself helped her to better manage her bipolar disorder: “Really taking control of my health. Watching out for my mental health. Learned a lot about how to do that through reading magazines and information on being bipolar, keeping up to date, going to meetings”. For some women, taking care of themselves and healing involved putting some things on hold for a while. Henrietta did not want the responsibility of working as an LPN while she recovered from her abusive marriage, so she gave up her license. Some women expressed an interest in pursuing another intimate relationship in the future, after allowing themselves time to heal and work through their experiences with IPV.

Ways of improving self-esteem, healing, and taking care of themselves vary from

woman to woman, however healing is something about which at least half of my sample spoke.

Spirituality.

Two women spoke of suffering spiritually during their abusive relationships, one woman because her husband prohibited her from attending church, the other because she stopped praying as she was upset God would let her and her children suffer abuse. Both women, along with another interviewee, spoke of the importance of reconnecting with their spirituality following leaving their abusive partners.

Henrietta started praying again and prays nightly with her children. Oonagh “thought I needed something spiritual so badly, so I searched anything and everything”.

While in the mental health hospital she says she participated in sharing circles and smudges after being sought out by an Aboriginal Elder and attended Catholic church services. After moving to Winnipeg, she found a church that was a good fit for her; she now feels part of the church community, has support from other parishioners, teaches Sunday school, and has joined other church groups. Zoë found reconnecting with her “inner woman” helpful:

Zoë: Something else that I feel made a difference in my life is finding God, and I’m not saying that everybody needs to find God, but everybody needs to find a connection to their inner wisdom, to their, their sacredness, their higher power, whatever they want to call that, whatever it is, because it makes a difference. It’s a source of strength. When you are isolated, when you have nothing and you have no one, it’s your source of strength. It’s a part of you that keeps you moving forward.

Int.: Okay. So you think more women need to reconnect with whatever it is. . .

Zoë: We'll call it their inner women, you know, their greater self, yeah. I

never liked the term inner child because it kinda makes me feel that, my younger, the younger version of myself was wiser than the older version, you know what I mean? Or was more real or more authentic, so yeah, my inner woman.

For three women, spirituality was an important part of their healing process and gave them strength.

Community.

Community is important to many women; four women spoke about community involvement, reducing isolation by getting out into the community, and giving back. Getting out can make women feel better as Wendy explains: "you feel better about yourself when you're out and doing things and just being around other people. Plus your kids get a chance to go out if you have kids, especially if there's child care".

Oonagh recommends taking advantage of free activities to get out in the community:

Everybody says, I can't do anything cause it costs money. I've never paid for anything. Like I find all this stuff, and there's so much stuff free out there.

There is a lot of free stuff out there and you can enjoy yourself, and then you can save your money and then you can give. (Oonagh)

Giving back to the community is important to Oonagh: "I think that what this city, this province, has done for me and like I don't want to drain the system, but they've helped me quite a bit and now I want to give back". Oonagh talks of having been able to give back to second stage housing by arranging for second-hand vacuums to be donated to women moving out on their own for example, and her desire "to do

things for children". Audrey says it doesn't matter how women get back into the world, but it is important to do so in order to reduce isolation and to be reminded of "normalcy" through interaction with others:

I think if they get themselves back out into the world. It doesn't matter what they're doing: volunteering, going back to work, going back to school, anything, just get yourself back out into population. Yes I think that's a big step and it's hard. It's really, really hard to do but that is one really good first giant step to getting your life back. (Audrey)

Social change.

While several women spoke about the importance of women becoming involved in their communities to heal from and prevent further IPV, many also spoke about the role community must play in supporting abused women and putting an end to violence. Zoë was adamant that society needs to do more to discourage and intervene in IPV:

I think that society really needs to get involved. I think one of the biggest problems with exploitation of children and adults and abuse of children and adults is that those who aren't experiencing it walk around with blindfolds on, and I have a real problem with that, because until it becomes their family or their friends, they don't do anything. And when it does become their family or their friends, they don't know what to do. So I think that on all levels, you know, education is key. But I also believe that society needs to get more involved in the sense that, they are more active in encouraging these individuals when they see them instead of further isolating them by stigmatizing and alienating them. You know, when I walk down the street and

I see a man yelling at a woman, I walk up to that couple, whether I'm pregnant or I have my kids with me, whatever. I walk up and I will say, is there a problem? And regardless of what she says, I will take out my cell phone and dial 911, and I will say, you need to stop, you know. Too often I see people do nothing because they're worried about themselves and that gives men the message that it's okay. That nobody's can stop them and nobody's gonna do anything, and they're cowards. If you confront them, they will do nothing because they're cowards and that's why they're doing what they're doing, you know. And I just, I feel that society needs to become more active in making change, you know. On all fronts. (Zoë)

While Zoë had the most to say about the topic, other women echoed Zoë's views that society needs to stop ignoring abuse and that both individuals and society as a whole can and need to support abused women.

Protection strategies.

Several women mentioned measures and / or occurrences that protected them from further abuse. While some measures, such as an affiliation with crack dealers or a suicide attempt, are not advisable, safe, or healthy, they did prevent specific episodes of violence from escalating and / or provided a, sometimes temporary, reprieve from abuse. Behavioural strategies employed by the women include: "Good communication skills, being gentle, showing him lots of love, like just pure, unbridled love, cause he wouldn't know how to respond to that" (Patricia); stuffing her emotions and not screaming back so she wouldn't get hit; and "crank[ing] him in the nose" (Audrey). While strategies such as stuffing of emotions, not yelling back, and physical retaliation worked to prevent or mitigate physical violence they did not

prevent all forms of violence. In addition, stuffing of emotions had negative effects in the long run on Oonagh's physical and especially mental health. Many of the above strategies are also partner-specific and will not work for all abusive partners. For example, while "crank[ing] him in the nose" the first time her husband got physically abusive with her worked to prevent any further incidents of physical abuse in a predominantly psychologically abusive relationship, in subsequent relationships Audrey did not fight back as "there was too much violence, physical violence, that I just was too scared". Zoë reported that fighting back was ineffective though it did serve to bring them closer together:

It didn't do anything really except provide a release for me, yeah. Like he really didn't, it didn't change anything. I think in some ways it made us closer emotionally because he was proud of me. Like the first time I ever hit him, he laughed when I beat him and he said, yeah, I knew you had it in you, you know. And I think again that goes back to, you know, the modelling, of his family and how violence was love, right, so.

For some women, such as Wendy, fighting back was not only ineffective but also potentially dangerous:

Wendy: I fought back but it didn't help because he was bigger than me.

Int.: Okay. And do you find that that escalated his behaviour or did that make him?

Wendy: Well if I tried to fight back, whatever, he would just get more mad.

Learning to recognize the red flags, as a result of previous IPV, was something Audrey said protected her from further abuse, though "mind you I didn't always pay attention to them, which is what we do as women that have been abused". Similarly, Henrietta learned to read her husband's body language so that

she could anticipate when he was going to “go off”. She would then either play along, for example, by saying: “go ahead, you can go out if you want” or would “take our kids and go somewhere safe, and sort of stay out of the way”. “Locks on doors” was something else that protected Henrietta from further violence as it enabled her to put a physical barrier between her and her abusive husband. For several women, moving and / or changing their phone numbers served to protect them from further violence:

I have moved 6 times in 3 months. In the one year I had moved 7 times cause he was trying to find me. He stalked me on the phone. He knew my cell phone number and, if he wasn't gonna stop, I was gonna get a different, and I put a block on my phone. I'm unlisted, but yeah, he was stalking me and he was trying to get me back. (Oonagh)

Enlisting the help of others or outside intervention was a protective factor for some interviewees. Zoë in particular spoke about the role authorities and informal supports played in mitigating the abuse she experienced in her first abusive relationship. She found that the involvement of Child and Family Services “helped in . . . regulating his behaviour”:

So I think that, you know, things like that kind of kept him in his place when he did come back into my life. He knew that, you know, there was a risk of him being put in jail. There was a risk of him losing our son, you know, if he took things too far. So I think that always held him back, you know. (Zoë)

Calling the police and putting her partner in jail also gave Zoë a reprieve from the violence: “the fact that I put him in jail over and over and over again, you know. I didn't, I would drop the charges later but he at least got there, you know what I mean”. In addition, the support of a cousin and her affiliation with crack dealers

lessened the extent of the violence she experienced, both as a result of direct intervention and because her partner “always knew that there was a limit” (Zoë).

Audrey has also enlisted the assistance of others to keep her safe. As she and her ex still use the same chiropractor, Audrey has made it very clear that her ex is never to know she is still a patient. She ensures she and her ex never schedule appointments on the same day to avoid any potential contact with him. Although not specifically IPV-related, Patricia believes that speaking out about the sexual abuse she experienced at the hands of her adoptive brother during childhood protected her from further abuse “and protected me from becoming an abuser. That’s very important. I didn’t want to say it, but I have to say it’s very important because children live what they learn” (Patricia).

Women employed many strategies—likely sub-consciously at times—and the assistance of others to protect them from further abuse. Although these measures were not put forward as recommended intervention strategies—with the exception of learning to recognize red flags, which was suggested by a different interviewee—they did serve to prevent further violence in specific situations and were worth mentioning.

Summary

The stories of the six women in my sample speak volumes about the value of quality support during and post-IPV and the challenges in securing it. Women spoke about their experiences—helpful, unhelpful, and mixed—with a variety of potential sources of support including family, friends and other informal supports, counselling services, shelters and second stage housing services, the legal system, CFS, medical professionals, and a crisis centre. Their help-seeking behaviours and

experiences with support appear consistent with the findings of the help-seeking literature reviewed in Chapter One. Recommended prevention strategies included increased and / or improved: education and awareness; support systems; counselling; diagnosis and appropriate and effective treatment; addictions treatment services; recovery and abuse services; shelters and / or second stage housing services; culturally based services; legal mechanisms including restraining orders, better enforcement, and stiffer penalties; safety precautions and escape plans; and self-care, spirituality, community, and social change.

In the following chapter, I discuss the relevance of my findings in relation to what other research has found. I also explore how my intersectional analysis reveals the effects of women's social locations on their experiences of support and help-seeking and their ideas for prevention. I will also speak about the relationship between disability and abuse—which appears to be negated or overlooked by many services and service providers—and talk about the limitations and fluidity of categories and language.

Chapter 4: Discussion

In my secondary analysis of the transcripts from six interviews, I explored experiences of support, help-seeking, and intervention among women with disabilities. I sought to answer the following questions:

- What have women with disabilities experienced when accessing support (from family, friends, and services) for IPV?
- What do women with disabilities say would be helpful in the prevention or intervention of intimate partner violence?

Having presented the findings of my thematic analysis in the previous chapter, I will now discuss the significance of my findings and the results of my intersectionality analysis. I will explore the barriers women experienced in their efforts to access support for IPV before moving on to discuss the impact of women's social positioning on their experiences.

Barriers to Accessing Adequate And Appropriate Support

Women with disabilities in my study did not always receive the support they needed during or following the relationships in which they experienced IPV. The women in my sample reported a mix of positive and negative experiences with potential sources of support. This is consistent with the experiences of marginalized women (women living in poverty, women of colour, immigrant women, women in same-sex relationships, and women with disabilities) that have been reported in the literature (Bograd, 2005; Hunt et al., 2006; Josephson, 2005; Masuda, 1990; Moe, 2007; Raj & Silverman, 2002; Ristock, 2002; Womendez & Schneiderman, 1991). My research revealed numerous barriers to accessing adequate and appropriate

support including lack of education and awareness, lack of resources, lack of services, community size and dynamics, and potentially exclusive admission criteria and the relationship between abuse and disability.

Lack of education and awareness.

Lack of education and awareness regarding abuse, healthy relationships, and human rights may limit women's access to helpful support. Several women in my study spoke of ignorance as a barrier to seeking help and accessing quality support. Oonagh and Henrietta both gave examples of how their lack of awareness regarding abuse, healthy relationships, and their rights prevented them from seeking help for their experiences; since they did not realize that what they were experiencing was wrong, they did not know they could seek support for it. Oonagh said that witnessing IPV between her mother and father, and later between her mother and step-father, emotional abuse was her norm:

I totally lost my identity and I was just with him. Like I see all that now, I didn't see it before and I had to go to the *[name of service]* for a lot of counselling before I even realized I was emotionally abused. I didn't even know because I saw my dad beating up my mom till I was 8 years old, and then my step-father emotionally abusing my mom too. So I just thought everything was normal. (Oonagh)

Although Oonagh had been seeing a psychiatrist during part of her marriage and had left her husband briefly on one occasion, after 21 years of psychological torment, she "found the only way I could get out of it was trying to commit suicide. I thought that was my only way out". It was only after ending up in hospital

following her second suicide attempt that she realized divorce was an option and she began to rebuild her life with the assistance of various services.

Henrietta also spoke of the impact of lack of abuse awareness and human rights. She revealed that she had no idea that rape perpetrated by a marriage partner is unlawful; she only learned years after giving birth to her daughter—conceived during marital rape—that she could have sought help and had her husband charged. Conversely, ignorance on the part of the people to whom women turned for support affected the level of support women received. When Henrietta did tell family and friends about being raped by her husband, they condoned the abuse believing it was within her husband's rights. Patricia reported similar reactions when disclosing rape; the people to whom she turned acknowledged that her husband's physical violence was wrong, but condoned his sexual abuse. Oonagh finds the widespread ignorance about abuse, particularly psychological and verbal abuse, upsetting:

That's what is so maddening to us (*said with emphasis*). What's out there they say is physical abuse and everybody agrees with that. And if it was the physical abuse, we would leave, but it's not that easy. That's why we stay so long, is there's a lot of mental and verbal and emotional abuse that's ...

There's women with broken legs, black eyes and all of that, stitches in their head, we all say the emotional is 10 times worse. But all that's said out there is physical abuse, okay, but nobody understands the emotional... (Oonagh)

Oonagh spoke of the attitudinal barriers women confront as a result of people's lack of understanding of IPV: people often wonder why women don't leave an abusive spouse, don't understand why they sometimes go back, or conversely may question

why a woman would leave in the first place versus honouring her marriage vows.

Zoë also spoke about society's lack of awareness of, and discomfort with, the notion of IPV causing potential supports to react inappropriately or to fail to act at all. She highlighted the need for societal change.

Lack of resources.

Lack of financial resources also poses a barrier to accessing relevant support as revealed by several women in my sample. Women may lack the financial resources to access support, either directly in the form of being unable to afford private or non-subsidized services, or indirectly by lacking the financial resources to pay associated transportation and / or childcare costs. Financial constraints may have been a factor for Oonagh. Although she was not explicit in framing barriers in financial terms, Oonagh spoke of the inability of a hospital-run psychotherapy programme and some community counselling services to accommodate her request for therapy due to overwhelming demand and the long waiting lists at other community counselling services. She also talked about the temporary short-term counselling services she accessed as stopgaps while waiting to access long-term counselling services. This suggests that Oonagh was likely trying to access free or subsidized services, which would likely be in much higher demand than private services as a result of their affordability. In addition, Oonagh exclaimed that other women complain of not being able to afford to do anything, however that is not an issue for her; she appears to negotiate financial constraints by finding free activities, enabling her to save money so she can use it to help others in the future. Although Oonagh does not talk about limited finances being an obstacle for her and she appears to be quite resourceful in negotiating financial constraints by finding free or affordable activities, services and

supports, her economic position does appear to affect her help-seeking and access to support.

For other women, limited finances affected transportation and childcare. Wendy pointed out that a lack of financial resources paired with lack of appropriate services within close proximity creates barriers for women who can't afford transit fare. When the sharing circles Wendy attended ended, "they referred us to another place where it was hard to get over there, like transportation wise". In addition, when more local programmes are available:

some people too don't feel comfortable going to meetings in their area where they know everybody and what not. They prefer to go out somewhere, and then they don't have the money to get there, like bus tickets wise and stuff like that. (Wendy)

Both Henrietta and Wendy spoke about the barriers that lack of childcare or funds to cover childcare costs presented for women seeking support services to deal with abuse and / or addictions. For Wendy in particular, lack of childcare is a significant barrier to accessing support services:

child care is a big issue, cause like I found myself too wanting to go to some meetings, but child care is not provided, so I have to try and find money from my own budget to pay for a sitter so I can go, but sometimes that is a problem too, like not having that extra money to have to pay sitters. (Wendy)

She feels that programmes should provide childcare to enable women not only to attend programmes, but to be able to focus and get the most out of what the programme has to offer:

... some of them that women being single mothers have to take their children with them, which isn't very good either because you're busy looking after

them and trying to sit there and talk, and you just end up getting more frustrated. So when they do have meetings like that, they should also have child care provided for the mothers. (Wendy)

As mentioned above, lack of childcare is such a barrier that Wendy does not “bother” with programmes that don’t provide childcare. Limited financial resources, and lack of transportation and childcare can hinder access to abuse services and supports, so much so that women may not attend at all.

Lack of services.

A lack of services may also hamper women’s efforts to secure assistance. Lack of services may entail a lack of appropriate services or supports in a woman’s geographic area, a lack of a specific type of service sought, and a lack funding causing existing programmes or services to cease to operate. For example, Wendy mentioned how helpful she found the few sharing circle sessions she attended, however a lack of funding brought the programme to an end and she was unable to find other sharing circles within the city. Although probably not unique to Aboriginal organizations, a lack of sustained funding to provide specific ongoing programming appears to have been a problem for Aboriginal organizations when Wendy was seeking help following her third abusive relationship.

Wendy: It costs money to do things and money, it is a big issue, money, and just for them to put on programmes like that and things, you know.

Int.: So do you think there would be a need for more government funding to support these programmes?

Wendy: Um hum. That was one of the reasons why the Sharing Circle got closed down. There wasn’t too much funding for that, but they had

funding for the Medicine Wheel teaching, so a lot of people quit going to that and I guess a whole new other crowd went to the Medicine Wheel teachings and stuff like that, where some of them preferred to have been a Sharing Circle. But there wasn't enough funding. . .

Wendy spoke of the challenges facing organizations providing low or no cost services. While funding may be available for various programmes, it appears that organizations struggle to secure funding to continue existing programmes and must come up with new programmes or ones that have not been offered for some time in order to receive the funds required to offer affordable community services. While this may ensure continued programme delivery, it may impact the appropriateness and usefulness of services for women seeking help for IPV. Indeed, for Wendy, Aboriginal organizational funding constraints limited the availability of relevant and desired culturally based community services.

Lack of counselling services for children is also of concern. Several women in my sample commented on the lack of appropriate counselling services available when they were children and witnessed abuse, and more recently, some were unable to find affordable counselling services for their own children following their experiences of IPV. Limited availability of services also makes accessing emergency support difficult. For example, hospital emergency room wait times may be significant—Oonagh reported wait times of up to two days for people seeking emergency mental health care—and free or reduced-cost counselling services sometimes have waiting lists so long that they will no longer add women to their lists, referring them instead to other organizations with shorter—but often still

considerable—waiting lists (also reported by Oonagh). Limited availability often results in women being unable to access support in a timely manner.

Community size and dynamics.

Community size and dynamics may impact the availability and accessibility of services, and influence women's help-seeking behaviours. At least three women spoke of barriers related to community, although none of the women in my sample expressly labeled small communities as a potential impediment to support.

Community may refer to geographic communities—such as small towns or neighbourhoods within a larger centre—or cultural communities.

Wendy spoke about lack of comfort among community members being a barrier to starting a local sharing circle with childcare to address lack of relevant local Aboriginal IPV services. She says: “we were actually gonna try and get one started in our neighbourhood, but a lot of the moms didn't feel comfortable with some of the women around there”. As noted above, she also mentioned that women sometimes prefer to access services outside of their immediate areas as a result of discomfort attending services in which they will know most people. Clearly for many women in Wendy's neighbourhood lack of trust and rapport with other women and / or reticence to share one's personal experiences with people they know affects women's help-seeking decisions and can hinder the creation of local programming and supports.

Community dynamics and the culture of silence surrounding IPV may also present barriers to women—especially those in isolated communities—seeking help for IPV. Two women in my sample spoke about the barriers faced by women on

reserves or in the far North. Oonagh, who is white, relayed some of what she learned of the experiences of the Inuit women she met during her stay in the shelter.

I've seen a lot of Aboriginal women and children in the shelters and they seem to be getting beaten worse and a lot of them are on the reserves and in isolation, and I've met, at the [shelter] there too, the Inuits, and they come from down, but they're kind of thrown out of their communities once they get help, they're thrown out of their communities. But, the stories I've heard from them, and they don't talk too much. They're taught not to talk to white people. They go to the Elders and they work out their own problems and stuff. Like they get a lot less help, they ask for less help, I noticed. They don't know what help to ask for. (Oonagh)

The Inuit women Oonagh met had to leave their communities to access formalized abuse services and when they did so, they appear to have been ostracized from their communities. Patricia reported similar occurrences, though she appears to speak of about disclosures of childhood abuse. Patricia was thrown out of her adoptive family for disclosing being sexually abused by her brother. She received mixed reactions from others on the reserve after speaking out:

because I took a stand against it, a lot people don't like me, like from the reserve and that, and other people do. They say like, well she's courageous – age 12 to come out and say, hey guys, I need help, you know. (Patricia)

She too had to leave the reserve to get appropriate formal support for sexual abuse and later, after experiencing IPV and the removal of her children from her care, she felt she was being punished for having spoken out about violence as a child.

Community size also appears to have been a factor in Oonagh's experiences of support, although she does not explicitly say so. Oonagh was extremely isolated

socially and geographically during her 21-year abusive relationship. Her second suicide attempt put her in hospital where she realized divorce was an option. She spent four weeks in hospital before being referred to a women's shelter where she spent five weeks. The shelter then "sent me to second stage housing for abused women in the city" (Oonagh). Although Oonagh was able to access appropriate primary services available in her region, it appears that longer-term secondary supports were not available, hence her to move to Winnipeg. While Oonagh does not frame her experiences in terms of lack of services—in fact she is grateful for all the services and support she has received—her experiences point to the potential difficulty in accessing necessary or desired services for women living in smaller communities. Women who are unable or unwilling to move to larger urban centres may have fewer options for formal support services.

Similar issues have been reported in the literature. For example, Ristock (2002) addresses community size as a factor in help-seeking and service provision for women who have experienced violence in same-sex relationships:

There are many regional disparities in the level of helpful resources available for lesbian partner abuse. Urban areas are more likely to have gay and lesbian resource centers, organizations for women who are victims of violence, and more and more agencies with programs or individuals who do specific work on same-sex domestic violence. This is not the case for smaller cities or rural areas. (p. 96)

In addition, Ristock (2002, 2005) points to fear that confidentiality will be compromised in small geographic and LGBTQ communities. Ristock (2005) says for some women in abusive same-sex relationships, there is even a risk of ostracism:

Both survivors and perpetrators of lgbtq violence can be isolated from the wider, yet marginalized lgbtq communities. Many lgbtq survivors feel a great deal of shame and self-blame for being in an abusive relationship. People who are known to have been in abusive relationships may also be ostracized by members of lgbtq communities, which can lead to a loss of support that may negatively affect long-term recovery. (p. 5)

Similarly, Deaf women of colour who have experienced IPV may be reluctant to discuss their experiences with IPV as a result of the community stigma surrounding IPV and the small but nationally “well-connected” nature of the Deaf community as suggested by Lightfoot and Williams (2009b). Lightfoot and Williams (2009b) reported that focus group participants:

were in unanimous agreement that Deaf programs would be the first choice for a Deaf person of color experiencing abuse, followed by disability programs and domestic violence programs. . . . However, for the particular issue of domestic violence, many Deaf people might not want to go to a Deaf program because they would not want the broader Deaf community to know about their personal situation. (p. 147)

For many women, community size and dynamics may impact help-seeking and service delivery as is evident in my sample and the existing literature.

Potentially exclusive admission criteria and the relationship between abuse and disability.

Potentially exclusive admission criteria may serve to deny women services as was evident in Patricia’s experiences with shelters and second stage housing services. Shelters or second stage housing services often specify that in order to access their

services, women must not be suicidal, not self-harm, not have psychiatric illnesses “that will impede program participation”, not be addicted to drugs or alcohol, and “not have a history of violence toward others” (W.I.S.H. Inc, n.d.). Similar policies are also outlined in the research literature and examples are given of women being turned away from services for these reasons (Masuda, 1990; Smith, 2008). While such policies or criteria may make sense from an organizational standpoint—for example, services may not feel equipped to support women who are suicidal or struggling with addictions and may feel such suicidal, self-harming, and abusive behaviours are disruptive to other women accessing their services (Masuda, 1990)—they may prevent some women in desperate need of help from accessing support. For example, as reported earlier, Patricia, a woman with a history of mental illness including past suicidal and self-harming behaviour, was asked to leave three shelter / second stage housing facilities “because I cried too much”. Such policies seemingly fail to acknowledge the relationship between abuse and disability and /or addictions: abuse may cause disability or exacerbate a pre-existing disability. As Masuda (1990) points out:

These women with psychiatric disabilities are being denied the reality of their crisis as well as the fact that their psychiatric disabilities are greatly exacerbated by the abuse and may, in fact, have been brought on by abuse. They are also being denied support services that could be the stabilizing factor in their lives. (p. 53)

As mentioned above, Patricia decried shelters’ fear of her mental health history and their failures not only to understand her PTSD and other mental illnesses but also to recognize the links between her mental health and her history of experiencing violence. Although none of the other women in my sample reported being denied

shelter services based on their mental health diagnoses or psychological state, several spoke at length of the relationship between disability and abuse. All women in my sample said their health conditions were the result of and / or exacerbated by the abuse. Wendy and Oonagh said their conditions—anxiety, and anxiety and depression respectively—arose as a result of the IPV. For other women, some conditions may have been pre-existing, however others arose or became more prominent as a result of abuse. For Zoë, who was addicted to cocaine during her first abusive relationship but was unaware of her other mental health conditions, PTSD was likely a result of IPV in conjunction with “losing 2 children, and you know, addictions and sexual exploitation”. Audrey’s experiences with one abusive partner in particular significantly impact her anxiety levels:

That’s the scary thing about him, that mental thing will be there forever. . . .

that’s part of my anxiety disorder now too, is lately I don’t like going out of my safe zone. I don’t want to run into him because he had such a control over me that I wouldn’t want, I’d be afraid to run into him. (Audrey)

In addition, Audrey who said it took years to find the right medications and strategies to successfully manage her bipolar disorder explained how the turmoil of IPV compounded the pre-existing psychological turmoil of her bipolar disorder:

when you’ve got the bipolar and you can be thrown in a manic or depressive state at, you know, a whim. You never know from one day to the next what your day is gonna be like. You never know when you’re on that roller coaster and when you have a guy who’s controlling that roller coaster, it’s even worse. It’s even more, it’s even a more scary ride. . . . you’re trying to figure out who you are every day, all day long, it’s very difficult, very difficult.

Especially when [your abusive partner is] trying to suck your personality into them. So you have a sort of dual personality. You're trying to be yourself but you're trying to be what they want too at the same time. . . . when you're bipolar, emotional turmoil like that on top of the emotional turmoil just going on regularly in your brain, you know, you don't even have a chance, ever, at all. (Audrey)

Although Patricia's poor mental health including her suicidal and self-harming behaviours appear to have stemmed from childhood abuse, her husband's targeted abused exacerbated her condition to the point she felt: "he was driving me *insane (whispered)*". In addition her husband felt he could get away with his behaviour because of her "psychiatric background":

he was much more confident that he wouldn't get caught, because I used to have self-destructive tendencies, if something happened, oh she did it to herself, you know. So it was just the perfect relationship for him to do these little things, you know, but I didn't want it anymore. Not that I wanted it to begin with, I mean I couldn't. I knew it was either kill him or get out.

Basically, I will be completely honest with you, he drove me so crazy that I thought about killing him. I was tired of being bit and being raped and being told it didn't happen. (Patricia)

Patricia went on to talk about the effects of her husband's interference with her medication, something Oonagh also discussed. Given the potential for IPV in general and specific targeted abusive acts—such as interference with medication—to wreak havoc on a woman's emotional state, it seems especially problematic for shelters or other services to deny women service as doing so may fail to address the root cause of or triggers for her mental illness.

Another concern with potentially exclusive policies is the possibility that they may be used to deny service to women with mental health conditions on the basis of their mental health, irrespective of whether they qualify for admission to a service's programmes and facilities. Patricia's experience is that: "a lot of places don't take you if they think you're the slightest bit unstable. It's very hard to get help." (Patricia). Patricia's experience raises the question: who decides whether a woman's mental health condition will impede her ability to participate in a service's programmes?

Patricia also pointed out that denying service to women who may be acting out all they've ever known—violence—can be problematic:

there's a fine line in some of these shelters because some of these women practicing those behaviours on their children and they can't all throw out the abusive woman because she's only imitating what she's already experienced.

So quite often they have to retrain them and that's hard so that's where we have the long stage housing, and there's not enough of that either. (Patricia)

While service providers have a responsibility to disclose child abuse and to protect children, refusing service to women who have known nothing but violence only perpetuates the cycle of abuse and denies women the tools they need to change.

Intersectional Analysis

Women's social locations not only shape how they experience IPV, but may also impact their access to support and the quality of the support they are able to secure. In this work I have used a framework of intersectionality and thus paid attention to how social location and social contexts shape women's experiences of abuse, help-

seeking, and support. Below, I discuss how various social dimensions such as gender, cultural background, socioeconomic situation, religion, disability, and separation and relationship status may influence women's help-seeking actions and shape their experiences with support. I will also explore how the fluidity of these social dimensions complicates categorization. Sexual identity / orientation is another dimension of potential oppression that should be part of an intersectional analysis. That said, sexual identity did not appear to be a factor in the experiences of IPV, help-seeking, or support of the women in my sample. This is likely because all women self-identified as heterosexual and all experienced violence in relationships with men; in systems of power operating in contemporary North American society, heterosexuality is the assumed norm and tends to be situated at the dominant end of the spectrum.

Gender.

Gender may shape a woman's experiences of IPV, influence her ability to access support, and /or impact the quality of the support she receives. The degree to which it influences women's experiences may vary over time and depending on circumstances. For example, several women in my sample spoke about the seeming gender imbalance of the courts and legal system post-IPV; many felt that the judicial system seemed to favour men and work to women's disadvantage making divorce or other legal proceedings against an abusive male partner even more daunting. In accessing counselling and / or the services of shelters and second stage housing however, a woman's gender may have increased the number of options available to her since most anti-violence services have been developed for women who have experienced male violence. While many women in my sample

experienced barriers in accessing support, gender alone does not fully explain or account for these barriers or their experiences of IPV. As Ristock (2005) points out: “It is important to note that the exclusive emphasis on a gender-based analysis of violence can obscure the differing contexts surrounding . . . violence” (p. 7). Intersectionality therefore, provides a framework to explore how various social dimensions intersect to shape and contextualize women’s experiences of violence, help-seeking, and support.

Cultural background.

Cultural identity is rarely static and rarely an unproblematic category. How a woman chooses to identify or whether she chooses to identify as part of a particular cultural group may change over time or depending on the circumstances. This appeared to be particularly true for women of mixed Aboriginal and white backgrounds in the larger study; some women identified as Métis, some did not, and for some the decision whether to identify as Métis varied depending on the context. For example, when asked her cultural background, one woman in the larger study answered:

P: English, Scottish, and there’s Aboriginal in there, Ojibway.

I: So do you identify as Métis?

P: Not really, sometimes. Depends. (Hiebert-Murphy et al., 2011, p. 51)

While cultural background may serve as a useful demographic category, researchers should remain aware that cultural background may not be as straight-forward as it appears.

Cultural background may also impact how a woman is treated when accessing support. Patricia, for example, felt that Aboriginal women were treated less favourably in the shelters. She also noticed a racial divide between women in

the shelters and sometimes experienced name-calling and rude treatment by other women as a result of being of mixed heritage. In that instance, Patricia's mixed Aboriginal and white heritage seemed to create barriers to accessing the support of her peers within the shelter. For other women, cultural heritage may influence the types of supports with which they feel most comfortable: Wendy preferred attending sharing circles or speaking with an Aboriginal Elder to seeking services that required her and her children to leave their home. She says: "I guess it depends on what cultural, what your culture is, where you come from, but I find like the Aboriginal culture very useful".

Women spoke of other impacts oppression based on background had. Racism and ageism appeared to intersect during Henrietta's childhood. When she and her sister disclosed being sexually abused by their foster father, they were not believed:

And when we told the foster, the Children's, CFS, the supervisor and everything they didn't believe us. Because we were put in a foster home, the foster parents were well known people and they were very good people, and they did not believe us because we were little Aboriginal girls. What the heck did we know? They didn't believe us and because of that the cycle continued till we were older. (Henrietta)

For Henrietta, this had a long-lasting impact and shaped her later experiences of IPV.

Patricia spoke about the effects of racism both in her relationship and on a broader social level. She spoke of having never felt accepted by her mother-in-law as a result of her Aboriginal heritage:

His mother did not want him to marry me because, as she put it, all those Native girls do is run around and drink and sleep around. And then on my wedding day, I was coming down the stairs in my dress and someone whispered, oh she doesn't look Native, as if it was a comfort to my mother-in-law that I didn't look Native at that point, cause I had my hair in a bun, you know. So I never really felt accepted because of things that were actually said, not just because I was assuming things. (Patricia).

She also identified wider cultural oppression and misconceptions:

Racism was a big part of it too. I felt that there are people that were very impatient with Native women, almost looking at them as though they asked for it, but they don't realize we're born into it. I knew violence from even in my mother's womb. (Patricia)

As is evident from the narratives of the women in my sample, cultural background may shape women's experiences of IPV, limit, or taint their experiences with support and affect the types of supports they find most relevant.

Socioeconomic situation.

Socioeconomic status may also influence a woman's experiences of, and access to, support. Like other social dimensions, socioeconomic status may change over time or depending on the situation. For example, Wendy found that being in a low-income socioeconomic situation affected her ability to access supports, for example by not being able to afford childcare or transportation to enable her to attend programmes and services. For Patricia, on the other hand, poverty appears to have been more of a risk factor for experiencing IPV and returning to an abusive partner. She said: "poverty is for sure a risk because sometimes you're so hungry, you know, you have

to basically put up with what people give you to get food or something, and I don't want to talk about it anymore." Although Patricia explicitly names poverty as a risk factor for IPV, it is clearly a sensitive topic. Conversely, having a higher income than her partner may have been a factor in the IPV Henrietta experienced. Although Henrietta's financial situation and stability changed as a result of leaving her abusive husband and moving out of province, this change did not appear to greatly impact her ability to access supports.

Religion.

My research revealed that religious beliefs or affiliation may be a factor in the IPV women experience: it may influence how women make sense of the violence they experience in their relationships, what they decide to do about the IPV they experience, and how others respond to their disclosures of IPV. Both Oonagh and Patricia spoke about their intentions to honour their marriage vows. In part because of religious beliefs and in part because of family history, Oonagh did not initially consider divorce an option:

. . . cause my family was divorced. I hated divorce. I was Catholic. I really took my vows till death do us part, and I thought the only way out was death. And then the psychiatrist said, you know, divorce is an option. It was like a big lightbulb went off. (Oonagh)

Although religious beliefs appear to have contributed to Oonagh's belief that death was the only way to end the abuse she was experiencing, she later realized divorce was possible, found strength in her spirituality, and support in a new-found church community.

For Patricia however, religious beliefs appear to have created some inner conflict over the implications of her actions and negatively affected how others within Christian and Catholic faiths viewed and responded to her and other women experiencing IPV.

Patricia: although I took my marriage vows, I really meant them. I meant to stay with him my whole life, but he was driving me insane (*whispered*) and I found someone else. I don't know if that's right or wrong or if I'm gonna go to hell for it, you know, for all those religious things for people, it's very hard to, you know, like they've been told, oh God hates divorce, you know. So it's really hard cause your religion has a lot to do with it too. Some people believe you just stay no matter what. Others believe that you're crazy if you stay. There's a lot of different viewpoints out there. But it's slowly starting to come around.

Int.: So you think that a lot of people because of religious convictions can't or won't ...

Patricia: Or even if when they do try, if they're Catholic, they get expelled from the church for leaving their husband or with Christians, I'm considered an adulteress because I went away from my husband and went to another man. You know, I'm considered hell-bound I guess, and now it makes me feel even worse because I don't want to be hell-bound. I want to be a good person.

Patricia's narrative reveals some of the challenges in reconciling one's faith with one's decision to leave an abusive partner and the attitudes one may confront within one's faith group. Patricia ended her relationship with her husband a couple years

prior to the interview, however was “scared to divorce him”. Since leaving her husband she had been intimately involved with another man. As a result, her faith group considers her an adulteress, which was clearly upsetting to her. For two women in my sample, religious beliefs or affiliation influenced their thoughts regarding divorcing an abusive partner, shaped their experiences with support, and impacted the meaning they made of their experiences post-IPV.

Disability.

Disability is another dimension that may shape experience and serve as a potential source of oppression. Not all women with disabilities or long-term illnesses however, identify as disabled or consider disability part of their identity. A woman who does identify as disabled in some cases may not do so in every situation – her decision is likely contextual. For example, when asked about any disabilities or long-term illnesses, Henrietta responded that she had been diagnosed with Type II Diabetes. While she is open with friends and acquaintances about her diabetes and has taught them what to do in the event of medical emergency, she appears to view her diabetes as a medical condition to be managed through diet and lifestyle versus part of a cultural or other identity. Furthermore, she appears to regard disability as the domain of people with sensory or cognitive impairments over people with long-term medical diagnoses. In another example, Wendy seemed uncertain whether her anxiety qualified as a disability or long-term illness. When asked whether she had any disabilities or long-term illnesses, she asked: “Well like is anxiety and that a disability?” Her anxiety and bad headaches sometimes limited the amount or type of activity she could undertake and people were aware of her anxiety, however Wendy did not feel that her anxiety was a factor in her third abusive

relationship—it arose as a result of her second abusive relationship—and it did not appear to factor into her identity.

Another complication with using disability as a form of categorization is that disability can change over time: a condition may flare up and recede, or become progressively better or worse over time. For example, Audrey spoke about the unpredictability of bipolar disorder and the ease with which one could be thrown into a depressive or manic state. She explained that the combination of finally being on the right medications and the use of effective coping strategies has helped to stabilize her condition.

The women in my sample spoke about how disability and ableism can impact support and help-seeking. Several women identified societal misconceptions and negative attitudes about disability as a barrier to accessing quality support and as a form of oppression operating in the lives of women with impairments who have experienced IPV. Zoë says:

I think that women with disabilities are looked at just like I said, with deficiencies, like they're not looked at as equal. Like if I tell someone that I have post traumatic stress disorder, they look at me like I'm crazy, right, so that is, that is... if I'm in an abusive relationship it's reinforcing what my abuser is doing. And if I'm not in an abusive relationship, it's setting the groundwork, you know. I think that the way society looks at and treats individuals with disabilities minimizes them as individuals. It is in fact a form of abuse all on its own, because they're treated as, separate from...

Several women in my sample commented on how such views can impact how disclosures of abuse are received. Wendy felt that women with disabilities in general

might be less likely to be believed when disclosing abuse, whereas Zoë indicated that type of disability might affect credibility: “if it’s a physical disability, then I think in those cases they’re more likely to believe them and get impassioned for them than if it’s a mental health disability”. Patricia spoke in more personal terms regarding reactions to disclosures of abuse from women with mental illness: “It made people think that, oh, it’s just the way she perceives it to be. It’s not really abusive. It’s just the way she’s perceiving it. They don’t trust my mental assessment of things.” Henrietta suggested that people might misread potential signs of abuse exhibited by people with less visible disabilities such as autism or ADHD, attributing their behaviour to their disability instead of behavioural responses to victimization.

In addition to impacting the credibility of women disclosing abuse, women indicated that negative societal attitudes can result in the use of disability as justification for abuse. Patricia felt that society tends to blame the person experiencing abuse. She said: “they’d rather believe women are playing into it themselves”, explaining that people who say that women whose children end up in care should be sterilized fail to acknowledge that the women may be victims themselves. Wendy expressed similar thoughts: “maybe they would use their disability as a factor why there is abuse in the relationship, whereas sometimes it doesn’t even matter if there was a disability or not”.

Women also discussed whether disability put women at risk or increased the likelihood of ending up with a dominating and jealous partner. Opinion ranged from a belief that women with sensory disabilities might be at greater risk as a result of a perceived inability to see or hear any warning signs to the belief that disability alone

was unlikely to increase risk. Zoë and others indicated that men with abusive tendencies would likely seek out women they perceived as weak, including women with disabilities given commonly held beliefs that disability equals deficiency. However, Zoë pointed out that the intersections of various factors are what likely increases risk of abuse for women versus a single factor alone:

Well I think that women with disabilities that don't have, again, that don't come from healthy backgrounds, right, cause I can only speak for myself and my own experiences and the women that I know who have, you know, been in addiction, who have not had family supports, who have come from dysfunctional homes, I think that an individual with a disability who comes from a very strong solid home and has a healthy foundation, again that's not gonna happen, you know, because regardless of their deficiency or disability, they're not gonna feel weak. They're gonna know their strengths because they're gonna have been implanted in them from a young age.

The effects of intersections of disability with other social dimensions are evident in the context of Patricia's concerns that her children are being abused in foster care. Despite her repeated efforts to raise her suspicions with authorities, she feels her concerns are being discounted. In this context, it appears that the intersections of various social dimensions served to locate Patricia as a poor, uneducated, emotionally unstable abused woman with a vengeance against CFS.

I went to the workers. I went to the top director. I phoned the police, everything and nobody will believe me, cause they think I just have a vengeance against CFS. Seriously. The cops told me that. They're like, oh you just something against CFS. You just want to make things bad for them. . . . I don't feel like I'm being taken seriously at all.

In addition, similar intersections appear to have contributed to her children being removed from her care in the first place. She makes reference to authorities putting more value in the words of an abusive man than an abused woman, to having had to sacrifice her children (to CFS) for her own safety, and to feeling like she is being punished for having spoken out the abuse she experienced both at a young age and in her marriage. Although genuinely concerned for the safety and well-being of her children, in the context of trying to bring her concerns to the attention of relevant authorities, dimensions of power and oppression served to marginalize Patricia and appear to have situated her as a nuisance to be dismissed rather than a credible and worried mother with valid concerns.

Separation and relationship status.

Marital status and separation do not appear to be straightforward terms or categories. For example, when asked the nature of their relationship to their most recent abusive partners, two women in my sample answered “wife” while another indicated her most recent abusive partner was her husband. All three women however, were separated from their husbands and had been for some time. One was in the process of divorcing her husband, another was legally separated, while the third woman was afraid to divorce her husband but was dating someone new. Practically and psychologically, their marriages were over (though the psychological effects of the IPV and episodes of abuse often persisted) however, the legal status of their relationships did not always reflect this. As a result, the way questions are framed or answered may lead to confusion as is evident in the following exchange:

Int.: And what is your relationship to your most recent abusive partner,
 your abusive partner?

Henrietta: I'm his wife.

Int.: So are you currently still married or separated?

Henrietta: We're still currently legally married.

Int.: Legally married. Okay.

Henrietta: But it's been a year, almost a year and half since the courts said legally separated, but we're still married.

Another complication with relationship status and separation is that women may separate and return to their partners several times before separating for good. Several women in my sample left and returned at least once before ending the relationship. Reasons for leaving and returning were varied. When Oonagh first left her husband, she did so for temporary reprieve and to effect change. She says "I didn't want to get a divorce, I just wanted him to go for anger management and to stop the hitting". Unfortunately, although her husband did stop his physically abusive behaviour, "the emotional, mental, financial abuse, the sexual abuse, that just tripled" (Oonagh). Zoë found she gained strength and perspective each time she left her abusive partner:

Zoë: when I got the balls to leave, it was more than just fighting back to stand up for myself, like to prove a point, it was fighting because it wasn't okay anymore. Because there needed to be a change, you know, not that I needed you to be sorry. I needed you to stop and if you can't stop, then go away.

Int.: So there was a shift in your ...

Zoë: In my thinking. But it was gradual, like as many times as I left, it was a little bit further to the left, do you know what I mean?

For Zoë, separation appears to have been a process of coming to terms with the fact that the abuse she was experiencing was not acceptable and of working up to the point where she could remove herself from the situation when it became evident her partner would not change. For Patricia, however returning to her abusive husband appears to have been a result of despair over the loss of her children:

Patricia: sometimes I withdraw right into my relationship because I believe that everything he did to me was right, because I had lost the children to CFS, went back with him. I figured he wants to punish me, go ahead. It was either that or suicide.

Int.: So you went back because ...

Patricia: Because I just got lost without my kids. And I felt like, geeze, you want to kill me, go ahead because you've already killed the best part of me.

Patricia also outlined other reasons a woman might return to an abusive partner after leaving:

Why does she go back? Because maybe the anniversary is coming up and she knows that he gets murderously angry on the anniversary. Right? Or maybe she knows that if she does leave, he's gonna take the kids, or accuse her of being an incompetent mother or even throw her into a mental institution. It's been done thousands of times.

Another complicating factor of separation is that violence does not always cease with separation, including geographic separation. Henrietta moved two provinces away from her husband to increase their geographic separation, however she still experiences harassment and abuse from afar. In contrast, Hiebert-Murphy et al. (2011) reveal that the meaning of separation can be complicated for women

who experience violence while still residing with an abusive partner, following the end of the relationship. For the women in my sample, experiences of separation were varied, as were their reasons for leaving or returning to an abusive partner proving that separation is not an easily defined or uncomplicated dimension.

Summary

My research has revealed that women with disabilities—both those in my sample and others as reported by the literature—may experience a variety of barriers when seeking support for experiences of IPV. Barriers for women in my sample included a lack of education and awareness regarding abuse, healthy relationships and human rights; lack of resources; lack of services; community size and dynamics; and potentially exclusive admission criteria. Applying an intersectionality framework to my analysis revealed the ways in which social contexts and intersections of women's multiple identities shaped their experiences of IPV, help-seeking, and support. Many of the dimensions that appeared to have an impact on the experiences and choices of the women in my sample (gender, cultural background, socioeconomic situation, disability) are also reported in the literature. For example intersections of gender, poverty, and cultural background are widely reported (Bograd, 2005; Hiebert-Murphy et al., 2011; Richie, 2005) while intersections of gender, poverty, and disability have been reported to a lesser extent (Hiebert-Murphy et al., 2011; Mays, 2006) in intersectional examinations of IPV. Religion however, does not appear to have been discussed in literature examining IPV using an intersectional framework. The narratives of two of the women in my study illustrate that the powerful messages religion provides women regarding their rights and obligations can shape how women understand the IPV they experience and influence their help-seeking actions

and experiences. Religious identity and affiliation should therefore be included in intersectional analyses of IPV as it clearly intersects with gender and other social dimensions to contextualize experiences of violence and support. My research also supports other findings regarding the fluidity of identity and the permeability and limitations of categories that have been presented in the literature. For example, my work builds on Hiebert-Murphy et al.'s (2011) discussion regarding the complexities of defining both separation and disability and of using those social dimensions as categories for analysis. Despite a sample size of only six interviews, my analysis produced rich material that supports and adds to existing literature.

Chapter 5: Conclusions

My research adds to the existing body of knowledge regarding experiences of IPV, help-seeking, and support among women with disabilities. It supports other findings of mixed experiences with support and barriers to accessing quality support as revealed in the literature. However, my research also addresses gaps in the literature by examining areas that appear to have received little attention thus far, namely what women with a range of disabilities themselves indicate could help in the prevention or intervention of IPV.

Implications

My research is important for several reasons. It furthers our current understanding of the social dimensions at play in the lives of women with disabilities who have experienced abuse. For example, my research reveals that religious affiliation may influence how women understand and respond to the IPV they experience and how others respond to abused women's efforts to secure support. By using an intersectionality framework I have shown that various social dimensions intersect to shape women's experiences of IPV, help-seeking, and support; neither a gender lens nor a disability lens alone could fully explain the contexts surrounding the experiences of the women in my sample.

My research also expands current knowledge regarding what women feel is needed, helpful, or desired when accessing support for IPV. The women in my sample spoke about the importance of support; a desire for more culturally-based services; the need for greater education regarding abuse, healthy relationships, rights, and disability; and the need for change in how society at large responds to

IPV and disability. Women identified barriers to support, such as a lack of affordable childcare and transportation and ideas for how to address them: provide childcare on-site during abuse and addictions programming, and provide affordable babysitter training for teens from low-income households. The narratives of the women in my sample also point to potentially exclusive shelter admission criteria; denying women support based on their mental health state not only leaves women without formal support when they are particularly vulnerable, but also ignores the relationship between mental health and IPV. As a result of the findings from my research, there may be implications for services such as a need to review policies and practices, to address discriminatory policies and gaps in service provision, and to explore collaboration with other organizations.

Recommendations

More education and awareness.

Greater education and awareness is needed in order to prevent IPV as was identified by all the women in my sample. The women's narratives also reveal that despite the advances that have been made over the past 30 to 40 years—as outlined by Stark and Buzawa (2009)—there is still much work to be done.

Education regarding healthy relationships, abuse, and rights should begin early in life and be carried out in an age-appropriate manner. Ideally abuse education would be incorporated into school curriculum, for example alongside health and or sexual education. This may require action on the part of provincial governments and school boards: the government may need to make abuse, relationship, and rights education mandatory, while school boards will be responsible for incorporating such

educational goals into their curriculum. Enforcement may be required. This type of education could be phased in during scheduled curriculum reviews. Education could also be done through extra-curricular activities such as recreation groups, guide troupes, etc., and / or through popular media.

In addition to greater abuse education, several women in my sample advocated for more education and awareness regarding disability in order to dispel stereotypes and misconceptions, to reduce stigma, and to reduce or eliminate barriers. On a societal level, increased disability awareness is needed to effect social change, while on a professional level greater awareness is required to improve service delivery for women with disabilities. Smith, Foley, and Chaney (2008) point out that counsellors are not immune to prevalent misconceptions regarding disability, class, and sexual orientation and may be unaware of the impact the intersections of these social dimensions with cultural background have on the lives of their clients. They advise counsellors to critically examine their own beliefs and assumptions regarding class, disability, and sexual orientation and to “confront their own ableism” (Smith et al., 2008, p. 306). Smith et al. (2008) also outline multiple ways to incorporate ableism, heterosexism, classism, and intersectionality awareness into counsellor education programmes. They say:

In clinical courses, counselors-in-training are typically taught such skills as reflecting, summarizing, and questioning. However, these skills alone may not allow counselors to comprehensively assess the effects of prejudice and social injustice in the lives of persons in oppressed populations. Educators can augment counselors' skills by introducing learning activities that illuminate the exploration of the multiple injustices and oppressions. (Smith et al., 2008, p. 307)

Other professionals and professionals-in-training, such as abuse service providers, child protection workers, law enforcement, and medical professionals, would also benefit from disability and intersectional education. Similar to Smith et al.'s (2008) suggestion for counsellors-in-training, awareness activities could be incorporated into the education and training programmes of other professionals. To reach professionals already in the field, disability awareness could be incorporated into in-service training and continuing education, especially for professionals for whom continuing education is mandatory. Employers could also incorporate "sensitivity training" into existing training protocols for new employees, including employees responsible for answering inquiries from potential consumers and the general public.

Improve access to childcare and transportation.

My research reveals a need for more affordable and accessible childcare and transportation options. Services should consider providing on-site childcare where feasible or at the very least inform themselves about affordable childcare options nearby so they can knowledgeably respond to any inquiries from women needing childcare in order to access their services. Consideration could also be given to the feasibility of providing counselling, education, or other programming to children while their mothers attend adult programming. Facilitating increased childcare and child programming may be achieved through collaboration with other organizations. For example, organizations might consider combining resources to achieve greater service delivery, and partnerships with early childhood education (ECE) programmes and / or ECE training programmes could be explored. In regions where volunteer service hours are required in order to graduate from high school, organizations could

advertise volunteer childcare positions through high schools. Ways to increase access to childcare training opportunities for low-income youth should also be explored.

Ways to assist women with access to transportation should also be explored by programmes and professionals, especially those serving women across or outside their geographic areas. Examples could include providing bus tickets to women who attend their programmes. Again collaboration may be a way of stretching limited resources and addressing a need for better transportation access; organizations could try to negotiate free, reduced cost, or bulk prices for bus tickets.

For some of the women in my sample, intersections of disability—and, in some cases cultural background—with poverty or low socioeconomic status resulted in limited access to transportation and childcare, which in turn limited access to support services. Considering that IPV may cause disability or exacerbate pre-existing conditions, affecting women's ability to work or to access employment opportunities, attention should be paid to women's financial situations and the indirect financial barriers they experience in accessing services. Providing accessible and affordable childcare and transportation to women with disabilities can help remove some of the barriers to securing formal support services during and post-IPV.

Greater collaboration between organizations.

Organizations should seek out opportunities to collaborate with other agencies. As highlighted in my review of the literature above, cross-referral and cross training may improve services' awareness of the various social dimensions shaping women's experiences of IPV, support, and help-seeking. Collaboration may also improve

service delivery, address gaps and funding shortages, and avoid duplication of services. For example, mental health organizations could work with abuse service organizations to increase abuse service providers' awareness of mental health, correct misinformation, highlight barriers women with mental health conditions experience when seeking support, and, if knowledgeable enough about IPV, outline how IPV can affect women's mental health. Abuse services could provide training for people working in the mental health field to increase their understanding of IPV, the protective strategies women can employ, and the types of abuse services available in their regions. Together the organizations could work to address the constraints under which each operate, the barriers presented by potentially exclusive shelter admission criteria, and other barriers to accessing services. By working together, they could also increase their knowledge of the other services to which they may refer women and identify gaps in service provision, including identifying women who are not receiving the services they require. Similar collaborations would be useful between other disability groups and abuse services to increase cross-disability awareness, however, for the women in my sample, increased mental health awareness was of particular concern.

Organizations may also be able to expand service provision, increase awareness, and improve the quality of service provision for marginalized populations through collaboration with educational institutions. For example, disability and mental health organizations could provide workshops or training regarding disability, mental health, and ableism to students in professional training programmes. Educational programmes for their part, could work with existing services to provide training opportunities for students with the aim of increasing their competence in serving marginalized populations as suggested by Smith et al. (2008):

Counselor education programs can further enhance students' professional preparation by establishing relationships with agencies and clinics that provide services to queer people of color. Not only would this benefit the community organizations by making counseling services more available to their clientele, but it would also create potential internship sites for students who may want to gain experience working with this population. (p. 308)

Although Smith et al. (2008) refer to collaboration between counsellor education programmes and organizations serving queer people of colour, similar collaborations between professional training programmes and disability organizations and cultural organizations could yield similar results for women with disabilities of various cultural backgrounds. As mentioned above, collaboration with educational institutions may also be a good way of addressing barriers to affordable childcare and transportation that impact access to abuse services for women with disabilities who have low incomes.

There is a need for more sustained funding for services to provide continuous and new programming; lack of programme funding was identified by at least one participant. Although current economic pressures mean that government and charitable funding is more apt to be cut than increased, services should continue to advocate for, and seek out, additional funding opportunities. Organizations may find that collaboration not only enables them to make more effective use of limited resources and funding dollars, but may—as pointed out by Swedlund and Nosek (2000)—result in the identification of, or access to, additional funding opportunities. Disability and mental health organizations may be able to identify potential sources of funding for abuse services looking to make their programmes and facilities more accessible, or together they may be able to apply for funding to run joint

programming. Aboriginal organizations, abuse services, and mental health organizations for example could consider working together to address the lack of funding that ended the Aboriginal sharing circles that one participant found useful. Collaboration between various organizations and educational institutions may help to resolve some of the barriers to support identified by the women with disabilities in my research.

Regular review and evaluation of policies, procedures, and practice.

Organizations should regularly review and evaluate their policies, procedures, and practices to determine whether there are any discrepancies between organizational mandate and practice. Critical regular review may also help identify any potentially problematic or exclusive policies and determine ways to address them. In addition, programme and service evaluation may reveal whether services are achieving what they set out to do. It would be beneficial to elicit feedback from clientele / consumers and possibly outsiders as they may better identify gaps or problems or reveal issues the organization being reviewed might overlook or to which it might be oblivious. For example, shelters and second stage housing services should include women with mental health diagnoses, including those with histories of suicidal and self-harming behaviour, in their organizational and programmatic reviews to determine the barriers such women have experienced in seeking shelter support. Although organizations may be reluctant to include women they may view as outside their purview or women to whom they have denied service—either outright or women they have asked to leave—the experiences of such women are apt to be revealing and may reveal discrepancies between mandates and practice or other barriers to be addressed.

Further research.

Further research is required to increase our understanding of the barriers to supports experienced by women in general and women of marginal populations in particular. Further research regarding what women want and find helpful in the prevention, intervention, and recovery from IPV is required to address gaps in current knowledge. Ideas for additional research include a further examination of women's experiences of IPV, help-seeking, and support, and their ideas for prevention using a larger sample. My secondary analysis of six interviews conducted with women with disabilities resulted in a wealth of data regarding experiences with support and ideas for prevention and healing. Given that few other studies appear to have explored what women with disabilities indicate could help them heal post-IPV and prevent IPV, further investigation of this area is required to broaden our knowledge. Research could examine these issues among women with specific types of disabilities including mental health disabilities or from a cross-disability perspective. Attempts could also be made to recruit women from both urban and rural areas to further explore the difference geography and community size play in women's help-seeking and access to services; regional disparities in services have been briefly identified in both my research and in the literature (Ristock, 2002). In addition, the experiences of Aboriginal and Inuit women, especially those from isolated or remote communities should be sought as women having to travel great distances to receive assistance will likely have unique perspectives and needs.

Particular attention should also be paid to any discrepancies between organizational policy and practice, including possible causes and solutions. Ways to address potentially exclusive admission criteria, such as those identified in my study—denying service to women with active addictions or current psychiatric

conditions—should also be examined. One way to achieve this would be through interviews and or focus groups conducted with service providers to determine the barriers they experience in providing more accessible and effective services and the constraints under which they operate.

More research regarding organizational collaboration would also be useful. Several studies have identified the potential for collaboration between organizations to result in more effective service provision for women of various marginalized groups. I have also recommended collaboration as a means to increase awareness of both IPV and disability, and to address gaps in service provision. An examination of recent examples of collaboration between agencies offering abuse services and organizations serving women from marginalized communities, such as women with mental health diagnoses, would shed more light on the role of organizational collaboration, its benefits and successes, its drawbacks, and any barriers to its undertaking. Additional research on collaboration may provide a way forward for organizations struggling to address service gaps with limited resources.

A final suggestion for further research is the role that early and accurate diagnoses of mental health conditions and access to appropriate and effective treatment and coping mechanisms play in women's experiences of IPV, help-seeking, and support. Women in both my sample and in the larger study from which my sample is drawn identified appropriate and effective treatment and coping skills as potentially protective factors. In addition, more than one woman indicated that had she been correctly diagnosed earlier on, she might not have experienced IPV or at least not the extent she did. It would be interesting to examine whether early diagnosis and treatment can help prevent IPV for women with psychiatric disabilities.

Limitations of my Study

As is the case with all research, there are some limitations to my study. One potential limitation is the fact that my research is a secondary analysis of interviews conducted with women with disabilities for a larger project in which the main focus of study was risk, not prevention. Although the style of interview enabled me to ask interviewees to expand upon their responses and to probe subjects that arose during the course of the interview, having only one question in the interview guide specific to IPV prevention might mean some important questions went unasked. Despite selecting interviews that provided me with a wealth of material relevant to my research focus and undertaking a detailed and thorough analysis, it is possible that more or different information might have arisen were the main focus of data collection experiences of support and ideas for prevention. In addition, as a result of selecting only a portion of the interviews conducted with women with disabilities as part of the larger project, interviews that did not meet my selection criteria but contained valuable content were excluded from my analysis.

Recruitment may have limited the breadth of my potential participant pool. As participants were recruited by publicizing the study through various community organizations, women who were extremely isolated and / or had no involvement with the organizations through which we recruited likely would not have had the opportunity to participate in the study. Although we tried to recruit a wide variety of participants, it is possible some women with unique perspectives were missed or elected not to come forward.

As a result of my small sample size and the qualitative nature of my research, my findings are not generalizable. That said, the research resulted in rich and detailed narratives that offer important insights into the experiences of IPV, help-seeking, and support among six women with disabilities.

Finally, this is my telling of others' stories. My research comprised quality data and thorough analyses and I remained conscious of my positioning throughout the research process, however it is worth revisiting Meekosha's reminders that the interpreting of others' realities is not unproblematic.

Concluding Remarks

In conclusion, my secondary analysis of six interviews conducted with women with disabilities explored women's experiences in accessing support for intimate partner violence and women's ideas for IPV prevention, intervention, and healing. My thematic and intersectional analyses revealed mixed experiences with both informal and formal sources of support, desired prevention and intervention strategies, barriers to accessing support, and the social dimensions (gender, cultural background, socioeconomic position, religion, disability, and relationship status) that impact women's experiences. Although much progress has been made over the past four decades, more work is needed to effect societal change and reduce the stigma surrounding IPV and disability and eliminate the barriers women with disabilities experience in seeking support. More abuse and mental health education and awareness; improved access to affordable childcare and transportation; greater collaboration between organizations; and regular reviews and evaluations of policies, procedures, and practice may offer a way forward.

References

- Barnes, C., & Mercer, G. (2004). Theorizing and researching disability from a social model perspective. In C. Barnes & G. Mercer (Eds.), *Implementing the social model of disability: Theory and research* (pp. 18-31). Leeds, UK: The Disability Press.
- Bograd, M. (2005). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic violence at the margins: Readings on race, class, gender and culture* (pp. 25-38). Piscataway, NJ: Rutgers University Press.
- Chang, J. C., Martin, S. L., Moracco, K. E., Dulli, L., Scandlin, D., Loucks-Sorrel, M. B., ... Bou-Saada, I. (2003). Helping women with disabilities and domestic violence: Strategies, limitations, and challenges of domestic violence programs and services. *Journal of Women's Health, 12*(7), 699-708.
doi: 10.1089/154099903322404348
- Dienemann, J., Glass, N., & Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14*(3), 215-233.
doi: 10.1177/1054773805275287
- Esterberg, K. G. (2002). *Qualitative methods in social research*. Montreal: McGraw-Hill.
- Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help-seeking: Implications for intervention. *Violence Against Women, 11*(3), 290-310. doi: 10.1177/1077801204271959

- Goodkind, J. R., Gillum, T. L., Bybee, D. I., & Sullivan, C. M. (2003). The impact of family and friends' reactions on the well-being of women with abusive partners. *Violence Against Women, 9*(3), 347-373. doi: 10.1177/1077801202250083
- Hattery, A. J. (2009). *Intimate partner violence*. Toronto: Rowman & Littlefield Publishers, Inc.
- Hiebert-Murphy, D., Ristock, J. L., & Brownridge, D. A. (2011). The meaning of "risk" for intimate partner violence among women in same-sex relationships. In J. L. Ristock (Ed.), *Intimate partner violence in LGBTQ lives* (pp. 37-55). New York: Routledge.
- Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development, 84*(2), 163-173. Retrieved from: <http://www.counseling.org/publications/>
- Josephson, J. (2005). The intersectionality of domestic violence and welfare in the lives of poor women. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic violence at the margins: Readings on race, class, gender and culture* (pp. 83-101). Piscataway, NJ: Rutgers University Press.
- Kirby, S. L., Greaves, L., & Reid, C. (2006). *Experience research social change: Methods beyond the mainstream*. Peterborough, Ontario: Broadview Press.
- Kocot, T., & Goodman, L. (2003). The Roles of coping and social support in battered women's mental health. *Violence Against Women, 9*(3), 323-346. doi: 10.1177/1077801202250075
- Keys, S. (2007). *Pamphlet accessibility and women with disabilities: An analysis of abuse-related pamphlets*. Unpublished.

- Lightfoot, E., & Williams, O. (2009a). Critical issues in researching domestic violence among people of color with disabilities. *Journal of Aggression, Maltreatment & Trauma, 18*(2), 200-219. doi: 10.1080/10926770802675684
- Lightfoot, E., & Williams, O. (2009b). The intersection of disability, diversity, and domestic violence: Results of national focus groups. *Journal of Aggression, Maltreatment & Trauma, 18*(2), 133-152. doi: 10.1080/10926770802675551
- Masuda, S. (with Ridington, J.). (1990). *Meeting our needs: Access manual for transition houses*. Vancouver, BC: DAWN (DisAbled Women's Network) Canada.
- Mays, J. M. (2006). Feminist disability theory: Domestic violence against women with a disability. *Disability & Society, 21*(2), 147-158.
doi: 10.1080/09687590500498077
- Meekosha, H. (2006). What the hell are you? An intercategory analysis of race, ethnicity, gender and disability in the Australian body politic. *Scandinavian Journal of Disability Research, 8*(2-3), 161-176.
doi: 10.1080/15017410600831309
- Moe, A. M. (2007). Silenced voices and structured survival: Battered women's help-seeking. *Violence Against Women, 13*(7), 676-699.
doi: 10.1177/1077801207302041
- Oliver, M. (2004). The social model in action: If I had a hammer. In C. Barnes & G. Mercer (Eds.), *Implementing the social model of disability: Theory and research* (pp. 18-31). Leeds, UK: The Disability Press.
- Olkin, R. (2003). Women with physical disabilities who want to leave their partners: A feminist and disability-affirmative perspective. *Women & Therapy, 26*(3), 237-246. doi: 10.1300/J015v26n03_05

- Raj, A., & Silverman, J. (2002). The roles of culture, context, and legal immigrant status on intimate partner violence. *Violence Against Women*, 8(3), 367-398.
doi: 10.1177/10778010222183107
- Richie, B. (2005). A black feminist reflection on the antiviolence movement. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic violence at the margins: Readings on race, class, gender and culture* (pp. 50-55). Piscataway, NJ: Rutgers University Press.
- Ristock, J. L. (2002). *No more secrets: Violence in lesbian relationships*. New York: Routledge.
- Ristock, J. (2005). Relationship violence in lesbian/gay/ bisexual/transgender/queer [lgbtq] communities: Moving beyond a gender-based framework. Retrieved from Violence Against Women Online Resources website:
<http://www.vaw.umn.edu/>
- Ristock, J. L., & Pennell, J. (1996). *Community research as empowerment: Feminist links, postmodern interruptions*. Toronto: Oxford University Press.
- Sherry, M. (2004). Overlaps and contradictions between queer theory and disability studies. *Disability & Society*, 19(7), 769-783.
doi: 10.1080/0968759042000284231
- Smith, J. (2008). *Bridging the gaps. Violence, poverty & women's shelters: An update on non/resources for women with disabilities*. Retrieved from YWCA Canada website: http://ywcacanada.ca/data/research_docs/00000056.pdf
- Smith, L., Foley, P. F., & Chaney, M. P. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling & Development*, 86(3), 303-309.

- Stark, E., & Buzawa, E. S. (2009). Set introduction. In E. Stark & E. S. Buzawa (Eds.) *Violence against women in families and relationships* (Vol. 1, pp. vi-xviii). Santa Barbara, CA: ABC-CLIO.
- Swedlund, N. P., & Nosek, M. A. (2000). An exploratory study on the work of independent living centers to address abuse of women with disabilities. *Journal of Rehabilitation*, 66(4), 57-64. Retrieved from <http://www.nationalrehab.org/cwt/external/wcpages/index.aspx>
- Thomas, C. (2006). Disability and gender: Reflections on theory and research. *Scandinavian Journal of Disability Research*, 8(2-3), 177-185.
doi: 10.1080/15017410600731368
- Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.
doi: 10.1177/1077800410383121
- W.I.S.H. Inc. (n.d.) *Referral Criteria*. [Web page] <http://www.wishinc.ca/events.php> (cited 9 June, 2011).
- Womendez, C., & Schneiderman, K. (1991). Escaping from abuse: Unique issues for women with disabilities. *Sexuality and Disability*, 9(3), 273-279.
doi: 10.1007/BF01102397

Appendix A: Perceptions of Risk Project Qualitative Interview

Guide

Introduction:

In this study we are interested in learning about how you understand or make sense out of the abuse that you have experienced in your intimate relationship. We want to try to understand two things. First, we want to know more about why you think the abuse happened in your relationship – for example, might there have been something about the situation that resulted in or supported the abuse, and second, what you think could be done to prevent the abuse of women in similar circumstances.

Questions and Probes:

1. Looking back, when you think about the abuse that you experienced, why do you think it happened? How do you make sense of the experience?

Possible Probes:

Do you think there were things in your life situation that might have increased your risk of being abused? (e.g., age, living situation, poverty, homophobia, racism, etc.)

2. What things (e.g., things about your partner, your circumstances, you) do you think are important to help understand the dynamics of abuse in your relationship?

Possible Probes:

What do you think it was about your partner that made it possible for him/her to abuse you? (alcohol use etc.)

Were there things in your partner's life that contributed to him/her behaving abusively? (experiences of racism, colonization, history of abuse)

Do you think that there were particular circumstances in your life that made it possible for you to be in an abusive relationship (some women may have fought back)? Do you think there were any circumstances in your life that protected you from further abuse?

3. Do you think that your partner had a particular motive for acting abusively? If so, what was it?

Possible Probe:

What do you think your partner hoped to get from behaving this way?

4. Do you think that some women are more at risk for being abused than other women? If you do, what do you think makes some women at greater risk?
5. How do you think that the fact that you have a disability/were separated/were in a lesbian relationship affected the pattern of abuse in your relationship? Do you think that your experiences would have been different if you did not have a disability/were not separated/were not in a lesbian relationship?

Possible Probes:

Do you think the fact that you have a disability/were separated/were in a lesbian relationship affected the way your partner behaved towards you? How?

Do you think that your partner would have behaved differently towards you if you didn't have a disability/weren't separated? Or How might your partner's behaviour have been different if you weren't in a lesbian relationship?

6. For women with disabilities (in heterosexual or same-sex relationships):

Some research suggests that women with disabilities have partners who are more likely to behave in a dominating, possessive, and jealous way than women who do not have disabilities? What do you think about that? Does this statement fit with your experience?

Do you think that the way society thinks about women with disabilities is a factor in understanding the abuse of women with disabilities by their partners?

For women who are separated (from heterosexual or same-sex partners):

Some partners who are not dominating, possessive, or jealous and do not behave abusively when living with their partner, act abusively when they are separating from their partner. Is this the pattern in your relationship? Why do you think some partners behave abusively only when they are separating?

7. Is there anything else that we haven't talked about that you think is important in understanding the abuse that you experienced?
8. What do you think could be helpful to prevent the abuse of women with disabilities/who are separated/who are in lesbian relationships?
9. Is there anything else that you would like to add?

Appendix B: Prevention, Intervention, & Support Summary Sheet

Research Questions:

- What have women with disabilities experienced when accessing support for IPV?
- What do women with disabilities indicate would be helpful in the prevention or intervention of IPV?

Summary Sheet - #___

1. Demographics

Age	Back-ground	Education	Occupat'n	Sex-uality	Family History of Abuse	Kids	# of IPV	Length of Relationship (vs Abuse)

Disability:

Activity Limitations?	Threaten to withdraw disability supports?	Threaten to tell others about your disability?

Types of violence experienced:

2. Experience with support

Family:

-

Friends:

-

Counselling:

-

Shelters & 2nd stage housing:

-

Other (Police, courts, addiction services, etc.):

-

3. Prevention/Intervention

Education/Awareness:

-

Diagnosis:

-

Support System:

-

Counselling:

-

Services (specify):

-

Other:

-

Protected her from further abuse:

-

4. Analysis

Barriers to assistance / intervention:

-

How disability affected access to support, intervention, ♀'s choice to remove self from harm

-

Ableism, societal perception of disability, etc.

-

Relationship between disability & abuse

-

Other identities / structures at play

-

Language, challenges to status-quo / binaries, contradictions, questions...

-

Context / Relationship Dynamics (briefly)

-

5. What stands out from the interview?