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***Title Page (including all authors in order of appearance, and acknowledgements)**

A Theory-based Primary Health Care Intervention for Women Who Have Left Abusive Partners

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Intimate partner violence (IPV), a pattern of physical, sexual and/or emotional violence by an intimate partner in the context of coercive control (1), is a global health and social problem affecting women from all economic, social, religious and cultural groups (2). In both Canada and the United States, 25-30% of women experience IPV in their lifetimes (1, 3), with women's risk intensifying after they leave their partners (4). IPV results in tremendous personal, social and economic costs (2), which continue even after women have separated from their abusive partners (5, 6).

The negative physical and mental health consequences of IPV for women are well-established (7, 8). Such health problems may be acute or chronic and arise from both injuries, often untreated and/or unhealed, and women's physical and psychological responses to trauma (9-11). IPV has been conceptualized as a traumatic stressor because the threats, coercion, and intentionally harmful actions experienced by women are typically unpredictable, horrific, beyond women's control and life-altering (12). The long-term physical and mental health effects of IPV-related traumatic stress have been linked to neuroendocrine changes, altered immune activity, psychological responses (13), and epigenetic changes which reflect accelerated cellular aging (14). The onset and course of these changes are affected by lifestyle behaviors and genetics (15). IPV trauma also may lead to increased health risk behaviors such as smoking, or substance abuse, or risk factors for HIV and/or sexually transmitted infections (STI's) that contribute to further health problems (8, 16). Childhood abuse and other forms of trauma may further compound the health consequences of IPV (17, 18).

Not surprisingly, women who have experienced IPV-related trauma are high users of services in many sectors, but particularly so in health care (5, 6, 19-21). Although health professionals are well positioned to support women who have experienced IPV, to date, the

dominant response within health care settings has focussed on identification of IPV and referral of women to domestic violence services. More comprehensive interventions, including those designed to support women in improving their health and quality of life over time, have yet to be widely integrated into health care. IPV is a complex problem that may be best addressed through collaboration across health, domestic violence, social service, and legal sectors and with community stakeholders, including women themselves. The development of interventions to support women who have experienced IPV has been identified as a priority for research. However, few tested interventions exist, particularly those that focus on women's lives beyond the crisis of leaving (22).

In a systematic review of interventions for women who had experienced IPV, Ramsay et al (2009) concluded that there is evidence that domestic violence advocacy (i.e. information and support to deal with abuse and to access needed services) results in improvements in quality of life, safety actions, social support and access to services and a reduction in violence, when delivered to women who sought help, particularly through shelters. Similarly, *brief* nursing interventions focused on providing women with information and support to guide problem-solving and decision-making related to IPV, have been associated with a reduction in violence and increased use of safety behaviors (24, 25) and, in one randomized clinical trial (26), with a reduction in depressive symptoms and improvements in physical functioning. In contrast, clinical trials of advocacy interventions focused on system navigation delivered by paraprofessionals (27, 28) or a support and problem-solving intervention delivered by social workers (29), did not result in improvements in women's health.

Collectively, these findings suggest that interventions focused on support, safety, and system navigation are important for women who have left abusive partners but may not be

sufficient to address the health consequences of violence. While there is evidence that cognitive behavioral therapy (CBT) is helpful in reducing the psychological effects of IPV (23), complex interventions which concurrently address women's safety, the physical and mental health consequences of IPV and social and economic challenges which create barriers to change, have not been developed and systematically tested. In particular, trauma-informed approaches which explicitly address the impact of interpersonal violence and victimization on a woman's life, health and development (30) are needed.

To address this gap, we developed the Intervention for Health Enhancement after Leaving (*iHEAL*)(31), a comprehensive intervention which draws on and extends findings of our program of research. Specifically, the grounded theory *Strengthening Capacity to Limit Intrusion*, captures conceptually what women do to survive, promote their health and move on with their lives after leaving an abusive partner (32-34). The *i*HEAL represents a clinical application of this theory in which the interventionist works alongside a woman to help her engage in the health promoting work associated with strengthening her capacity to limit intrusion. The longitudinal patterns of abuse, access to resources, health, and health service use experienced by abused women after separating from their partners documented in the *Women's Health Effects Study* (6, 11, 35-38) further sharpens the therapeutic health focus of the intervention.

Our purpose here is to provide a comprehensive overview of the *i*HEAL, detailing its underlying assumptions, guiding principles and structure. The theoretical basis of the intervention is presented, highlighting how the theory has shaped the central focus and the components of this health intervention designed for women who have separated from an abusive partner. Current feasibility and efficacy testing of this intervention is briefly discussed.

Theoretical Grounding of the *i*HEAL

The *i*HEAL is informed by a set of philosophical, assumptions and the theory of Strengthening Capacity to Limit Intrusion (SCLI) which, together, provide a broad frame of reference for understanding women's gendered experiences, including those related to health and health care, intimate partner violence, leaving an abusive partner, and the nature of the collaborative relationship between the woman and the interventionist.

Philosophical Assumptions

At the broadest level, this intervention is informed by philosophical assumptions drawn from feminism, woman abuse advocacy, health promotion, trauma-informed care, harm reduction, cultural safety, social justice and primary health care (39). These assumptions reflect the shared perspectives and values used in our ongoing program of research related to violence, women's health and health inequities. We assume that:

- IPV is sanctioned and enabled by broader social, cultural, and political structures that systematically oppress women, the poor, and those from non-dominant cultural backgrounds (40, 41).
- Leaving an abusive partner is a process, not a single event, and presents an opportunity to create a different kind of life (42).
- The experiences of particular women must be at the center of health care related to IPV. Although women have many commonalities, they are diverse; each woman and her experiences of IPV and health are unique.

- A lens of cultural safety (i.e. paying attention to how an individual or group is disadvantaged in social and health care contexts by historical, political, and social injustices)(43), is essential for practice with women who have experienced IPV.
- Trauma-informed care recognizes that seeking help can be emotionally unsafe and disempowering because the health care milieu (i.e. lack of control, sounds, sights, smells, actions) may trigger varying levels of anxiety and potentially re-traumatize (30, 31).
- Common responses to the traumatic stress of IPV include high risk health behaviors such as withdrawing from others, smoking, substance use, unsafe sexual practices, extreme involvement in work and parental responsibilities or self-neglect that may further jeopardize women's health. Harm reduction, an approach that focuses on reducing the health and social harms associated with risky behaviors, not eliminating behaviors (44), is a respectful, non-judgmental strategy for helping women who have experienced IPV.
- Women's health is socially determined by income and social status, education, social support, employment and working conditions, social environment, physical environment, personal health practices and coping skills, health services, childhood development, gender, and culture (45-47).
- Women and their children have the right to live safe, healthy, productive, autonomous lives and to participate fully in community life. A just and equitable society ensures that its citizens have reasonable access to the determinants of health that are modifiable, such as safe, affordable housing, quality education, and opportunities to earn a decent living (2).

- A primary health care approach, which seeks to develop an integrated system of acceptable, accessible, relevant, affordable services that address a range of issues important to health and that are delivered in local communities (48), is a cornerstone of safe, equitable services for women who have experienced IPV.
- Nursing approaches that are framed within a health determinants perspective, emphasize capacity building through collaborative relationships with women and across sectors, and view women within the context of family and community are well-suited to a primary health care approach to care for women who have experienced (49-51).

The Theory of Strengthening Capacity to Limit Intrusion

The substance and structure of the *iHEAL* are informed by the grounded theory S*trengthening Capacity to Limit Intrusion (SCLI),* which was developed to understand family health promotion after leaving an abusive partner through repeat interviews with 40 women and children (32-34). The theory captures the intrusive challenges women faced after leaving and the strategies they learned both to survive day-to-day and to strengthen their capacity to promote their health into the future. These strategies reflect women's efforts to create new lives after separation and, thus, apply not only to mothers but to all women who have separated from abusive partners.

In the theory, the central problem which women face in attempting to move beyond a life of abuse is *intrusion* -- unwanted interference from ongoing harassment or abuse, cumulative physical and mental health consequences of abuse, undesirable life changes such as reduced economic circumstances and social isolation, and the 'costs' (i.e. stress and conflict related to bureaucratic process and personal expectations) of getting help from family members, friends and 'the system'. Intrusion is often persistent and difficult to ignore; it places limits on

women's choices, derails them from working on their priorities, robs them of control and negatively affects their quality of life. After leaving, women typically experience multiple intrusive stressors that compound the negative health effects of violence over time.

Depending on the level and type of intrusion in their lives, women survive and gradually gain control over their lives by strengthening their capacity using four processes: providing, regenerating family, rebuilding security, and renewing self. *Strengthening capacity to limit intrusion* does not follow a predetermined trajectory but is an incremental process of change over time in response to intrusion and the woman's current priorities. To survive in the context of intrusion, women develop skills and knowledge to limit intrusion and build stability by taking risks to strengthen capacity for the future. Over time, reduced intrusion leads to enhanced personal control, enabling women to more proactively address long-term priorities, resulting in improvements in their health and quality of life.

How women engage in the 4 processes depends on the degree and type of intrusion. *Providing* includes *managing basics* and *managing symptoms* and involves securing and building the basic resources (income, safe housing, food, energy, health care, leisure, transportation and child care) needed to establish and sustain themselves over time, and seeking relief from symptoms and health problems. Stability in providing for basic needs and managing symptoms permits women to purposefully take risks to improve their future prospects for providing (for example, quitting jobs and going back to school, or incurring debt to acquire permanent housing). *Regenerating family* entails developing a storyline that helps the woman, family members and others understand her experiences of violence and why she left, and the challenges faced and strengths of the woman and her family as they try to develop a new life. The storyline helps to reinforce the necessity of developing new roles, rules and routines for

daily functioning so that they can more effectively deal with normative family conflict and chaos and survive on their own. As women gain confidence in working with others purposefully, they begin to name and use new standards for relationships within the family and with others. *Rebuilding security* includes *safeguarding* from threats to physical and emotional safety through vigilance, self-imposed isolation and pulling back from others, as well as *cautious connecting* with the larger community. *Cautious connecting* involves weighing the benefits and costs of relationships in terms of what they provide for the woman/family versus the intrusive demands or conditions that might come with such contact. *Renewing Self* focuses on working toward a more personally fulfilling future by making meaning of their past, making their personal needs and interests a priority, and developing ways of finding comfort and relief from everyday stress. As they gain confidence in themselves and their strengths, women are able to shift toward living better.

The six ways women strengthen capacity to limit intrusion (managing basics, managing symptoms, regenerating family, renewing self, safeguarding, and cautious connecting) provide the substantive focus for the components of the intervention (See Figure 1).

The Intervention

The goal of the theory-driven *iHEAL* is to improve women's health and quality of life after leaving an abusive partner by: a) reducing intrusion, and b) enhancing women's capacity (knowledge, skills, and resources) to limit intrusion. The *iHEAL* is a short-term (6 month) intervention designed for women who are past the initial crisis of leaving, but who are working through the transition of creating a life separate from their abusive partners. It is a primary health care intervention delivered by a nurse and a domestic violence advocate, working in partnership in the context of a larger team. The nursing role falls within the scope of practice of

a Registered Nurse. The intervention is designed to take place over six months through approximately 12 to 14 meetings with an interventionist (nurse and/or domestic violence advocate) in a safe, private community setting of the woman's choosing, typically in the woman's home or a community agency. Approximately 80% of the meetings are expected to be with a nurse, with some variation depending on the woman's needs and priorities. Interventionists validate the woman's values and strengths, listen, cognitively engage her in reframing the effects of abuse and, in an active problem-solving partnership, engage her in harnessing the system and building her skills and resources.

Intervention Principles

Ten principles provide a guide for how the interventionists and the woman will work through the *i*HEAL together (see Table 1). These principles were developed to provide a guide for how the more abstracts philosophical assumptions and theoretical concepts can be put into practice within the specific activities identified in the intervention. In essence, the principles provide a set of criteria which interventionists can use to critically reflect on, critique and envision how to support women in ways which are consistent with the goals, theoretical orientation and structure of the *i*HEAL. In this sense, the principles provide a structure for engaging in reflective practice, while supporting the creative development of approaches that are tailored to fit with the needs, preferences, context and priorities of each woman.

The *i*HEAL Delivery Model

The six month intervention follows a three phase relational process (see Figure 2):

Phase 1: Getting in Sync (2-4 meetings in the first month)

Phase 2: Working Together (8-10 meetings in months 2-5)

Phase 3: Moving On (1-3 meetings in the final month of the intervention)

Because any visit may result in emotional distress for the woman, interventionists debrief with the woman at the end of each visit, highlighting that, after any meeting, she may experience varying degrees of anxiety as a healthy stress response to talking about emotionally important issues within the context of a trauma history. Common signs of distress are reviewed and ways for her to manage these are discussed, with an emphasis on strategies which fit with her preferences and situation.

Women wishing to take part in the *i*HEAL complete an intake process in which information regarding their living situation, health, abuse history, safety risks and reasons for taking part in the *i*HEAL is collected. This information provides a basis for planning contacts that respect her physical and emotional safety, and for the initial work of "getting in sync".

Phase 1: Getting in Sync

The purpose of "Getting in Sync" is to establish a beginning level of trust and relationship between the interventionist and the woman and to discuss how they will work together. "Getting in Sync" is the main focus in the first month of the intervention, and typically takes place in 2-4 meetings, depending on the woman's needs and wishes. However, this process of engagement continues throughout the intervention as the relationship between the interventionists and the woman continues to develop. Because women may have overwhelming emotions and struggle intensely with trust issues, "Getting in Sync" requires mindful attention to women's responses on the part of the interventionist. This phase involves:

1. Broadly reviewing the intake data with the woman as a means of: a) getting a sense of her situation, b) emphasizing the health focus of the intervention, and, c) providing a vehicle for the woman to talk about what she hopes to gain from the *iHEAL.*

2. Introducing the theory of *strengthening capacity to limit intrusion* using handouts about types of intrusion, and a diagram of the theory (see Figure 1) in order to help the woman engage cognitively and begin to reframe her situation in light of other women's experiences of survival and health promotion. The theory is presented as rough road map outlining the territory other women have travelled (rather than a prescribed route), the common challenges and processes, and what was central in their ability to establish themselves, counter the abuse and move on with their lives. The theory helps to challenge some common assumptions about violence against women. For example, it highlights women's agency and strengths in the context of many intrusive challenges and does not dwell on personal deficiencies. Interventionists invite the woman's response to the theory, giving the woman an opening to tell her own survival story as she sees fit: "Do you see yourself here? How does this fit with your personal journey?"
3. Listening to the woman's story of survival in a manner that provides an opportunity for the woman to be heard and validated, provides a basis for tailoring the collaborative work, and begins the process of supporting the woman to express, expand, and evolve her personal storyline *safely*. Rather than probing for a detailed history of her lifetime trauma, the interventionists actively discourage her from sharing in such a way that creates more intrusion for her. The intent of the interventionist's open, respectful, empathetic listening is ***not*** to gather detailed descriptions of the trauma and abuse the woman has experienced but to begin to understand the intrusive *impact* of the trauma on the woman. Encouraging women to share detailed examples or incidences of the abuse or trauma could trigger PTSD symptoms for those who have not had the chance to fully develop their emotional safeguarding capacity. Instead, the goal is to discern

lifetime patterns of trauma and women's responses to trauma, and to begin to identify what remains important, meaningful, troubling, and unanswered for women related to the abuse they have experienced.

4. Reviewing the 6 components and possible ways of working together such that the woman gains a sense of how the interventionists might support her, understands that safety is a priority, and begins to think about her own health and identify what is most important to her. A handout that lists the six intervention components, their scope and what the woman might gain from each is used to guide the discussion.

Phase 2: Working Together

"Working together" involves focused work on each of the six components to achieve the goals of reducing intrusion and enhancing women's capacity to limit intrusion and improve their health and quality of life. The order in which the components are addressed and how much time is spent on each is determined by the woman. Typically, "working together" takes place over four months and involves eight to ten meetings. Guided by the 10 iHEAL principles, the interventionists work through each of 6 components using a consistent process of: 1) exploring intrusion, 2) sharing options, and, 3) strengthening capacities.

Exploring intrusion involves assisting a woman to frame her personal intrusive experiences within each component in light of what is known about other women's experiences of intrusion, drawing on the SCLI theory and research findings. A key goal is to help the woman gain awareness about how she and her situation are unique, while, at the same time, potentially gaining comfort from the knowledge that she is not alone in her journey; other women have had similar experiences and survived and there is something to be learned from their wisdom and experience. Focused discussion and standard tools are used to explore how the intrusion has

affected her, and what strategies she has tried to deal with intrusion. By helping a woman say how she would like things to be different, interventionists help her name her priorities and begin to envision a better life.

Sharing options involves collaboratively sharing more detailed information about what has worked for other women to build their capacity to manage and, where possible, eliminate problematic intrusion, and what has worked for the woman in the past. Strategies known to be more effective are discussed in light of what is available and what the women believes is possible. Interventionists help each woman to begin to name her capacities, strengths, resources and challenges as part of discussing her successes in managing difficult situations in the past. An important step in sharing options is helping the woman weigh the intrusive costs, risks and benefits of current and possible strategies, considering the tradeoffs so that she can take more calculated risks. This deliberation helps the women identify what she wants to do and what she will need in terms of knowledge, skills, and resources to accomplish those goals.

Strengthening Capacities focuses on supporting the woman to develop the knowledge, skills, and resources needed to enhance her health and quality of life. Depending on the woman's priorities and the decisions she makes in *sharing options*, interventionists may use a range of strategies (see Table 2).

Standard tools have been developed for each component to assist the interventionists and women explore intrusion, share options and strengthen capacity. Information tools are brief summaries of what is known from the theory and research about key issues faced by women; they help women "frame" their own experiences relative to other women and consider the types and intensity of intrusion in their lives. Assessment tools are structured activities such as a symptom diary or risk assessment that can be used to gather more in-depth information about a

particular issue or problem. Strategy tools support actions by helping women identify possible options, track their use of specific strategies and identify outcomes of those actions as a basis for reinforcing and/or changing directions. Some tools are required (such as a safety plan); others are optional (such as a symptom diary).

For each intervention component, we developed a guide outlining expected outcomes, key concepts unique to the component based on our research and other sources, and an illustrative script to guide the work between the interventionist and the woman. All six components are addressed and each required activity carried out but the length of time spent on the component, and the sequence is directed by the woman.

Safeguarding. The component most commonly addressed early in the 'working together' phase of the *i*HEAL is *Safeguarding.* Within Safeguarding, interventionists help women build their sense of security and limit their exposure to people or circumstances that threaten their physical and emotional safety. Central to the work of *safeguarding* is raising a woman's awareness of past and current patterns of intrusive threats, helping her anticipate, avoid and become more confident in her ability to safely manage crises and her emotional response to the crises. The Danger Assessment(7), a required tool, helps a woman to recognize her current and future safety risks from her ex-partner based upon the nature and pattern of past behavior. A comprehensive safety planning tool, which addresses a wide range of physical and emotional safety risks (e.g. safety at home, safety on the internet, safety and substance use) is reviewed as a way of generating discussion about safety strategies which the woman has put in place and additional strategies which may be helpful to her. Throughout *safeguarding*, the interventionist validates the woman's need and right to feel secure in her home and neighborhood, and reinforces her need and right to personal boundaries that may have been violated by well-

meaning but intrusive helpers and family. Emotional safety is addressed with all women by validating the terror and usual range of emotional responses to interpersonal trauma and reminding her that telling her trauma story may, at times, threaten her emotional safety, especially if she has not had the chance to build emotional safeguarding skills. When needed, interventionists assist the woman to develop emotional safeguarding strategies, such as relaxation routines and grounding skills, to better manage the emotional fallout of habitual stressors and more acute threats to her security. When community resources beyond the *i*HEAL are needed to help build women's sense of security, the interventionist coaches the woman to harness services in the system to better meet her security needs. This might include, for example, accessing advice from legal and/or domestic violence services to help the woman minimize safety risks associated with her ex-partner's legal right to access children or helping her investigate and choose a group program to refine her emotional grounding skills.

Managing Basics. Managing basics involves assisting the woman to secure and build the economic, material and personal energy resources needed to establish and sustain herself separate from the abuser over time. For any woman leaving a relationship, finding the material resources she needs can be a major struggle, but women leaving abusive relationships face unique challenges and intrusion. The abuser has often systematically undermined the woman's economic independence and credit rating, her sense of social credibility and status, damaged material possessions and sabotaged work opportunities and career advancement. Within *Managing Basics*, the interventionist shares how other women have experienced this sort of intrusive erosion of their resource capacity and confidence over time, and clarifies how other woman have found it hard but critical to name hopes, dreams and personal aspirations. Our research challenges dominant assumptions about basic needs by extending them beyond food,

shelter, and money to include energy, health care and leisure (32). In their struggle to survive post-separation, women often feel exhausted and beyond empty. Addressing intrusion that reduces energy and helping a woman find ways to gather and draw energy is key to helping her *manage basics*. The need for leisure is one basic that is often considered a luxury by many people, including service providers; this is an example of an area where advocacy by interventionists may be necessary, particularly given increasing barriers to low cost leisure facilities in Canada (52). The required *iHEAL* Basics Assessment tool is used to assist the woman to explore and redefine her basic needs, key sources of intrusion, immediate goals and hopes for the future (see Figure 2). Interventionists need a working knowledge of local health and social resources, women's rights and eligibility for services to help women more effectively navigate the system and build their capacity to manage the intrusion associated with getting the basic resources they need to survive and eventually thrive.

Managing Symptoms. Managing symptoms entails supporting the woman to identify her most intrusive symptoms and health problems and to build confidence in preventing and managing symptoms, both through self-care strategies and support from health professionals. Interventionists use a secondary prevention approach focused on early identification of the health consequences of IPV and interventions to enhance the woman's capacity to manage and prevent long term intrusive complications of chronic problems and, where possible, to eliminate the problem. Using the required *iHEAL* tool, *Common Health Problems After Leaving*, developed from findings of our longitudinal study of women's health in the early year after leaving, nurses assist the woman to identify on the tool the symptoms that are most intrusive to her and to choose three of these to explore in more depth using a second tool, Health Problem and Symptom History. The option of completing a symptom diary is provided to women who may

need more information about the pattern of intrusion symptoms (i.e. frequency, intensity, triggers, factors that affect symptom frequency and severity, impact on daily activities, medication use, and other therapies). Root causes of the health problems are discussed within the larger context of the symptom profile, the woman's trauma history as well as the woman's personal and family health history. This provides a basis for discussing possible strategies and resources and improving the match between women's needs and health resources. A series of brief documents, each of which summarizes current knowledge about a health problem (e.g. PTSD, chronic pain, fatigue) associated with trauma, along with best practice health management strategies, provide quick references to assist the interventionists in this work.

Cautious Connecting. Cautious connecting entails supporting the woman to enhance her instrumental support, sense of belonging and social connection. Importantly, interventionists help women identify key sources of intrusive relational strain and conflict within their immediate and extended network and to evaluate the costs and optimize the benefits of current and potential relationships with peers, extended family, social networks or formal service agencies. The social isolation and stigma associated with past abuse compounded by the leaving process itself, commonly results in usual support networks being disrupted and strained. Women are forced to make hasty connections to meet immediate needs before being able to establish trust or weigh the costs and benefits of the connection (32). For example, they may need to make child care arrangements under pressure so that they can work, or decide which of their new neighbors should be told about the abuse. Completing an Ecomap helps the woman appraise the pattern and quality of connections in her life, including the benefits and intrusive 'costs' of each. This sets the stage for learning about and working toward strengthening her network, considering when the conflict or difficulties in relationships might outweigh the benefits, and

examining relationships where guarding and withholding her trust is warranted and, indeed, healthy. Interventionists assist women to problem solve ways of addressing and possibly easing the strain in relationships important to her. Family of origin issues are sometimes important for women to explore and consider in light of their renewed support networks. Women often want to consider new partner relationships in ways that will help them avoid repeating 'past mistakes'. Interventionists work with women to develop strategies for harnessing available system, community and family supports to better meet instrumental needs and cultivate a sense of meaningful connection and belonging.

Renewing Self. Renewing self focuses on helping women turn inward and focus on personal restoration and the realization of a more personally fulfilling future. Abusive partners often ration and constrain women's personal time, and use touch to hurt and shame rather than soothe and comfort. Interventionists reinforce the woman's personal strengths and gifts as well as her need and right to love, comfort, personal time and the opportunity to develop herself as a person with a sense of purpose and meaning. Because public systems tend to devalue women's personal development while giving priority to the development of their parental and employment capacities, the interventionist may need to advocate for women making their personal needs a priority. Using the required *Renewing Mapping Tool*, the interventionist helps the woman to name her hopes and dreams, recognize her strengths and gifts, and identify the intrusion, particularly intrusive echoes of past abuse, that prevents her from realizing her potential. Women often get stuck in their abusive past trying to sort through "why me"? Within renewing self, the interventionist highlights how these intrusive abuse echoes constrained other women and how they have renewed themselves. Because some self-soothing and comforting strategies used to gain relief from distress can be destructive over time (for example,

overinvesting in work or parenting, overeating or fitness training, smoking, abuse of alcohol or drugs, or engaging in risky sexual practices), a harm reduction approach may be helpful. The interventionist needs to remind the woman to be patient with herself as it takes time to get in better touch with feelings, and regain a sense of value and purpose.

Regenerating Family. Regenerating family involves supporting the woman in constructing and modifying the family "storyline", finding functional ways to work together to meet everyday needs in a predictable way through rules, routines and new roles, and purposefully developing new constructive ways of getting along as a family unit or team. Women with and without children need help to identify who is on their team and how that team works together to accomplish daily household and family work. The work of regenerating family begins when women first begin to articulate their storyline in "getting in sync". Throughout work with the woman, the storyline is repeatedly reworked as her situation changes and she makes sense of her experience (34). Interventionists support women in creating public and private storylines that can be protective for them and significant others, particularly their children. For example, women may use the storyline as a rationale for routines, rules and new roles for family members needed to quell intrusion related to changes in lifestyle. As intrusion is reduced, the focus may intentionally shift to talking about and changing the standards for relationships among family members.

Phase 3: Moving On

"Moving On" takes place in the last month of the intervention and typically involves one or two visits. The goals are to: a) provide closure; b) name and emphasize the woman's capacities; c) help the woman reflect on changes in intrusion, health, and quality of life; d)

reinforce potential sources of support; and, e) end the relationship in a positive way that is fortifying for the woman.

The woman together with the interventionist reflects back on her life and health, including changes which have occurred while taking part in *i*HEAL. Moving on provides the opportunity to raise awareness about the progress she has made as a way of celebrating her successes, while also helping her consider what else she would like to achieve in her journey and how she plans to go about this. Moving on also provides a last opportunity for the interventionist to share any thoughts about remaining health concerns (no more than one or two) which were identified but not addressed, and to provide suggestions for the woman to follow up if she chooses. Facilitating a connection to other community services is an important aspect of moving on for many women. For example, a woman may not have asked to be referred to a local support group before, but now the interventionist could suggest that she might want to consider joining such a group. The intent is to leave the woman feeling fortified and as in control of her health and situation as possible.

Progress in Examining the Feasibility and Usefulness of the *iHEAL*

Two studies are underway in two different provinces in Canada with women who have separated from abusive partners from 3 months to 3 years previously. The first study, based in Ontario, is an independent pilot with a community sample of 30 women. A team of three nurses and one advocate hired specifically for the study are delivering the iHEAL in a large city and surrounding area. In addition to examining feasibility, initial efficacy of the iHEAL is being assessed by comparing changes in selected outcomes in the sample to those in a matched comparison group of 30 women from the same region who took part in our previous longitudinal study of women's health after leaving (36).

The second study is being conducted in New Brunswick with 50 women to determine the feasibility of adding the *iHEAL* to existing outreach services for abused women in two urban and two rural areas. This study is a partnership with Liberty Lane Incorporated (second stage housing for abused women), and the Government of New Brunswick (Women's Issue Branch and Department of Health). Outreach programs do not currently include health services, although this has been identified health as an important need. Four part-time nurses have been hired to work as partners with the domestic violence outreach worker in each of the four sites.

In both studies, all interventionists (nurses and advocates) took part in 30-40 hours of face to face team training using an intervention manual developed by the researchers. The manual includes an overview of the research study, the SCLI theory, and a description of each intervention component, including evidence to support that component. Illustrative scripts for working through the stages of each component and the required and optional tools are included. Standard protocols for recruitment, safety, debriefing, assessing suicide risk and providing follow up care are provided, along with standard forms for recording intervention activities and guidelines for use. In both studies, bringing all interventionists together during training facilitated team building and provided opportunities for them to identify individual and team strengths and their own support needs. During implementation, regular meetings (every two to three weeks) between the interventionists and researchers have been essential in reinforcing iHEAL principles and standardization of the intervention, addressing learning needs, and problem-solving unexpected challenges or complex situations, drawing on the breadth of expertise on the team.

In both studies, pre-intervention, post-intervention (6 months), and 6 month follow-up (12 months) measures of intrusion, health and quality of life are being taken with all

participants. Qualitative interviews with participants and all interventionists are also being conducted in order to explore issues of acceptability and feasibility and to identify strengths, challenges and gaps. Field notes are being used to capture key process challenges and decisions made during team meetings and will be used along with a chart audit to describe the process of delivering the intervention. In Ontario, the study sample has been recruited and the first participants are now completing the intervention. In New Brunswick, recruitment is in progress, with completion of the intervention expected by December 2011.

Learning Along the Way

Interventionists have been challenged to practice intentionally through the lens of the theory of Strengthening Capacity to Limit Intrusion and to use the theory language in their interactions with women. Enacting the *i*HEAL guiding principles and the philosophical assumptions has not been difficult for the interventionists who sought out these roles. However, becoming comfortable working the components through with women was initially awkward. They report that the language of intrusion has resonated with many women who are validated as they review the types of intrusion and see their experiences reflected in the theory. Interventionists have highlighted that the structure, clearly stated goals, activities and tools have been very helpful, particularly when working with women who are interested but feel hopeless and are facing multiple intractable stressors. Biweekly discussions among the interventionists have been helpful for sharing individual challenges and strategies and collectively problem-solving how to address these in ways that are consistent with the theory-based *i*HEAL.

The intervention has been developed for women who are beyond the immediate crisis of leaving, with the plan being to introduce the theory initially, and then reinforce it through each component according to women's priorities. Interventionists have found, however, that some

women who enter the study are facing immediate crises, such as housing or child custody issues, that make it challenging to work through the components of the *i*HEAL. The initial reaction of interventionists was to deal with the crises because these were the women's priorities, leaving introduction of the theory until the crisis abated; however, crises tend to evolve and continue for women after leaving. A related challenge has been clarifying that the *i*HEAL is not a crisis service and that interventionists are not able to respond as such – as well as helping women to learn how to access crisis services when needed. Over time, we have learned that framing the crisis in the language of intrusion and relating it to the appropriate component assists the woman to look at her options and build capacity. Furthermore, despite the primacy of the immediate crisis, often women strengthen their capacity to manage when other forms of intrusion are addressed. For example, a woman dealing with a housing or custody crisis may have high levels of anxiety and insomnia that interfere with her ability to think and problem-solve. Support from interventionists to identify and manage these symptoms through intentional use of relaxation or grounding strategies may assist her ultimately in dealing with the crisis.

In these and other situations, the intervention may not roll out as systematically as it appears in the manual. Over the course of their work together, interventionists are learning that delivering the *i*HEAL is complex and requires flexibility to shift between components and to adjust the pace so that components are covered in ways that best suit the individual woman's situation. There is a clear learning curve in terms of the interventionists' understanding of the theory and comfort in working with the components, which develops from actively engaging with the intervention.

Many of the interventionists have needed their practice strengthened to be better able to help women manage intrusive symptoms of PTSD. From our longitudinal study of women's leaving, we learned that although almost half of the 309 women in the study had at least mild symptoms of PTSD, with a significant number presenting with severe symptom levels. However, only 7% reported that they had been diagnosed with PTSD (38). Thus, many women who have left abusive partners do not receive formal help with PTSD symptoms. For nurses in generalist practice, the focus is on early identification of these symptoms and helping women to understand that their PTSD symptoms are not uncommon responses to trauma (31). The approach in the *i*HEAL is also to educate and help women better understand the nature of PTSD and its association with past trauma. While trauma reprocessing is beyond the scope of the *i*HEAL, interventionists help women build their emotional safeguarding skills and capacity to link their PTSD symptoms to triggers, manage intrusive anxiety, and re-engage in daily routines, social networks and physical activities. Women who have unstable co-morbid psychiatric symptoms and/or who require reprocessing of traumatic events, require specialist referral, as this is beyond the scope of the *i*HEAL. While follow up referral to such services is often appropriate, the availability of specialist trauma services is very limited in some regions and interventionists have been challenged to assist women to make appropriate and timely connections.

Conclusion

The *iHEAL* is an innovative, trauma-informed, primary health care intervention that addresses a gap in health services for women after leaving. The theoretical base derived from qualitative research with women after leaving grounds the intervention in women's experiences and offers a starting point for change that resonates with women. Nurses, advocates, and

researchers are challenged in this work to critically reflect on their understandings and assumptions about IPV and the health consequences of IPV, social factors that affect IPV and societal responses to it. Our ongoing studies provide an opportunity for: a) detailed assessment of the feasibility and acceptability of implementing this intervention as part of domestic violence outreach services or as a separate program with links to domestic violence and other services; and, b) evaluating the initial efficacy of the *i*HEAL in improving women's health and quality of life after leaving. Results of these studies will provide insights useful in refining the *i*HEAL prior to conducting a more rigorous, multi-site trial of this promising health intervention.

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Table Captions

Table 1. *i*HEAL Principles

Table 2. Interventionist Approaches to Strengthening Capacity

Table 3. *i*HEAL Components

Figure Captions

Figure 1. Theory of Strengthening Capacity to Limit Intrusion (SCLI)

Figure 2. The Basics Assessment Tool

Table

Table 1. iHEAL Principles

Principle	Focus
Safety First	Women's emotional and physical safety will be promoted in all interactions.
Health as Priority	Women's physical, mental, emotional, and spiritual health will be prioritized.
Woman-Centered	Women will direct the pace, what is given priority, and who is involved.
Strengths-Based	Women's strengths and capacities will be recognized, drawn upon and further developed.
Learning from Other Women	Women's own experiences of leaving an abusive partner and those of other women, as reflected in the theory of Strengthening Capacity to Limit Intrusion, will be a key source of knowledge to help them reflect on, reframe and name their experiences, concerns and priorities.
Woman in Context	Attention will be focused on each woman in the context of her family and network close relationships as she defines them.
Calculated Risks	Women will be supported to assess, judge and take calculated risks necessary for moving forward.
"Costs" Limited	The costs of getting help, including from the interventionists, will be assessed and limited.
Active System Navigation	Women will be helped to seek and obtain support from community resources and services, and to deal with the barriers she encounters.
Advocacy	The interventionists will work to reduce intrusion from community services and to advocate for improved system responses to women who are situated in varied contexts of social inequity.

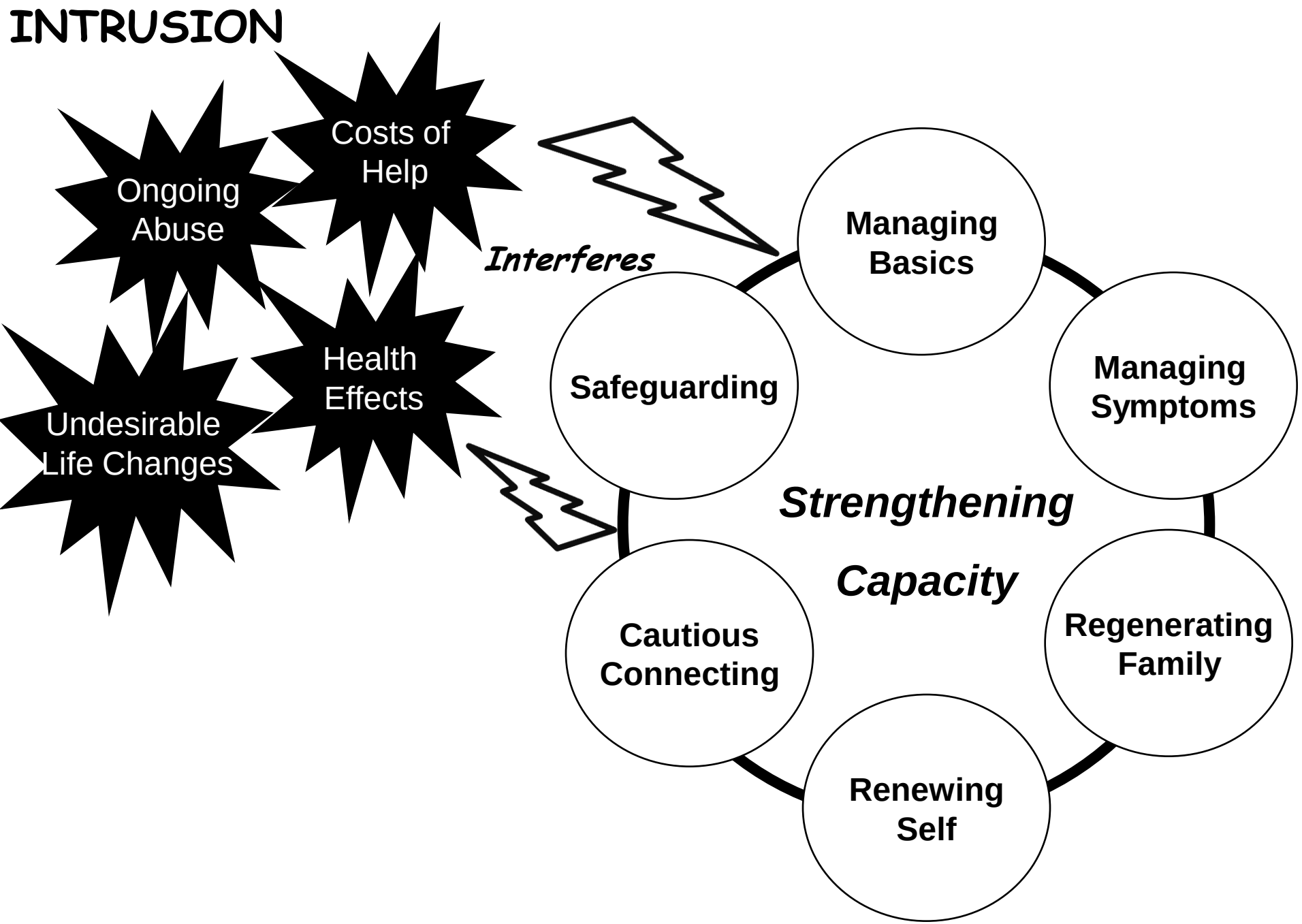
Table 2. Interventionist Approaches for Strengthening Capacity

Pacing	Knowing and responding to the woman, supporting her choices regarding if and when to proceed and helping her set time-limited goals.
Informing/Educating	Drawing on expert knowledge to provide tools, countering inaccurate information, and tailoring information to her context.
Acknowledging strengths	Helping her recognize and name her own expert knowledge, affirming her successes particularly in dealing with adversity, and reinforcing her abilities/capacities.
Coaching/guiding	Providing support for skill development, role play, and opportunities for her to use evolving skills.
Monitoring change/progress	Supporting her in reflecting on outcomes of efforts, effectiveness of resources, and revising plan as needed.
Connecting to services and resources	Helping her to obtain information on sources of practical support, supporting her in making needed contacts, and helping her to evaluate the "costs" of this help.
Advocating	Working with others to address structural or social barriers encountered.

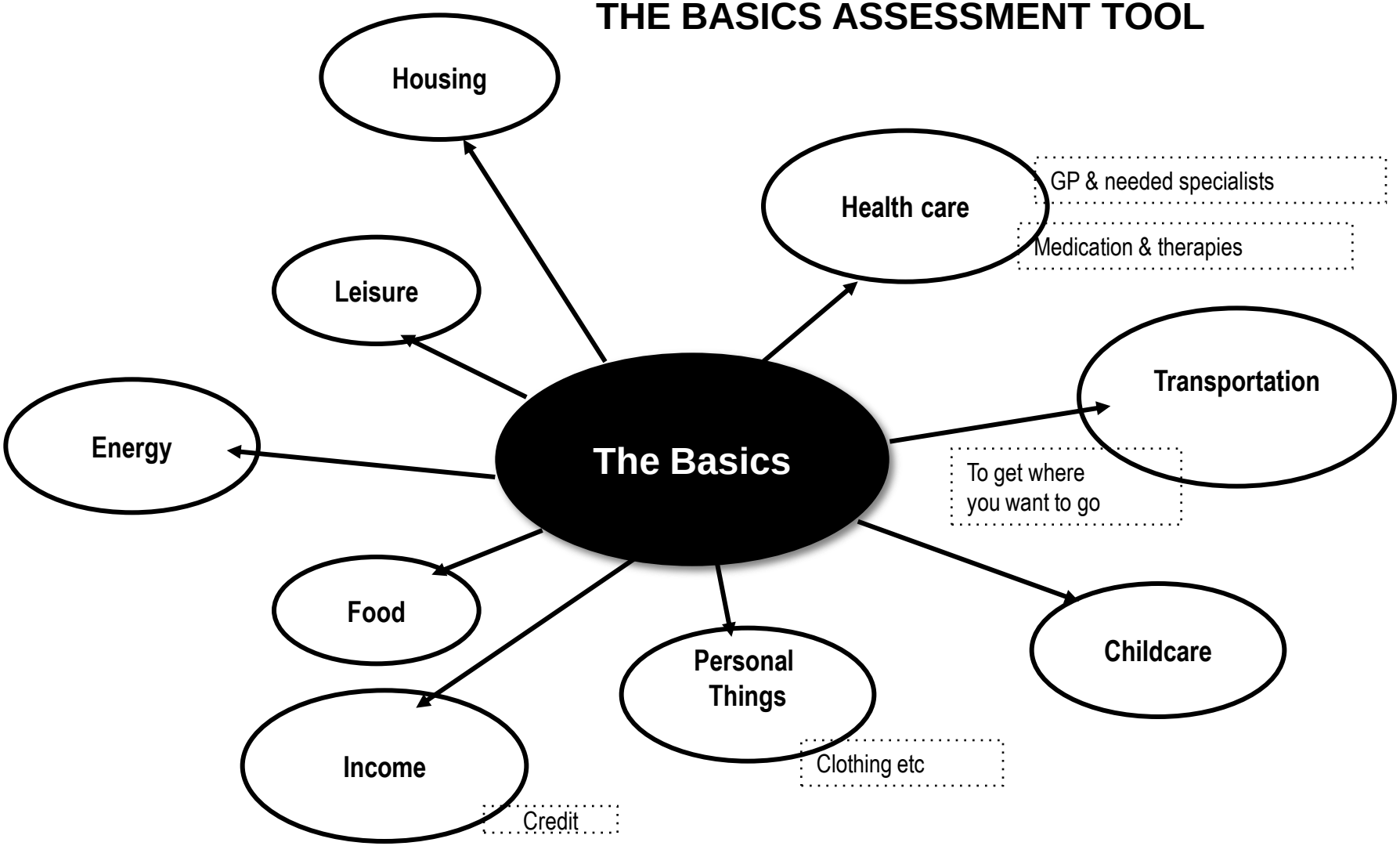
Table 3. *i*HEAL Components

Safeguarding	Assisting the woman to limiting her exposure and that of her family to people or circumstances that threaten their physical and emotional safety by assessing her sense of safety and developing strategies to manage risks and build her sense of security.
Managing Basics	Assisting the woman to secure and build economic, material and personal energy resources needed to establish and sustain herself separate from the abuser over time.
Managing Symptoms	Supporting the woman to identify her most intrusive symptoms and health problems and to build confidence in preventing and managing symptoms, both through self-care strategies and support from health professionals.
Cautious Connecting	Supporting the woman to enhance her instrumental support, sense of belonging and social connection by evaluating the costs and optimizing the benefits of current and potential relationships with peers, extended family, social networks or formal service agencies.
Renewing Self	Helping the woman to turn inward and focus on personal restoration, making meaning of their her past, and working toward a more personally fulfilling future.
Regenerating Family	Supporting the woman in constructing and modifying the family "storyline", finding functional ways to work together to meet every day needs in a predictable way through rules, routines and new roles, and purposefully developing new constructive ways of getting along as a family unit or team.

Figure


INTRUSION
Costs of Help
Ongoing Abuse
Health Effects
Undesirable Life Changes
Interferes
Managing Basics
Managing Symptoms
Regenerating Family
Renewing Self
Cautious Connecting
Safeguarding
Strengthening Capacity

THE BASICS ASSESSMENT TOOL



Major Issues:

Current Primary Goal:

https://dspace.org/

A theory-based primary health care intervention for women who have left abusive partners.

Ford-Gilboe, Marilyn; Merritt-Gray, Marilyn; Varcoe, Colleen; Wuest, Judith

2011

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